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Wydawnictwa Artystyczne i Filmowe,
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APOSTOLIC PENITENTIARY

Decree

Indulgences granted on occasion of the 14th. World Day of the Sick

The Supreme Pontiff Benedict XVI, motivated by the deep desire that human sickness and pain, borne with resignation and offered to the Eternal Father through the Virgin Mary together with the sufferings of her Son the Redeemer, may produce abundant spiritual fruits, and sustained especially by the hope that works and projects of Christian piety and social solidarity for the sick may be encouraged, particularly for those affected by some mental handicap who are more easily marginalized by society and by their own family, at the Audience granted to the undersigned Cardinal Major Penitentiary on 2 January this year, has disposed that special Indulgences be granted to the faithful as follows, on the occasion of the '14th World Day of the Sick', 11 February 2006, the liturgical Memorial of Our Lady of Lourdes, which will culminate in the Eucharistic celebration in the Cathedral of St. Francis Xavier in Adelaide, Australia.

A. A Plenary Indulgence is granted to members of the faithful who, on the usual conditions (sacramental Confession, Eucharistic Communion, prayers for the Holy Father's intentions) and in a spirit of total detachment from any inclination to sin, take part devoutly this 11 February in the Cathedral of Adelaide or in any other place established by the ecclesiastical Authority, in any sacred ceremony celebrated to implore from God the aims of the 'World Day of the Sick'.

The faithful in public hospitals or in any private home who charitably care for the sick as 'Good Samaritans', especially those who due to some mental handicap require greater patience, diligence and attention, and, because of their service are unable to take part in the ceremony mentioned above, will obtain the same gift of the Plenary Indulgence if on that Day, at least for a few hours, they generously devote their charitable assistance to the sick as if they were tending Christ the Lord himself (cf. Mt 25:40), in a spirit of total detachment from any inclination to sin and with the determination to fulfil as soon as possible the conditions required for obtaining the Plenary Indulgence.

Lastly, members of the faithful who, due to sickness, advanced age or other such reasons, are prevented from taking part in the above-mentioned ceremony, will obtain the Plenary Indulgence provided that, in a spirit of total detachment from any inclination to sin, with the intention of fulfilling the usual conditions as soon as possible and the desire to take part in spirit with the Holy Father on that day, they pray devoutly for all the sick and offer their physical and spiritual suffering to God through the Virgin Mary, "Health of the Sick".

B. A Partial Indulgence is granted to all the members of the faithful who, from 9 to 11 February 2006, at any time, address fervent prayers to God with a contrite heart, to implore the above-mentioned aims for the benefit of the sick.

This present Decree is in force for this occasion. Notwithstanding anything to the contrary.

Given in Rome at the Offices of the Apostolic Penitentiary, 18 January 2006, beginning of the Week of Prayer for Christian Unity.

Cardinal JAMES FRANCIS STAFFORD
Major Penitentiary

Rev. GIANFRANCO GIROTTI, O.F.M. Conv.
Regent

XIV World Day of the Sick

11 February 2006
St. Francis Xavier Cathedral
Adelaide - Australia

TO OUR VENERABLE BROTHER
CARDINAL OF THE HOLY ROMAN CHURCH,
JAVIER LOZANO BARRAGÁN,
PRESIDENT OF THE PONTIFICAL COUNCIL
FOR HEALTH PASTORAL CARE

From afar, we would like Our greetings to reach all sick people in the world, about whom We are always deeply concerned with an attentive mind and heart. We exhort all those who offer them due care. As the memorial of Our Lady of Lourdes, on which the World Day of the Sick will be celebrated, draws near, We take this opportunity to assure them of Our special closeness.

Knowing that these celebrations will take place in Australia, in the city of Adelaide, we would like to send a Cardinal to represent Us. You, Venerable Brother, are particularly qualified to fulfill this mission, since for many years you have with profound interest devoted yourself to the plight of sick people throughout the world, moreover you superbly lead the Pontifical Council for Health Pastoral Care as its President.

Since the special theme for this gathering is mental illness, We would like to show Our special charity to those people who so suffer, to their relatives, and to all brothers and sisters, who assist these patients with love and patience. Therefore, You Venerable Brother, will convey to them Our feelings and assurance of prayers for their needs. At the same time, you will kindly exhort all Christians and the leaders of religion and nations to recognise the dignity of each and every one of these afflicted, and do everything possible to protect that dignity.

Therefore, next February 11 you will preside over the liturgical celebrations in the city of Adelaide on Our behalf, and you will convey Our greetings to all. You will invite the believers in Christ who gather there to maintain a constant devotion to the Most Holy Virgin Mary, *Salus Infirmorum*, so that she implores from her Divine Son abundant graces; patience for those in difficulty and a truly outstanding degree of charity for everyone.

Finally, we wholeheartedly impart to you Our Apostolic Blessing, which you will, in turn, bestow upon those people who gather in the beautiful Cathedral of St. Francis Xavier on the World Day of the Sick.

From the Vatican, 6 January 2006, the First year of Our Pontificate.

BENEDICT XVI

Account of the XIV World Day of the Sick

ADELAIDE, AUSTRALIA, 8-11 FEBRUARY 2006

For its fourteenth version, the World Day of the Sick returned for the second time to Australia after the experience of 2001 in Sydney, when thousands of people took part in the Holy Mass celebrated in the Cathedral of St. Mary.

The preparations for the event in Adelaide involved the whole of the Australian Church and in particular the local Church of Adelaide, led by Archbishop Philip Wilson, who received the initiative with enthusiasm. The subject that the Bishops of Oceania wanted to examine at this event was 'Mental Health and Human Dignity'.

The Holy Father, in full harmony with the Bishops' Conference of Australia, wrote in his Message for the World Day of the Sick of 2006 that through the event of Adelaide the Catholic Church 'wanted to call the attention of public opinion to subjects connected with mental disturbance which by now afflicts a fifth of mankind and constitutes a real and authentic socio-health-care need'.

In expressing his own nearness to all people afflicted by mental disturbances and to those who provide inestimable service to them, especially in Oceania, the Holy Father appointed as his Special Envoy His Eminence Cardinal Javier Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care, who went to Australia accompanied by a group of people representing his Pontifical Council, under the leadership of its Secretary, H.E. Msgr. José Luis Redrado OH.

The Celebration of the World Day

As is by now a tradition, the celebration of the World Day of the Sick of 2006 in Adelaide also had three principal aspects: the doctrinal-scientific aspect; the pastoral aspect, and the liturgical aspect. Also of fundamental importance were the visits to places of treatment and care where the Special Envoy of Benedict XVI was able to touch with his own hands various aspects of pastoral care in health in the capital of southern Australia.

The visits to places of care

The celebration of the Holy Mass in the great chapel of the Calvary Health Care Hospital began the intense day of 8 February, which was marked by prayers and meetings that the Special Envoy of the Pope held with the health-care professionals and the agents of pastoral care in health of three important health-care centres in Adelaide.

After the Eucharist was over, Cardinal Lozano Barragán, accompanied by the delegation of the Pontifical Council, visited the modern departments of the Calvary Health Care Hospital: the maternity section, the surgery department, the oncological unit, and the hospice for long-term patients. The President of the Pontifical Council expressed his thanks and gratitude to the Sisters of the Little Company of Mary, who are in charge of this famous hospital structure in the city. This religious Congregation, which was founded in 1877 in England with the aim of serving very poor sick people, administers nine hospital centres in Australia. The work and the devotion of the Sisters to the sick and infirm is a confirmation of the fundamental role that the Catholic Church has had in bringing the Gospel of Life and Health to the population of the distant continent of Australia.

The second hospital structure visited by the delegation from the Vatican was the Women's and Children's Hospital, a hospital centre which is highly advanced in the prenatal diagnosis, the prevention, and the treatment of children's illnesses. This hospital treats and cares for children and young people who suffer from mental disturbances. This hospital is famous above all for its neonatal intensive care unit and it neurogenetics laboratory, which, indeed, enjoys international prestige.

The last place of care to be visited by the Special Envoy of the Holy Father was the Hutt Street Centre. This is a day centre, founded by the Daughters of Charity of St. Vincent de Paul, at which over two hundred homeless men and women are given help every day. Most of these people are victims of mental disturbance brought about both by a complex family situation and by alcohol and drug addiction. In addition to medical doctors, psychologists and social workers, hundreds of voluntary workers offer their service free every day at this centre. This structure is the flagship of the charitable activity organised by the Archdiocese of Adelaide.

The day of study

On Thursday morning, 9 February, over three hundred people gathered together at the modern Convention Centre of Adelaide to take part in a day of study on the subject 'Mental Health and Human Dignity'

After the presentation of the proceedings by Dr. Francis Sullivan, the Director of Catholic Health Care Australia, which is an association of the Catholic health-care institutions of Australia, the Special Envoy of the Holy Father officially opened the conference on the scientific analysis of the state of mental illnesses and the mentally ill in the world and in particular in Australia.

In his prolusion Cardinal Lozano Barragán expressed the concern of the whole of the Church about the alarming figures on mental disturbance,

which, indeed, is continuing to grow in all parts of the world, and emphasised the urgent need for joint action by governments and civil society. All government institutions are called to intensify their efforts on behalf of people who suffer from mental disturbance because 'every mentally ill person is a creature of God who faithfully reflects the image of the crucified Christ'. The President of the Pontifical Council for Health Pastoral Care accompanied his paper with the results of research carried out by the Pontifical Council itself based on eighty-four centres for the mentally ill. From this survey it emerged, *inter alia*, that in the spread of mental illnesses cultural and religious factors, which are themselves characterised by a profound crisis of values of reference, play an important part.

The second speaker, Prof. Ian Hickie, the Director of the Brain and Mind Institute and Professor of Psychiatry at the University of Sydney, discussed the situation of mental illness in Australia and exhorted the political authorities to make a greater economic contribution to non-governmental agencies.

This was followed by the moving testimony of Ann Deveson, a member of the Mental Health Review Tribunal and the mother of a child with schizophrenia who committed suicide at the young age of twenty-five. This painful experience led Mrs Deveson to create an association for the relatives of people afflicted by schizophrenia with the aim of improving their quality of life.

The afternoon session of the conference was opened by Garry McDonald, a famous Australian actor and a member of the Byondblu Association which addresses questions connected with depression. It is significant that in Australia the most incapacitating illness is not cancer but depression: a million adults and a hundred thousand young people suffer from this malady.

This talk was followed by papers by Rev. Peter Comensoli, an export in moral theology of the diocese of Wollongong; Dr. Prue McEvoy, President of the Council for the Defence of Children of the Archdiocese of Adelaide, who spoke on the mental health and emotional wellbeing of pregnant women as fundamental elements in the future development of children; and lastly Msgr. David Cappo, the Vicar General of the same archdiocese who in his paper 'Towards, Where, From Here?' outlined the pastoral strategies that the local Church must implement, beginning specifically with the observations to emerge during the proceedings of the World Day of the Sick in Adelaide 2006.

The pastoral day

On Friday morning, 10 February, at the Convention Centre of Adelaide, the Special Envoy of Benedict XVI met two-hundred and fifty pastoral workers of the Archdiocese of Adelaide together with their invited guests.

In his introductory speech, Cardinal Lozano Barragán presented the general vision of pastoral care in health in the Church and emphasised that in Oceania two thousand and sixty-four health care structures are currently active. In carrying out their mission they are today encountering new difficulties: 'Pain, suffering and death are hidden or presented in a distorted way…religious personnel are decreasing, Orders and Congregations have had to leave some hospitals because they no longer had the people to run them. In addition, very many problems of an economic, scientific, technical and political character have arisen because of the contemporary needs and requirements of medicine and because of the approach adopted by various governments'. In the face of these problems, the President of the Pontifical Council for Health Pastoral Care emphasised four aspects: 'to offer an orientation on the value of health, pain, illness and death'; 'to unite all the agents of pastoral care in health'; to enter into contact with the local Churches, and with international, national and local organisations'; and 'to achieve a constant scientific, technical, juridical and political up-dating'. Effective pastoral care in health must be based upon these priorities, to which should be added 'the sense of responsibility and the strong religious motivation of each person that is involved in the provision of such care'.

A moment of key awareness was represented by the words of Shirley Peisley, who is involved in the evangelisation of the Aborigines of Kauma and who spoke about the various initiatives by which the Christian message is being spread amongst that people.

The paper of Magde McGuire also commanded much attention. Magde McGuire is the director of Catherine House, a structure in southern Australia which provides accommodation and care to women suffering from mental disturbances and to women addicted to alcohol and drugs, of whom 95% suffered from sexual abuse when they were children. Sister Julie Dean, of the Congregation of the Sisters of Mercy, who provides pastoral service at Catherine House, observed that in that centre hard work is engaged in to find some kind of social response for these girls who are afflicted by mental disturbance.

Pat Peake and Annie Boots, of the organisation 'Southern Cross' described their experiences with elderly people, above all those elderly people afflicted by dementia. Other papers were given by a person in charge of spiritual assistance at the women's prison of Adelaide and by a mother and father who talked about the daily experience of living with a schizophrenic child.

In the afternoon those taking part in the seminar met in work groups co-ordinated by Sister Clare Condon and Francis Sullivan in order to draw up an 'action plan' to harmonise all pastoral care for the mentally ill at a local, diocesan and national level.

At the same time, the guidelines for pastoral care in heath were proposed again during the meeting of the Special Envoy of the Holy Father with the Bishops of Oceania. All the bishops resident in Australia and also two from Papua and

New Guinea came to this meeting. At this meeting the Bishop-Secretary of the Pontifical Council for Health Pastoral Care and its priest Officials were also present. During the fraternal and confidential discussion the following burning problems connected with pastoral care in health in Oceania emerged: secularisation, the lack of women religious in Catholic care centres, the fight against the introduction of the morning after pill; and the questions connected with biogenetics.

The liturgical day

The solemn celebration of the Eucharist of 11 February, the liturgical memorial of the Blessed Virgin Mary of Lourdes, took place at the Catholic cathedral of Adelaide, which is dedicated to St. Francis Xavier.

The following people concelebrated with the Special Envoy of Benedict XIV: Cardinal George Pell, Archbishop of Sydney; Philip Wilson, Archbishop of Adelaide, and about twenty representatives of the Australian Episcopate; Archbishop Ambrose B. De Paoli; Bishop José L. Redrado Marchite, Secretary of the Pontifical council for Health Pastoral Care; brothers of the dioceses of Oceania; and Bishop J. Paul Marx and Bishop Francesco Sarego of Papua New Guinea. A large number of priests of the clergy of Adelaide were concelebrants, for example; Msgr. James O'Loughlin, parish priest of Salisbury, and Msgr. Vincent Tiggeman, Emeritus Judicial Vicar; members of the delegation of the Holy See; and the Vicar General of the Archdiocese Msgr. David Cappo. With them there were also the Officials and the collaborators of the Pontifical Council for Pastoral Care in Health who had come to Australia with the Cardinal-President.

After his welcome to the assembly given in the name of the Aborigine population of Kauma, the Archbishop of Adelaide read the letter of the Pope appointing the President of the Pontifical Council for Health Pastoral Care his Special Envoy for the celebrations of 11 February. Through his close collaborator and by a special indulgence issued for those who took part in the Eucharist, the Holy Father made himself spiritually present amongst the faithful who had gathered in the cathedral.

In his homily Cardinal Javier Lozano Barragán, after giving the very affectionate greetings of the Holy Father to those taking part in the World Day of the Sick, emphasised that through this event the Church sought 'to underline the inviolable dignity of mental disabled people and to strive the defend that dignity at any cost, from a cultural point of view as much as from an institutional, family and individual point of view'. The performance of this task, explained the Special Envoy of Benedict XVI, imposes on all Catholic health workers a precise commitment 'to have their own mental equilibrium, indeed the greatest possible, and thus to be strongly anchored in a solid objective system of values'.

Afterwards the assembly of about a thousand faithful raised up prayers and songs, animated by the choir of the cathedral, asking the Holy Spirit to descend upon the Church and to fill those who suffer with consolation. The visible sign of this spiritual consolation was the Sacrament of the Anointing of the Sick which the Special Envoy of the Pope and the Archbishop of Adelaide administered to thirty people afflicted by mental disturbances.

Before imparting the solemn blessing, Cardinal Lozano Barragán said the prayer that had been specially written for the World Day of the Sick in Australia, and called on Mary, Mother of God and our Mother, 'not to leave us alone on our journey' and 'to help us to create in the world of health, of illness and of suffering, friendly and healthy relationships that are full of hope and love'.

The cathedral was full of the faithful and many took part in the rite through large screens that had been placed outside. Reference should be made to the presence of three great international health-care federations: the FIAMC (Catholic medical doctors), represented by Dr. Michael Shanahan; the CICIAMS (Catholic nurses), represented by its President Mrs An Verlinde; and the FIPC (Catholic pharmacists), represented by Dr. Pauline La Siew Mei.

Conclusion

The celebration of the XIV World Day of the Sick in Australia was a strong moment to call the attention of civil society to people who are afflicted by mental disability, and the Church made herself their spokesman in relation to the governors and the civil institutions of the state. In this area there were promising meetings with the highest civil authorities of southern Australia: the Prime Minister, the Minister for Health, and the Mayor of Adelaide. Each meeting was a valuable opportunity to focus in on various subjected connected with the field of mental health. The President of the Pontifical Council for Health Pastoral Care expressed cordial greetings to all the authorities on behalf of the Holy Father and thanked them for having contributed to the excellent unfolding of the World Day of the Sick. Alluding to the first encyclical of Benedict XVI, the Special Envoy referred to the value of marriage and the family founded on love, the inescapable foundations of a healthy society.

Rev. DARIUSZ GIERS
Official of the Pontifical Council for Health Pastoral Care

Address of His Holiness Benedict XVI to the Sick at the End of the Mass in the Vatican Basilica, in Memory of the Blessed Virgin Mary of Lourdes on the Occasion of the XIV World Day of the Sick

SATURDAY, 11 FEBRUARY 2006

Dear Brothers and Sisters,

I join you with great joy and I thank you for your warm welcome. I greet you in particular, dear sick people who are gathered here in St Peter's Basilica, and I want to extend my greeting to all the sick who are following us on radio or television, and those for whom this is not possible but who are united with us by the deeper ties of the spirit, in faith and in prayer.

I greet Cardinal Camillo Ruini who has presided at the Eucharist, and Cardinal Francesco Marchisano, Archpriest of this Vatican Basilica. I greet the other Bishops and priests present. I thank the National Italian Union for Transporting the Sick to Lourdes and International Shrines (UNITALSI) and the *Opera Romana Pellegrinaggi,* which arranged for and organized this meeting with the help of numerous volunteers.

I am also thinking of Australia on the other side of the globe, where Cardinal Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, presided a few hours ago in Adelaide at the main celebration of the *World Day of the Sick.*

Fourteen years ago, 11 February, the liturgical Memorial of Our Lady of Lourdes, became World Day of the Sick. We all know that the Virgin expressed God's tenderness for the suffering in the Grotto of Massabielle. This tenderness, this loving concern, is felt in an especially lively way in the world precisely on the day of the Feast of Our Lady of Lourdes, re-presenting in the liturgy, and especially in the Eucharist, the mystery of Christ, Redeemer of Man, of whom the Immaculate Virgin is the first fruit.

In presenting herself to Bernadette as the Immaculate Conception, Mary Most Holy came to remind the modern world, which was in danger of forgetting it, of the primacy of divine grace which is stronger than sin and death. And so it was that the site of her apparition, the Grotto of Massabielle at Lourdes, became a focal point that attracts the entire People of God, especially those who feel oppressed and suffering in body and spirit.

"Come to me all of you who labour and are heavy laden, and I will give you rest" (Mt 11:28), Jesus said. In Lourdes he continues to repeat this invitation, with the motherly mediation of Mary, to all those who turn to him with trust.

Dear brothers and sisters, this year, together with my collaborators at the Pontifical Council for Health Pastoral Care, we wished to focus attention on people affected by mental illness. "Mental health and human dignity" was the theme of the Congress that has taken place in Adelaide, at which the scientific, ethical and pastoral aspects were also examined.

We all know that Jesus stood before man in his wholeness in order to heal him completely, in body, mind and spirit. Indeed, the human person is a unity and his various dimensions can and must be distinguished but not separated. Thus, the Church too always proposes to consider people as such, and this conception qualifies Catholic health-care institutions as well as the approach of the health-care workers employed in them.

At this time I am thinking in particular of families with a mentally-ill member who are experiencing the weariness and the various problems that this entails. We feel close to all these situations, especially where legislation is lacking, public structures are inadequate and natural disasters or, unfortunately, wars and armed conflicts are producing in people serious psychological traumas. These are forms of poverty which attract the charity of Christ, the Good Samaritan, and of the

Church, indissolubly united with him in her service to suffering humanity.

I would like today to present symbolically to all the doctors, nurses and other health-care workers and all the volunteers involved in this sector the Encyclical *Deus Caritas Est,* in the hope that God's love will always be vibrant in their hearts so that it will enliven their daily work, projects, initiatives and especially their relations with the sick.

By acting in the name of charity and in the style of charity, dear friends, you also make a precious contribution to evangelization, for the proclamation of the Gospel needs consistent signs that reinforce it. And these signs speak the language of universal love, a language that is understandable to all.

In a little while, to recreate the spiritual atmosphere of Lourdes, all the lights in the Basilica will be switched off and we will light our candles, symbols of faith and of the ardent invocation of God. The singing of the *Ave Maria* of Lourdes will invite us to go in spirit to the Grotto of Massabielle, to the feet of the Immaculate Virgin.

With profound faith let us present to her our human condition, our illnesses, a sign of neediness that is common to us all as we journey on in this earthly pilgrimage to be saved by her Son Jesus Christ. May Mary keep our hope alive so that, faithful to Christ's teaching, we renew the commitment to relieving our brethren in their sickness. May the Lord ensure that no one is alone or abandoned in a time of need, but, on the contrary, can live illness too in accordance with human dignity. With these sentiments, I wholeheartedly impart my Apostolic Blessing to you all: sick people, health-care workers and volunteers.

Angelus

SAINT PETER'S SQUARE, SUNDAY, 12 FEBRUARY 2006

Dear Brothers and Sisters,

Yesterday, 11 February, the liturgical Memorial of Our Lady of Lourdes, we celebrated the World Day of the Sick. This year its most important events took place in Adelaide, Australia, and included an international Congress on the ever pressing topic of mental health.

Illness is a typical feature of the human condition, to the point that it can become a realistic metaphor of it, as St Augustine expresses clearly in his prayer: "Have mercy on me, Lord! See: I do not hide my wounds from you. You are the doctor, I am the sick person; you are merciful, I am wretched" (Conf. X, 39).

Christ is the true "Doctor" of humanity whom the heavenly Father sent into the world to heal man, marked in body and mind by sin and its consequences. On these very Sundays, Mark's Gospel presents Jesus to us at the beginning of his public ministry, totally involved with preaching and healing the sick in the villages of Galilee. The countless miraculous signs that he worked for the sick confirmed the "Good News" of the Kingdom of God.

Today's Gospel tells of the healing of a leper and expresses most effectively the intensity of the relationship between God and man, summed up in a wonderful dialogue: "If you will, you can make me clean", the leper says. "I do will it; be clean", Jesus answers him, touching him with his hand and healing him of leprosy (cf. *Mk* 1:40-42).

We see here in a concise form the entire history of salvation: that gesture of Jesus who stretches out his hand and touches the body covered with sores of the person who calls upon him, perfectly manifesting God's desire to heal his fallen creature, restoring to him "life in abundance" (cf. *Jn* 10:10), eternal life, full and happy. Christ is "the hand" of God stretched out to humanity, to rescue it from the quicksands of illness and death so that it can stand on the firm rock of divine love (cf. *Ps* 39:2-3).

Today, I would like to entrust all the sick to Mary, "*Salus infirmorum*", especially sick persons in every part of the world who, in addition to the lack of health, are also suffering loneliness, poverty and marginalization. I also address a special thought to those in hospitals and every other health centre who care for the sick and spare no effort for their recovery.

May the Blessed Virgin help each one find comfort in body and spirit through satisfactory health-care assistance and fraternal charity, expressed by means of practical and supportive attention!

Homily of Cardinal Javier Lozano Barragán, Special Envoy of the Holy Father for the XVI World Day of the Sick, During the Celebration of the Eucharist in the Cathedral of St. Francis Xavier in Adelaide, Australia

11 FEBRUARY 2006

Your Eminences, your Excellencies, in particular His Grace Archbishop Philip Wilson, Archbishop of Adelaide, I convey to you the most fervent greetings of the Holy Father, Benedict XVI.

The Holy Father asked me to bring his warmest greetings to all of you dear priests, religious sisters and brothers participating in this memorable liturgical celebration, to all health care professionals here present, to all the people of God gathered in this beautiful Cathedral, and to all the people of this great continent of Oceania: which embraces Australia, New Zealand, Papua New Guinea and the Pacific Islands.

This celebration of the World Day of the Sick places mentally ill people at the centre of our attention. As we heard from his letter, the Holy Father reserves a special attention to mentally sick people. And as a sign of his deep concern for the wellbeing of these sick people, the Holy Father has on this occasion granted a Plenary Indulgence to all those who participate in this celebration here in Adelaide, and in similar celebrations around the world. In this special way, the Pope accompanies mentally ill people with his friendship, closeness and effective spiritual help.

Mental illness is, alas, growing very fast in the world. It is reported that there are about 500 million people with mental disturbances.

There are many and varied causes at the origin of the illness: among the most important we find the negation of God and ethical-religious relativism, the crisis of reference values, hedonism and materialism, technological culture closed in itself, the exasperation of desires produced by this culture, the pursuit of the impossible, religious and cultural conflict and the magic ritualism of several religious sects.

As major risk situations one notes the precarious means of subsistence, work, formation and education, the lack of help networks, alienation of human rights, exclusion and marginalization, terrorism and wars, lack of the education of sentimental life, the process of alienation of reality, the negative conditions of the environment, lack of social protection, corruption, inequality between male and female roles, absence of parents, separation and divorce, loss of the value of the marriage institution, lack of communication and time to stay together in the family, immaturity of the father and mother figures, the undue delegation of parents' responsibility to third persons or institutes, the weakness of the life project, inadequate preparation for married life, conflicts between parents and their children and aggressive and violent behaviour.

According to the indications of the Holy Father, both in the letter referred to above and in the Message for this World Day of the Sick, we must in our approaches underline the inviolable dignity of mentally ill people and do everything possible to protect it at the cultural, institutional, family and individual levels.

At the cultural level, protecting the inviolable dignity of the mentally ill means going to the root of the problem. It means attending to the system of values. Since mental illness is a disequilibrium, any distortion in the system of values that sustain a person generates personal disequilibrium. In a simple paradigm of reference assumed by contemporary global ethics, which is produced by mere consensus of the majority, we cannot arrive at the desired equilibrium. The reason is that this paradigm must always change according to the mutability of the majority consensus. It is well known that this consensus easily changes and is often manipulated by the mass media. Instead, we need a firm and balanced system founded on objective ethics. These ethics must be rooted in the satisfaction of the person's true necessities and not determined by the whim of desires. Such objective ethics are in the heart of each person, and lead one to insert oneself in a vital and creative order that improves day by day.

Since due to the disorderly presentation of the fundamental drives this order is sometimes not very clear in the heart, there is a need for a further enlightenment that helps to lead the personality towards a true satisfaction of necessities. We Christians know that this enlightenment is divine Revelation, which we receive gratuitously from God. The Holy Father exhorts the leaders of different religions in the world to protect mentally ill people. One profound way of doing this is by

strengthening the above mentioned system of values, especially in the face of the present growing secularisation. As we said already, in this secularisation the only remaining support for a personal life is the changing ethical paradigm, whose instability is determined by the frequently manipulated consensus of the majority.

Mental health professionals have an important role to play here. Above all, something they must take as fundamental to the exercise of their profession is having the best possible psychic equilibrium, and therefore they must be firmly anchored in an objective system of values. Mental illness in a particular way involves the whole person, and to a major extent its cure does not depend on drugs alone but on the personal relationship between the patient and the healer. The dependence of the mentally ill person on the health professional is particularly strong; therefore any disequilibrium affecting the health professional disqualifies him as such, because his profession is directed to achieve the equilibrium of the patient.

The Holy Father also recommended that I exhort government leaders to protect the dignity of the mentally ill people. We hope that we have now gone beyond the dehumanising practices used in the past in the treatment of mentally sick persons. They were cruel methods that absolutely ignored the dignity of the mentally ill, who were often treated as if they were not human beings. We also hope that the practice in some countries of classifying those with a different political opinion as insane is something of the past. In order to institutionally protect the dignity of mentally sick people, according to the development and proven achievements of psychiatric medicine, it is necessary that appropriate legislations be promoted and applied all over the world, especially regarding the hospitalisation of mentally sick people.

Since one of the prime causes of psychological imbalance is family disequilibrium, the protection of the dignity of the mentally sick person should have its cradle in the family itself. Unfortunately, in many parts of the world we observe today the disintegration of the family. We must insist on a programme for the stability of the family, which ought to proceed from a serious, adequate and profound preparation for marriage. We have to strengthen the family. There is a need to achieve in the family a serene, realistic, joyful and loving understanding between spouses, their children, relatives and the extended family, and the community in which they live. Consolidating a total and indissoluble stability of the marriage will provide the right equilibrium that will be the best prevention of the mental illness of a family member.

For we Christians it is obvious that the true sense of life is only Christ, dead and risen, and at the centre of the life of Our Lord Jesus Christ is the Holy Spirit, the Spirit of Love, who led Christ through redemptive death, and with Christ leads all of us to our heavenly Father. On this World Day of the Sick we have the opportunity to proclaim that at the centre of the prevention and care of the mentally ill person there is Love. Only with the loving understanding of the Holy Spirit who "heals who is sick" can we prevent mental disequilibrium and heal it when it presents itself. It is truly a crucified love, because it makes us identify with disequilibrium in order to balance it. With the Holy Spirit we reach the equilibrium of the cross of Christ. It is very painful, but it is the only way to the resurrection. It is only with this kind of Love that we can come out of the obscure tunnel of mental illness.

In this regard Pope Benedict XVI in his first Encyclical letter *Deus caritas est* says that: "The Spirit, in fact, is that interior power which harmonizes the hearts of the believers with Christ's heart and moves them to love their brethren as Christ loved them, when he bent down to wash the feet of the disciples (cf. *Jn* 13:1-13) and above all when he gave his life for us (cf. *Jn* 13:1, 15:13).The Spirit is also the energy which transforms the heart of the ecclesial community, so that it becomes a witness before the world to the love of the Father, who wishes to make humanity a single family in his Son" (*Deus caritas est* n. 19)

In fact, individuals who care for those in need must first be professionally competent: they should be properly trained in what to do and how to do it, and committed to continuing care. Yet, while professional competence is a primary, fundamental requirement, it is not of itself sufficient. We

are dealing with human beings, and human beings always need something more than technically proper care. They need humanity. They need heartfelt concern. Those who work for the Church's charitable organizations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of their humanity. Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. *Gal* 5:6). *Deus caritas est* n. 31.

Today we celebrate the feast of Our Lady of Lourdes, health of the sick. When a mentally sick person feels the affectionate maternal hand of Our Lady help and protect him, the world ceases to be hostile for him, he feels himself sure and full of happiness. Today we implore Our Mother Mary, health of the sick, to place all mentally ill people in the world under her maternal protection, so that she may console them, enliven them, give them confidence and trust, strength and happiness. May she confirm us in an outstanding fraternal solidarity with our afflicted brothers and sisters who unite with the suffering Christ in the depth of their souls!

Finally, it is my pleasure to assure all of you the blessing of the Holy Father Benedict XVI, who though in the Vatican is spiritually present, united in prayer with us in this beautiful Cathedral of St. Francis Xavier, of the Archdiocese of Adelaide in Australia, and in this wonderful Continent of Oceania.

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The Mentally Ill Patient: a Faithful Image of God

9 FEBRUARY 2006

Is the Mentally Ill Patient a Deformed Image of God?

I SOME DATA ON MENTAL ILLNESSES

1. Current Situation

According to the World Health Organization there are 450 million people in the world affected by neurological or behavioural mental disorders, of which 873,000 commit suicide each year. Mental illness is a true health and social emergency. 25% of countries do not have laws concerning mental health, 41% have no defined policy on the issue and in over 25% of health centres patients do not have access to basic psychiatric medication; among 70% of the world population there is less than one psychiatrist for every 100,000 people.

As to dealing with mental disorders, it may be asserted that in the past 50 years great strides forward have been made, evidence of which are the technological advances in the field of new psychotic and mental health medicines, which have considerably improved the quality of life of the mentally ill. Nevertheless, the conditions of assistance to mentally ill patients are quite deficient as a result of limited funding, the lack of understanding among authorities, the serious problem of the social stigma that the patients and their families have to face, all of which have serious repercussions on social support networks in many countries that consequently deteriorate. The number of "homeless" mentally ill patients has considerably increased in wealthy countries. It is alarming to see how serious mental disorders are simply dealt with using bureaucratic and juridical or legal solutions without in the least taking into consideration the daily needs and the quality of life of patients and their families.[1]

Mental disorders affect more frequently those populations that are less fortunate economically culturally and intellectually. Millions of individuals have to bear on their body and mind the psychological consequences of malnutrition, armed conflicts or natural disasters with their heavy burden of morbidity and mortality.

2. The Action of the Catholic Church

For this World Day of the Sick, celebrated here in Oceania, the Pontifical Council for Health Pastoral Care made a survey on the pastoral care of mental health in 84 centres dedicated to mental patients in the Catholic community in various countries across the five continents.

A questionnaire, carefully drafted by experts in the field was sent to 129 Bishops responsible for pastoral care in health in various countries of the world. We received replies from 23 countries, of which 9 from Africa, 17 from the Americas, 6 from Asia, 51 from Europe and one from Oceania. The data collected from Africa came from Cameroon, Ghana, Senegal and South Africa; in the Americas from Bolivia, Canada, Chile, Colombia, Cuba, Ecuador, Mexico and Trinidad and Tobago; in Asia from China, Indonesia and Turkey; in Europe from Austria, Belgium, Ireland, Italy, Poland, Portugal and Spain; and in Oceania from Australia.

The structures of interest were mental health centres, day hospitals, psychiatric services, residential and semi-residential centres, centres of cooperatives for reintegration, consulting rooms and clinics. 43% of the funding is from public sources, 33% from private sources and 23.3% from donations.

The personnel in the above centres is comprised of medical doctors, psychologists, psychiatrists, rehabilitation therapists, professional educators, social assistants, nurses, auxiliary technical staff, administrative staff, volunteer workers, chaplains, religious men and women, counselling experts and service staff. 75% of the centres reported that they have a just sufficient number of medical doctors; in general there is lack of adequate professional resources. These centres offer various services such as consultation, rehabilitation, school medicine, family support, social services, work orientation, accompanying, home care and pharmacy.

The most significant mental disorders taken care of in these centres are: personality disorders, drug abuse-related disorders, psychosis, mood disorders, anxiety disorders, cognitive and dissociative disorders, eating disorders, sleep disorders, adaptation disorders, severe degenerative organic disorders, and congenital mental insufficiency. The most frequently treated pathologies are personality disturbances, psychosis and mood disturbances. Personality disturbances mainly due to psychosis and drug abuse are more frequent in the age band of 17-25 years. Regarding the prevention of mental disorders, it is interesting to note that disorders hardly appear in the age band of 0-16 years; hence, it is in this stage that prevention can be much more effective.

The approach in these centres is mainly characterised by teamwork, even though it is generally not systematic. Innovative therapies used are hypnotherapy, music therapy, game therapy, theatre and art laboratories.

At the level of prevention, a culture of welcoming people with problems of mental health is promoted, together with appropriate pastoral pro-

grams that give due attention to the psychological aspects of patients. When facing a full-blown disorder therapeutic interventions – some of which are systemic – are given to reduce disabling consequences for the patient: screening, self-help groups, training of health professionals, family support, context analysis, reconstruction of the affective and relational fabric, pastoral programmes, collective prayers and assessment.

These centres are connected with universities, public hospitals, ministries of justice, education, labour, public relations and health. They also relate with local bodies, dioceses, parishes, police forces, employers, home neighbours, neighbourhood communities, trade unions and charitable institutions.

Specific courses for training in pastoral care in mental health are organised. In these courses ethical questions related to drug abuse, coercive forms of treatment, and the way to approach a mental patient are discussed.

It is commonly believed that at the origin of mental disorders there is a strong cultural and religious influence fostered by a crisis of values of reference, hedonism and materialism, technological culture, and the exasperation of desires and the search for the impossible, the conflict of culture and religion, the magic ritualism of some religious sects, the denial of the transcendent and ethical-religious relativism.

High-risk situations include insecure means, subsistence means, unemployment, poor education and training, lack of help networks, alienation of human rights, exclusion and marginalization, wars, terrorism, lack of education in sentimental life, the process of detachment from reality, influence of the environmental context, lack of social protection, corruption, imbalance in gender roles, lack of parental figures, separation and divorce, loss of the value of the institution of marriage, lack of communication, lack of time to spend together in the family, immaturity of parental figures, delegating responsibilities to third parties or institutions, weakness of the shared life project, inadequate preparation for married life, conflicts between parents and children, and aggressive or violent behaviour.[2]

II. MENTAL DISORDER

By God's grace, the work carried out by the Catholic Church in this area is indeed praiseworthy; it is work that has been done for centuries as testified by religious orders and congregations whose charisma consists mainly in taking care of mentally ill patients.

Considering how widespread this illness is – 450 million people as mentioned above – the bishops of Oceania have certainly made a timely decision to have the mentally ill person as the key issue for the discussions of this World Day of the Sick. This shall undoubtedly spur the Catholic Church to continue the work undertaken and it shall foster dialogue and cooperation with the institutions in charge of such duties in modern societies.

We shall now embark on a reflection on the mentally ill patient, starting from a Christian point of view. We shall begin from basic scientific information on mental disorder and then consider how the mental patient does not cease to be an image of God, and as such he deserves every respect.[3]

1. The Disorder

There is no doubt that the mentally ill patient – though still a human being – is someone who escapes classification as a normal person. In other words, he does not have the necessary equilibrium that enables one to define him as a person with full use of the human faculties. As an individual, he suffers from an alteration of internal order and this is translated into an alteration of the external order that involves the whole universe.

Actually, the great thinkers of humanity have made happiness coincide with order, in its cosmic adjustment. In Oriental thought we find Taoism, according to which the active masculine principle, Ying, must adjust to the flexibility of the feminine principle, Yang, which in the final analysis represents the order of the universe, even though this order is flexible only up to a certain point and changes according to the transformations of the universe. More or less the same idea was followed by several Stoics of Greek culture who sustained that one had to be in agreement with the whole of cosmic dynamics, and that perfection actually consisted in

being in harmony with the inexorable order. At the beginning of the Renaissance we find the organological thought of Theophrast Bombast Von Hohenheim and Paracelsus, who asserted that in a flower one could find the perfect and total order of the universe, a macrocosm in a microcosm. The entire universe is like a huge living organism to which we all belong and are its synthesis; the activity of each individual is sustained by a higher order to which one has to conform oneself, otherwise one runs the risk of becoming a cosmic anomaly. In a way this is close to the thought of Nicholas de Cusa with his ideal of the coincidence of opposites, as an order in apparent disorder. Even in the concept of Redemption – especially under the influence of St. Anselm of Canterbury – in Western theology, the work of Christ is classified as the

restoration of the violated juridical order.

2. The Disorder of Neuronal Synapses

In recent studies on neuronal activity, mental disorder is associated with alteration in the order of the neurons. Actually, according to the description of the organic functions in neurosciences, there is evidence of the complexity of communication between the neuronal cells' send and receive messages. It is a network of very complex connections, which enable one to perceive and classify, to judge and put in action, along the route that extends from the external stimulus to the cerebral cortex and manages, so to say, to organize the organism and attain equilibrium and harmony.

We know that the central nervous system collects and processes the information sent by our sensory organs, which it subsequently organises and manages. All these operations are the material underpinning of the higher functions: thinking, memory and consciousness.

There are in particular two main instruments to follow the sensorial – neuronal – cerebral journey, namely the propagation of the mechanism of action and the synapses, in other words the transmission of the electrical impulse of the neurons and the passage of a signal from one neuron to another. Each of the 100 billion of our nerve cells is connected via synapses to about 1,000 to 10,000 other neurons. Learning and acquiring new skills by the human organism requires changes in the synapses, known as "plastic changes". In order to achieve this change, all the synapses are involved and they will, in turn, change in every new connection. It is argued that some human skills and abilities depend on the various patterns of connection present in every individual.

Connections take place thanks to the electric impulses, which neurons receive through the so-called ion channels, as a wave of positive electric charge propagating all along the cylindrical extension of the cell body, known as the axon. Such channels represent special permeability points present in each nervous cell. These points are special proteins that form pores in the cell membrane of the neuron, which open and close when they are appropriately stimulated, permitting the passage of external fluids. Through the ion channels they transform the fluids into electrical impulses. The electrical impulses of the synapses are integrated into the neuronal dendrites, thus generating a potential action which is transmitted to other neurons. It is normally said that the basic model of the whole set of connections between neurons represents the material base of the memory, that is both of the so-called "declarative" or conscious, as well as the "procedural", memory (the portion which is used when performing tasks and governing unconscious reactions). Hence, the sensory information is processed progressively in consecutive layers of neurons.

With the aid of computational techniques (neuronal networks), the patterns of synapses of the networks of the different layers of neurons have been plotted. Nevertheless, though these techniques have worked well at a lower neuronal level, the real synapses of the cerebral operations in the whole complex of neuronal activity have not been fully understood, especially those concerning the higher mental functions of consciousness, thought, and emotion.[4]

3. Understanding the Neuronal Synapses

The mere comprehension of the action of neurons and the relative complexity of their connections is certainly very important for the understanding of cerebral activity, yet it is not sufficient for its complete and adequate understanding. On the one hand, the brain operates simultaneously as one whole through large assemblies of neurons, and this whole action has not been fully penetrated yet; on the other hand, the mere biological-chemistry explanation is inadequate when it comes to the higher functions, especially the ones that refer to abstraction and consciousness. As to consciousness, we clearly ask ourselves, if it involves turning back into itself yet it is entirely made up of a mere biological element, is it possible that a quantitative element turns into itself? It would be and not be at the same time. Yet, this implies the absurd violation of the principle of contradiction.

Studies carried out in the scientific field, to which we have referred above, are certainly very useful, since, though a neuronal disorder alone does not explain the whole reality of mental illness, it is nevertheless an extremely important element leading to its explanation and therefore its treatment.

4. The Soul Factor

For a more complete understanding of the mentally ill patient, neuronal factors should be underpinned by a holistic understanding of the psyche. Already in ancient times it was understood that human life was necessarily made up of two fundamental aspects and that its relations for subsistence had to be directed to the care of those elements that we have classically defined as soul and body. When speaking about a mentally ill patient in ancient Greece, Socrates preferred to consider only the soul, and he stated that the illness of the soul could only be resolved by means of maieutics – a technique leading to the knowledge of oneself by purifying the sick soul so that it may reveal its inner truth and is recovered by the knowledge and practice of virtues. Plato and Aristotle also dealt with the issue. Plato, with his dualistic mentality, believed that the major cause of mental illness was the body; mental illness is like the mud of the body that soils the soul of the mental patient, which could here be compared to a beautiful amphora lying on the sea-bed and becomes covered with mud and debris. Aristotle supports this view, though with

a more balanced approach, when he asserts that it is the intellect which imposes harmony on the body; a harmonious soul will give life to suitable forms of the body, avoiding illness which is typically of the body, but at the same time basically arising from a disharmonious soul.

We could however affirm that classical Greek thought is still present in the current way of conceiving the biochemical model of psychiatric disorders. Today the soul is identified with the biochemical energy of the neurochemical, neuroendocrine and neurovegetative systems of the cerebral cortex, the hypothalamus, the brain stem, the epiphysis, and the vegetative system. All these structures are linked to each other according to a plan aiming at self-equilibrium for the prevention of possible irregularities. Mental disorders express an imbalance of this multi-system, diffused like a network throughout the whole body. The moment one of these systems is unbalanced, all the rest will be unbalanced.[5]

The mentally ill person suffers from this disorder, which varies depending on the type of psychic disorder that affects him. In all disorders there is an alteration of these connections, or parts of them, which produces an internal disorder that will lead to an external disorder that is relational in the social sphere.

Regarding the complexity and the seriousness of this disorder, we should not forget the opinion of some psychiatrists who assert that the instinct for life relates in an indissoluble way to the instinct for death. Both drives intertwine and psychiatry studies them complementing the "pleasure principle" with the "reality principle" – the pillars of psychotherapy – considering the death instinct as an inner necessity of life.[6] The disorder affects both instincts and further complicates the state of mental illness.

On the other hand, when referring to the treatment of a mentally ill person, psychiatry presents a wide grey area of uncertainties that clinical practice and scientific research help to identify under three different aspects: the precariousness of the theories on mental illnesses and therapeutic strategies, the high emotional involvement of the mental health care professional and technology. Some scholars believe that the level of technology in psychiatry is indeed low, in fact the therapy used is not technological but interpersonal.[7]

Nevertheless, in spite of all the difficulties of the studies of psychological sciences on the reality of mental illnesses, there is at least evidence of the fact that mental illness is due to a disorder in reasoning, which is however not lost. It has been affirmed outside Christian thought that man is made in the image of God because of his rational soul, or in classical terms, because man is a rational animal. Now, if man loses his rationality, there would be no objection if he were treated as a being with human features who is no longer human.[8]

Obviously, this way of thinking is just a sophism, because the mentally ill patient has not lost his rationality, but, rather, it does not function as it should.

III. WHAT CAN BE DONE?

1. Mental Disorder in Christian Thought

In Christian thought it is said that these severe mental illnesses reduce man to sad conditions, like a deformed image of God, which is compared to the suffering servant of Isaiah (Is 53,1-7). Yet, apart from that deformation, or rather due to it, the mentally ill person resembles our Lord on the cross; and since the cross is the only way to the resurrection, the mentally ill person has, so to say, a superior level, is worthier and reaches such a level of excellence because of the magnitude of his love and the suffering he endures.[9]

2. Is he a Deformed Image of God?

If the above holds true, I would like to move a step further and venture a statement that might shed light on the issue, from the point of view of moral theology. The statement is that: the mentally ill person is not a deformed image of God but, rather, a faithful image of God, our Lord.

Such a statement intuitively finds confirmation in the thought of our Lord when he says: "The Kingdom of God is within you" (Lk17:21) and "what comes out of the mouth proceeds from the heart, and this defiles man" (Mt 15:18). "For from within, out of the heart of man, come evil thoughts, fornication, theft, murder, adultery, coveting, wickedness, deceit, licentiousness, envy, slander, pride, foolishness. All these evil things come from within, and they defile a man" (Mk 7, 20).

The Kingdom of God, the existence of the Holy Trinity in each one of us, may be found in our heart, the heart seen as the ultimate source of decisions that give form to our whole existence; not only that which was previously defined as the fundamental option, but also the whole meaning of this option, with all the actions we perform to realize it. In other words, the heart represents all our dynamism at the service of the mission that God has entrusted to us.

The Kingdom of God enters into the loving knowledge and the decision made in the deepest intimacy of our person, which are then realised by the power of the Holy Spirit, who leads us by the hand like Children of God, and by the total collaboration that give form to our existence, according to the Law of God. If we want to separate from the Kingdom of God, we can do so only with an evil heart, to which Christ our Lord refers, and from which all the sins come.

3. Faithful Image of God

Therefore, once the mental illness has caused such a disorder as to take away from the mentally ill patient any responsibility for his actions, qualifying them as separation from the divine will – as a sin – the mental patient cannot separate

from God. In other words, the image of God in him cannot be distorted. In this case his knowledge or his volitive option are no longer sufficient to motivate any human action that separates him from God. His bodily and psychic conditions do not allow him to commit a grave sin, given that in his state of disequilibrium he does not have that full knowledge and ability of assent required to sin.

If we approach the argument from this point of view, whereby the mentally ill patient does not have the knowledge or the faculty of full consent required to commit a mortal sin, his is not a deformed image of God, since that image can only be deformed by sin. Certainly, it is the suffering image of God, but not a deformed image. He is a reflection of the mystery of the victorious Cross of the Lord. Inspired by the image of the Suffering Servant of Yahweh (Isaiah 53:1-7) we are drawn to a conscious act of faith in the suffering Christ.

It is not by chance that in the old popular Mexican language, a mad person was called "*bendito*", that is "blessed" not without the full use of reasoning, he was unable to commit sin and was, therefore, destined to eternal life.

It is true that the objective disorder of sin and its consequences are manifest in the mentally ill patient; however, at the same time, there is in him the historical equilibrium of the only possible order, the order and equilibrium of the Redemption.

This is not comprehensible to a secularized mentality; it is only understood within the context of Christian optimism, which stems from a reasoned faith that tells us how in such circumstances our obligations towards a mentally ill person on the one hand satisfy our duty to see the suffering Christ in the poor and less protected, and on the other promote the idea of seeing in the patient the love of God who has indicated him as his chosen one, in the sense that he shall not be separated from Him.

He is therefore a proof of the crucified love of God. Hence, the best thing we can do is to give him a treatment of love. Since the mentally ill patient is also the image of the resurrected Christ, we have the obligation of being the "Good Samaritan," that is, providing all that is necessary for his care. We need to think about a series of treatments that should be devised to pull these patients out of the prostration that is all the more painful the deeper the psychic suffering is. In fact these patients often lose a sense of human relations and feel persecuted by a hostile surrounding environment; or the subjectivity of the environment disappears and for them people become objects, or are indifferent or even real threats to their security.

4. Treating the Mentally Ill

The treatment for a mentally ill patient should be a treatment of loving care, tenderness, and kindness, in order to help him cope with his imaginary world, perceived as an enemy, a world in which he often drowns. The treatment which should be personalised and of maximum quality also requires maximum diligence in prescribing treatments and most appropriate medicines. It will draw from all the resources made available by science, be it from medical and technical arts or from the research that is always progressively looking for the most adequate medicaments from the psychosomatic point of view.

Practical Lines of Action

In this perspective, allow me to suggest some guidelines for practical interventions, which will help us offer loving care to the mentally ill:

General Interventions:

– Establish, in the education systems, solid religious foundations that help one to work out clear and stable horizons, to be followed for a lifetime.

– Be aware of the system of values underpinning the whole of human life and make reference to it, especially to avoid mental illness being lived with anxiety, sadness and desperation.

– Fight against relativism, consumerism, the pseudo-culture of instinctive desires and pansexualism.

– Promote the dignity of mentally ill patients.

– Foster a healthy development of the child, including his brain functions.

– Make awareness programs on mental illnesses for society so that people may know about them and prevent them.

– Exhort religious Orders and Congregations, whose charism it is to take care of these patients, not to waver in their commitment and to dedicate particular care to them, given the particular emergency

that this illness presents.

– Support these patients with the administration of sacraments where this is possible.

– Enlighten and console the mentally ill with the Word of God, if their mental and physical condition allows it.

– Be aware of the fact that the rehabilitation of a mentally ill patient is a duty of whole of society together, within the context of solidarity that shows preference for those who are most in need.

– Promote a social and physical environment that favours human relations and for the mentally ill patients a sense of belonging to a concrete community.

National Interventions:

– Promote, at the national and international political level, appropriate laws to safeguard the rights of mentally ill patients.

– Urge the Health Ministries

of various nations to have special attention for the mentally ill patients, designing effective programs for them.

– Develop and integrate mental health services in all primary health units.

– Create appropriate institutions for better broad-ranging care for the mentally ill patients.

– Allocate all the necessary funds to provide the necessary care to mentally ill patients.

– Provide hospitalization for mentally ill patients who require it, as well as their stay in compliance with the recent advances in psychiatric medicine.

– Provide housing to the mentally ill who are homeless, roaming or cannot be kept in families.

– Institutionally support families in which there is a mentally ill patient with technical and scientific assistance as well as with understanding and respect.

– Promote research related to the different types of mental disorders and appropriate therapies for them.

– Humanize therapeutic programmes by means of continuous education for health care workers.

– Adjust psychiatric treatments to the diverse cultural patterns of patients.

Personal Initiatives:

– Educate within and from the Christian family providing everyone with solid life foundations in the acceptance of Christ – dead and risen – the reason of our existence.

– Intensify prevention of mental illness through effective action within families, especially in the first years of children's lives.

– Strengthen the unity of families, giving the marriage institution all the power it deserves.

– Give more room to coexistence in the family, between spouses, parents and children and among siblings.

– Enhance bonds of affection and understanding in the nuclear as well as in the enlarged family.

– Let grandparents assume their proper roles.

– Offer your own children an appropriate maternal and paternal image.

– Treat children lovingly, offering them at the same time education with determination, clearness and vigour.

– Establish in the family solid relationships with teachers and other persons helping parents with their children, without entrusting them with duties that should never be delegated.

– Accept mental illness positively, fighting the stigma to which such patients are subjected.

– Understand both the physical and psychological needs underlying mental disturbances.

– Enhance the individual potential of every mental patient.

– Foster interpersonal communication between the patient and the people around him, especially within their own family.

– Free the patient from loneliness, isolation and abandonment.

– Teach the mentally ill the way to develop their own capabilities and sense of self-determination.

– Teach the family members the proper behaviour in relating to a mentally ill member.

– Understand that science alone is not enough to treat a mental disorder: there is a need for a holistic approach, including all its religious, philosophical and scientific aspects.

– Instil hope in the patients and their families.

– Intensify the therapy of loving care and kindness when treating the mentally ill.[10]

CONCLUSION

Remembering that sentence engraved on the lintel of a German hospital "*Infirmis sicut Christo*" – to the sick as to Christ – I would like to conclude my reflection insisting on this image of Christ suffering in the depth of his soul, full of pain and affliction, yet he succeeds in transforming this evil into a source of life, since his pain and suffering constitute the nucleus of his Resurrection, and therefore our salvation. Our approach to the mentally ill is a difficult test for our faith. Handling them effectively means professing our faith in the agonizing and suffering, but at the same time, victorious Christ. This is the sense of today's celebration of the World Day of the Sick, which is dedicated to mentally ill patients.

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

Notes

[1] OPS. 1992. issues on mental health in the community, serie paltex

[2] Deriu Fiorenza and Others, Descriptive Report on the Results of the Research of the Pontifical Council for Health Pastoral Care on 'Mental Health'.

[3] Cf. JOHN PAUL II, "Address to the 11th International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers," in Dolentium Hominum 34 (1997) 7-9; JOSEPH RATZINGER, "The Likeness of God in the Human Being," *ibid.* 16-19

[4] Cf. ERWIN NEHER, "Basic Mechanisms of Signalling and Information Processing in the Brian," in *Dolentium Hominum* n. 34 (1997) 21-24; D. JOHNSTON AND S.M. WU, *Foundation of Cellular Neurophysiology,* The MIT Press, Cambridge Mass, 1995; E.R. KANDEL, J. H. SCHWARTZ AND T.M. JESSELL, (eds)., *Essentials of Neuronal Science and Behaviour*, Prentice Hall International, Inc. London, 1995; E. NEHER AND B. SAKMANN, 'The Patch Clamp Technique', *Scientific American,* March 1992, pp. 44-52.

[5] Cf. GIUSEPPE ROCCATAGLIATA, "From Deseases of the Soul to Psychoneuroses," in *Dolentium Hominum*," *Ibid.*, pp. 33-39.

[6] J. DERIDA, *Speculare su Freud*, Raffaello Cortina Ed. 2000.

[7] CONTINI G., *Il miglioramento della qualità nella riabilitazione psichiatrica*, Centro Scientifico editore, 1999.

[8] Cf. IGNACIO CARRASCO, "The Dignity of Madness," in *Dolentium Hominum*, Ibid., pp. 124-126.

[9] Cf. JOHN PAUL II, "Address to the 11th International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers," in *Dolentium Hominum* 34 (1997) 7-9; JOSEPH RATZINGER, "The Likeness of God in the Human Being," *ibid.* 16-19

[10] Cf. JUAN LÓPEZ IBOR, "Research in the Field of Neuroscience and Mental illness", in *Dolentium Hominum* n. 34 (1997) 52-58; ANDREA CALVO PRIETO, "Family Reality in Regard to Mental Patients in African Countries," *ibid.,* 101-103; FRANCO IMODA, "Psychotherapy," *ibid.,* 186-192: PIERLUIGI MARCHESI, "The Role of the Church in the Treatment of the Mentally ill,", *ibid.,* 205-207; CARLO LORENZO CAZZULLO, "The Acceptance of Mental Illness," *ibid.,* 81-85.

‘Go home to your people and tell them all that the Lord in his mercy has done for you’ (Mk 5:19): Issues of Human Dignity

SPEECH BY REV. PETER COMENSOLI , 9 FEBRUARY 2006

Your Eminence, Your Grace, My Lords, Minister Zollo, distinguished guests, ladies and gentlemen:

At the outset, I wish to make clear that actual situations of people in matters concerning their dignity do not actually feature in my presentation. The fact is that I am not an expert – or even experienced – in matters of mental illness. I come to you as someone who has simply known and befriended some people who live with a mental illness. What then, do I hope to contribute today? Firstly, I wish to put forward a theological perspective that, I believe, strongly upholds the dignity of people living with mental illness. Secondly, I wish to consider the matter in its ethical context and suggest a foundation that might ensure the dignity of these people is respected.

I have entitled my presentation: *Go home to your people and tell them all that the Lord in his mercy has done for you: Issues of Human Dignity.* Not surprisingly, I shall begin with the person of Jesus and an incident from his healing ministry (Mk. 5:1-20).

Everyone deserves a name, don’t they? After all, God calls us each by name. To be known only by a condition – the demoniac – seems unfair. So, for the sake of his memory on this day, let’s give him the dignity of a name: let’s call him Joshua.

Dignity lies at the heart of why we have gathered in Adelaide over these few days. Our English word ‘dignity’ finds its roots in the Latin word *‘dignus’,* meaning ‘worthy’. It is a word that affords value, respect, honour to its recipient. While dignity can be used of things (the dignity of labour), such uses are by way of analogy. Dignity’s primary use is in regard to persons. The bond between person and dignity is so strong that we recognise that persons have a right to dignity – a person *is* worthy of value, respect, honour. So to be afforded the status of person is to be owed certain things, one of them being dignity. What happens then, to someone whose status as a person is denied or questioned in some way? Do they cease to enjoy the right to dignity? These questions raise a prior, critical question, namely: *Who is person?*

‘Person’ is one of those genuinely complex words in our vocabulary. Its very existence as a word cannot be separated from its origins in the ancient philosophical and theological controversies surrounding the status of Jesus Christ. What emerged from these debates was a word that both grounded and explained the nature of our human lives. Over the past few hundred years, however, there has been a systematic disentangling of ‘person’ from its religious and metaphysical underpinnings. Today, many philosophers and ethicists speak of the human person in terms of selfconsciousness or the capacity to rightly subjectify our thinking and feeling and experiencing. Rather than ‘person’ being seen as the *principle* of our human nature, it is seen by many as being more akin to a *property* of our nature.

As you might expect, these competing philosophies walk very different paths. From the theistic point of view, personhood is the absolute principle of human life: you cannot be a human being without being a person. From the non-theistic point of view, personhood is seen as a measurable property of our human nature: it is something relative in each individual. (Perhaps the most dramatic example of these differing worldviews can be seen in the current debates over the status of human embryos and whether or not they are to be afforded the same rights as other human beings).

Much of what I have to say has its origin and explanation in the theistic understanding of person. It is important, then, to briefly outline this position before focussing on what it might bring to our consideration of the human dignity of those people who live with mental illness.

1. In the image of God He created them: a theological anthropology[1]

At the heart of the Christian understanding of human life is that extraordinary statement from the Book of Genesis: *God created man in the image of himself; in the image of God he created him: male and female he created them*. (Gen. 1:27) While there is something of God in everything that exists, the Creator chose to invest human creation with the image of God’s own self. In the Catholic tradition this belief is known as the doctrine of the *imago Dei*: being made in the image of a *personal* God gives us personhood and hence the *dignity* of God’s own self. Thus, as I pointed out earlier, dignity binds itself to person. We are never just a human some*thing*; we are always constituted as a human some*one*.

This sets up an important

corollary: the 'image of God' that I am is not assigned to, say, my intellect only or my self-consciousness. Rather, every aspect of me is created in God's image – all of me is invested with the dignity of God's own self, including my body. This 'all of me' is significant: it says that each and every human being is both *entirely* and *always* a person created in God's image. Entirely, because there is no part of me that is not imbued with the dignity of the personal image of God, and always, because there is no time in my historical reality when I am not imbued with this same dignity.

Returning to our scripture reading, we are told that when Jesus first encountered Joshua he was living amongst the tombs, howling day and night and mutilating himself. His mental torment had left him disoriented and confused. There was only one thing of which he was certain: the pain he experienced when he gashed himself. It is in his self-mutilation that Joshua locates himself. This pain is real: I am real.

The doctrine of *imago Dei* not only tells us that human beings are persons in the image of God, but it also tells us something of the type of persons we are. The God of the Christian faith is a triune God: three persons – Father, Son, Spirit – in one being. There is something essentially *relational* about the nature of God. And it is this relationality that is embedded in human nature. Like God, each human person is both uniquely his or her own self and made for others. We are each a unique subject – with its concomitant sense of personal autonomy; however, this subjectivity is constituted only in and through our relationship to others. We, like the God in whose image we are made, are relational beings.

It is because we are relational beings that we recognise anyone with a human nature as being 'one of us'. This 'one of us-ness' does not – cannot – admit of degrees: it is not something that is first quantifiable and then comparable between people. The measure of me as a person is not relative to someone else: I am absolutely a human person or I am not human at all. By implication, when someone's status as a person is relativised, their dignity is undermined.

Moving our focus again to Joshua: when Jesus approached him – amongst the tombs and in all his violence and torment – he did so with that sense of him being 'one of us', a person. "I am the same as Joshua, and Joshua is the same as me." The villagers, it seems, had ceased to view Joshua as a person. Had they stopped thinking of him as 'one of us' because he could no longer live among them, a marker of his relational self? And what about Joshua himself? Had he, too, perhaps ceased to see himself as a person, unable, as he was, to tell Jesus his own name, a marker of his integral self?

2. … and being found in human form: moral implications

If it is true that God created each of us as persons in his image, then it is also true that God's own self is in every human being. As Pope John Paul put it: "When God turns his gaze on man, the first thing he sees and loves in him is… his own image".[2] This belief poses, for me, a quite profound question in the context of our gathering. What is it that God experiences of himself in the life of someone with a mental illness? What aspect of God's own *completeness* is reflected in the life of a mentally ill person?

In the story of Joshua, I am struck by the way Jesus and he interacted. Initially, Jesus seems to approach Joshua as if he were being attacked by a parasite: "Come out of the man, unclean spirit". And then we have the image of Joshua sitting calmly with Jesus, "clothed and in his full senses", restored to his pre-illness self. Clearly Joshua was deeply thankful for his healing, wanting to stay with this man who had offered him back his life. But then follows an unexpected twist: Jesus says no, and charges him to: "Go home to your people and tell them what the Lord has done for you".

Did Jesus heal Joshua because he felt sorry for this flawed, broken, disordered man? What purpose did the healing achieve? In asking these questions, let's not fall into the trap of interpreting the healing actions of Jesus as 'proofs' of his divinity or 'special favours' bestowed upon the few. Rather, the healing ministry of Jesus was a sign of the presence of God among God's people: here, in these actions, God's kingdom is revealed and people are renewed in God's image.[3]

What Jesus did was not to *fix* what was broken in Joshua, but to *restore* him to his dignity as a person in God's image. Jesus did not heal Joshua out of pity; he did it as an act of *restorative justice*.

This restorative act by Jesus illustrates the integral and relational form of personhood on which we have been reflecting: Joshua could not be fully restored to himself (the 'all of me') without also being restored to his place in the community (the 'one of us'). He had been stripped – figuratively and literally – of his dignity, but he had never ceased being a person. Because Jesus recognises this, he is able to see himself in Joshua. Pope Benedict, when he was a Cardinal, expressed this beautifully when he said that Jesus saw in this man the full splendour of human creation that had been externally dimmed through the suffering of his illness.[4] The injustice *towards* the man needed to be addressed, not the nature *of* the man.

With these remarks in mind, I wish now to suggest a response to the question I posed earlier: What aspect of God's own *completeness* is reflected in the life of a mentally ill person?

It is said that if you have to give someone a crash course

in Christianity, two doctrines will suffice: the doctrine of the Trinity (which tells us who God is) and the doctrine of the Incarnation (which tells us who God is for us). As I have mentioned, relationships are intrinsic to being human and in this we reflect the life of the Trinity. This tells us something of *what* our human nature is. The Incarnation – that God became one of us – adds, I believe, the reason *why* we are persons in God's image. God longed to experience the texture of human creation so that human creation could share in the texture of God. It takes us from *a way of being* to a *manner of acting*: in terms of moral philosophy, from *is* to *ought*.

The doctrine of the Incarnation proclaims that in Jesus Christ God assumed our human nature without ceasing to be the second person of the Trinity. But it is the *reason* behind this divine initiative that is of particular importance to our topic today. Jesus himself said: God so loved the world he gave his only Son (Jn 3.16). Jesus' human nature is constituted as such by a specific act of divine love. God gives his very self a human life so that God could be in communion with us, as one of us. In the words of St Paul: "Though being in the form of God, Jesus Christ did not count equality with God a thing to be grasped, but emptied himself to take on a human form" (Ph.2:6-8). In our Christian faith, this divine act of self-emptying is most fully reciprocated in the human self-emptying of Jesus on the cross.

It is the Crucified One who is the definitive human icon of the divine image. This man, in the midst of his suffering, remains true to himself – that is, fully human – in an act of sacrificial love. … [T]he crowds were appalled on seeing him – so disfigured did he look that he seemed no longer human…; a thing despised and rejected by men, a man of sorrows and familiar with suffering, a man to make people screen their faces; he was despised and we took no account of him: (Is 52:14; 53:3). These words of the Prophet Isaiah are applied to the person of Jesus. A broken, torn, despised body – emptied as an act of utter self-giving – reveals the heart of what it means to be fully a human person.

In an analogous way, Isaiah's words can also apply to persons living with mental illness. We are challenged to recognise in them the broken Christ and to accord them the dignity and reverence we would give to Christ himself. If anything is to be the 'measure' of true personhood, it is the communion created in the reciprocal act of love between persons. Any – and every – person 'made in God's image' can participate in this communion, no matter how externally dimmed that image might be. In a paper on mental health given in 1997, Cardinal Ratzinger captured this truth well: Our value in the eyes of God does not depend upon intelligence, stability of character, or… health… Our value in the eyes of God depends solely upon the choice we have taken to love as much as possible.[5]

The phrase 'as much as possible' is particularly significant when we consider the mentally ill for whom the mystery of suffering is so potent and the need for love so acute. What does God experience of himself in the suffering of the mentally ill? God experiences his choice to be in communion with his own. Dignity belongs to persons, and human persons are made to be with God in a communion of life and love.

3. Not tolerance, but gift: a possible framework

Thus far we have explored a theological understanding that seeks to identify the dignity integral to our nature as persons. I am mindful, however, that this is not the only path to establishing a set of rights that recognise the dignity due to all persons, including – and especially in today's context – those with a mental illness. We here share a common commitment to ensuring that the rights of the mentally ill are accepted and honoured in society. However, this commitment encompasses an additional responsibility. We must make certain that these rights rest on a solid foundation: pillars need foundations and the foundations largely determine the moral weight that the pillars can support.

Late last year Sydney experienced a weekend of rioting. For those of you not from these parts of the world, it was nothing like the Paris experience. Nonetheless, it was an ugly affair, ignited by racial issues and fuelled by alcohol and testosterone. At the time, and ever since, there have been persistent calls for greater tolerance among the various cultural groups in our society.

At much the same time as the Sydney riots, the NSW police were bringing to public attention their increasing intervention in situations involving people with mental illness. From their perspective, police have been inappropriately manoeuvred onto the front-line of mental health action, especially in acute crisis situations. They, too, are appealing for tolerance, in this context a more tolerant and less institutional approach to the mentally ill.

Tolerance has a particularly strong place in Australian culture. It is both a word and an idea that has made its way into our national psyche. We pride ourselves on being a tol-

erant society, ready to welcome and embrace people of all nations and traditions. We label intolerant behaviour as 'un-Australian'. Tolerance is also a word that has made its way into Australian Catholicism, especially in the education scene, as a key interpretive tool of the Church's social justice teaching.

Yet, I find talk about tolerance somewhat alarming because, by definition, it does not demand much of us. Tolerance does not require any real meeting of persons. It simply says: I'll put up with you doing your thing, so long as it doesn't interfere with me doing my thing. Yet, we are presenting this as an ideal for which to strive! In its Australian understanding, tolerance is a deeply utilitarian idea, and for this reason alone we should tread warily.

Tolerance speaks of a culture unwilling to become involved in the lives of others, born perhaps of a desire to dominate. We are taught to climb up the social ladder of life, not climb down it: to be a competitor, not a servant. In such an environment, intolerance can easily surface in us all because we are not prepared to acknowledge our own inner fragilities.

The founder of l'Arche, Jean Vanier, who has lived much of his life in community with the mentally and physically broken, recently wrote: 'The mystery of the weak and the broken is that they call forth not only the deep well of love and tenderness in us but also the hardness and darkness'.[6] I find Vanier's words both confronting and true – perhaps you do, too. There can emerge within me a deep inner anguish when I am faced with the life and actions of a person suffering from mental illness. Uncalled-for and unbidden fear can well up in me like a poison: I do not want to become entangled in the struggles of this person whose ways seem strange to me. It unmasks my own vulnerability and insecurity and, at times, my own inner violence.

Jean Vanier makes this very point: Jesus calls us not only to welcome the weak and the rejected… but also the weak and broken person within ourselves. We are not different from the Joshuas of this world: we are simply better at controlling our fragilities. Vanier reminds us that to befriend the 'stranger' (I was a stranger and you welcomed me – Mt.25:35) is to befriend ourselves as images of God.

Yet, none of this can be achieved on a diet of tolerance. With tolerance my own darkness goes unchallenged as I simply allow the stranger to slip further into his or her world. Tolerance does not address in any meaningful way the distorted desire to dominate. In fact, tolerance relegates human dignity to a commodity. Appearance and outcome become paramount and external structures replace the commitment of persons to persons. Perhaps this is why there is a tendency in Australia to revert to institutional modes of action in addressing the mental health of people. Obviously, tolerance cannot provide the foundation on which to build a society that upholds the dignity of all people. In fact, I believe that we travel this road to our own detriment.

Where then, do we look to find a more secure framework upon which to build a common commitment to the human dignity of the mentally ill? This brings me to the final point in my presentation today.

In recent times, the concept of 'gift' has become arguably the interpretive key to the Church's moral teaching, with God's own self-giving as a paradigm for the moral life. For example, in his 1993 encyclical, *Veritatis spendor*, Pope John Paul speaks of love as the principle and source of the moral life, a love that is most fully witnessed in the "sacrificial gift of Jesus' life on the Cross": a love that is a gift "to the end" (VS §20). The moral theologian, Brian Johnstone, has provided a helpful analysis of 'gift' upon which I would like to briefly draw.[7] Something is a gift only if it can be both given and received. This presupposes the possibility of a relationship between the giver and receiver – in other words, a sense of self in relation to another. Further, the very act of giving a gift teaches the receiver how to give in turn. The very act of giving a gift enables others to become receivers and, in their turn, givers and in this way persons becomes more fully themselves in that dual sense of 'all of me' and 'one of us'.

But it is not only the act of giving and receiving that is important here: the gift itself has moral significance. Something can only truly be a gift if it can be freely given *and* freely received. Not all ways of human interaction, nor all things exchanged, respect this fundamental freedom. There are some things which the giver is not free to give. Likewise, not all 'gifts' are about protecting the freedom of the receiver. The moral structures of justice are needed to ensure that gift, giver and receiver are all in a coherent right relationship with one another.

Unlike tolerance, gift giving is truly other-centred. Gift giving says: you are important to me and somehow I am created in and by my giving to you and you receiving what I give as a gift. I truly become what I do – I give as an act of myself – and in this giving you, too, are created. I note here particularly, the giving and receiving of our bodily reality.[8] Our bodies are not processions to be disposed of, but gifts caught up in the very act of giving and receiving – and at times all we have let to *give of* or to *receive with* is our bodies. Such a reality lies at the heart of the Eucharist: "This is my body given for you… Do this in memory of me".

I believe this understanding of 'gift' offers a robust foundation on which to build a moral framework capable of strongly upholding the dignity of each person. With tolerance there is really no exchange of gifts between persons: it precludes the possibility of com-

munion between persons. However, by committing to the internal structures of 'gift', communion can be achieved. I can think of no better image to capture this than St Paul's extraordinary insight that we are all a part of the one body: 'God has put all the separate parts into the body as he chose… What is more, it is precisely the parts of the body that seem to be the weakest which are the indispensable ones. It is the parts of the body we consider least dignified that we surround with the greater dignity; and our less presentable parts are given greater presentability, which our presentable parts do not need. God has composed the body so that greater dignity is given to the parts which were without it, and so that there may not be disagreements inside the body but each part may be equally concerned for all the others' (1Cor 12:18-25).

Who was Paul thinking of as the weakest, the least dignified, the less presentable? Perhaps we can see here those who suffer from mental illnesses: so often they are hidden away, alienated, isolated. To these Paul says: you are the indispensable ones, you are the greatly honoured; you are the necessary gift to each of us if we are to complete ourselves. And when you suffer, we suffer also.

The presence of mental illness in human lives can seem such a paradox. These people, whom we struggle at times to recognise as 'one of us', oblige us to look more deeply into our own lives. What is it that is at the heart of being a human person? Whose dignity is to be upheld? Why does one person's suffering make a claim upon others? Perhaps, answers to these questions will come only when, like God, the mentally healthy see themselves in the mentally ill, and come to love the gift they receive.

As I was preparing this talk, I tried to keep in mind those whom I wished to address. You may be surprised to learn that you are not the totality of my intended audience. The ideas I have presented are not entirely new to health professionals who are on the front line of care for those with mental illness. Nor should they be new to Church leaders who have a particular responsibility to live the Gospel of the poor, the sick and the little ones of society. And I'm sure much of what I have said is very familiar to those of you who either live with a mental illness or share the life of a person with a mental illness.

It is my hope that, through you, I might be able to touch a wider audience comprised of people who in their day-to-day living, come into contact with individuals and families that live with mental illness and struggle to know what to do and how to respond. Perhaps there is something in what I have said that could be taken to these people: maybe something about being a human person – the all of me and the one of us; or perhaps something of the understanding of gift; or even better, the story of the encounter between Joshua and Jesus. May I be so bold as to invite you to become an emissary, a messenger of hope, to: '*Go home to your people and tell them all that the Lord in his mercy has done'...* (Mk 5:19).

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Notes

[1] For a thorough presentation of the position adopted in this section of the paper see: GERALD P GLEESON, *Being Human: A Reflection Paper Commissioned by the Australian Catholic Bishops' Conference Committee for Doctrine and Morals* (Canberra: ACBC, 2004), and International Theological Commission, *Communion and Stewardship: Human Persons Created in the Image of God*, 2004, found at: http://www.vatican.va/roman_curia/congregations/cfaith/cti_index.htm.

[2] JOHN PAUL II, 'The Mentally Ill Are Also Made in God's Image', in *Dolentium Hominum* No.34 (Year XII – No.1) 1997, p.8.

[3] N T WRIGHT, *Jesus and the Victory of God* (London: SPCK, 1996), p.194.

[4] JOSEPH CARD. RATZINGER, 'The Likeness of God in the Human Being', in *Dolentium Hominum* No.34 (Year XII – No.1) 1997, p.18.

[5] RATZINGER, *ibid.,* p.19.

[6] JEAN VANIER, *Befriending the Stranger* (London: Darton, Longman and Todd, 2005), p.64.

[7] BRIAN V JOHNSTONE, 'The Gift: Derrida, Marion and Moral Theology', *Studia Moralia* 42/2 (2004), and 'Intrinsic Evil Acts', *Studia Moralia* 43/2 (2005).

[8] TIMOTHY RADCLIFFE, 'How to Discover what we Believe', *The Tablet* (28 January 2006), p.12.

Where to from here?

SPEECH BY MONSIGNOR DAVID CAPPO, 9 FEBRUARY 2006

We come together at this important international event to affirm the human dignity of all people; an equal human dignity given to every person, made in the image of God.

Also, we come acknowledging that human nature is both frail and limited, in need of the love and grace of God. We see a broken world and much suffering. We strive as disciples of Christ to assist in bringing about his Kingdom, a healing Kingdom; a Kingdom which seeks justice and dignity for all humanity.

The frailty of the human condition seen in mental illness has many forms, some mild and some very acute and very debilitating. His Holiness Pope Benedict XVI says in his message to us for the World Day of the Sick that mental illness throughout the world is "a real and authentic social-health care emergency."

The key to overcoming this emergency is confronting negative attitudes to mental illness and the provision of strategic and proper services for people suffering mental illness.

We know that the global burden of mental disorders is staggering. Neuropsychiatric disorders account for 31% of the disability in the world – and they affect rich and poor nations and individuals alike.

As His Eminence Cardinal Barragan informed us, as we gather here today there are at least 450 million people dealing with a mental or neurological disorder worldwide. One-hundred and twenty-one million people are suffering from depression, twenty four million people dealing with schizophrenia and fifty million people with epilepsy. Every year, 873,000 people commit suicide and ten to twenty million attempt suicide.

For our Oceania region, this represents some 7 million people who are dealing with one or more of these mental or neurological disorders (WHO: *World Health Report 2002*).

In 1959, almost 50 years ago, the World Heath Organisation warned that "efforts to have the mentally ill treated as other sick people who can be cured are likely to remain fruitless as long as the irrational fear of 'madness' is not conquered." Clearly, we still have a long way to go. In Australia, despite our economic and technological affluence, despite our auras of sophistication, the discrimination associated with mental illness has never gone away. It just seems to disappear for a time, only to reappear, almost insidiously, when circumstances and opportunity permit. And sadly, the context of today means that we must work even harder to change these attitudes. The historical record of this early part of the 21st century in Australia may well define it as a period where fear challenged the cohesion, compassion and good sense of a country built on the principles of a 'fair go'.

On a more positive note, the record is also likely to show that, almost ironically, many of our regional neighbours, Papua New Guinea, Fiji, will reap enormous benefits from *not* being in a position to have psychiatric units as the mainstay of their mental health systems. Around the globe, and because of necessity, developing nations have recognised that provision for mental health care must be integrated at the local health centre, dispensary or village health post level. And the key figure in such a venture is the primary health worker (a community nurse or allied health professional), working through existing local community structures and resources such as school teachers and volunteers. I understand, for example, that Fiji has invested heavily in education, and the high level of participation by the community is credited as the single most important factor explaining Fiji's progress in health education development.

The majority of people with mental health disorders throughout the Oceania region are still connected to the community and this will result in greater acceptance and allows for community involvement in mental health care. This fosters strong partnerships between professionals and families unlike anything that we see in the developed world. As recently as 12 January this year, His Holiness Benedict XVI made particular mention of mental illness in an audience with civil administrators and called upon them "not to leave without adequate help families which often find they have to cope with very difficult situations."

It is also clear that developing countries are recognising the importance of incorporating traditional healing in their systems. This creates that essential cultural bridge which we are still struggling in Australia to understand and incorporate into mental health services for our indigenous communities.

This is the stuff of contemporary national plans and visions in Australia that we now recognise as 'best practice' but we are still trying to implement. It is vital that you recognise this integration as an immense strength that will stand you in good stead for the future.

On the other side of the ledger, it is important to recognise that psychological and social distress appears to be increasing worldwide. In developed nations this is seen as a direct effect of social change. In developing countries, there is increasing evidence that higher levels of distress can be linked to the planned development projects that import economic and technological change without heeding the social impact and the effect on the national psyche. It is important that we all recognise the potential threat and the opportunities for developing countries to avoid the pitfalls of the developed world.

I want to turn now to talking

about the challenges that inevitably we all face in influencing policy settings and service development planning in mental health. Where to from here? And I particularly want to focus on the constructs of social inclusion being used here in South Australia and other parts of the world.

A social inclusion construct begins with the recognition that issues such as poor health, homelessness, crime rates and poverty are interconnected in their causes. Therefore responses and solutions to these causes must be interlinked and focused on clear outcomes.

From a social inclusion framework, there are three key issues that need to be addressed.

Firstly, the degree to which mental health is separated from, often excluded from, the mainstream reform agendas for physical health. There is an increasing understanding of the close inter-relationship between mental health and physical health. Studies in Australia have shown that just under half of those with a mental health disorder had a chronic physical disorder. Many people with undiagnosed affective disorders will present with somatic symptoms. The sense that mental health is managed as an acute illness could separate those people from the significant mainstream thinking about system reforms for chronic illness that are now centre stage in developed countries.

Secondly, we need to focus on services for children and young people and the degree to which these are again separated from developments in universal care particularly around the early years of life. The issue of children living with parents with a mental illness is only now beginning to make it onto the policy agenda in Australia. Throughout Australia and other countries many young people are the primary carer of a parent with a physical or mental illness. This goes largely unrecognised by our policy makers and our services, and means that many families live in great stress and have inadequate quantity of services around them.

Thirdly, there is evidence that people with serious mental illnesses are likely to have the worst social outcomes. Even for people with more common mental health problems, there is real risk of social exclusion, of withdrawal and a lack of connection with the community. We must not only improve access to accommodation and support services but also assess whether clients with a mental illness are getting effective services through existing accommodation and social care programs. I understand that many professionals in the mental health system often have low expectations of what people with mental health problems can achieve both in employment or when contributing to society and this is likely to be reflected in their case planning and management.

The words of our late Pope, John Paul II, on the dignity of work resonate within as I reflect on this issue. In his encyclical *Laborem Exercens* (1981) the Holy Father said:

'Work is a good thing for man – a good thing for his humanity – because through work man *not only transforms nature,* adapting it to his own needs, but he also *achieves fulfilment* as a human being and indeed, in a sense, becomes "more a human being"'.

I believe that the lack of meaningful activity in the lives of many people with mental illness and the fact that many spend much of their time alone represents one of the most profound and unacceptable social exclusions. It is an issue we must work together to address.

Underpinning these three key themes is a range of issues that are disturbingly common across Australian jurisdictions, and indeed, internationally. In his address, Professor Ian Hickie has given us an invaluable insight into the mental health system in Australia.

There can be little doubt that in moving away from one form of institutionalisation for people with mental illness, we have new institutions. They are our prisons and remand centres, our homeless shelters our boarding houses and hostels. The churn of mentally ill people through our prison system is alarming and needs great attention.

Also, one of the most important battles that we face with mental illness is ensuring that people have a better understanding of the options for treatment particularly for depression. Solutions that are based on solid scientific evidence are now available because we know more about brain functioning and behaviour than every before.

The work of the Beyondblue organisation and the inspirational leadership of Hon. Jeff Kennett former Premier of Victoria cannot go unacknowledged in this context. It was wonderful to hear from Gary MacDonald talking about the work of the organisation and his own experiences with depression.

And we need to respond to the demoralisation that afflicts the workforce in our mental health service systems. It goes beyond individual services, regions or States and it creates a level of psychological distress for staff that is continually reinforced by the inability to provide appropriate, effective and safe services for the people to whom they are deeply committed. We have to understand in Australia that every day we do not address the system failures is another day where we chip away at the resilience and self-respect of the hard working committed people that struggle to keep an outmoded system going.

As Anne Deveson reminds

us in her presentation today and her work on what it is that enables some individuals and communities to rise above adversity and still find hope and meaning, resilience is about connectedness.

We face probably our most significant challenge in reforming our mental health system, as we see the professional 'hope and meaning' that keeps our practitioners connected to their chosen field increasingly eroded.

In this regard I must acknowledge how valuable it is to be able to learn from the ground-breaking experiences of our near neighbour New Zealand. A country recognised around the world for creating a blueprint for reform and implementing that reform on the ground.

Clearly, Federal and State Governments have an important leadership role in the delivery of mental health services and in the reform of our mental health services. They must also acknowledge that non-government agencies will be key players in the adequate provision of community services for sufferers of mental illness, and in turn have a leadership role as well.

The Catholic Church as an international leader in many humanitarian causes also has a leadership role in mental health. And as Cardinal Barragán outlined for us, the Church is already fulfilling this role in many parts of the world. And doing so insisting on a holistic understanding of the psyche and a deep respect for the human dignity of people with a mental illness.

In his address on human disturbances of the human mind, the then Cardinal Joseph Ratzinger reminds us that "one of our tasks as Christians for our brothers or sisters who suffer from mental illness is to ensure that their humanity, their dignity and their vocation as creatures in the image and likeness of God are fully recognised, respected and promoted."

Seeing this as our task, and building on the guidelines for practical interventions suggested by Cardinal Barragán, I would like to present a challenge to our Catholic health and social welfare agencies in Australia.

We have an opportunity through the pastoral care services that our Church organisations provide to the socially disadvantaged to make a difference.

We have an opportunity to ensure that people with mental illness are cared for through our health and social welfare services in ways that support rehabilitation. For example, by providing access to work through employment services provided by Church agencies.

And we have an opportunity to integrate many of our existing health and social welfare services to provide holistic and respectful services to people with mental illness.

Let us embrace these opportunities.

I understand the deep commitment that our management and staff bring to the day to day work of supporting and caring for those in need, particularly in the context of high levels of demand and finite resources.

Yet in the face of this demand we must focus on the dignity of people experiencing mental illness and on the real and authentic social-health care emergency referred to by the Holy Father.

In closing I would like you to consider the aspiration of a young women with a psychiatric disability who was an US adviser on mental illness. She said: "I'd like my psychiatric health needs to be part of all my health needs, my psychiatric services to be delivered in natural health settings, and the language about psychiatric disability to be the language of all health and disability. When I am isolated and ignored because of my psychiatric disability, when I am distinguished unjustly and my rights disregarded, that is prejudice; that is discrimination. Calling it by a word only used for mental illness ["stigma"] allows people to separate the wrong from other social injustices."

This World Day of the Sick 2006 held here in Adelaide has the ability to give a clear pastoral message to policy makers in the mental health area as well as those operating services. You are to be honoured and supported in your work. You are not alone. Many see the problems you see and we are becoming more focussed giving more energy to your needs; your urgent needs.

And to so many people suffering mental illness, we state our clear commitment to acknowledge and affirm your human dignity and the assist in providing dignified and integrated services for your wellbeing and the wellbeing of the community.

Thank you for your kind attention.

Msgr. DAVID CAPPO
Vicar General,
Archdiocese of Adelaide,
Australia.

Health Pastoral Care in the Church

10 FEBRUARY 2006

One of the most important tasks of the Pontifical Council for Health Pastoral Care is to guide people in issues concerning pastoral care in health. The aim of this study is precisely to answer the question: "What do we mean by the Council for Health Pastoral Care?"

After a preliminary consideration on the meaning of pastoral care in health, we will discuss three issues, namely: what is the present situation of health pastoral care worldwide, the positive and negative aspects; the meaning of health pastoral care, according to the evangelical and pontifical proposal and the elaboration of the proposals by the Council and, lastly, what should practically be done in this field, what are the challenges, the proposals, the ways to be followed and the answers.

Starting from this perspective, we are going to offer some guidelines that seem to be important for the planning or enhancement of the organization of health pastoral care within the Catholic Church. There may be several levels, but the content does not change, it will always be health pastoral care. Certainly, suggestions can be accepted for its organization and enhancement at the level of the Bishops' Conferences, dioceses, parishes, as well as the religious Orders and Congregations that work in collaboration with the bishops in the field of health pastoral care worldwide.

PRELIMINARY REMARKS

1. Biblical Foundations

A general answer as to the meaning of Health Pastoral Care can obviously come from the Word of God. It is the Lord who tells us what Health Pastoral Care is, and all our reflections can only be a development of what He tells us.

In general, we can say that chapter 10 of John's Gospel, where Jesus Christ tells us that he is the Good Shepherd (Jn 10:1-21), offers us the primary approach to understanding the whole of pastoral care. In synthesis, we can say that he focuses on three fundamental features: he speaks to his sheep and they listen to his voice; he feeds his sheep, to the point of giving his life for them; and he gathers them in the sheepfold, where they should all converge and where he defends them against the wolves.

To be able to understand the link between the Church and health, we need to analyse the mission of the disciples and apostles. In Luke chapter 10, the disciples are sent to heal illnesses (Lk 10:9) and in Mark chapter 16, when Christ finally sends the apostles he tells them to heal the sick (Mk 16:18).

If we now wish to put these two concepts together, pastoral care and health, and see how we could carry out health pastoral care, we can join John's chapter 10 with Mark chapter 16 (as well as Luke chapter 10). Reading them together we see that health pastoral care consists in curing the sick and making them hear Christ's voice, in feeding them to the point of giving our life for them, in gathering them all in Christ's sheepfold and in defending them against the wolves.

I. THE PRESENT SITUATION

The first question that we ask ourselves now concerns the current situation of health pastoral care in the Church.

Looking at the statistics, we realize that today there are 109,363 Catholic health centres worldwide. These include asylums, dispensaries, orphanages, re-adaptation and rehabilitation centres, mother and child centres, etc. 5,236 are real hospitals. Many of these centres have been set up at the level of parishes, others at the level of dioceses, while others are national and are directed by bishops, religious Orders and Congregations, or by charities.

It is worth noticing that in almost all Bishops' Conferences there is a Department for Health Pastoral Care, directed by a Bishop appointed *"ad hoc"* by the same Bishops' Conference.

In addition to this, there are various associations for health pastoral care: chaplains, men and women religious, physicians, nurses, pharmacists, volunteers, hospitals, who are all in close contact with health care authorities, at diocesan, national and world levels.

If we focus on the continent of Oceania, according to the most recent figures available to us, this is the institutional framework for health pastoral care: 2,064 Catholic healthcare centres, comprising 152 hospitals, 406 dispensaries, 2 leprosy centres, 381 charity homes (for chronic patients, disabled and elderly people, etc.), 64 orphanages, 87 nursery homes for children, 260 marriage advisory bureaus, 554 special re-education centres, and 58 various institutions.[1]

1. Positive Issues

All what is mentioned above is positive; however, we would like to underline in particular the presence of bishops in charge of health pastoral care in each Episcopal Conference, the efficacy of international associations of catholic doctors and nurses, the starting of a union of hospitals operating within the Catholic Church, the union of hospital chaplains and the interest of several Bishops' Conferences in health pastoral care, manifested to this Pontifical Council during their "*Visita ad Limina.*"

2. Negative Issues

A first negative issue that one observes in health pastoral care is that of secularism. Because of the latter, pain, suffering and death are concealed or presented in a distorted manner. Quite often, a false idea of the virtue of charity is introduced, that is, it is presented as mere philanthropy, so as to gain acceptance in the contemporary world. Many times, health pastoral care is obscured by shades of pain, making it lose an essential element that should characterize it, that is, faith in the Resurrection. If both faith and charity fail, the virtue of hope too is weakened and, instead of celebrating Jesus Christ's victory over pain and death, health pastoral care is merely focused on charity and compassion.

II. WHAT IS HEALTH PASTORAL CARE?

Gospel Proposal

If we wish to deepen the answer we have been suggesting in our opening remarks, we can succinctly consider four points: a general review of healings accomplished by Jesus Christ; the enumeration of the basic elements derived from these healings, in order to carry out health pastoral care according to the Gospels; the evangelical way that we can design on the basis of such elements, so as to actually implement health pastoral care and the synthesis of this way, in the model of the "Good Samaritan".

1. General View of Healings in the Gospels

In the Gospel of Mark we come across the following miracles: the healing of Peter's mother-in-law, the healing of the paralytic, who is brought down through the roof, the resurrection of Jairus's daughter, the healing of the bleeding woman, the man with a dry hand, the deaf and dumb, the blind man from Bethsaida and of leper.

Mathew reports the healings of the centurion's servant, of two blind men, of the deaf and dumb and of two blind men from Jericho.

In Luke, we meet the resurrection of the son of the widow of Naim, the healing of the hunchbacked woman in the synagogue, of the dropsy sufferer and of 10 leprous men.

John reports the healing of the centurion's son, of the paralytic from Bethsaida, of a blind man and the resurrection of Lazarus.

On the whole, the Gospels report 22 miracles, but it is evident that for the synoptics, many times different evangelists refer to the same miracle.[2]

2. Basic elements for Health Pastoral Care in the Gospels

Reflecting on these narratives we can identify the following elements that, having been developed by Jesus Christ when healing the sick, will always be present in health pastoral care accomplished according to the Gospels. We enumerate the following: touching Christ, seeing Christ, hearing Christ, the resurrection, salvation, life, the theological virtues of faith, hope and charity, prayer, praise, thankfulness, friendship, compassion, forgiveness, personal identification of the sick and touch. In all, there are fifteen major levels in Christ's approach to healing the sick, which should be considered when outlining the direction to be taken by health pastoral care in the evangelical path.

3. The Evangelical Way for Health Pastoral Care

If we now wish to outline, on the basis of the above elements, the path that health pastoral care should take, in order to follow in the footsteps of Christ, the Good Shepherd, in healing the sick, we could say that the path for health pastoral care consists in realizing the vital link between the world of health care and Jesus Christ, by showing his salvific presence as a source of love and as a way to master life. In this health pastoral care, it is necessary to hear and see Christ and be full of hope for the resurrection. Each person should be fully friendly, tactful and should identify with each patient; should be compassionate, forgiving, remove any form of alienation and strive to see that health pastoral care converges both in the Resurrection of the Lord and in one's own. In order to follow this path, the three virtues of faith, hope and charity should be revived, and deepened by means of prayers of petition, commendation and gratefulness to the Lord.

4. A Practical Synthesis of the Gospel Proposal

The practical synthesis can be reached if we see in the parable of the Good Samaritan (Lk, 10:25-36) Christ himself (the emblem of our Pontifical Council).

Eight elements can be identified in this parable: (i) the Good Samaritan is fully conscious of the reality, he sees the wounded man; (ii) he feels compassion, he is touched; (iii) he treats him, he puts vinegar and wine on his wounds; (iv) he shares his property, he puts the wounded man on his horse; (v) he entrusts him to competent people, he puts the wounded man in the care of the hotel owner, (vi) he spends his money and gives him two coins, he is

completely generous, (vii) if anything lacks…; (viii) he checks the results when he returns.

Pontifical proposal

How does the teaching of the Church, especially that of Popes John Paul II and Benedict XVI, view the evangelical proposal on health pastoral care?

The answer can be found especially in 7 Documents: *Gaudium et Spes, Dolentium Hominum, Pastor Bonus, Salvifici Doloris, Message for the Year 2000* (Message for the World Day of the Sick in the Jubilee Year), *Novo Millennio ineunte* and the Address of Pope Benedict XVI to the Pontifical Council for Health Pastoral Care on the occasion of its XX International Conference.[3] In these documents, the Popes establish the tasks of the Pontifical Council in the field of pastoral care in health, and the finality of the Pontifical Council itself. This is also valid for particular Churches.

The pontifical proposals are the following four: to offer guidance on health, focusing on pain, disease, suffering, death and life; to unite health care professionals, bishops, chaplains, doctors, nurses, pharmacists, administrators of health care centres, volunteers etc.; to be in touch with particular Churches, with international, national, regional and local organisations working in the field of healthcare; to be up to date with problems of health: at the scientific, technical, legal and political levels.

If we want to organize these pontifical proposals according to health pastoral care as described in the opening remarks, then they should be ordered according to the there mentioned characteristics: listening, feeding and uniting. These characteristics are the foundation of the three ministries existing in the Church: that of the Word, of Sanctification and of Communion, according to which, and in the direction of which, we are now going to organize the magisterial teaching.

1. The Word

This is the teaching of the Church on fundamental issues, such as life, death, pain, disease, anxiety, etc.. John Paul II notes that at the centre of the teaching on health pastoral care we find Jesus Christ who suffers in those suffering; our suffering is his suffering and, because of this, is transformed into the joy of his Resurrection. As a result, health appears as a tension towards harmony, which is understood and lived thanks to the love of the Holy Spirit, since the Holy Spirit is the only one that can unite us with Christ.

Therefore, in health pastoral care, both training and a profound study of the essence of the human condition are extremely important. Ethical and religious training is indispensable, in seminaries, as well as in Catholic universities and in the elementary cathechesis. Moreover, the reality of health care systems and their orientations in different countries should be thoroughly studied and special attention should be given to their proposals in the various programs on health care which they intend to carry out.

In the above-mentioned address of Pope Benedict XVI, the Holy Father emphasises the renewal and deepening of health pastoral care, keeping in mind current developments in the knowledge of health care issues, as diffused by the mass media, and the high level of education of the people to whom they are addressed. Consequently, the Pope says that it is necessary to carry out a clear and profound formation of human consciences and to enlighten them, especially as regards the ethics of biogenetics, in order to guarantee that each new scientific discovery may serve the integral good of the person, always in full respect of his individual dignity. It is therefore evident that health pastoral care should count on competent and well-trained advisers. Within health pastoral care it is absolutely necessary to update priests and educators on these issues, so that they may assume their responsibilities, in line with their faith, in a true and respectful dialogue with non-believers. In such a way, our own expectations, along with our need for assistance, can be adequately guaranteed and met. Health pastoral care should also study the proper methodology to assist people, their families and society as a whole, so as to ensure an incisive presence of the Church in this pastoral field. It will be necessary to combine loyalty to the doctrine of the Church with openness to dialogue with the contemporary health world. As a result, we should carry out a deep theological study of all these issues and increase our capacity for mediation.[4]

As a result, it is extremely important to take a stance in the new frontiers and be up-to-date in the scientific, technical and legal novelties, at a local, national and world level.

2. Sanctification

Health pastoral care manifests the solicitude of the Church for the sick and the suffering. It also requires special attention to health care workers. Pastoral care in health should always start from the face of Jesus Christ, at the same time agonized and glorious, and should accomplish the Redemption that Christ offered us, both in illness and in death itself. Pastoral planning should include the way to sanctification in health pastoral care. It should start from the holiness of life through prayer, the sacraments of the Eucharist and Reconciliation, Grace, and the

Word of God. It should make us converge in the Communion of the Trinity.

3. Communion

To accomplish communion in health pastoral care it is necessary to coordinate it in an intelligent way: all the associations of health care workers should be properly coordinated and contacts should be kept with the local Churches and with healthcare organizations, whether they are Catholic or not, at local, national and international level.

Operational Synthesis

If we wish to summarize the pontifical proposal for pastoral care in health, we could state that its task is to show the concern of the Church for the sick and the suffering, through its doctrine, coordination, its contacts and research activity.

ELABORATION OF THE PONTIFICAL PROPOSAL BY THE COUNCIL FOR HEALTH PASTORAL CARE

In agreement with the evangelical proposal, as interpreted by the Holy Father in the above-mentioned form, the Pontifical Council for Heath Pastoral Care proposes one general objective and three specific goals for health pastoral care.

General Objective

The general objective is: manifesting the face of Christ, both agonized and glorious, in line with the Apostolic Letter *Novo Millennio Ineunte,* in order to enlighten, through the Gospel, the world of health, sickness and suffering; sanctifying the sick as well as health care workers and coordinating pastoral care in health within the Church.

This general goal is in line with the Apostolic Letter *Novo Millennio Ineunte*, where the Church as a whole is invited to plan its pastoral action by taking as a starting point the face of Christ both agonized and glorious. John Paul II explains this paradox of Christ being both agonized and glorious by saying that when he is on the Cross, despite his extreme suffering and pain, he never stops being God. He is both God and man in the mystery of his death on the cross. This paradox meant the resurrection. Therefore, the goal of health pastoral care should always be to evangelize pain, suffering and death, starting from the death and the resurrection of Christ.

Specific Goals

These specific goals should be ordered in agreement with the organization envisaged in the pontifical proposal, that is, on the basis of the three ministries of the Church: the Word, Sanctification and Communion.

Goal of the Word

To enlighten, through the Gospel, the world of health, illness and death, transmitting to it the strong testimony of the Resurrection.

In this goal, we wish to highlight in particular the virtue of Hope, in order to answer the problem of immanent secularism. We do not want to remain in a deistic type of transcendency, but rather in a transcendency revealed by Christ, by means of his death and resurrection.

Goal of Sanctification

To sanctify both the sick and healthcare workers, so that they may be united to Christ's death and resurrection.

In agreement with the Holy Father's teaching in *Salvifici Doloris*, it is our goal to evangelize the world of sickness and health by integrating what is missing in the Passion of Christ, because this is the only way to respond to the absurdity of death and the effects of pain and diseases.

This goal is mainly the goal of prayer, whereby we ask Christ to take up our death, suffering and pains in his own Passion and death, thus offering us the only possible and true health. In this goal, we obviously realize that health is not merely made up of wellbeing, but rather of happiness, which is reached whenever we head towards the harmony of life, by taking the only possible way, that is accepting the cross and living in the Crucified Christ. This life is only possible if Christ gives it to us, that is, when he takes upon himself our death in his death and all the evil of the world. It is the meaning of Christ who comes to take away the sin of the world. This union is effected by the Holy Spirit. Therefore, the goal of the health pastoral care is to raise prayer, so that the Holy Spirit may

give us health, by joining us in Christ, dead and risen.

The Goal of Communion

To coordinate health pastoral care, in order to accomplish ecclesial communion.

Our task in health pastoral care is solidarity. The sheepfold mentioned by Christ when he presents himself to us as the Good Shepherd (Jn, 10) is built upon an image, in the Holy Trinity, where life is supreme harmony in infinite mutual donation. Through this, it is possible to achieve the union of all in health pastoral care by accomplishing a reciprocal loving donation, in order to actually implement a pastoral care in health that brings life in abundance.

In this way, Christ builds his body, which is the Church, whereby each one of us, according to the measure of his own donation, receives the Spirit to accomplish his mission in this form: "making the truth in love, may grow up in all things into Him who is the head – Christ – From whom the whole body, joined and nit together by what every joint supplies, according to the effective working by which every part does its share, causes growth of the body for the edifying of itself in love." (Eph 4:15-16). This is the way of realizing in health pastoral care the union of all pastoral workers among themselves and with Christ, dead and risen.

III. WHAT SHOULD BE DONE?

With regard to the realisation of this pastoral care in health, I would like to mention the following four points: challenges, general proposals, paths and answers.

1. Challenges

One of the challenges consists in guiding it. As we have already said, it is not mere philanthropy or even a feeling of solidarity and compassion for the disabled or suffering humanity, or a mere social commitment that we have towards the poor and unprotected. The challenge consists in proclaiming it according to the Goal of the Word, as we noted above. It is the proclamation of the Lord's resurrection. That is to say we do have answers to the most profound problems of mankind and therefore to death. Today, we usually say that a respectful silence is more valuable to delicately accompany these people in front of unbearable situations. But saying that reveals a lack of faith, when we have answers, or better, if we do have the answer of Christ, dead and risen.

Another challenge consists in promoting it. We may get the impression that in some places this pastoral care, once a real priority, is now starting to be forgotten. It is too often absent from pastoral plans. Here we are perhaps running into the problem of secularism, as we mentioned earlier.

The third challenge consists in trying to unify health pastoral care in the Church. We are trying to accomplish this, or, rather, we have always accomplished this, but we now need to increase coordination at all levels: international, national, diocesan and parish.

2. General proposals

Generally speaking, these proposals refer to the first challenge related to coordination. We shall refer later to the two other challenges.

We propose to organize health pastoral care in each country; to keep in touch with the Pontifical Council; to have diocesan, regional and national coordination.

3. Paths

We wish to point out four different paths we should follow in the field of health pastoral care. First of all, to offer guidance on the meaning of health, suffering, the problems raised by the new age we are living in, the complex problems raised by bioethics, by the relationships between globalization and health, by the economy, by politics and by health. Second, to collaborate with the various health workers, such as doctors, nurses, pharmacists, volunteers, hospital administrators, bioethics committees, etc. Third, to favour the development of sanctuaries, where many people go to pray for their health, Catholic Schools of medicine, schools for nurses, health organizations, both Catholic and non-Catholic, public and private. Fourth, to accompany people in asserting their rights to health care; in keeping up to date with the most recent advances in science and technology and in biogenetics; in facing problems of the socialization or re-privatization of medicine; in dealing with emerging diseases, such as AIDS or drug addiction, or re-emerging ones: tuberculosis and malaria and other diseases that are sexually transmitted.

4. Answers

Proceeding in this way, we can already find the answers for those who are working in the field of health pastoral care. We could even be more concrete, by identifying fields of action in each one of the ecclesial ministries, in health pastoral care.

Regarding the Word, we should develop a sound and profound theology on pastoral care in health and work closely with the catholic Schools of medicine; we should both publish and stimulate the publication of studies focused on key problematic issues raised by modern society. We need a pastoral guide for health care workers and we should promote, organize and direct meetings, conferences and research in all fields of interest, especially, today, that of bioethics.

Regarding sanctification, we should further revitalize the sacrament of the anointing of the sick, emergency baptism, especially in paediatric hospitals, Viaticum, the celebration of the sacrament of reconciliation and, whenever necessary, of marriage. We should make use of the various existing rituals for pastoral care in health,

and make them available to those who need them. It is necessary to increase the number of liturgical celebrations both for the sick and for staff in healthcare institutions. It is necessary to increase prayer, especially by sick people themselves. In accordance with the invitation of the Holy Father, the recitation of the holy rosary is to be privileged. There is the Union of Sick Missionaries who offer their sufferings in the form of prayer for the spread of the Kingdom of God.

Regarding communion, it is necessary to encourage the above associations of the sick, of the chaplains devoted pastoral care in health, of catholic doctors, of Catholic nurses, of pharmacists, of hospital administrators, and of volunteers in health pastoral care. The Association of Catholic Hospitals is also very important.

There is a need to promote the celebration of the World Day of the Sick, which is held every year in a different continent and is addressed to the whole world. We should intensify guidance in these areas by means of social communication tools; we should defuse statistics for our mutual assistance, use the Internet, know the various existing websites, make the appropriate connections and use more easily the press, the radio and the TV.

We should especially take care of sick people who are victims of the above-mentioned diseases: AIDS, drug addiction, tuberculosis, malaria, chronic diseases of the third age and cancer; we should increase palliative care and follow the correct procedures for organ donation, etc.

A very special role is played by The "Good Samaritan" Foundation, created by Pope John Paul II at the end of his life and confirmed by Pope Benedict XVI, the purpose of which is to assist financially the poorest and less protected sick people worldwide.

CONCLUSIONS

As a conclusion to all we have said above, we can state that health pastoral care represents the ecclesial call to harmonize death and life. This apparent paradox and contradiction can only be accomplished by the Holy Spirit, when he joins together suffering mankind with Christ, so that Christ himself assumes this suffering and this death, incorporating them in his own passion and death. This union accomplished by the Holy Spirit is not limited here; rather, by uniting us to the suffering Christ he at the same time unites us to the risen Christ. Thus, the Spirit unites us to the victorious Christ, who re-creates the whole universe, and accomplishes the eternal decree of the Father, that is, total harmony, by pacifying, through the blood of Christ, all that is in earth and heaven (Col 1:20).

Therefore, health pastoral care is not a mere project of charity in favour of the sick, but rather a profound penetration in the essential mission of the Church, a task that Christ assigned to his disciples and apostles. To accomplish this pastoral care a profound faith is needed, along with efficient charity and a hope capable of standing any challenge. This is the only way to accomplish God's plan for health pastoral care, which consists in the imitation of the life of Holy Trinity: "Making the Truth in Love" (Eph 4:15).

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

Notes

[1] Cf. *Annuarium Statisticum Ecclesiae*, 2003, p.365.

[2] Mt 8, 5-13; 9, 27-31; 12 2-23; 20, 29-34; Mk 1, 29:32, 40-45; 2, 1-12; 5, 21-43; 7: 31-37; 8, 22-26; Lk 7, 11-17; 13, 10-13; 14, 1-6; 17, 11-19; 22, 50-51; Jn 4, 46-54; 5, 1-9; 9, 1-7; 11, 38-44.

[3] *Gaudium et Spes* 10; *Salvifici Doloris*, 26; *Pastor Bonus*, 152-153; *Dolentium Hominum*, 2-6; *Message of the Holy Father for the World Day of the Sick for the Year 2000*, n. 13, in *Dolentium Hominum* 42 (1999) 9; *Novo Millennio inenute*, 28-58; *Address of Pope Benedict XVI to the Pontifical Council for Health Pastoral Care on the Occasion of the XX International Conference on the Human Genome*, 19 Novemeber 2005.

[4] Cf. BENEDICT XVI, *Address to the Pontifical Council for Health Pastoral Care on the Occasion of the XX International Conference on the Human Genome*, 19 November 2005.

Topics

A Pluridisciplinary Dialogue on Human Life

Human Life: a Precious Gift of God

Modern Society in Conflict Between the Culture of Life and the Culture of Death

Prison and Conditions for Depression

Medical Saints of Our Time: Giuseppe Moscati, Riccardo Pampuri, Gianna Beretta Molla

A Pluridisciplinary Dialogue on Human Life

A PRESUMED CONFLICT BETWEEN MEDICAL-TECHNICAL PROGRESS AND MORAL NORMS

In his address to the members of the Biblical Commission, Pope Ratzinger very rightly observed: 'You have once again come together to explore a very important subject: the relationship between the Bible and morality. This is a subject that concerns not only the believer but every person as such. And it concerns us specifically at a time of cultural crisis and moral crisis. The primordial impulse of man, in fact, is his wish for happiness and a fully successful life. Today, however, there are many who think that such fulfilment must be achieved in an absolutely autonomous way, without any reference to God and His law. Some people have even theorised an absolute sovereignty of reason and freedom in the domain of moral norms: such norms are said to constitute the field of ethics that are only 'human', they are said to be, that is to say, the expression of ethics that man gives autonomously to himself; the proponents of this 'secular morality' state that man, as a rational being, not only can but even must freely decide on the value of his behaviour'.[1] Pope Benedict XVI further makes clear, and this is what led me to write this article, that this is an erroneous belief that is based on a presumed conflict between human freedom and every form of law; and in the final analysis between the Creator and his chosen creature – man. 'In reality, the Creator – because we are creatures – has inscribed into our being 'natural law', a reflection of His creative idea in our hearts, as an interior compass and yardstick for our lives'.[2] This papal clarification provides an overall introduction to the multi-disciplinary dialogue on human life which rightly so much concerns our contemporaries, especially as regards those extreme cases in which the advances of science and technology, on the one hand, provoke wonder and gratitude and, on the other, generate worry about the human species and its dignity.[3] To enter into the subject before us, I would like to point out, first of all, the religious character of this dialogue.

1. The Religious Character of this Dialogue

'For us too Moses' invitation rings out loud and clear: "See, I have set before you this day life and good, death and evil... I have set before you life and death, blessing and curse; therefore choose life, that you and your descendants may live" (Dt 30:15, 19). This invitation is very appropriate for us who are called day by day to the duty of choosing between the "culture of life" and the "culture of death". But the call of Deuteronomy goes even deeper, for it urges us to make a choice which is properly religious and moral. It is a question of giving our own existence a basic orientation and living the law of the Lord faithfully and consistently: "If you obey the commandments of the Lord your God which I command you this day, by loving the Lord your God, by walking in his ways, and by keeping his commandments and his statutes and his ordinances, then you shall live ... therefore choose life, that you and your descendants may live, loving the Lord your God, obeying his voice, and cleaving to him; for that means life to you and length of days" (30:16,19-20)'.[4] Indeed, 'The root reason for human dignity lies in man's call to communion with God. From the very circumstance of his origin man is already invited to converse with God. For man would not exist were he not created by God's love and constantly preserved by it; and he cannot live fully according to truth unless he freely acknowledges that love and devotes himself to His Creator'.[5] Man, created in the image of God and preserved in life by Him is, therefore, by his nature 'a dialogic being' to the utmost who recognises, first of all, that his life is a gift of God, that he is able to know the existence of a personal God beginning with the creation: the material world and the human person that allow him to attain true certainties.[6] As regards the dialogue on human life, it is even more important to emphasise that 'with his openness to truth and beauty, his sense of moral goodness, his freedom and the voice of his conscience, with his longings for the infinite and for happiness, man…discerns signs of his spiritual soul…The soul, the 'seed of eternity we bear in ourselves, irreducible to the merely material',[7] can have its origins only in God'.[8] 'The world, and man, attest that they contain within themselves neither their first principle nor their final end, but rather that they participate in Being itself, which alone is without origin or end. Thus, in different ways, man can come to know that there exists a reality which is the first cause and final end of all things, a reality 'that everyone calls 'God''.[9] This religious character of the dialogue on human life – and this is what I have sought to emphasise – denotes the incomparable value of every human person from his conception to his natural death. John Paul II makes clear on this point: 'Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God. The loftiness of this supernatural vocation reveals the greatness and the inestimable value of human life even in its temporal phase. Life in time, in fact, is the fundamental condition, the initial stage and an integral part of the entire unified process of human existence. It is a process which, unexpectedly and undeservedly, is enlightened by the promise and renewed by the gift of divine life, which will reach its full realization in eternity (cf. 1 Jn 3:1-2).[10] At the same time this supernatural call emphasises two very important criteria for ethical needs: the first crite-

rion concerns relativity and the second concerns sacredness. As regards *relativity* it should be said that the earthly life of man and woman, in truth, is not an 'ultimate' reality but a 'penultimate' reality. However, this is always a *sacred reality* that is entrusted to us for us to steward it with a sense of responsibility and bring it to perfection in love and the giving of ourselves to God and our brethren.[11] This gospel of life has been entrusted by the Creator to the Church and to every man of good will, above all to theologians, to philosophers, to scientists and to technologists. As Pope Wojtyla observes: 'Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and the hidden action of grace, come to recognize in the natural law written in the heart (cf. Rom 2:14-15) the sacred value of human life from its very beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree. Upon the recognition of this right, every human community and the political community itself are founded'.[12] Specifically for this reason, Holy Scripture, Tradition and the Magisterium of the Church tells us that the vocation and the full realisation of man lies not in the rejection of the law of God but in life according to the new law. Between the law of God and the freedom of man there is no contradiction: the law of God uprightly interpreted does not attenuate or eliminate the freedom of man. On the contrary it assures it and promotes it.[13] Indeed, 'freedom…attains its perfection when directed towards God, our beatitude'.[14] The moral action of man, therefore, is directly founded on obedience to the law of God, on union with Christ and on the dwelling of the Spirit in the soul of the believer. The action of man is never action dictated by solely exterior rules: it comes from the vital relationship that connects believers with Christ and with God.[15] What has been said hitherto in this paper on the religious character of dialogue or discussion on human life between moral norms and medical-technical progress is very illuminating at our present historical time, when science and technology have revolutionised the position of the human being in relation to life, illness and death, and that way of differently approaching life, illness and death that involve innumerable ethical questions that we cannot ignore. I will now address above all else the beginning of human life and abortion in order to point out the presumed character of a possible conflict between science, technology and morality.

2. The Presumed Conflict over the Beginning of Life

In the field of procreation reference has been made for some time now to two alternative techniques, indeed techniques that substitute each other: on the one hand, *in vitro* fertilisation, with the transfer of the embryo into the womb and the freezing of embryos; and, on the other, the separate freezing of two, male and female, chromosome layettes.

In this case, given that one is no longer dealing with an embryo and thus with a new human life, this technique is said to the raise the question of the overcoming of the rejection of every form of artificial fertilisation, whether it is homologous or heterologous. I answer that from a purely biological point of view no embryo exists. And not only this: if the gametes had not been frozen, the female gamete and the male gamete would soon cease to exist. The question of the overcoming of the rejection of the artificial transmission of human life concerns first of all and above all else the ethical sphere. Every technique of artificial fertilisation must measure up to the explicit will of God. The transmission of a new human life implies a certain participation of man in the lordship of God, which is manifested in the *specific responsibility* that is entrusted to man *as regards specifically human life*. This specificity, and this is a point that I want to stress, reaches its summit in the donation of life *through generation* by a man and a woman in marriage. God Himself said: 'It is not good for man to be alone' (Gen 2:18) and Jesus said 'he who made them from the beginning made them male and female' (Mt 19:4). Wanting to communicate to man a certain special participation in His creative work God blessed man and woman and said to them 'be fruitful and multiply' (Gen 1:28).[16] Now, it is specifically that certain special participation of man and woman in the creative work of Man that requires for the generation of a child be an event that is profoundly human and highly religious. It involves the spouses who form 'one flesh' (Gen 2:24) and God Himself who is present. Each new human being i*s not a product* of a certain 'technique', not even of that technique that unites two gametes – frozen separately or otherwise – *he is an unborn child*, the fruit of the love of the two spouses. A new human being brings with himself into the world a particular image and likeness of God Himself, and thus *in the biology of generation is inscribed the genealogy of the person*. To co-operate as parents with God in conceiving and generating a new human being is never a question of 'biological techniques' but of a working presence of God Himself in human fatherhood and motherhood. A man and a woman, united in marriage, are associated with a divine work: through their act of generation the gift of God is welcomed and a new life opens up to the future.[17]

'The various techniques of artificial reproduction, which would seem to be at the service of life and which are frequently used with this intention, actually open the door to new threats against life'.[18] The criterion for evaluation of an ethical order derives from the very originali-

ty of the human person. Pope Roncalli observed: 'the transmission of human life is entrusted by nature to a personal and conscious act and as such it is subject to the most holy laws of God: immutable and inviolable laws that should be recognised and observed'.[19] John Paul II makes clear that this personal act is *the intimate union of love of the spouses, who in giving of themselves totally to each other give life*. This is a unique and indivisible act, which is at one and the same time unitive, procreative, conjugal and parental.[20] Before the Roncalli and Wojtyla papacies, Pope Pacelli taught that this act, which is the 'expression of the mutual gift which, according to the words of Holy Scripture, effects the union "in one flesh"'[21], is the spring-centre of life. It is by now *luce clarius* that one is dealing with a presumed conflict because procreation is not of a technical-biological order, in the sense that a certain technique 'would allow the overcoming of that rejection of every form of artificial fertilisation, still present in by no means few circles, and which produces a painful gap between the practice that is commonly admitted by people and also sanctioned by laws and the at least theoretical approach of many believers'.[22] The very dignity of the human person requires that 'it comes into being as a gift of God and as the fruit of the conjugal act, which is proper and specific to the unitive and procreative love between the spouses, an act which of its very nature is irreplaceable'.[23] The suggestion that we should distinguish between homologous and heterologous fertilisation is, therefore, unsustainable; the radical rejection of every form of artificial fertilisation is not based upon the fate of the embryos.[24] The Magisterium allows no doubts on the matter: '*heterologous techniques* are "burdened' by the "ethical negativity" of conception outside marriage. Recourse to gametes of people other than the spouses is contrary to the unity of marriage and the fidelity of the spouses, and it harms the right of the child to be conceived born in and from a marriage'.[25] Such techniques 'offends the common vocation of the spouses who are called to fatherhood and motherhood: it objectively deprives conjugal fruitfulness; it brings about and manifests a rupture between genetic parenthood, gestational parenthood and responsibility for upbringing. Such damage to the personal relationship within the family has repercussions on civil society'.[26]

3. The Presumed Conflict over Abortion

It is stated that 'one of the most difficult subjects to address, which people ask themselves about continually precisely because of its sensitivity and complexity, is abortion. In Italy the state has passed laws on the matter trying to link the principle of the self-determination of women with the freedom of the conscience of medical doctors who can choose conscientious objection'.[27] This approach to the question/problem of abortion immediately denotes how much the conflict is a presumed one because here, too, one sets aside the divine right to life. 'The divine lordship of life is the foundation and guarantee of the right to life, which is not, however, a power over life. Rather, *it is the right to live with human dignity*, as well as being guaranteed and protected in this fundamental , primal and insuppressible good which is the root and condition of every other good-right of the person'.[28] Thus abortion is not first of all or above all else a question of self-determination as regards the woman, and/or conscientious objection on the part of the medical doctor. 'The inviolability of the innocent human being's right to life from the moment of conception until death is a sign and requirement of the very inviolability of the person, to whom the Creator has given the gift of life.'[29] 'Nobody can attack the life of an innocent man without going against the love of God for him, without violating a fundamental, inescapable and inalienable right'.[30] The right to life of every human being comes *immediately* from God and not from others: neither parents, nor society nor human authority. This is why abortion is always a defeat. However, and here we encounter the sensitivity and complexity of the question 'faced with extreme cases such as when a woman has been subjected to violence, a pregnancy in an adolescent of eleven or twelve years of age, a woman who does not have the economic means to bring up a child, what is the approach of the Church? If one concedes the principle of the choice of the lesser evil and, as the Catholic Church suggests, that of entrusting the response to the innermost part of one's conscience *(conscientia perplexa*: in that condition in which a man and a woman at times find that they have to face up to situations which make the moral judgement uncertain and the decision difficult), would it not be ethically correct to openly explain this point of view? And also sustain it publicly?'[31] I will quote the answer: 'it is important to recognise that the prosecution of physical human life is not in itself the first and absolute moral principle. Above it is the principle of human dignity, a dignity which in the Christian vision and many religions involves an openness to the eternal life that God promises to man. We may say that here is the definitive dignity of the person'. The words of Jesus are quoted: 'Is not life more than food, and the body more than clothing?' (Mt 6:25), and also his exhortation not to be afraid 'of those who kill the body but cannot kill the soul (Mt 10:28).[32] I agree: the duty that certain professionals possess of exposing their own lives to danger to the point of being able to lose them confirms the thesis. For that matter, martyrdom is the most convincing proof. However, later on, in relation to thera-

peutic abortion, it is asserted that 'moral theology has always supported the principle of legitimate defence and the lesser evil, even though this is a reality that demonstrates the dramatic character and the fragility of the human condition'.[33]

As regards legitimate defence, the *Catechism of the Catholic Church* teaches that this 'is not an exception to the prohibition against the murder of the innocent that constitutes intentional killing. 'The act of self-defence can have a double effect : the preservation of one's own life and the killing of the aggressor…the first is intended, the second is not''.[34] The reason for this is that 'Love toward oneself remains a fundamental principle of morality. Therefore it is legitimate to insist on respect for one's own right to life. Someone who defends his life is not guilty of murder even if he is forced to deal his aggressor a lethal blow'.[35] Now, and here we encounter the non-applicability of the principle, the unborn child is never an unjust aggressor of his mother. For this reason, 'since the first century the Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable. Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law: You shall not kill the embryo by abortion and shall not cause the newborn to perish'.[36] The documents of the Church do not underestimate certain problems, indeed she draws attention to them explicitly.[37] However, those who presume to bring to bear on these problems solutions that are not honest, even that of killing, are reminded by the Second Vatican Council that 'For God, the Lord of life, has conferred on men the surpassing ministry of safeguarding life…Therefore from the moment of its conception life must be guarded with the greatest care while abortion and infanticide are unspeakable crimes'.[38] And the Congregation for the Doctrine of the Faith makes clear that 'life, in fact, is too fundamental a good for it to placed in relation to certain inconvenient facts, even very grave ones'.[39] Thus 'man must never obey a law that is intrinsically immoral, and this is the case with a law that allows, at the level of principle, the licitness of abortion'.[40] Indeed, the Church has always taught that the civil law should conform to the moral law. 'Authority', declared John XXIII, 'is a postulate of the moral order and derives from God. Consequently, laws or decrees enacted in contravention of the moral order, and hence of the divine will, can have no binding force in conscience…indeed, the passing of such laws undermines the very nature of authority and results in shameful abuse'[41] I would here like to observe that this is not a 'confessional' stance but a stance that derives from rational logic. Indeed, any law made by men, because it derives from natural law, has the force of law. Thus whenever a law is in contrast with natural law it would not only not be law but would be its corruption.[42] For this reason conscience requires its primary right and appeals to the primary role of divine law: 'We must obey God rather than men' (Acts 5:29). I will not enter the question of euthanasia because the same approach applies to the termination of life. A law that authorises or fosters euthanasia places itself radically not only against the good of the individual but also against the common good, and thus it is totally without authentic juridical validity. It follows from this that when a civil law legitimises euthanasia it ceases, for that very reason, to be a real civil law that is morally binding'.[43]

Conclusion

'Today, the human race is involved in a new stage of history. Profound and rapid changes are spreading by degrees around the whole world. Triggered by the intelligence and creative energies of man, these changes recoil upon him, upon his decisions and desires, both individual and collective, and upon his manner of thinking and acting with respect to things and to people'.[44] However much this statement by the fathers of the Second Vatican Council may be more than right, they could not yet know about scientific progress and that technological advance in the mechanisms that would regulate the beginning and the end of life. Indeed, science and technology run faster than the rest of society and even of members of parliaments. Thus every scientist and every technologist should, in their own field, face up to their own responsibilities but, given that rational evaluation is always indispensable, members of parliaments, or rather supra-national institutions, should, it is said, on the basis of the common feelings of citizens, establish rules of responsibility, balanced by the assessment of risks and consequences.[45] At this point it is affirmed that researchers must always contribute to the good of life and never the opposite, and for this reason they must also at times halt and not go beyond the limits but instead respect the uncrossable parameters of the dignity of every human existence. However, this is not a matter of appealing to faith or religion but of relying on the ethical sense that each person has within them. One wants a great effort of conscience and a good measure of good will to ensure that man does not devour man but, rather, serves him and promotes him. As regards the Catholic Church, emphasis should be laid first and foremost on her task of forming consciences, but prohibitions and otherwise, especially if premature, will not be useful. What is needed is the formation of minds and hearts to respect, love and serve the dignity of the human person in every manifestation, with the certainty that every human being is destined to participate in the fullness of divine life and that this also requires sacrifices and renunciations.[46] One cannot but be in agreement with these general indications regarding the task of the Catholic Church; indeed, I emphasise them. In the whole dialogue, however, I observe the lack of answers to the underlying theories of subjectivism, relativism and teleologism in general,[47] but above all in the field of life in particular. I believe that I have provided, even *per eccessum*, the documents of the Magisterium *ad rem,* which express and explain the teaching of the Church with the greatest clarity. I would like once again, in conclusion, to specify the pedagogic value of

the prohibitions, of the 'no's of God and thus of the Church: 'God's commandments teach us the way of life. The negative moral precepts, which declare that the choice of certain actions is morally unacceptable, have an absolute value for human freedom: they are valid always and everywhere, without exception. They make it clear that the choice of certain ways of acting is radically incompatible with the love of God and with the dignity of the person created in his image. Such choices cannot be redeemed by the goodness of any intention or of any consequence; they are irrevocably opposed to the bond between persons; they contradict the fundamental decision to direct one's life to God.'[48] For this reason I would not refer so much to the limits of science and technology, because man is always a limited being, as to their religious-moral direction. In the design of the Divine Creator man and woman are called to 'dominate' the earth as its 'stewards', thus not as arbiters but as participants in divine Providence towards other creatures. Hence their responsibility towards the world that God has entrusted to them. This collaboration has a character all of its own, which is specific and unique, in the transmission of life, when God, in marriage, unites them to form a 'single flesh' (Gen 2:24). It is in this way that a man and a woman co-operate as spouses and parents in a unique way in the work of the Creator, obeying the divine mandate 'be fruitful and multiply' (Gen 1:28).[49] In the light of these absolute truths about the non-negotiable values of life, the Magisterium of the Church seeks to help mankind to advance along the way of life and authentic freedom. 'In contemporary circumstances', declares Benedict XVI, 'in appealing to the value that certain fundamental ethical principles that are rooted in the great Christian heritage of Europe have not only for private but also for public life…we do not engage in any violation of the secularity of the state but contribute, rather, to assuring and promoting the dignity of the person and the common good of society'.[50] Indeed, at their beginning the truths about life, marriage and the family do not have a religious character, nor even a Christian one. These are natural truths and values expressed in natural law and guaranteed by natural law. Indeed. 'The moral law presupposes the rational order, established among creatures for their good and to serve their final end, by the power, wisdom and goodness of the Creator. All law finds its first and ultimate truth in the eternal law. Law is declared and established by reason as a participation in the providence of the Living God, Creator and Redeemer of all. 'Such an ordinance of reason is what one calls the law''[51]. Thus only when scientific progress and technological advance accept the ordinance of reason do they really place themselves at the service of the dignity of the human person and of the common good of society.

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Notes

[1] BENEDICT XVI, Address to the Members of the Biblical Commission, *L'Osservatore Romano*, Friday 28 April 2006, p. 5.
[2] *Ibidem*.
[3] Cf. the conversation between Carlo MARIA MARTINI AND IGNAZIO MARINO, *Dialogo sulla vita,* edited by Daniela Minerva, *L'Espresso*, 27 Aprile 2006, pp. 52-61, hereafter Martini-Marino, p.
[4] JOHN PAUL II, *Evangelium vitae,* 25 March 1995, n. 28; hereafter *Ev*,
[5] Ecumenical Second Vatican Council, *Gaudium et spes*, (GS), n. 19.
[6] Cf. *Catechism of the Catholic Church* (hereafter *CCC*), n. 31.
[7] *GS*, n. 18.
[8] *CCC*, n. 33.
[9] *CCC*, n. 34: see St. Thomas Aquinas, *Summae theologiae,* I, 2,3.
[10] JOHN PAUL II, *Evangelium vitae.* n. 2.
[11] *Ibidem*.
[12] *Ibidem*.
[13] *Ibidem*.
[14] *CCC*, n. 1731.
[15] Cf. BENEDICT XVI, end of the address cited above.
[16] Cf. *Gaudium et spes*, n. 50.
[17] Cf. *Evangelium vitae*, n. 43.
[18] *Evangelium vitae*, n. 14.
[19] JOHN XXIII, Encyclical, *Mater et Magistra,* III in AAS 53, 1961, p. 447.
[20] Cf. JOHN PAUL II, 'Udienza generale 16 gennaio 1980', in *Insegnamenti* III/1 (1980), pp. 148-152.
[21] Cf. PIUS XII. 'Alle congressiste dell'Unione Cattolica Italiana Ostetriche', 29 Oct. 1951, in *AAS*, p. 43, 1951, 850.
[22] Martini-Marino, p. 55.
[23] *Charter for Health Care Workers*, Vatican City, 1995, n. 22.
[24] Cf. *Ibidem*.
[25] *Ibidem*, n. 27.
[26] Congregation for the Doctrine of the Faith (CDF) Instruction *Donum vitae,* 22 Feb. 1987, in *AAS*, 80 (1988) , pp. 87-89.
[27] Martini-Marino, p. 57.
[28] *Charter for Health Care Workers*, n. 46.
[29] CDF, Instruction *Donum vitae,* pp. 75-76.
[30] CDF, 'Dichiarazione sull'eutanasia', 5 May 1980, in *AAS* 72, 1980. p. 544.
[31] Martini-Marino, p. 57.
[32] *Ibidem*.
[33] Martini-Marino, p. 58.
[34] *CCC*, n. 2263; see St. Thomas, *Summa theologiae,* II-II, 64, 2.
[35] *CCC*, n. 2264.
[36] *CCC*, n. 2271. see the references: Didache, 2,2; cf. Ep. Barnabae 19, 5; Ad Diognetum, 5,5; TERTULLIAN, *Apologeticus,* 9; see B. HONINGS, Miscellanea, *Iter Fidei et Rationis*, vol. II, Moralia and vol. III, Jura/Lateran University Press,
[37] 'It is also true that in certain cases, by refusing an abortion, other important goods – which it is only normal that one would want to safeguard – are put in jeopardy. These could be: danger to the mother's health, the burden of another child, a serious malformation of the fetus, a pregnancy caused by rape. These problems cannot be ignored or minimized, nor the reasons supporting them' (*Charter for Health Care Workers*, n. 141).
[38] *GS*, n. 51.
[39] CDF, 'Dichiarazione sull'aborto procurato', 18 June 1974, in *AAS* 66(1974), p. 739.
[40] *Ibidem*, p. 744, n. 22.
[41] JOHN XXIII, *Pacem in terris,* (11 April 1963) II: *AAS* 55 (1963), p. 271, quoted by JOHN PAUL II in *Evangelium vitae,* n. 72.
[42] Cf. ST. THOMAS *Summa theologiae,* I-II, q, 93, a. 3 ad secundum.
[43] Cf. JOHN PAUL II, *Evangelium vitae,* n. 72.
[44] *GS*, n. 4.
[45] Cf. Marini-Marini, 61.
[46] *Ibidem*.
[47] Cf. JOHN PAUL II, *Veritatis splendor*, 6 August 1993, in AAS 85, 1993. The moral life 'has an essential "teleological" character, since it consists in the deliberate ordering of human acts to God, the supreme good and ultimate end (telos) of man. This is attested to once more by the question posed by the young man to Jesus: "What good must I do to have eternal life? ". But this ordering to one's ultimate end is not something subjective, dependent solely upon one's intention. It presupposes that such acts are in themselves capable of being ordered to this end, insofar as they are in conformity with the authentic moral good of man, safeguarded by the commandments. This is what Jesus himself points out in his reply to the young man: "If you wish to enter into life, keep the commandments" (Mt 19:17) (VS, n. 73). Cf. B. Honings, 'Il discernimento di alcune dottrine morali ed etiche. Una lettura della 'Veritatis splendor'' in *Veritatis splendor. genesi, elaborazione, significato*, edited by Giovanni Russo (ED, Rome, 1994), pp. 131-153.
[48] *Evangelium vitae,* n. 75; cf. *CCC*, nn. 1753-1755; John Paul II, *Veritatis spendor* , nn. 81-82.
[49] Cf. *CCC*, nn 372-373.
[50] BENEDICT XVI, *L'Osservatore Romano,* Friday 19 March 2006, p.5.
[51] CEC, 1951.

Human Life: a Precious Gift of God

DOCUMENT OF THE BISHOPS' CONFERENCE OF SPAIN

'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' (*Evangelium Vitae*, hereafter *EV*, n. 1).

1. The Preaching of the Gospel of Life

Ten years ago, and more exactly on 25 March 1995, Pope John Paul II published the encyclical *Evangelium Vitae*. The Church, which ever since the time of the Apostles has preached the value of human life, works with ever greater intensity to defend life and to care for those most in need. In this service to life, the encyclical *Evangelum Vitae* represents a milestone.

In continuity with the teachings of John Paul II, we, Pastors of the 'People of Life', give thanks to God the Father for the gift of life. In the fullness of time, He sent us His Son, born of the Virgin Mary, so that men could have life in abundance, a 'new' and 'eternal' life, 'which consists in communion with the Father, to which every person is freely called in the son by the power of the Sanctifying Spirit' (*EV*, n. 1).

On the occasion of this anniversary, and following the recommendation of the LXXXI plenary assembly, we extend an invitation to ensure that the solemnity of the Incarnation – which in the year 2005 is commemorated on 4 April – is celebrated in the right way with various initiatives that act to make known, and preached in our churches, consideration and respect for life, which, indeed, constitute the heart of the message of this encyclical.

2. The Value of Human Life

All cultures have universally recognised the value and the dignity of human life. The commandment 'thou shalt not kill', which preserved the gift of human life, is a rule which every healthy culture has recognised as being a fundamental principle. The right to life and respect for the dignity of the person are values that the Universal Declaration of Human Rights presents as a foundation for living together in society.

This recognition at a universal level finds full confirmation in the revelation of he gospel of life with the mystery of Christ. Human life, a precious gift of God, is sacred and inviolable. 'Human life is sacred because from its beginning it involves 'the creative action of God', and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can, in any circumstance , claim for himself the right to destroy directly an innocent human being' (*EV*, n. 53). For this reason, every attack on human life is an attack on reason and on justice and is a grave offence against God.

3. A Fundamental Continuity

The process of being an embryo is a continual process in which, from the very beginning, what we have in front of is a human life. The embryo is not a mere aggregate of living cells but is, rather, the first stage of existence of a human being. All of us were embryos.

From the moment of fertilisation there is a human life and thus personal dignity. It is a human life that develops and experiences important morphological changes but we are always dealing with the same continual process that goes from the beginning of life with fertilisation until death. 'The body of course develops, but in a fundamental continuity that does not allow any stage of its development to be defined as pre-human or post-human. Where there is a living human body, there is a human person and thus an inviolable human dignity'.

As a result 'the human being is to be respected and treated as a person from the moment of conception, and therefore from that very same moment his rights as a person must be recognised, among which in the first place is the inviolable right of every innocent human being to life' (*EV*, n. 60). This truth of the gospel of life is broadly shared by many people and institutions. What the Council of Europe stated many years ago has been adopted by the United Nations in its recommendation in favour of the prohibition of research on embryos and any type of human cloning, whether reproductive or therapeutic.

4. At the Service of Life

In the recognition and respect for life, as in its promotion, science achieves its highest purpose: service to life and to the dignity of the person. The last ten years since the publication of the encyclical *Evangelium Vitae* have been years of great advance for science which, indeed, have opened up new possibilities – full of hope – of prevention and treatment.

Thanks to these developments, forms of treatment and care, and even intra-uterine operations to help the unborn child, have been made possible. In addition, the time that is needed in a pregnancy to ensure

that a premature baby can survive outside the maternal womb is growing increasingly smaller. For that matter, the therapeutic application of mother cells derived from adult tissue have obtained results that give rise to realistic hopes. True therapies are those that provide treatment without causing damage or eliminating a person's life.

We cannot forget that these advances are powerful instruments that must be used at the service of man, bearing in mind ethical principles. Science and technology need ethics so as not to degrade human dignity but to promote it. For this reason, we call on all researchers and centres of education and training to inculcate respect for life in everyone and to deepen people's knowledge so that this knowledge can be places at the service of others.

We thus exhort everyone to always promote life in the face of very many threats to it posed by a 'culture of death' which expresses itself in many ways: contraception, the widespread use of sterilisation, the worrying decline in birth rates, abortion, the morning-after pill (which in addition to being a contraceptive is also abortion- inducing); the manipulation of language where reference is made to 'pre-embryos' as though they were not already human persons to the full, the selection and the destruction of embryos, the manipulation and destruction of embryos so as to obtain mother cells for research, and the always threatening practice of cloning. These expressions of the culture against life are an insidious ideology of the evil condemned by John Paul II: 'One can, indeed one must, place the question of the presence in this case of another ideology of evil, which at times is more insidious and concealed, which seeks to attack human rights, against the family and persons'.

5. The Family: a Sanctuary of Life

'So God created man in his own image, in the image of God he created them; male and female he created them. And God blessed them and God said to them: 'Be fruitful and multiply' (Gen 1, 27-28). The gospel of life begins with Adam and Eve, who were called to conjugal love and through their love to be parents, thereby co-operating in a singular way with the creative work of God.

Conjugal love between a man and a woman, the foundation of the family, is the holy context in which a person is conceived with dignity. A child is born from the love of the parents and is invited to share in their communion of love. The family is also the sanctuary in which life is received with joy and celebrated in daily life and is enriched by the rich relationships between parents, children, grandchildren, etc.

These families are a splendid proclamation of the gospel of life and are a reason to render thanks to God: families that notwithstanding crises and difficult moments know how to remain united in love; families that despite the difficulties live in a way that is generously open to life; families that support their weakest and most in need members with their time and their best energies, and so forth. All these families, very many of which are Christian families, are a living magnificent witness to the value of life and provide a valuable service to society.

This generous witness of very many families is the best school for children there is by which to learn the sacred value of human life and to respect and promote the lives of everyone, and especially the lives of the weakest. The joy of a family in receiving a new life is the best proclamation there is in front of children of the sacred value of conceived life and of the life that is still to be born of a new child. For this reason, the celebration of the day of life could be a valuable opportunity for families to acquire a deeper awareness of their mission of service to life.

6. Affective-Sexual Upbringing and Education

The family is also the context in which children learn about the meaning of sexuality at the service of love and the family. We bishops have often observed the need and the urgent necessity for suitable affective-sexual upbringing. This has a privileged position in pastoral care for families because 'the vocation to love, which is the guiding theme of all pastoral care for marriage, requires especially careful attention to be paid to education in love'.

In the Directory of Pastoral Care for Families (DPF) of the Spanish Bishops it was observed that 'parents are the first to be responsible for education in sexuality, in the years of childhood as during adolescence. They must know how to be able to offer their children, in a climate of trust, those explanations that are suitable for their age so that they can acquire knowledge about, and respect for, their own sexuality on a pathway of personalisation. One always obtains more by persuading than by prohibiting, especially when one is dealing with education' (DPF, n. 81).

At the right moment, the catechesis should also address the question of sexuality and the discernment of vocation. 'In the process of the catechesis, during the distinct moments that characterise this stage, a complete and profound catechesis on sexuality in its different dimensions (the anthropological, the moral, the spiritual, the social, the psychological, etc.) is to be present' (DPF, n. 62).

Schools also have an important role to play in this endeavour: 'as a complement to. and a help for, the task of the parents, it is absolutely necessary for Catholic schools to draw up a programme of affective-sexual education, beginning with methods that have been sufficiently tried and tested and with the supervision of the bishop. The Diocesan Delegation of Pastoral

Care for the Family must prepare people who are expert in this field' (DPF, n. 93).

We are all aware of the urgent need for this affective-sexual education and of its relationship with the gospel of life. For this reason, we exhort everyone to implement the indications of the Directory for Pastoral Care for the Family, ad to pay especial attention to the overall training of expert people to perform this task.

7. For a Culture of the Family and of Life

In educating young people in love and life we will lay the most solid foundations there are for a culture of the family and of life. But this function requires the commitment and involvement of everyone. Scientists in a particular way are entrusted with the task of preserving the value of life in the 'conscience' of researchers and society. As people who are experts, they are listened to by society, by the mass media, and by politicians. For this reason, we call on them to proclaim with courage the sacred value of human life from the moment of conception and not allow themselves ever to be seduced by possibilities that are contrary to ethics.

Health care professionals also have an important task. It falls to them, indeed, to always support life, and to reject and to condemn every practice that attacks the integrity or the life of people, the life of the weakest among us such as embryos, unborn children, the disabled, the elderly and the terminally ill. Here we would like to observe once again the advisability of promoting processes that involve adoption and we suggest this possibility to those people who are considering the possibility of engaging in an abortion. We also appeal to Catholic professionals, especially those involved in the world of information, to make their presence felt in the mass media so that in the mass media the message of the gospel of life is heard and rings out.

All Christian professionals at a personal level or at the level of associations must exercise their influence in a responsible way in society and in relation to legislation. It is a sign of hope to see the presence of family associations in the social debate engaged in promoting the values of the family and the values of life. In doing this they contribute in an effective way to the drawing up of a suitable policy towards the family (which, indeed, is very urgently needed) that will promote access to housing, to work and to economic conditions that are compatible with motherhood and fatherhood, and also bears upon the availability of that time which is needed to look after a family and after life as a gift of God.

It was in this sense that John Paul II in his encyclical *Evangelium Vitae* exhorted us with the following words: 'To be truly a people at the service of life we must propose these truths constantly and courageously from the very first proclamation of the Gospel, and thereafter in catechesis, in the various forms of preaching, in personal dialogue and in all educational activity. Teachers, catechists and theologians have the task of emphasizing the anthropological reasons upon which respect for every human life is based. In this way, by making the newness of the Gospel of life shine forth, we can also help everyone discover in the light of reason and of personal experience how the Christian message fully reveals what man is and the meaning of his being and existence. We shall find important points of contact and dialogue also with non- believers, in our common commitment to the establishment of a new culture of life' (*EV*, n. 82).

8. Prayer for Life to the Immaculate Mary

We would like to end this message on the occasion of the tenth anniversary of the encyclical *Evangelium Vitae* by invoking Mary, the mother of Love, in this year that the Church of Spain is dedicating to the mystery of her Immaculate Conception. To her we entrust the cause of life. Under her protection we place families, the sick, the weakest and the most threatened, while at the same time we invite all Christians, and in particular families, to address to the Immaculate Mary, the mother of life, the prayer with which Pope John Paul II ended his encyclical:

'O Mary,
bright dawn
of the new world,
Mother of the living,
to you do we entrust
the cause of life
Look down, O Mother,
upon the vast numbers
of babies not allowed
to be born,
of the poor whose lives
are made difficult,
of men and women
who are victims of brutal
violence,
of the elderly
and the sick killed
by indifference
or out of misguided mercy.
Grant that all who believe
in your Son
may proclaim the Gospel
of life
with honesty and love
to the people of our time.
Obtain for them the grace
to accept that Gospel
as a gift ever new,
the joy of celebrating it
with gratitude
throughout their lives
and the courage to bear
witness to it
resolutely, in order to build,
together with all people
of good will,
the civilization of truth
and love,
to the praise and glory
of God,
the Creator and lover of life'
(*EV*, n 105).

Madrid, 4 April 2005,
Solemnity of the Incarnation

H.E. Msgr JULIAN BARRIO BARRIO
Archbishop of Santiago di Compostela, President of the Bishops' Conference of Spain

H.E. Msgr JUAN ANTONIO REIG PLA
Bishop of Segorbe-Castellón, President of the Sub-committee for the Family and the Defence of Life

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Archbishop of Burgos

Modern Society in Conflict Between the Culture of Life and the Culture of Death

Modern society is experiencing conflicts that some people believe are generational; others think that they are the result of differing religious approaches; and yet others attribute them to forms of fundamentalism, to the so-called hawks who prevail over the doves. There are also those people who see an economic opposition: the peoples of hunger who call on the peoples of opulence: the countries of the East and the countries of the West of the world, the countries of the North and the countries of the South of the world. All of this has an enormous impact but the gravest conflict, which today requires to be solved with wisdom and love, is of a cultural character. Modern society finds itself between the culture of life, which makes it strong, and the culture of death, which destroys it.

Even before the social level, in the heart of man strong duels between these two opposing cultures are fought out. Man can use his intelligence and his freedom in a upright way; strong in God and faithful to His law of mercy, he can continue in good and the culture of life; meek with divine mercy, he can revisit himself, desist from choices in favour of death, not die, and live. Or he can abuse life as well; do wrong and go on doing wrong; he can engage in choices for death; induce others into error; he can also drag down who is just, but weak. He can make him his victim…

Love for life, a commitment to defend and affirm its culture, are required for one to be faithful to man, to his history and to God. The cult and the defence of life could be rediscovered as a light that illuminates the countenance of every man of good will, who is commonly called an anonymous Christian.

Every Christian, even an anonymous Christian, can be the carrier and the implementer of this promise: 'the land that was desolate shall be tilled'.[1] It is comforting to apply this promise to the land of the heart of man. However, it is necessary for vigorous commitments to arise in order to respond to the needs of redemption and the requirements of love that one can see emerging in particular in men oppressed by sadness and by mourning. In the recess of the human heart the culture of death is fomented by powers against man; this culture is also taught from university teaching chairs when they are occupied by criminals of the spirit; it provokes the worst forms of behaviour in man and peoples. It achieves scandalous successes but brings with it ruin and destroys itself. When it achieves victories it dissociates hearts, consciences and peoples.

It is certainly the case that one cannot and one must not impose choices of faith: to affirm and to defend the right to life and the value of life is a duty for everyone, believer and non-believer alike.

Experience proves that the non-believer encounters greater difficulties in honouring this duty. However, it is not right to look for and offer deceitful cultural mediations, which are gravid in fatuity and compromises, with inhuman and cynical hypocritical forms of selfishness that camouflage themselves under appearances of respect for conscience, freedom, humanity, the defence of women, sensitivity, delicacy, and a kind heart.

It is never licit for anyone to kill, nor, and even worse, is it ever licit to legalise the killing of innocents, especially if they are undefended and defenceless. And yet there are millions of undefended and defenceless innocents who are treacherously killed through abortion. Innocent blood cries out. Even though one may not be capable of listening to the silent cries of the killed, this reality is more tragic and more impious than very many wars when taken as a whole.

Other millions of human persons are killed in a large number of ways: murder, suicide, infanticide, wife-killing, parricide, drugs, alcohol, weapons, murderous sports, tragic games, speed and accidents on an asphalt that is often soaked in human blood…

Other millions die, are killed, out of desperation; because of hunger; because of thirst; because of a lack of help or because of late or inadequate medical care and treatment; because of incompetence or neglect; because of an insufficiency of health-care staff, of hospital beds, or of the necessary equipment; or because of the removal vital human organs before the patient has died…

These tragic situations against life are in front of the very eyes of everyone but there are those who pretend that they know anything about this. They rave about wanting to legislate or secure the passing of laws on exaggerated treatment, or on biological wills, which are not understood uprightly in a scientific way but are seen as instruments of euthanasia, even of passive euthanasia.

There are those who in a cynical way instead of obtaining bread for those who are dying of hunger and water for those who are dying of thirst, or providing relief to those who suffer, urge them, and want to impose on them by law: not having indigestion…, removing the disturbance of not seeing them suffer…, allowing to die and being killed…

In this perverse approach the emphasis is placed on quality of life and not on its value; on dying with dignity and not on the right to live and being helped to live in order to carry out, even unknowingly, one's mission. Quality of life is not improved by eliminating life. To die with dignity absolutely does not mean to condemn oneself or to be condemned to death and to be killed by one's own will or by that of others or by law.

At this point I will consider the patients at Cottolengo in Turin, the paralysed and those in need of everything, those afflicted by progressive multiple sclerosis, those with dementia, those afflicted by Alzheimer's disease,

old people who are very advanced in years, and those who suffer from Parkinson's disease. It is certainly the case that in a conscious or unconscious way they do not experience a good quality of physical life, nor is there any hope that their physical condition will improve. The condition of those in comas is different. Experience teaches us that where there is life there is hope. Many comas, thought to be irreversible, even after a marked number of years have lifted. Only after its negative conclusion can one say in scientific terms that a coma was irreversible. Whatever the case, no person can deprive another person who has been in a state of coma even for many years or has reached the terminal stage of his or her infirmity of a little oxygen, of water, of the necessary food. There can be no direct or indirect action that accelerates the ending of life.

But I ask: what criminal can decide or pass legislation to kill all of them and accelerate death of even only one of our brethren? A medical doctor who is a friend of mine said to me: 'well that's the way it goes. A doctor prescribes an injection to be made when his round had finished. The day after that he returns and finds that the bed of the patient, who has died, is occupied by another patient'. That is to say that patient was killed and made to be killed by him! I advised that doctor to change his ideas or to change his profession.

Life is always valuable. Even if it involves suffering, even if unconscious, even if economically unproductive, even if physically disabled and not autonomous. It is always valuable. Nobody, specifically nobody, can, as Hitler did, see a person as a 'useless mouth'. Hitler was defeated and condemned. It seems, however, that today his criminal ideas against life are unfortunately triumphant and have achieved hegemony!

I have avoided presenting statistical tables on killed human lives; they are many, very many, indeed millions in number. The situation is tragic and quantitatively striking but even one life is a masterpiece that is worth more than the whole world…

Can one hope? The answer is 'yes'. Hope does not disappoint. Blood, especially innocent blood, can purify and fertilise this arid land, this land of death; it can transform it into a land where the culture of life buds and flowers. Indeed, the last word does not lie with those who kill the but can no longer do anything[2]… because the spirit is immortal.[3]

In other contexts as well it is advisable to see the life in a perspective that involves:

– The family, created in the design of the creation, in dignity, in fidelity and in fertility, in holiness, or betrayed in infidelity, violated and undermined in tragic, absurd and impious forms.

– The homeland and the state, with structures and institutions, well rooted in its own culture, faithful to that culture, or corrupted through the worst historical experiences, without roots, without memory, irreverent, with rebels, under the dominion of the culture death.

– Safety, that is ready, with heroic acts as well, to uphold truth, freedom, justice, and peace, or ready to launch into transgression, induced to justify and carry out revolutions, terrorism, armed struggles, with betrayals as well.

– Culture in its multiple aspects, with activities sustained in their noble end, freed from the culture of death, or servile and subjected to that culture, lazily resigned to endure it in order to have a quiet life, and without adequate provisions.

– Law and justice with the application of just laws for the defence of the innocent and the rehabilitation of the guilty, or with the separation between law and justice with the abuse of power and rigorously restrictive or permissive methods, to the full advantage of the violent and with the injury of the honest.

– An economy in line with the principal of the universal destination of goods and the right to private property, or with selfish and enslaving possessiveness, in situations not of common well-being but imbalanced ones with impoverishment and enrichment, exploitation and greed, hunger and miserliness…

Life, family, homeland, safety, culture, justice, and the economy rise up like seven pillars for the temple of life. It is necessary to construct that temple and not to dig sepulchres for the dead. We are all called to carry out this work of construction, to be a *people of life and for life*.

In the Church we are all invited and committed to the defence of the culture of life. To follow Christ. Those who are standing must be careful not to fall.[4] Those who lack strength and have fallen should remember that with the help of God one can renew one's strength.[5] Those that lie in the culture of death should feel the urgent exhortation to shake off this condition of theirs and rise from the dead and not oppose Christ who wants to illuminate them and wants to shine forth on them.[6]

In order to rise up, so as not to fall, in order to defend oneself and save oneself from errors and from the culture of death there is the Word of God and the sacraments, there is the Magisterium of the Church, and there is the divine force of prayer. The Christian witness of men and women, of young people, of elderly people and of children, of the gifted and of the ignorant, illuminated and made strong by divine grace are heroic Teachers and Witnesses, the cultivators and defenders of life, is something that is valuable. These people do not fall, they remain standing, or, if they fall, they trust in the mercy of God,[7] and they are immediately risen up, they rise up, and they remain intrepid even unto martyrdom.

Everyone can feel that to them is addressed the biting exhortation of Herder: 'let us work, my friends, with courageous and happy hearts, perhaps

amongst the clouds, since we work for a great future. And let us give ourselves a task which as much as possible is pure, clear, without blemishes: now, in fact, we are running amongst the fatuous fires, in the light of twilight, in the mist'[8]. After quoting such striking words one should observe that the light of the Magisterium of the Church always illuminates us with the infinite, with the eternal. It strengthens our faith in Christ who came to save the world,[9] he is the saviour of the world,[10] he gave himself for the life of the world.[11]

To everyone grace is given for the maturation of the conscience in relation to life; for education in freedom; to repair evil that may be done; to encounter Christ who came to give life in abundance: 'I came so that they may have life and have it in abundance'[12].

In this mystery of life and salvation everyone should encourage us and honour us. At the level of ideals I here relive what happened with the Great Jubilee of the year 2000, which marked the triumph of the culture of life: the pilgrims of the Jubilee who came to Rome were received with love by the great John Paul II, who thanked them at the level of their different categories of membership, blessed them, and directed and drew them, all of them, near to Jesus Christ God, Way, Truth, Life.[13]

Thus it is a coherent fact that the Church once again in a solemn way has proclaimed that Jesus is the Lord,[14] and in the heart of man 'the Halleluiah of the Living One, who gave a new spring to history'[15] has found resonance in the hearts of man and has re-echoed in his home and in the world. Every man is waiting for the new spring, the spring of the culture life, which will achieve its full triumph in the spring of the resurrection of bodies.

For resurrection in glory the drawing near to eternal life must be well effected. Exemplary models are not in short supply. Each person can remember them and imitate them.

I have in my mind the drawing near of Cardinal Corrado Ursi to eternal life and I remember what is recommended by the Author of the Letter to the Hebrews: 'Remember your leaders, those who spoke to you the word of God; consider the outcome of their life, and imitate their faith. Jesus Christ is the same yesterday, today and for ever. Do not be led astray by diverse and strange teachings; for it is well that the heart be strengthened by grace.[16]

The culture of death is a diverse and strange teaching. It agitates and tempts every man, who is often torn between the culture of life and the culture of death. Those who love life are built up in the omnipotence of the grace and the witness of leaders share in the victory of the culture of life and in the triumph of God Christ.

In the choices that we are called to make *between* the culture of life *or* the culture of death we are not left abandoned to ourselves. Christ guides us, the Blessed Virgin takes us by the hand, the Mother of the Living, the Mother of the Church. In the Church, with the light and the strength of the Holy Spirit, the Pope guides us, the defender of life, together with the Pastors who are in communion with him.

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Italy

Notes

[1] *Ez* 36, :34,
[2] Cf Mt 10, :28; Lk 12: 4.
[3] Cf Wis 2:23; 3, 2-5; Lk 20:35-36; 1 Cor 15:53; 2 Tim 1:10.
[4] Cf. 1 Cor 10:12.
[5] Cf. Is 40:31.
[6] Cf Efph 5:14.
[7] Cf S. BENEDICTI, *Regula Monasteriorum,* chap. IV.
[8] J. G. HERDER, J. G. HERDER, *Ancora una filosofia della storia per l'educazione dell'umanità*, translated by. di F. VENTURI, Turin, 1971, p. 118.
[9] Cf Jn 12:47.
[10] Cf Jn 4:42.
[11] Cf JN 6:51.
[12] Cf Jn 10:10.
[13] Cf. Jn 14:6.
[14] CONGREGATION FOR TJE DOCTRINE OF THE FAITH, *Dominus Iesus*, Vatican City, 2000.
[15] C. URSI. (Card.), *La morte e la vita in duello*, in *Una vita in dono,* Naples, 1981, p. 457.
[16] Eb 13, 7-9.

Prison and Conditions for Depression

1. Introduction

Depression is an illness that has been widely researched, particularly in recent years. There are, however, certain conditions for this illness which, basically, are not discussed. Although every illness (i.e. its symptoms) has a universal nature, this does not mean that a given illness is not conditioned by circumstances that are likely to increase its intensification or direct its course. In the case of depression, this is specifically conditioned by prison isolation. Consequently, presenting the above relationships is the aim of this article.

According to the '*Słownik psychologiczny* ('Psychological Dictionary'), depression is 'an inhibition, to a varying extent, of a man's mental activity, which manifests itself in a feeling of general dejection and frequent delusive behaviour' (Szewczuk, 1985, p. 56). A wider description of depression is given by Norbert Sillamy, who defines it as 'a more or less prolonged pathological state, characterised by sadness, the decrease of tonus and the loss of energy. Sufferers from depression are apprehensive, devitalised and dispirited, incapable of facing even the slightest difficulty, which is why they show no initiative of their own. Suffering from incapacity, they have a simultaneous impression that their intelligence, and their attention and memory in particular, have deteriorated' (1995, p. 50).

However, it is not the task of this paper to define depression. The above general definitions are only employed as a reference point for the following discussion.

2. Prison Isolation and Types of Depression

Prison isolation, even in the case of the most ruthless criminal, is linked to stress and existential shock. It does not apply to those individuals who feel fulfilled in prison conditions, which, however, is a matter of certain psychopathology.

Prisoners – as a globally-understood population – are characterised by a greater weakening of their instinct for self-preservation than other people (cf. Szaszkiewicz, 1997, p. 117). This is connected with disturbed socialisation and the impact of the criminal lifestyle. A young person, brought up in a disordered family with daily occurrences of aggression and violence, becomes accustomed to these circumstances. This, successively, results in a diminishing of the meaning of life (and, even, of experience). The above symptom, combined with depressive symptoms, may constitute a dangerous accumulation (also in the sense of suicidal behaviour) which will threaten the prisoner's life.

Various types of depression may be observed, whose divisions may be agreed on to a higher or lesser extent. It is significant, however, that clinical psychiatry lists depression among the affective illnesses (Kaplan, Sadock, 1990).

An affective disturbance is 'an emotional reaction of a strong intensification' (Sillamy, 1995, p. 12) which reduces control of one's behaviour. As a result, an individual becomes increasingly aggressive, uses vulgar vocabulary, flies into a rage, and, eventually, resorts to violence. When being unable to use violence towards another person, he is likely to make attempts at self-mutilation through laying violent hands on himself or falling into the state of withdrawal or depression.

When writing about affective illnesses, psychologists and psychiatrists refer to Emil Kraepelin, who introduced the term of 'maniac-depressive psychosis' (later described as cyclophrenia) into clinical psychiatry in 1899 (cf. Sulestrowska, 2000, p. 267). Affective illnesses are characterised by the emergence of mood disorders such as mood-lowering (depression) or mood-rise (mania). Among these, one needs to differentiate between bipolar disorders (maniac-depressive, i.e. cyclophrenia) and monopolar disorders (depressive).

Apart from any individual forms of conditioning, prison – at least in theoretical terms – seems to be a natural area for the development of bipolar, maniac-depressive psychosis. The basic emotions of prisoners are aggression, fear (although this emotion is not easily admitted), anger, and anxiety (cf. Kosewski, 1979). These may increase the degree of mania, particularly in a revenge situation – which is coerced directly by prison conditions. In the case of revenge-blocking, the prisoner may fall into depressive states which manifest themselves in downheartedness and discouragement in relation to the current situation (including the need to bear the harsh demands of prison reality).

It appears from the research I have been conducting for several years by means of, among other things, the method of participatory observation, that rehabilitation in prison conditions ought to be based on a therapy aimed primarily at a person's emotional life – which, consequently, is linked to the affective aspect of depression. The treatment of such disorders has to be preceded by gaining the necessary recognition of the illnesses that exist in the family of a given prisoner, given that, according to the literature (cf. Angst, 1966), suffering from affective illnesses results in great part from genetic factors.

3. Depression and Self-aggression in Jail

Self-aggression in prison may have a complicated genesis and may take various forms (Szaszkiewicz, 1987, pp. 103-121). The very fact of imprisonment, quite apart from the question of responsibility or a just punishment, is sensed as a humiliating interference with human freedom. Personal habits become disrupted by the need to conform to prison regulations. Monotony, boredom, the lack of the sense of self-autonomy and privacy, as well as sensory depravity – all these factors evoke a depressing sense of a lack of life opportunities such as satisfying one's needs, receiving interesting impressions, and gaining experiences. All the factors mentioned above result in frustration, which, in turn, breeds aggression. Several decades ago (cf. Dollard, Doob, Miller, Mowrer, Sears, 1938) a thesis was formulated which assumed that aggression – when it cannot be expressed – is likely to turn into self-aggression.

The above-mentioned reasons for self-aggression in the conditions of prison isolation may also be responsible for the deepening of depressive states. Undergoing a state of mania – whose level may further be increased by drugs, alcohol, or very strong tea (i.e. addictions that are easily available in jail) – or having the intention to link up with the prison subculture, the prisoner commits acts of self-aggression, which, he assumes, may be effective in overcoming not only his changing moods but also his depressive states. There are various types of self-aggressive acts, all of which refer to self-inflicted harm such as laceration, the swallowing of foreign bodies, self-inflicted poisoning, eyeball injuries, bloodletting, self-inflicted infections, head injuries, hunger strikes, and other instances of deviated self-inflicted injury.

It is necessary to increase self-awareness of the possible acts of self-aggression in the case of prisoners suffering from depressive disorders which are committed with the intention of applying self-punishment. B. Sanecka (1984) describes a case of a male's self-castration (the individual was not a prisoner, though). It resulted from his emotional experiences – the aftermath of his difficult family situation which led to a deep sense of guilt about the problems that had arisen. Eventually, he decided that he had to inflict self-punishment.

The individuals that commit acts of self-aggression are generally characterised by a pathological weakening of their instinct for self-preservation, which may also be a symptom of depression. Nevertheless, it is certain that self-aggression in prison has a much wider psychological background and it may not always be linked to depressive disorders. There are prisoners for whom self-aggression is the ultimate end of their masochistic inclinations. They are generally unaware of these experiences and find them largely incomprehensible, which is why they seek a pretext for their self-aggressive acts – the hardest of which is suicide.

4. Depression and Suicides in Jail

Suicide is a very complex phenomenon and happens to people of different races, cultures, and historical eras. The subject matter of suicide is studied by several scientific disciplines, such as sociology, psychology, psychiatry, forensic medicine, criminology, philosophy, and theology. Furthermore, the second half of the twentieth century brought the emergence of a new scientific discipline – suicidology – whose primary focus has been the subject matter of suicides. One of the co-originators of suicidology, E. Shneidman, lists ten characteristics that are common to all people who commit suicide (Shneidman in Płużek, 1991, pp. 128-129), namely:

1) a purpose – to seek a solution to the problem;

2) a goal – the cessation of consciousness – in order to evade thinking about the hardships of existence;

3) a stimulus – resulting in unendurable psychological pain;

4) a stressor – frustrated psychological needs;

5) an emotional state – a sense of helplessness and hopelessness;

6) an internal attitude – ambivalence about living, i.e. a willingness to 'play around' accompanied by wishes for death (the 'toward life' attitude with a simultaneous 'away from life' approach);

7) a cognitive state – the constriction of horizons;

8) a type of action – escape;

9) an interpersonal act – the communication of suicidal intentions;

10) consistency – with ways of handling hard situations throughout life.

Some of these characteristics may also refer to depression and to living in prison conditions. Psychologists are unanimous in asserting that suicides are associated with syndromes of neuroses, character disorders, the difficulties of adolescence, depressive syndromes, and alcoholism. Consequently, a member of the prison population concentrates all the above disorders in himself to a much larger degree than other people do.

Another factor of primary importance in the isolating conditions of prison is the type of crime that has been committed. In point of fact, prisoners display particularly hostile attitudes towards fellow-prisoners who have committed sexual crimes towards children. Being put in jail and subject to intense persecution, the perpetrator of such offences is likely to be concerned about his life, which in turn may be one of the reasons for his depression. The prisoners' hierarchy of values – especially in the case of prisoners who manifest symptoms of psychopathic disorders – is largely based on specific short-term goals. When the possibility of their fulfilment becomes blocked, the emer-

gence of such disorders is also facilitated.

5. Depression and a Prison's Other Life

The prison's other life can be described as a system of mutual references between the prisoners themselves and between the prisoners and the prison guards (Szaszkiewicz, 1997; cf. Moczydłowski, 1991). Putting aside the distinctions connected with this phenomenon as regards individual countries, one ought to indicate its main distinguishing feature – i.e. the division of prisoners into two categories: the worthy and the worthless, or, in other words, the so-called 'humans' and the 'sub-humans'. The prisoners that belong to the category of 'human beings' constitute a group that aims at meeting determined goals. The three higher goals that are formulated by the members of this group are: a) the struggle against the law and its institutions, primarily the police and the prison guards; b) intra-group solidarity; c) the protection of 'human' dignity and honour. The meeting of these aims is ensured by rules, i.e. norms within a 'code of human conduct'. The two most important of these norms claim that 'informing on others' as well as 'sexual intercourses between the human-rank prisoners' is prohibited. Although being the object of a homosexual intercourse is not allowed, the prison code allows relationships between the 'humans' and the 'sub-humans' – in which the latter may only take a passive attitude. The 'humans' make every effort to emulate the model of the 'tough man' – a strong, steadfast and uncompromising conqueror of enemies and the deeply hated law.

Not all prisoners may be admitted into the category of 'humans'. A paedophile, for instance, will never be accepted as a member of this group, while a murderer will. When talking to me, murderers claim frequently they have killed a human but they admit they would never do any harm to a child. In this regard, the 'humans' do possess their own peculiar 'morality'. Nevertheless, a lot of prisoners, even sexual criminals, choose not to belong to the 'human' category, and consider the system as silly and illogical. By doing so, however, they condemn themselves to certain pressures, including mental pressures, from the 'humans'. Being subject to such pressure, the individual is likely to suffer frequent breakdowns, which in turn may correlate with the morbidity rate of depression.

6. Conclusion

As a criminological psychologist, I have been conducting my research among prisoners for several years. As well as that, I work as a prison chaplain. These two circumstances made me include at least some basic indications to be used by prison chaplains as well as by other prison staff.

Part of my research has concerned the connections between the prisoners' personalities and their attitudes towards the penitentiary chaplaincy (Woźniak, 2002, pp. 105-108). The research has employed the 'personality questionnaire' of R.B. Catell, the 'neurotic scale' of G. Geras, and the 'scale of attitudes towards the penitentiary chaplaincy' of W. Woźniak, which were designed specially for this research. The research involved four hundred convicts. The results, obtained using the 'scale of attitudes towards the penitentiary chaplaincy', constituted the basis for the division of prisoners into two groups – individuals with a high intensity of positive attitudes towards the penitentiary chaplaincy (100 people) and those showing highly-intense negative attitudes (100 people). It appears that the prisoners with positive attitudes towards the penitentiary chaplaincy seek support from a chaplaincy team in order to reduce the levels of their neuroticism, apprehensiveness and lack of self-confidence. The above qualities may be linked with a very significant factor in a person's religious life – a sense of guilt and remorse. In the case of prisoners, their sense of guilt is frequently disturbed. To relieve the situation, the chaplaincy ought to carry out therapeutic and healing functions in relation to these prisoners, side by side with their typical functions of salvation. The prisoners with a high intensity of negative attitudes towards the penitentiary chaplaincy, in turn, are characterised by strong egos, the need to engage in domination and aggression, and the power of resistance in situations of

danger. Furthermore, the individuals of this type are generally cool and distant, and they display independence of action and thought. The above qualities may be indicative of an individual's strong nervous system.

The above-mentioned observations may, to some extent, be referred to depressive prisoners (i.e. those susceptible to depression). In fact, it is wrong to claim that depressive prisoners are more religious than the non-depressive ones. I have not yet engaged in diagnostic research on depression in conditions of prison isolation, but, in recent years, I have been conducting research among prisoners with the method of participatory observation. Its results make me feel competent enough to state that depressive prisoners (including non-believers) report to chaplains in search of support and assistance. Yet depression is linked directly to apprehensiveness, lack of self-confidence, and a disturbed sense of guilt. Therefore, the chaplain ought to be acquainted with the conditions that induce depression in the prison situation, such as affective disorders, attempts to overcome depression through self-aggression, the relations between depression and suicidal tendencies, as well as the prison's other life.

Finally, there is another important point to be made. The chaplain ought to remain in constant touch with the prison psychologist and constitute a permanent bridge between the latter and prisoners who are in need of professional assistance.

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Medical Saints of Our Time: Giuseppe Moscati, Riccardo Pampuri and Gianna Beretta Molla

The relationship between the figure of the medical doctor and the figure of the saint is summarised in the following way by Adalberto Pazzini (1898-1975) in his work *I santi nella Storia della medicina* ('Saints in the History of Medicine') of 1937: 'the doctor saints of the early centuries, for the history of medicine, were negative entities, and demonstrated the idea in the very early Christian psychology of the uselessness of human art compared to the power of grace. Only at a subsequent psychological moment would an accommodation take place and human science would rise again, not destroyed but corroborated at many points by the religious element. And thus there would be saints who, in addition to their holiness, were of real scientific value'.

Pazzini, in this work, largely dwelt upon the saints and blesseds of the distant past (those who lived at the time of the Roman Empire, during the Middle Ages, or during the Renaissance), some of whom may be seen as physicians more of the soul than of the body, and the biographies of whom tend to slide off into hagiography. This author also dwelt, finally, on some saints who from the sixteenth to the seventeenth centuries founded hospital orders, such as St. John of God (1495-1550), or established care-providing institutions, such as St. Vincent de Paul (1581-1660), but he totally neglected the most recent picture.

But it was in a more modern era that there began to emerge figures who reached saintliness by engaging in medical-scientific activity. On the of the first doctor saints in this sense was Niccolò Stenone (1638-1686), the subject of a previous article. It was however during a more recent epoch that medical doctors, who did not demonstrate their saintliness through wonderful and exceptional actions or especial healing capacities, even though they exercised charity in a heroic way during their daily activities, and often remained members of the laity, attained the honour of the altars.

The three medical doctors who are the subject of this article knew how to decline their religiosity and achieve saintliness through existences that were rather ordinary and normal (one was a university lecturer and a freelance professional, one was a medical doctor and then a hospital friar, and one was a general practitioner and the mother of a family).

Giuseppe Moscati

This saint was born in Benevento on 25 July 1880, the seventh son of nine children, to Francesco, a magistrate of noble origins, and Rosa de Luca dei Marchesi di Roseto. After a brief stay in Ancone, the family moved definitively to Naples on 1884 when Franceso Moscati became a Counsellor of the Court of Appeal in that provincial capital city. As was the custom with well-off families at that time, the young Giuseppe received his early education at home at the hands of a tutor. After finishing elementary school he went to state schools and attended a primary school and then high school, obtaining his leaving certificate in classical studies in 1897. At the end of that year he lost his father who died in December as a result of a cerebral haemorrhage.

Perhaps influenced by a grave misfortune that had in the meantime befallen one of his older brothers (Albert, the second son, after falling from a horse during his military service, had suffered a severe head injury which then led to the development Jackson's epilepsy), Giuseppe enrolled at the Faculty of Medicine and Surgery. While he was attending the lectures of the university and dedicating himself with energy and success to his studies (at the end of the first year of his course he received a prize for the best exam result in zoology), this young student continued the pathway of spirituality which he had already been following for some time, and always found some time for prayer or reflection and drew near to the sacraments, even though he frequented scientific circles that were at that time immersed in materialism and atheism.

Moscati was awarded his degree on 4 August 1903 with top marks and discussed his thesis with Prof. Giuseppe Albini and Prof. Pasquale Malerba. The thesis was experimental and was on 'Hepatic Ureogenesis'. The university thought that it deserved the honour of being published. Just five months after obtaining his degree, the young doctor, following a public examination, became an 'extraordinary co-helper' at the hospital for the incurably ill. In particular he looked after people suffering from rabies. In the spring of 1906, at the time of the eruption of Vesuvius, he went as a volunteer to the geriatric hospital of Torre del Greco, an outlying part of the hospital for the incurably ill, to organise the evacuation of patients. He worked for many hours together with the nursing staff to carry all the patients to safety before the building collapsed. Moscati in the meantime had published his first scientific works and their subject was the research into physiological chemistry that he had engaged in both in the hospital wards and in his laboratory. In the spring and summer of 1911 this young medical doctor won a public examination at the hospital for the incurably ill to become an 'ordinary helper' (equivalent to the role of a consultant). At the same time he passed his professional examination for teaching and became an aggregate member of the Academy of Medicine and Surgery of Naples. In the same year he worked in the fight against an epidemic of cholera that had struck Naples and went wherever his help was needed (from the hygiene-health committees to the homes of the working-class districts). During the First World War he was entrusted with the military section

of the hospital for the incurably ill after being called up to the army with the rank of captain. Beginning in 1911 he had given lectures in the same hospital as an untenured lecturer in physiological chemistry in his courses on 'laboratory research applied to clinical practice' and on 'chemistry applied to clinical practice'. In 1920 he was called to give the official course on clinical chemistry at the medical faculty of the University of Naples and in 1922 he qualified as an untenured lecturer in medical clinical practice because of his qualifications.

In the meanwhile Moscati had intensified his scholarly output by publishing articles in various medical journals, amongst which may be cited the publication *Riforma medica*. At first he was a regular contributor to this journal as a reviewer of works that appeared in English and German journals, but later he became its editor. One may list from his numerous publications the following: 'Indagine chimico-fisica del peptone nell'urina' (1910), 'Azione della chinina sull'autolisi epatica e splenica' (1910), 'Peritonite tubercolare sperimentale nei cani sani ed ipofiso-privi' (1915), and 'I La determinazione della quantità del sangue con il metodo ottico. II Studio sulla quantità del sangue in alcune nefriti' (1922, jointly with his student Giuseppe Napoletano). Reference should also be made to the obituary he wrote in 1923 of the General Director of the Joint Hospitals, Prof. Michele Pietravalle, who was attacked and killed outside his home by an unknown person (near to where Moscati lived), and a historical essay on the Neapolitan doctor Giovanni Alfonso Borelli (1608-1679) entitled 'Il primo padre della medicina nuova' (1924).

Prof. Moscati also engaged in professional medical practice at his home in Via Cisterna dell'Olio which was visited by a number of patients who were attracted by the fame and the reputation of this acute clinical physician. He was visited, amongst others, by the famous tenor Enrico Caruso in 1921. Caruso had returned to Italy after American doctors had been unable to diagnose the malady he had suffered from for a notable period of time. Moscati correctly interpreted the symptoms as a manifestation of a sub-phrenic abscess but he was unable to save this opera singer because of the septic condition which had become well established.

Throughout his life Moscati conserved a profound religiosity which was expressed not only in practices of devotion (he began his day by going to mass in the early morning and taking communion) and his style of living (he lived very modestly and paid little attention to honours and rewards), but also in his daily professional life where he refused to be paid by patients in need, to whom, indeed, he often gave medicines and drugs or sums of money. In his relationships with his patients he always conjoined spiritual assistance with professional assistance. In the summer of 1923, after returning from a trip to Edinburgh, which had been organised by his Neapolitan colleagues in order to take part in an international congress on physiology, he left his companions to go to Lourdes where he stayed for two days.

In the early afternoon of 12 April 1927, a little time after examining a patient in his private surgery, Giuseppe Moscati died of a heart attack. His colleague Gaetano Quagliarello remembered Moscati in the following way in the pages of the journal *Archivio di Scienze biologiche*: 'the faith that illuminated his life, which was completely dedicated to science, to learning and to the alleviation of human suffering; the serene happiness of his conscience which was translated into the sweetness of his smile; and the Christian heights of his feelings, all these conferred on him an especial appeal which had the power to infuse in those who turned to him both hope in justice and secure confidence in good'. The mortal remains of this doctor saint (he was beatified in 1975 and canonised in 1987) have lain since 1930 in the Neapolitan Church of Gesù Nuovo, and they have always been the subject of intense devotion and constant pilgrimage.

Riccardo Pampuri

This saint was born in Trivolzio, a small agricultural town on the borders of the province of Milan and the province of Pavia on 2 August 1997. His father, a wine seller, was named Innocente, and the name of his mother, who came from a well-off family, was Angela Campari. As a child he was baptised with the name of Ernino and he was the tenth of eleven children. Pampauri, however, did not have a happy childhood. When he was just three years old he lost his mother, who died of tuberculosis at the age of forty four, and when he was ten years old his father, who drank a lot and had an irascible character, died in a traffic accident. A little time after losing his mother, the little boy (who in his family was called Emilio) was entrusted to his maternal aunt who lived in the neighbouring village of Torrino and whose husband was a medical practitioner in Trivolzio. In his new home, which was in the centre of a large agricultural estate, there lived, in addition to the maid, also his maternal grandfather and two great uncles. The little boy, who was brought up in the Christian faith in his new family, had to go to two nearby villages to go to elementary school, given that in Torrino there was no school building. At the age of eleven he moved to Milan to attend the primary school and here he was the guest of his older brother, Ferdinando. He was then sent by his uncle and aunt in Torrino to Pavia to the College of S. Agostino where he was a boarder for six years until he took his leaving certificate in classical studies.

During his years at primary and secondary school the young Pampauri further cultivated his spirituality (he went to confession and took communion every day) and on more than one occasion he confided to his sister Longina Maria, a missionary sister in Egypt, about his aspiration to become a priest. He decided to enrol at the Faculty of Medicine and Surgery of the University of Pavia, and in this decision he was probably influenced by the fact that his uncle was a medical doctor who directed him towards the medical profession. However, he was also driven forward by the wish to engage in work that placed him at the service of his neighbour. As a university student he con-

tinued to move in Catholic circles and marked himself out for his works of charity and apostolate until, in the spring of 1917, he was called to the army and sent to the front as a 'health adjutant'. As a young man he performed his new task with his usual charitable spirit. He even won a golden medal for valour and was made a sergeant: during the retreat from Caporetto he managed, in the rain and under enemy fire, to load all the health care material that his companions had abandoned onto a cart drawn by a cow and to take it back safely to the rear. In subsequent months Pampuri, who contracted a lung infection from this episode, had frequent periods of leave and was posted to areas distant from military operations. As a result of this he was able to follow his university studies with relative ease. He left the army in the spring of 1920 with the rank of sergeant-major. A year later, on 6 July 1921, he was awarded a degree with the highest possible marks at the University of Pavia with a thesis on 'the ascertaining of ar-

terial pressure with a new sphigmomanometre'. A few days previously he had become a Franciscan tertiary and received the name of Friar Antonio.

Dr. Pampuri, after a brief internship with his uncle, was made medical practitioner of Morimondo, which was about fifteen kilometres from Torrino. He thus went to live with his sister Margherita in this small town in a home near to a famous Cistercian abbey. In the practice of his profession he immediately displayed an attitude of great readiness to help and charity in relation to his patients (he went to patients in response to every call, refused payments from patients, and often gave them medicines). He also gave sums of money to the poor or gave them what he had in his home (from food to clothes). He also gave the comfort of religion to patients by reading them passages from the Gospels or some sentences from a book of meditations. In his free time he went to church to pray and he was involved in parish activities (the preparation of children for their first communion, the organisation of spiritual retreats for young people and adults, and propaganda for Catholic missions).

This young medical doctor, who continued to feel within himself the vocation to the priesthood, had first asked to be accepted by the Franciscans and by the Jesuits, and from both of these religious orders he received a clear rejection on the grounds of his rather precarious health (he had been given the official status of an invalid because of his lung condition which had been contracted during his war service). However he was accepted by the hospital order of the Fatebenefratelli after spending a summer of trial in 1927 (officially this was a period of rest for convalescence) in the home of Solbiate Comasco. With the Fatabenfratelli he began that same year his period as a novice in their home in Brescia, and took the name of Friar Riccardo. Both his relatives and his patients of Morimondo were greatly surprised by the decision taken by Pampuri. This life shaping choice was commented on in an article that appeared in the *Corriere della Sera* under the heading 'A Doctor becomes a Friar'. On 24 October 1928 Friar Riccardo took the vows typical of the Fatabenefratelli (poverty, chastity, obedience and hospitality) and he was entrusted with running a dental surgery connected with the Hospital of Sant'Orsola.

In the spring of 1929 the first symptoms of pulmonary tuberculosis which Pampuri had contracted began to appear (frequent low fever and bleedings). This illness was probably due to excessive work undertaken by a body that was already weakened (in addition to working in the dental surgery he also did replacement work during the night for the medical doctors of the hospital and never refused to perform any health care task or task of a spiritual nature when it was requested of him). He was thus sent by his superiors for a few weeks to their home in Gorizia and after this he returned to the dental surgery of the hospital in Brescia. After another relapse he was sent to the home of his aunt and uncle in Torrino for a month of convalescence. Afterwards, in response to a request made by his aunt and uncle, he was moved from Brescia to Milan, and was admitted in a very serious condition on 18 April 1930 to the Hospital of San Giuseppe where he died on 1 May 1930. The mortal remains of this doctor saint (who was beatified in 1981 and canonised in 1987) have lain since 1997 in a chapel of the parish church of Trivolzio, the object of devotion by a very large number of the faithful.

Gianna Beretta Molla

This saint was born in Magenta (MI) on 4 October 1897, the last child of three. Her father was Alberto Beretta, a manager in industry, and her mother was Maria De Micheli. Both parents, who both came from Lombardy, were deeply religious and belonged to the Franciscan Third Order. The family moved in 1925 to Bergamo, in Città Alta, where it remained until 1937. It then moved to Genoa-Quinto, only to move back to Bergamo again in 1941. Gianna went to elementary schools in Bergamo and then to primary school until the fourth year of study. In Genoa she went to the fifth year of primary school but interrupted her studies for a year because of her bad health. In the meantime she had developed a deep religiosity which had allowed her to overcome such dramatic and painful moments as the death of her older sister, who had been ill for some time, in 1937. In Genoa she further developed and explored her spirituality under the guidance of a spiritual director and began to take an active part in Catholic Action. In Genoa she continued her studies at secondary school with her sister Virginia, and this went on even after the outbreak

of war when her family moved once again to Bergamo and lived in the house of her maternal grandparents, where, in 1940, fourth months apart, both parents died of illness. In the same year she received her leaving certificate from her secondary school and then moved definitively with the rest of her family to Magenta to the home of her Beretta grandparents. She enrolled in the Faculty of Medicine and Surgery of the University of Milan, following in this the example of her brothers Ferdinando and Enrico. In 1942 two of her brothers set out to be priests: Giuseppe in the seminary at Bergamo, and Ferdinando, who had already become a medical doctor, as a novice of the Capuchin Fathers in Lovere. During her university studies Gianni continued to be involved in apostolate and works of charity, and was active both in Catholic Action and San Vincenzo. She advised the girls of the Female Youth of Magenta to engage above all in prayer and meditation. At the end of the Second World War, in 1945, Gianna moved from the University of Milan to the University of Pavia where she completed her studies in the company of her sister Virginia, who had also enrolled in the Faculty of Medicine and Surgery. She was awarded her degree with the highest marks on 30 November 1949. Immediately afterwards she enrolled at the University of Milan to study at the School of Specialisation in Paediatrics and she received her diploma in 1952.

Gianna Beretta saw the medical profession as a true mission of Christian care and apostolate, as is clear from the following thoughts which she expressed when she was still a student: 'All of us in the world work in some way at the service of men. Medical doctors work directly on man. Our subject of science and work is the person who in front of us tells us about himself and asks us to help him, expecting from us the fullness of his existence. We medical doctors have opportunities that the priest does not have. Our mission is not over when the medicines are no longer of use. The soul is to be brought to God. There is Jesus who says: 'who visits a sick person, helps me…'.

In 1946 her brother Giuseppe had become a priest and in 1948 her pther brother Enrico had also been ordained a priest. Enrico was to be sent to Brazil as a missionary medical doctor of the Capuchin order. Her sister Virginia, who had graduated in medicine in 1951, had entered the congregation of Magdalene of Canossa and would be sent to India as a missionary doctor.

The young doctor began to practice her medical profession in Mesero, a small town near to Magenta, where in 1950 she had opened a clinic with her brother Ferdinando. In 1952 she provided paediatric care to the summer colony of the town council of Magenta; in 1953 she was a doctor who accompanied sick people in the train for Lourdes. In the meantime she continued to be active in Catholic Action and cultivated the wish to join her missionary brother in Brazil. However she was advised against this by those who thought that her physical constitution was not suited to a tropical climate. As a health care professional she was especially interested in matters connected with pregnancy, birth and neonatal care (she also worked in the consultancy section of the ONMI of Magenta as the head of the nursery section). Profoundly convinced of the sacredness of human life, she sought to offer spiritual comfort to pregnant women who were experiencing difficulties. She supported giving birth at home and only advised hospitalisation when there was a risk for the mother or the child.

In 1954 Gianna Beretta met Peltro Molla, an engineer and a manager in industry, who lived in Mesero near to her clinic. After a few chance meetings the two began to spend time in each other's company and discovered that they were united in sharing the same Christian values. At the end of a period of a few months of engagement they married in Megenta at the basilica of San Martino on 24 September 1955. After their honeymoon the two newly weds went to live in a part of Magenta in a factory where the engineer worked as a director. Dr. Beretta continued her activities as a medical doctor in Mesero even after giving birth to three children over a sort period of time (in 1956 Pierluigi was born, in 1957, Maria Zita, and in 1959, Laura). In addition, she looked after her children and the home, notwithstanding the frequent absences of her husband who often went abroad for reasons of work. In the summer of 1961, a little time after becoming pregnant for the fourth time, it was discovered that she had a large uterine growth for which she was operated on, in line with her beliefs, with a view to removing the growth. She managed to carry on with the pregnancy and went back to her usual activities as the mother of a family and a medical doctor.

Gianna Beretta Molla carried on with her difficult pregnancy until the birth on 21 April 1962 of her last child, Gianna Emanuela. However she was afflicted a little time afterwards by a septic peritonitis which, despite the treatment she received, became worse to the point that she had to be taken back in a dying condition to her home. She died there on 28 April 1962. This saint (she was beatified in 1994 and canonised in 2004) was buried in the cemetery of Mesero (the place where she had engaged in the major part of her activity as a medical doctor), venerated by the faithful as an example of Christian love for human life in a world that is all too often insensitive to that value.

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Testimonies

The Lord has done
great things for us:
He Has Filled Us with Joy!

Document of the
Episcopal Commission for Health
of Madagascar

From Athens to Sparta:
we are All on a Journey
with Terri Schiavo

The Lord has Done Great Things for us: He has Filled us with Joy!

THE FOURTEENTH WORLD DAY OF THE SICK ON THE TWENTIETH ANNIVERSARY OF THE BIRTH OF THE OFFICE FOR PASTORAL CARE IN HEALTH OF THE ARCHDIOCESE OF BARI-BITONTO

In front of the 'wonders of God' we members of the diocesan consultative body for pastoral care in health, like the community of pious Israelites of Psalm 126 (125), can also exclaim: 'The Lord has done great things for us: he has filled us with joy!' This psychological and spiritual state of joyous feelings, together with gratitude and thanks, accompanied us during the whole of the pastoral year 2005-2006. The twentieth anniversary of the foundation of our diocesan office and its service (1986-2006) was the principal celebratory event and the Fourteenth World Day of the Sick became the convergent and divergent point of all the initiatives that were engaged in. The pastoral appointments were conceived and took place in the light of these two special dates.

An Office that was Born in the Middle of the 1980s: a Prophetic Intuition

The Bari-Bitonto Office for Pastoral Care in Health was one of the first in Italy to be established thanks to a prophetic intuition of the Archbishop, Msgr. Mariano Magrassi, who in 1985 began to think about entrusting pastoral care for the sick and suffering and the promotion of health to a new body that was different from Caritas and which, indeed, he created in 1986, the year when the first director was appointed.

It is helpful to remember the context of that event: in the 1980s the letter *Salvific doloris* had been published, a papal work on the Christian meaning of human suffering (1986), and there had recently been created what is now called the Pontifical Council for Health Pastoral Care (1985). At that time few diocesan consultative offices existed and the national Consultative Office of the Italian Bishops' Conference was active in this field. Indeed, a few years later this Consultative Office published its 'Pastoral Care in Health in the Italian Church' (1989). The national Office only came into being many years later (September 1996). Structures to train pastoral workers were absent and these were only to appear in later years, structures such as the Camillianum (1987) and the diocesan schools for pastoral care in health (in the 1990s).

The commemoration of the twentieth anniversary of the birth of the Office was solemnly celebrated on 25 March 2006 with the holding of the third diocesan conference on pastoral care in health. The subject of this meeting was 'twenty years at the service of our local church'. The Archbishop of the archdiocese, Msgr. Francesco Cacucci, together with a numerous group of extraordinary ministers of holy communion and associations and bodies of patients or of people who care for the suffering, took part in this conference.

The conference provided an opportunity for the director of the Office to give a paper on 'the journey of the Office under the banner of research and creativity' and in this paper he identified four pathways that had been followed during this long period: the initial and ongoing training of pastoral workers, the creation of bodies for communion and participation, attention towards, and the promotion of, socio-health care voluntary work, and the preservation of records on what had been achieved (archives). He ended his paper by pointing to the paths of the imminent future: the development of the missionary dimension of pastoral care in health, new ministry in hospitals and the local area, the greater professional skill and expertise of pastoral workers in health, and a more decisive promotion of bodies of communion (hospital chaplaincies and pastoral advice).

The paper given by Prof. Arnaldo Pangrazzi, a lecturer at the Istituto Internazionale di Telogia Pastorale Sanitaria "Camillianum" of Rome, provoked a great deal of interest. His paper was on the subject 'from the pastoral care of suffering to the pastoral care of health' and he demonstrated with clarity the development of such pastoral care over the last two decades at the level of identity, subjects and purpose. Prof. Pangrazzi indicated the seven ways or directions that the new pastoral care in health needs to pursue: from pastoral care of the sick to pastoral care of health, from sacramental pastoral care to pastoral care involving evangelisation, from the pastoral care of compassion to the pastoral care of justice, from the pastoral care of death to the pastoral care of life, from autonomous and isolated pastoral care to co-ordinated and harmonious pastoral care, from hospital pastoral care to pastoral care of the Christian community, and from a pastoral care of improvisation to a pastoral care of projects.

The conference also proved very useful in achieving greater knowledge about certain associations that belong to the Consultative Office: the Centre for Voluntary Workers of Suffering (CVS), UNITALSI, the Pastoral Centre for the Deaf 'Don Filippo Smaldone', the Diocesan Centre for Social Integration (CEDIS), and Fratres. All of the rich material produced by the conference was put in the proceedings, which were published by the Office in April 2006.

Two Special Appointments: the Meetings of Chaplaincies and of Chaplains

The twenty years of existence of the Office were also celebrated with two important meetings: the meeting of the pastoral workers of hospital chaplaincies and the meeting of the hospital chaplains with the Archbishop.

The experiences undergone by the hospital chaplaincies, which our archdiocese has promoted through connections at a national level, are an innovative element as regards pastoral care in health. For this reason, on 5 November 2005 the 'first meeting of pastoral workers' was held in the hall of the synod. It gave itself the task of reflecting on the ecclesiology of communion, the basis of this new organism of participation, with a paper by Msgr. Domenico Ciavarella, the vicar general, and also the task of achieving an exchange of views and experiences between pastoral workers in order to promote greater personal knowledge and the stimulation of growth in their activity.

The meeting of the hospital chaplains with their own pastor, organised at the Home of the Clergy on 5 December 2005, proved useful because it allowed an in-depth exploration of the subject of mystery, which is the pastoral choice of the diocese, applied to the communities of the health-care world. In the light of the last universal synod on the Eucharist, reflection took place on the need to rediscover the dimension of sacrifice of Holy Mass in order to propose it to sick people, their family relatives and all health-care workers as a means by which to participate in the paschal mystery of Christ, illuminated by the theology of the mystic body.

The Fourteenth World Day of the Sick: a Date Experienced Creatively

The World Day of the Sick in our local Church is a consolidated tradition which has been celebrated ever since the 1980s, and thus before the proposal made by John Paul II in 1992 to celebrate it at an international level. It is awaited and experienced creatively by the Office and the ecclesial communities of the parishes and the hospitals.

As has been the case in previous years, the World Day of the Sick was celebrated by *a day of on-going training of the extraordinary ministers of holy communion on 21 January 2006* in the main hall of the Faculty of Engineering of the Polytechnic of Bari. In the diocese there are more than one thousand two hundred such ministers. Don Armando Aufiero, a priest of the Silent Workers of the Cross, dwelt in an excellent way on the subject 'if pain is a school, the sick person has much to learn and to teach', and drew upon the publication of the national Office and Consultation Office which was produced for this year – 'At the School of the Sick Person'. At the same meeting the material to support the World Day of the Sick was also presented, illustrated and distributed, namely the Message of the Pope, a large poster and the publicity poster, a summary of the above publication, and the prayer of the sick person.

The director of the Office asked and obtained from the National Office of Social Communications of the Italian Bishops' Conference *the broadcasting on television of the concelebration of the Eucharist of Sunday, 12 February 2006, at 11.00 on RAI I*, presided over by the Archbishop, Msgr. Francesco Cacucci, from the sanctuary of Our Lady of the Well of Capurso (BA). In his homily the Archbishop commented on both the importance of the World Day of the Sick and the anniversary of the Office. The Holy Mass was animated by singing by the diocesan choir; readings from the Bible and the prayers of the faithful, involving some members of the Consultative Office. Sick people were given the front rows in the church and the deaf in particular were assured the simultaneous 'translation' of all the moments of the celebration.

The regional newspaper *La Gazetta del Mezzogiorno* gave suitable space to this event on the special page for Bitonto, a metropolitan area (Sunday 12 February 2006 – 'The World Day of the Sick – The Cameras of the RAI in the Basilica of Our Lady').

Other initiatives involving catechesis, fostering and training, preceded and followed the memorial of Our Lady of Lourdes of 11 February: the participation of the Office with a numerous group of pastoral workers in the national conference of the Italian Association of Pastoral Care in Heath (AIPAS) which was held in Collevalenza (PG) in October 2005; the lessons at the vicariate's courses of initial training for the new MSSCs; the catechesis on the anointing of the sick in the parish of Our Lady of Consolation in Altamura (BA) and on the subject of fragility at the fourth ecclesial conference of Verona on the S. Fara parish of Bari on the contribution at an educational level to the schools of pastoral care in health of the diocese of Southern Italy.

The Diocesan School of Pastoral Care in Health, directed by Dr. Ornella Scaramuzzi, continued its ten-year service to the diocese with a rich programme of subjects on 'ethics and humanisation' that was presented in weekly lectures at the main hall of the parish of St. Fara in Bari. Amongst others, the following subjects were addressed by the speakers: the contribution of the Church to the humanisation of the health-care world, identity – horizons and workers in the world of pastoral care in health, the parish as a home for communion and charity for 'difficult' sick people, enneagram – module B, AIDS and chastity, mourning in children, the ethics of virtue, depression, and adoption.

The World Day of Health: Echoes from the Parish Communities

We can gather certain resonances from the celebration of the Fourteenth World Day of the Sick in our parishes from the papers that were sent to the director of the Office. Much space was given to liturgical and sacramental celebrations which were experienced with intensity in a solemn way, such as the Eucharist and the anointing of the sick administered in a communal way, but initiatives involving charity and solidarity towards the suffering were not absent.

The episcopal vicariate of the Bitonto-Palp del Colle (BA) area, as had been the case in previous years, renewed its interest in the commemoration of the World Day of the Sick with the especial involvement of members of the laity. At the *Pontifical Basilica of Holy Doctors* in Bitonto the representatives of the brotherhoods and the various associations of voluntary work (UNITALSI, Volontariato Vincenziano, 'Anotrocolo', UAL, CVS, UVOLA, MAC, Associazione mariana, 'Arcobaleno', AISFA, Gruppo mariano dei SS. Medici), organised a unique celebration of the World Day of the Sick in which over four thousand sick people took part. The commemoration was a joyful opportunity to experience charity extended to missionary horizons as well: all the offerings of the event were given to a sister from Bitento who works in a mission in New Caledonia, an island in Oceania that is near to Australia. Spectacles, used lenses and health care material were also collected to help those in need. A statuette of Our Lady of Lourdes was given to all the sick people who were present.

In the first vicariate, the parish of San Carlo Borromeo organised for 11 February, amongst other things, a Holy Mass with reflections on the message of the World Day of the Sick, a supplication to Our Lady of Lourdes and a communal celebration of the anointing of the sick for elderly people and suffering people.

In the second vicariate, at the parish of the Holy Cross, in addition to the celebrations of the Eucharist in church and the saying of the rosary at the grotto of Lourdes, the following were organised: a meeting of sick people, a torchlight procession along certain streets of the city, and a pilgrimage to the French sanctuary during the month of August. The Sundays before and after the commemoration of 11 February have by tradition witnessed the organisation of a fraternal *agape* by volunteers for people who are alone, for the poor, and for those who want to spend a day in the company of others. For those who cannot move from their homes a lunch is brought to them.

In the third vicariate, the World Day of the Sick has by now become a regular appointment. All the parishes have followed a pathway of training with moments of catechesis, home visits to sick people, the donating of blood, the adoration of the Eucharist and the sacrament of the anointing of the sick.

In particular, in the parish of Maria SS. Annunziata in Modugno the happy event was experienced of the ordination of a new priest, Fra Gianni Gelato, who chose specifically this date to offer greater visibility and attention to sick people with the involvement of the parish community and the citizens of the town. The presence of the Archbishop, who presided over the celebration of the Eucharist, in which numerous priests took part, was also an opportunity for reflection on pastoral care in health. The World Day of the Sick was ended with a rich buffet offered by the new priest both to the sick and to all the participants. For some months the local area has been enriched by a new rest home with sixty beds managed by 'S. Raffaele' of Milan.

The sixth vicariate experienced the World Day of the Sick because in its territory is to be found the great Hospital of St. Paul and throughout the whole liturgical year it organises a multiplicity of initiatives involving concrete care for the hospital community, especially at Advent and Lent.

The parish of the Holy Family encouraged the MSSC and the group of Caritas to act to sensitise all the whole of the local area to the Feast of Our Lady of Lourdes and the World Day of the Sick with visits to the families of sick people, with catechesis meetings on the Message of the Pope and on the publication of the national Office of the Bishops' Conference of Italy, and the pinning up of posters on the event in apartment blocks.

In the *seventh vicariate* all the parishes celebrated the World Day of the Sick and at Holy Mass had homilies with reflections on health and illness. The parish of *Maria SS di Monteverde a Grumo Appula* prepared for the feast with adoration of the Eucharist and reflection on the Message of Pope Benedict XVI.

The eighth vicariate organised the celebration of the World Day of the Sick at various levels with special initiatives in the individual parishes (home visits by priests and the MSSCs to sick people, the gift of the Message of the Pope, a distribution of the image of Our Lady and other small examples of care).

At the *parish of the Immacolata di Lourdes di Gioia del Colle*, a concelebration of the Eucharist was held which was presided over by the director of the diocesan liturgical office. This was marked by the involvement and the presence of all the parish priests. In the afternoon, and despite the very great cold, a torchlight procession took place, with a large image of the Virgin being carried down the streets.

In *Mola di Bari*, which forms a part of the *eleventh vicariate*, the World Day of the Sick was celebrated together by the five parish communities of the town at the parish of the Sacred Heart. This very large church was able to accommodate the large number of sick people and the people who accompanied them. At the end of the mass the women volunteers of St Vincent gave a mimosa branch and a medallion of Our Lady of Lourdes to those present.

The parish of Our Lady of Lourdes (Parchitello-Noicattaro) organised a exhibition of sacred art under the heading 'the colours of faith' and a concert of witness by Giuseppe Cionfoli on the subject 'life is a gift'.

In *the twelfth vicariate* the parish of the Resurrection, as it has done every year, bestowed the tonality of a special celebration on 11 February since sick people are usually provided with the caring service of weekly home visits where holy communion is never absent. This year sick people and their families were offered the opportunity to celebrate the Eucharist, and this was followed by a social moment when the sick people were able to spend some time together, to talk about themselves and to express their joy at seeing each other again. The young people of the youth group entertained those celebrating the day with songs, little plays, riddles and other forms of entertainment. The parish priest ended the meeting by inviting all those present to feel that they were active subjects of the community and to offer their own specific individual form of co-operation.

A Day that Lasts a Year: Resonances from the Hospitals and the Associations

In the hospital and healthcare structures the World Day of the Sick has become a special opportunity to increase the awareness of chaplains and pastoral workers about their pastoral role which, indeed, lasts the whole year. It thus also acts to call the attention of the hospital community to its responsibilities of service towards those who suffer and their family relatives through special initiatives of encouragement and training.

In the great polyclinic of Bari the hospital chaplaincy, which is made up of twenty-five pastoral workers, carried on with the implementation of projects that were already engaged in previously: a listening centre, receiving the family relatives of sick people, an Internet site, support for people experiencing mourning, training activity, help in the form of food for families in need, helping in providing care to the homeless at the central railway station of the city, and hours every month dedicated to the adoration of the Eucharist and encouraged and prepared by the parishes of the diocese. In addition, a large number of initiatives were organised as part of the annual programme which had been drawn up in the month of September: monthly training and planning meetings, days of spiritual retreat before Advent and Lent, taking part in meetings on pastoral care in health, *Sante Quanrantore*, a via crucis along the corridors of the hospital, and a day dedicated to a final assessment. At the time of the World Day of the Sick special liturgical celebrations in clinics were organised which were accompanied by gifts to the nurses and other specific initiatives.

In the *hospital of St. Paul of the ASL BA/4* the World Day of the Sick had the task of renewing the commitment of daily services by the pastoral workers of the chaplaincy: a visit to the patients of the seventeen wards of the hospital centre with the gift of the Eucharist-Jesus, the immediate response of the chaplain to the requests for confession or anointing of the sick, a via crucis at the time of Lent, vocal-instrumental concerts in church, taking part in meetings of the vicariate and the diocese level as a concrete sign of communion with the local church and the bishop, working with the Association of Hospital Volunteers (AVO), synergic work with the social worker in cases of special and urgent need on the part of sick people, and the promotion of the donating of blood with the Frates in the local area.

In the *hospital centre 'Di Venere' of the same ASL BA/4 in Carbonara (BA)* on the morning of 11 February the MSSCs distributed six hundred missionary rosaries with the prayer of the World Day of the Sick to patients and staff, and in the afternoon the episcopal vicar, Don Vito Marotta, presided over the Eucharistic concelebration and then led the Eucharistic procession, with the display of the host in all the wards, including the resuscitation unit. The participation of the patients and their family relatives, who were understandably very moved, was very great.

The hospital chaplaincy of the oncological hospital and the Mater Dei hospital organised a series of events in preparation for the feast of Our Lady of Lourdes: a thoughtful saying of the rosary, and a procession of the Eucharist which witnessed the passing of the Risen One through all the rooms of the patients with the involvement of some lay faithful of the parish of St. Francis of Assisi of Japigia. For its part, the administration of the oncological hospital, as was reported in *L'Osservatore Romano* (Friday, 10 February, p. 10), 'decided to dedicate the name of the health-care centre to the Servant of God John Paul II' because of 'the care that Karol Wojtyla always managed to express towards the weakest part of human society'. This proposal met with the approval of the metropolitan Archbishop of Bari-Bitento, Msgr. Francesco Cacucci, who expressed 'his strong appreciation and pleasure, fully agreeing with the reasons for the proposal'.

At *the hospital of Bitonto* the chaplain and the members of the chaplaincy managed to in-

volve the medical and nursing staff as well in the celebration of the Eucharist during the World Day of the Sick, which was transformed into a moment of intense human and spiritual communion between all those who were present.

In *the hospital centre of Grumo Appula (BA)* the adoration of the Eucharist was organised, enriched by the catechesis. The commemoration of the World Day of the Sick was an opportunity for the general management of the hospital company to renew its promise of imminent work to build a chapel, which is indispensable for liturgical celebrations. At the Padre Semeria nursing home and the Villa Lucia nursing home moments of spirituality and joyful fraternity were also organised for the residents thanks to the contribution of youth groups from the parish area.

In Triggiano (BA) the community of the F. Fallacara Hospital experienced the World Day of the Sick with creativity thanks to the role of the chaplain and the sisters. In the morning the MSSCs visited the patients and gave each one of them a copy of the gospels, and the parish priests of the individual parishes concelebrated in the church of the hospital with the participation of all the hospital staff, the volunteers and the faithful. In the afternoon a statue of Our Lady was carried in procession through the various wards and the next day a theatrical performance was organised in memory of Mother Theresa of Calcutta and the work that she engaged in for marginalised people. In the same town a citizens' committee for the revival of the hospital drew up and distributed a leaflet to explain to the citizens the reasons for the need for a renewal of their health-care centre at the level of an improvement in services through professional skills and expertise, humanisation and hope, for the benefit of the south Bari area.

For all those connected with the UNITALSI, the World Day of the Sick had a dual spiritual value: the annual appointment for the suffering wanted by John Paul II and the feast of Our Lady of Lourdes. This year they met at the *parish of S. Gabriele dell'Addolorata* in the neighbourhood of St. Paul with their assistant and experienced a moment of intense spirituality with the saying of the holy rosary, the celebration of the Eucharist, and the torchlight procession within the grounds of the church.

The Centre for the Volunteers of Suffering (CVS) took part in the celebrations and in the initiatives of the parishes, where it is present in the form of small apostolate groups (called 'advanced groups'), indeed in fifteen parishes! Some specific initiatives may be referred to here: some disabled people offered their contribution in the liturgy as readers of the Word or during the prayer of the faithful or by animating the procession involving the giving of gifts or with songs. The publication of the association 'The Sick Person is Me!' was used, together with the initiatives suggested in that publication.

At the parish of St. Mary the feet of a disabled person and of an elderly person were washed during the celebration of the Eucharist. In the parish of the Good Shepherd the MSSCs wrote to each sick person who had received a visit certain reflections addressed to the parish community, which were then written on large posters placed in the church for the attention of all the faithful.

In Walking One Opens up a Pathway: One Goes on Towards New Goals

In conclusion we can really state that we are grateful to God both for the commemoration of achieving twenty years of life for the Office and for the Fourteenth World Day of the Sick. We would like to stress certain significant aspects of both events.

The long journey walked by the Office has not stopped. Indeed, specifically because of the work that has been carried out and the successes that have been achieved it must continue with renewed enthusiasm towards the new goals outlined by the Church in Italy and by the new needs of society. Naturally enough, one cannot walk alone. It is always necessary to advance in harmony with regional and national ecclesial bodies. The new Note on pastoral care in health, which was recently approved by the permanent Council of the Italian Bishops' Conference (March 2006), will constitute a secure point of reference through the study and the implementation of the working guidelines that it contains.

The celebration of the World Day of the Sick turned out to be increasingly rich in initiatives in the individual parish communities and in hospitals. We would like to emphasise the seriousness with which this annual appointment is experienced (some communities prepare for it with a special meeting or encounter!). In addition to the more common initiatives of prayer and liturgical and sacramental celebrations, the creativity and the originality of commitments that spring from

the imaginative capacities of love are not absent. The proposing of initiatives of solidarity, the pastoral encounter between chaplains and the parish priests of the local area, the co-operation between Caritas workers and workers in pastoral care in health, and the pastoral initiatives taken and implemented communally by the parish priests of a city, are all very striking. They are shining examples of a future that is rich in hope.

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Activity in the Field of Health and Health Care

DOCUMENT OF THE EPISCOPAL COMMISSION FOR HEALTH OF MADAGASCAR

You will find enclosed a copy of the Statutes of the Episcopal Commission for Health (ECH) of Madagascar which will provide you with an idea of the activities that have been carried out in this field.

We know that the bishop is the first person responsible for health and health care in his diocese. For this reason, such pastoral care varies notably from diocese to diocese. For us, the members of the ECH, it is important to be in contact with the Diocesan Commissions for Health (DCHs) that were created by the bishops of various dioceses to help them in relation to the activities that are carried out in this field. These commissions are present in seventeen of the twenty dioceses of Madagascar and about ten of them function very well. The DCHs organise and co-ordinate activity at a diocesan level, and this is the reason why there is great diversity within the country. Since 2004 we have decided to hold meetings every year with the presidents of all the DCHs of the national territory. At these meetings the presidents present a report on the activities that have been engaged in and on the problems that have to be addressed in the performance of the health-care ministry. These meetings are very important and with time they will allow us to closely follow the activities that are engaged in in the field of health and health care in the country. The ECH knows the Catholic institutions that operate in the health-care field at a diocesan level. We will gradually manage to obtain complete data on the situation in Madagascar. Some dioceses are already well organised in the field of pastoral care in health.

We have divided pastoral workers in health into four categories:

1. State religious nurses (both men and women). There are about 250 of these.
2. Catholic obstetric nurses (both men and women).
3. Catholic hospital chaplains.
4. Catholic medical doctors.

Thanks to a sum that we receive from Missio, we are able to organise twice-yearly meetings for each category. These are above all meetings for the exchange of information and views with speakers who give papers on medical subjects and on Catholic teaching on medical ethics. In general, at each meeting at least seventeen dioceses out of twenty are represented, and we publish a detailed report on the proceedings of these meetings which are then distributed to the participants.

In Madagascar there are few Catholic hospitals for the simple reason that the costs of a hospital are very high and in such cases a very substantial financial contribution from Europe is required. Otherwise, hospitals can only be used by rich people. Given that we want to serve poor people who do not have the money to pay for health care it is very difficult to have a hospital. The FMM sisters have a clinic in Tananarive and there are hospitals in Ambanja, Fianarantsoa and Farafangana. In the other dioceses, on the other hand, Catholic hospitals do not exist. Many of these dioceses are studying the possibility of creating a hospital in the name of the Bishops' Conference of Madagascar but many efforts are required for such a project to be implemented. Other congregations have the possibility of opening a Catholic health-care centre.

Most of the activity that is carried out in the field of health and health care in all the dioceses of the country is engaged in at the level of leper hospitals and dispensaries. The Catholic Church has twenty-eight centres which have this purpose. Despite the difficulties that exist in convincing the World Health Organisation that leprosy still exists in Madagascar and that these centres have to be maintained, women religious do a wonderful job for these sick people. There has always been a misunderstanding between our centres and the World Health Organisation because the WHO would like us to close them. However, in Madagascar these centres are needed. There are also Catholic dispensaries and we hope to have statistics on how many there are of these on the island soon. The needs in the field of health and health care are immense and this is why the religious Congregations do not hesitate to organise this ministry. Thanks to the nursing school of Ankadifotsy, every year we have new women nurses to work in these dispensaries.

We should not minimise the work of women religious in the state hospitals. In this difficult context they bear witness to the charity of Christ and to service to the poor. Even though they are employees of the state, they are able to serve the poor and to avoid the abuses of corruption.

However, in Madagascar there are few women religious with degrees in medicine and also here, despite the difficulties at the level of training, various Congregations do not hesitate to send out women religious to become doctors.

The ECAR has diagnostic centres for AIDS, which are financed by the CRS, but because the number of people with AIDS is difficult to determine we have no centre which treats such people.

This year the Commission for Pastoral Care in Health signed an agreement with the Ministry for Health to strengthen the fight against tuberculosis. Thirty-three centres in our twenty dioceses will receive financial help to carry out this new programme. Because this is beyond the responsibilities of the Commission, we have formed a group to manage this programme. The Ministry of Health increasingly wants to organise a partnership with the ECAR for these programmes financed by the Global Fund.

Thanks to the Camillian Fathers and the hospitals in Tananarive, we hope to organised this ministry in a better way in all the health-care centres in the country. Progress has already been made and sixteen of the twenty diocese send participants to the meeting for hospital chaplains. National associations for these chaplains do not as yet exist but we are working in this direction.

Each diocese has its own pastoral care in health and specific activities that are very interesting but too much space would be required here to list them and to explain what they are. The report on the last meeting of the DCH of January 2005 explains some of these activities.

There is a great deal to be done in the health and health-care field in Madagascar. Women religious are in the front line in this service of the Church. The Episcopal Commission for Health, through its support, wants to be a sign of this work of the Church.

H.E. Msgr. DONALD PELLETIER MS,
Bishop of Morondava, President of the Episcopal Commission for Health, Madagascar.

STATUTES

EPISCOPAL COMMISSION FOR PASTORAL CARE IN HEALTH

Preamble

Article 1

In response to an express request from the Pontifical Council for Health Pastoral Care and Health Care Workers, the BCM (Bishops' Conference of Madagascar) hereby establishes within its own orbit the ECPCH (the Episcopal Commission for Pastoral Care in Health) in order to animate, co-ordinate and inspire pastoral care in health. This Commission is placed amongst the various Episcopal Commissions of the BCM.

Article 2

The purpose of the Commission is to express the care and concern of the Church towards sick people, the suffering and the elderly. 'Ny marary mandriana sady andrianina' and to help health care workers so that the apostolate of mercy in which they are engaged responds in an increasingly better way to the new needs and requirements of the times.

Article 3

The work of the Commission covers four areas:

3.a. To make known the Christian meaning of health, life, illness, suffering and death in conformity with the age we live in.

3.b. To take part in the ongoing training of health-care workers at a national level.

3.c. To work with national and diocesan organisations for pastoral care in health in both their theoretical and their practical activities..

3.d. To keep abreast of news in the scientific and legislative fields in order to illuminate them through the pastoral action of the Church in the health-care field.

Article 4

According to its possibilities, the ECH strives to help bishops and the dioceses through the promotion, the co-ordination, the inspiration and the direction of pastoral care in health.

Structure
Respective Functions

Structure

Article 5

The ECH is presided over by a titular diocesan bishop, according to the Statutes of the BCM, who is elected by the plenary assembly of the BCM for a mandate that lasts two years which can be renewed twice.

Article 6

In addition to the Bishop-President, the ECH has two voluntary members who represent the various categories of health-care workers:

– A hospital chaplain.
– A medical consultant.
– A woman religious nurse.
– A representative of the UMWR (Union of the Women Religious of Madagascar).
– A man or woman state nurse.
– An obstetrician.
– A general secretary.
– A priest who is a delegate of the Bishop.

Article 7

The Bishop-President appoints the members of the Commission after consultation. It is preferable for these members to reside in Antananarivo so as to facilitate the periodic meetings of the Commission.

Article 8

After consulting the members of the ECH, the choice of the General Secretary will be presented for the approval of the Permanent Council of the BCM. The General Secretary will be chosen according to his professional qualifications in the field of health and health care, his capacities to administer the secretariat, and his spiritual qualities.

Article 9

The ECH, the secretariat and a delegate of the DCH (Diocesan Commission for Health) make up the General Assembly.

The Bishop President

Article 10

It is the task of the Bishop-President to convene the ECH and the General Assembly, to preside over meetings, to provide general guidelines for its

activity, and to provide an account of its activities to the Permanent Council of the BCM and where necessary to the Plenary Assembly of Bishops.

Article 11
The Bishop-President can appoint a priest as a delegate to second him in the work of the Commission or to act on his behalf in his absence.

Article 12
It is the task of the Bishop-President to approve the moral and financial report on his office, which is drawn up by the secretariat, and to present it to the permanent office of the BCM, with a view to the distribution of the sums agreed with the Nuncio's office or 'extraordinary' councils of external bodies, such as Missio, the CRS, the CEI or the annual communication with the Pontifical Council for Health Pastoral Care in Rome.

The Secretariat

Article 13
The secretariat, guided by the General Secretary, is responsible for:
– The communication and the translation of the documents of the Magisterium and the Pontifical Council for Health Pastoral Care in matters relating to health and health care.
– A report on all meetings: ECH, the Plenary Assembly.
– A report on the sessions, which will then be published and sold to the participants.
– The sending out of correspondence to the DCH, the diocesan bishops, hospital chaplains and the various partners of the ECAR.
– Ensuring that the meetings of the ECH are held regularly and correctly.

Article 14
It is the task of the Secretariat to maintain:
– Communication with the Ministry of Health in Madagascar.
– Co-operation with NGOs.

Article 15
The secretariat is also responsible for:
– Communications with the other Episcopal Commissions that are responsible for social-charitable matters.
– Communications with the BCM and its Permanent Office.
– Communications with the Pontifical Council for Health Pastoral Care in Rome.
– All correspondence, in agreement with the Bishop-President.

Article 16
The ECH employs a secretary to ensure the working of the office and to carry out the work of the secretariat. A contract will be drawn up according to the provisions of the Labour Code.

The Episcopal Commission fot pastoral care in health

Article 17
This Commissions meets ordinarily three times a year but it can meet extraordinarily to prepare a session. In the absence of the Bishop-President the General Secretary will convene the meeting under the presidency of the priest who is a delegate of the Bishop-President.

Article 18
It is the task of the Commission to plan and organise sessions for the various categories of health-care workers:
– Hospital chaplains.
– Men and women religious nurses.
– Catholic state men and women nurses.
– Catholic medical doctors.
– Catholic obstetricians.
– DCHs.

The frequency of the sessions depends on the financial resources of the ECH.

Article 19
Under the responsibility of the Bishop-President, the ECH attends to the accounts and works closely with the Administrative Secretary of the BCM. The General Secretary is the first person responsible for the finances.

Article 20
All of his activities are carried out with reference to the Bishop-President and must receive the approval of the Bishop-President.

The General Assembly

Article 21
The General Assembly meets once a year to:
– Assess the activities that have been engaged in.
– Assess the sessions.
– See how the dioceses can be served in a better way.

Where necessary, it can hold an extraordinary meeting.

Article 22
The General Assembly decides on the Statutes which will be presented by the Bishop-President to the BCM for its approval. Every change to the Statutes will be presented to the General Assembly for its approval and then presented to the BCM for its approval.

From Athens to Sparta: we are all on a Journey with Terri Schiavo*

Now that the sad story of Terri Schindler Schiavo is coming to an end, some reflections are urgently required to face up to the devastating wave that will inevitably hit our country beginning with this case, cancelling consolidated values and violently modifying the topography of the beliefs of a people. Warnings about this cultural Tsunami have already been seen in the sea of idiocies published in recent days by authoritative opinion leaders and upheld with disarming detachment on television talk shows.

It has been said that the poor Terri was in a 'vegetative coma', that she no longer had a brain, that it was necessary to take out the plug, that she was kept alive thanks to machines, that it was necessary to stop the exaggerated treatment practiced on a patient who was terminal and whatever the case could not be cured. There have been those who compared the life of Terri to that of a vegetable, unable to feel anything or any pain. Indeed, there have even been television philosophers who have stated that this was no longer a human life and former government ministers have referred to a condition between life and death. Some authoritative scientific journals even fell into the trap of sensationalism by stating that we were faced with a patient with a flat electroencephalogram – the condition that is to be observed with brain death. There were many *maîtres à penser* for this patient who were scandalised at the inhuman and invasive tubes with which the patient was said to be kept artificially alive and invoked for her a compassionate death 'without suffering' brought about by the suspension of alimentation and hydration.

It is necessary to begin to make clear what the boundaries of things are by calling them by their name for those people who have only heard of cases such as that of Terri on television.

A patient in a vegetative state is not in a state of cerebral death because his or her brain, with varying degrees of imperfection, has never stopped functioning. He or she is not even in a coma; indeed, he or she remains awake with his or her eyes open. His or her electroencephalogram is not flat. Indeed, periods of being awake can alternate with periods of being asleep. No plug exists which should be taken out for the simple reason that the patient is not connected to a machine. He or she is not a terminally ill patient given that with basic help alone (above all hydration and alimentation) he or she can live for many years. He or she is not necessarily a patient that cannot be cured if one takes into account that the definition '*permanent* vegetative state' does not have a diagnostic value but only one that is exclusively diagnostic and indicates only that the possibilities of recovery become reduced with the passing of time. He or she is not a patient without feelings given that the evoked potentials can demonstrate the arrival of a stimulus to the cortex. Although there is often a lack of indications of further cortical elaborations of such signals, there have also been well documented scientific cases in which a rudimental process of discrimination and recognition was nonetheless possible. A patient in a vegetative state does not tells us if he or she feels pain but a pain stimulus reaches his or her brain and our knowledge about the physiology of pain is still insufficient for us to be certain that the absence of evidence constitutes evidence of the absence of all pain.

Patients in a vegetative state are not all equal. The images that explore their anatomy (such as RMN) or the functionality of their brain (such as PET and functional RMB) demonstrate a wide variability in responses from case to case. For these reasons, as well, the diagnosis of a vegetative state is not easy and important studies indicate margins of error that are higher than 30% even in qualified centres.

Another myth that has to be exploded is that of the tubes by which alimentation is given to the patient. They are depicted as infernal instruments that are not very respectful of the dignity of the patient. In reality, the nasal-gastric tube is a procedure of care that is broadly used and is usually practiced only during the initial stages of the vegetative state, whereas in the case of PEG this is a procedure that is very easily tolerated by the patient. It is also easy to use and manage at home, even in the hands of non-health care personnel, and it is invisible to onlookers and lies under the clothes of the patient. There are patients with non-cerebral illnesses that have to be nourished with the PEG tube for years without this impeding a life of work and of relationships.

Lastly, a reflection on the beautiful death inflicted on poor Terri, a death that is defined as being serene, peaceful and without suffering, effected by making an organism die of starvation and thirst defined in *a priori* terms as an organism that cannot feel any pain. In reality death by starvation and thirst is a slow process of dying which slowly devastates the whole of the organism. The patient in a vegetative

* Article written by Prof. Gigli at the time of the event, which ended in March 2005.

state can suffer in ways that we do not know, and to such an extent that the promoters themselves of the procedure practice in parallel a total sedation of the patient with morphine so as to avoid the risk that his or her organism manifests physical signs of a rebellion to the pain that may be felt. This is such an inhuman death that if some of us were to inflict it on a dog we would be condemned for cruelty and ill-treatment.

I say this at a general level to throw the most realistic light possible on the vegetative state and before going on to examine the consequences of this disgraceful story it is necessary to clarify that the deliberate and barbaric murder

of Terri Schindler Schiavo was carried out on a poor patient who was not even in a vegetative state. From an examination of the films and according to the opinion of distinguished American colleagues, the patient could at the utmost be defined as being in a condition of minimal consciousness (MCS) or in a low level neurological state (LLNS), and capable of certain elementary movements, of rudimentary mimesis, and of a partial capacity to swallow. This patient has been denied detailed diagnostic examinations (such as PET and f-RMN) and rehabilitative interventions over the last ten years, and this to the point of denying her receiving communion during days of hunger and thirst so that no indiscreet eye could assess the suffering caused by the suspension of nutrition and hydration.

Terri Schiavo was put to death on the basis of three falsehoods. The first is that assisted nutrition and hydration are a form of 'medical treatment' and not a fundamental element of basic care for the patient (together with mobilisation and hygiene). The second lie is that Terri Schiavo should have been killed so as to respect her wish not to receive the 'medical treatment' of artificial nutrition and hydration. This was a matter, it is asserted, of respect for the principle of the autonomy of patients. A discussion on the limits of prior directives goes beyond the intentions of this brief paper. However, one cannot avoid emphasising how in this specific case the ascertaining of the presumed wish of the patient is based solely on general declarations made during an informal conversation that took place many years ago, declarations recounted by a husband who is somewhat to be suspected of a conflict of interests and declarations in contrast with the presumed wish of Terri as indicated by her parents and siblings. How can one entrust decisions about human life to a general conversation of some years ago on the subject of nutrition administered through a tube? This would be adjudged insufficient evidence even in a criminal trial, and even more so when one is dealing with putting to death a woman who is certainly innocent!

When such an idea of the autonomy of patients is subjected to criticism, those that established that Terri, whatever the case, had to die invoke the last falsehood of this dirty story: the suspension of basic help (hydration and nutrition) is said to be not only justified but something that should be done on the basis of the principles of futility, extraordinariness (disproportionality) and excessive burdens, which are the basis of every ethical judgement on care and treatment. It is a pity that a treatment that can achieve for years in an effective way its task of nourishing a person costs very little, does not require machines, and is very well tolerated by millions of patients in relation to the most varying pathologies, can certainly not be defined as futile, unless at the price of falsifying truth.

Why, then, does such a large part of American society agree with a bad husband such as Michel Schiavo in wanting to bring about the death of Terri at all costs? Behind the story of Terri Schiavo disturbing truths are concealed which go beyond this specific case and take on a universal value. It is advisable to reflect on these dramatic truths before it is too late for our society.

It is not the hydration and the nutrition that are futile: it is the lives of patients such as Terri that are considered futile and without meaning. It is not the PEG that is disproportionate but having to look after patients who will not go back to being 'healthy and beautiful'. It is not the 'treatment' that is excessively burdensome for the patient but the lives themselves of so many subjects with chronic disabilities who are seen by our society as a burden of which it would willingly free itself.

In order to mask the intrinsic immorality of such conclusions, recourse is made to very dangerous divagations on the insufficient quality of life that is said to characterise patients in a vegetative state and those

patients, such as Terri, who resemble them. On the basis of a judgement that cannot be appealed against and which comes from outside, the quality of life is deemed insufficient to defend life itself when the patient is not able to maintain a sufficient capacity for relationships, when he or she does not demonstrate sufficient awareness, when he or she does not have any hope of an acceptable recovery, when he or she is not able to express an autonomous will, and when he or she is not able to communicate his or her own decisions. In these conditions one is said to be dealing with a life that is no longer human or, employing a more subtle sophism, we are said to have before us human beings who are by now without the minimum requirements that are said to characterise a human person.

It is easy at this stage to draw conclusions and realise why the Schiavo case opens up worrying prospects. First of all, starting with the day after the death of Terri, the same groups of opinion that had requested the suspension of hydration and nutrition will request the possibility of achieving death in a quicker and less painful way (without having to fill the patient with morphine). This will be a decisive argument for the legalisation of euthanasia in the United States of America, and after the United States of America, in the whole world. In addition, if an opulent society such as American society by now believes that care for patients without any hope of recovery is a waste of money, then it is the overall level of care for fragility that is called into question, and with irreversible damage to the principle of solidarity in care. Lastly, if patients in a vegetative state should be seen as human beings whose life is no longer worthy of being lived, and who are no longer recognised as having the status or the rights of a human person, then such a discriminatory principle can be extended to many other categories of patients who are equally without autonomy, lives with relationships, awareness, and the capacity to communicate their decisions. I am referring here to the demented, to the mentally retarded, to people in long comas, and to gravely deformed newly born children. In the name of a high court of human dignity a discriminatory regime will be installed that will be in net opposition to the Universal Declaration of the Human Rights and will contain further dangerous democratic negative tendencies. After leaving Athens and humanism we will return to Sparta and the selection of the best.

Prof. GIAN LUIGI GIGLI
Director of the SOC of the Neurology and Neurophysiopathology, The Hospital of 'Santa Maria della Misericordia', Udine, Former President of the International Federation of the Association of Catholic Doctors (FIAMC)

The World Congress of the International Federation of Associations of Catholic Doctors FIAMC

Barcelona, Spain
11-14 May 2006

The World Congress of the International Federation of Associations of Catholic Doctors (FIAMC)

BARCELONA, SPAIN, 11-14 MAY 2006

From 1 May to 14 May 2006, at the Palace of Congresses in Barcelona (Montjuïc), the World Congress of the International Federation of Associations of Catholic Doctors (FIAMC) was celebrated. This organisation brings together forty thousand medical doctors from seventy professional associations from all over the world. This Congress, which meets every four years, had returned to Spain after thirty-two years.

The primary subject of the Congress was 'Catholic Doctors and the Challenge of Poverty in the Era of Globalisation' and the Congress focused on the challenge that the elimination of poverty represents for a society such as ours. Together with scientific sessions and sessions of a general character, as well as testimony and the parallel work groups, various initiatives were presented designed to eradicate the phenomenon of material and health-care poverty in various regions of the world.

The Congress offered companies and institutions belonging to the health-care world or otherwise the possibility of working with this event of a global importance which would have major repercussions. In addition, the aim was to promote a concrete initiative of health-care practice in those less favoured regions of the planet to be found in the north of Kenya. Mater Care is the international agency dealing with mother-child care belonging to the FIAMC to which will be given the contributions made by the Congress.

The wish of the organisers of the meeting was that this event would be a sort of ideal forum for the exchange of knowledge and experiences. They also wanted everything that the Church does in the world for the less fortunate to be known about. Lastly, the Congress wanted to encourage Catholic health-care professionals to become committed to the construction of a more just world, beginning with their specific professional tasks. Over one thousand participants and an important echo in the mass media at an international level gave prominence and lustre to the event. The previous congresses had been celebrated in New York (1998), Rome (the extraordinary Congress of 2000) and Seoul (2002).

The subject of the session was divided into five parts: the first dealt with access to health care: the rights of the poorest, a question of justice; the second, focused in upon distance learning in medicine: opportunities and risks; the third was dedicated to international health-care associations and institutions and their approach to poor countries; the fourth addressed the subject of Catholic medical doctors and professionals of other religious confessions: respect for life and the dignity of man; and, lastly, the fifth part dealt with medical doctors at the service of peace.

The NGOs and other institutions that work to eradicate poverty were presented, as were over forty initiatives. A cultural circle was organised for those people who accompanied the participants. Parallel symposia took pace that dealt with various specialisations. And, lastly, there was the general assembly of the FIAMC, with the presentation of activities that had been engaged in, the guidelines for action over the next years, and the election of the new office-holders.

The symposia and work groups on various subjects were many in number: mother-child care in the Third World (Mater Care International); the natural regulation of fertility (RENAFER); Catholic psychologists (the DIF Foundation); medicine in the field of sport (Fundación Árbol de la Vida); a study group on affective-sexual education and upbringing; and natural family planning (TEENSTAR).

The International Federation of Associations of Catholic Doctors is made up of about seventy national associations of Catholic doctors from all over the world. The Federation is present in six regions: Africa, Asia, Australia and New Zealand, Europe, North America, and Latin America, and its mission is the safeguarding and the promotion of human life in the different cultures of the world, as well as the professional, human and spiritual improvement of its associates.

Metges Cristians de Catalunya, an association of professional doctors that has worked for many years in Catatonia and is a part of the FIAMC, was entrusted with organising the Congress in Barcelona.

During the proceedings of the Congress a new world President of the FISMC was elected, namely the Catalan doctor José M. Simón.

A Holy Mass, presided over by His Excellency Msgr. José Luis Redrado and concelebrated by sixteen Archbishops and bishops and thirty-five priests from all the continents of the world, was celebrated in the cathedral of the city as the final act of the Congress.

In his homily, Bishop Redrado, the first bishop in the history of the Hospital Order of St. John of God, expressed the emotion that had been provoked in him by presiding over this Eucharistic celebration in the cathedral of Barcelona. For this reason, he thanked H.E. Msgr. Martínez Sistach for wanting to concede to him the honour of presiding over the Holy Mass that closed the Congress. These two prelates are long-standing friends from the time when they worked together in the sector of pastoral care in health in the Ciudad Condal.

'Let us thank God', said Msgr. Redrado, 'for the Congress that we have celebrated and for the fruits that we expect from it. Thank you, Lord, for everything that helps us to be better

servants of the sick.' This prelate, when referring to the readings of the fifth Sunday of Easter (which were read in various languages), guided the participants in their work as Christian medical doctors. 'We are celebrating a paschal feast in honour of the Risen Christ. In imitating the women and the apostles of the time, Christ invites us today to be witnesses to resurrection. And we can be such if we remain united to him through the gift of Faith. We take leave, therefore, from this Congress and from this celebration ready to be, at every moment and for everyone, witnesses to Christian joy, men and women full of a life dedicated to service to sick people. Also sensitive to pain but always open to hope and to joy because pain and joy always walk together in our lives (Cf. *Catalunya cristiana*, 25 May 2006).

CONCLUSIONS OF THE 22nd CONGRESS. OF FIAMC 14 MAY 2006, Barcelona

The 22nd. Congress of the World Federation of Catholic Medical Associations (FIAMC) met in Barcelona, representing 78 countries.

The subject of the congress was 'Catholic physicians, globalisation, and poverty. We propose the following conclusions:

1. The current international order condemns entire populations to remain in poverty and misery, which is unjust and against the will of God.

2. We, Catholic doctors, reject the kind of globalisation which results in the exploitation of disadvantaged peoples, which exploits their natural resources, and which results in environmental destruction. We also reject the exploitation of cheap labor in some countries.

3. We reject those aspects of Western medicine which promote treatment of desires whilst a large part of the world is condemned to remain without basic health care, leading to high rates of maternal and infant mortality and shortened life expectancy.

4 We condemn pressures exerted by international organizations which link aid to the acceptance of unethical reproductive health practices, such as abortion, contraception, and sterilization.

5. We applaud the kind of globalisation which promotes positive values, such as respect for life, and solidarity between peoples, countries, and classes. This results in breaking down the barriers of marginalization and leads to the true promotion of health.

6. We acknowledge that many developing countries have cultural and family values and respect for life which should be accepted by Western culture.

7. FIAMC intends to cooperate with international bodies, distance learning programs, and health education programs which promote positive globalisation, which leads to true equity among nations.

8. We will continue to exert pressure on international organizations so that they truly respect human rights.

List of the new office-holders elected during the General Assembly, May 2006

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Catholic Doctors: Love Your Profession!

1. I address a special greeting from Cardinal Javier Lozano Barragán, the President of the Pontifical Council for Heath Pastoral Care, and also from me, to the President of the FIAMC, Prof. Gian Luigi Gigli, to the chairman of the organising committee, Dr. José M. Simón, to the organisers of this congress, and to all the participants.

2. I would like to thank the organisers of this congress for their invitation to the Pontifical Council to take part in this congress, to speak a few words by way of an introductory greeting, and to celebrate Holy Mass as an action of grace at the end of the meeting.

3.The subject of the congress has a global aspect that characterises our society, namely that of poverty, which is not extraneous to the health-care world because, as we know, poverty is the cause of a significant number of few illnesses. However, this is not what I want to underline in my greeting because the speakers that are listed in the programme of the congress will perform this function in a very appropriate way.

4. What I would like to speak about, instead, is the responsibility, today, of medical doctors – and I would here like to emphasise Catholic medical doctors – in the whole of the process of change that is being produced in our society and bears upon medicine and the work of medical doctors themselves. One need only look at everything brought about by the secularisation of medicine, the values that are abandoned, and relativism in questions that concern life. All of this calls medical doctors to greater responsibility in the study and the exploration of their profession. In this era of technology, indeed, the temptation is strong to entrust everything to machines. The medical doctor knows, indeed more than anyone else, how much he needs technology and information and computer technology and that he cannot be extraneous to it. He knows how much the development of technology has changed life, philosophy, language and mentality and to what point one can end up by thinking that man is able to change man. For this reason it is necessary to search for a balance between technological development and ethical values, the ultimate and overall meaning of life (*Fides et ratio*, n. 81), and the sapiential dimension, in which side by side with scientific and technological advances there are also those of philosophical and ethical character (*Fides et ratio*, n. 106).

The Second Vatican Council says: 'our epoch...needs this wisdom to humanise all of its new discoveries. Indeed, the future of the world is imperilled unless wiser men are not brought forth' (*GS*, n. 15). In the same way, John Paul II in his *Redemptor hominis* (n. 16) tells us that dominion over the world is based upon the primacy of the spirit over matter; of the person over things; and of morality over technology.

A lack of anthropological, philosophical and bioethical grounding in health-care professionals in relation to matters that bear upon the mystery of life – whether this is a matter of the beginning or the end of life – provokes outrage and the manipulation of the human person. I am referring here in particular to medical doctors and leave aside other professionals: doctors are at the service of life and must be very good advisers who should guide us as to how to make life healthier. A medical doctor is at the service of life, he or she is a minister of life who must defend, educate and serve. The *Charter for Health Care Workers*, which was published by our Pontifical Council for Health Pastoral Care, devotes its first ten sections to this subject. I would like to quote here only the beginning, which reads as follows: 'The work of health care persons is a very valuable service to life. It expresses a profoundly human and Christian commitment, undertaken and carried out not only as a technical activity but also as one of dedication to and love of neighbour. It is "a form of Christian witness". "Their profession calls for them to be guardians and servants of human life"' (n. 1).

5. In an interview Fra. Pierluigi Marchesi, the former Superior General of the Order of St. John of God, a pioneer and prophet of humanisation, replied to a question that had been posed to him about the contemporary role of medicine in the following terms: 'Medicine is at a critical crossroads under the pressure of technology and politicisation, and it debates its future between two extremes: whether to be an increasingly 'scientific' medicine or whether to be an increasingly human medicine. We could be satisfied with the fact that medicine remains the way it is, understanding by medicine that discipline which goes beyond the contemporary technological impact of science and mass and state care: that medicine which down the ages has drawn near to affective, cordial and human protection; that medicine whose root has been the Greek concept of 'philanthropy' and the Christian concept of 'charity', that is to say love for man.

How can I render authentic my way of living out my service if to begin with I have not measured myself to needs, hopes and the service itself? If I did not engage in such an undertaking I would transmit a sort of counterfeit coin, I would carry out an action that is imposed on me by work, by a contract, by a law which makes me do it. I would place my hands on a sick person as though he or she were absorbent paper impregnated with water and I would end up by destroying it because I would, beyond that paper, be looking for a payment, a prize, a small quantity of happiness. However, in reality, I myself should immerse myself in this wet absorbent paper and transform myself into

one thing with it, at the same time, however, remaining mysteriously myself while it continues to be itself'.

6. Health-care professionals: love your profession! You have a great task ahead of you, one that is technical in character, certainly, but your profession at the service of man poses a challenge to you: am I able to care and treat man with humanity and in an overall way?

With your welcome you will build a 'new home' for the sick person, that 'new home' that he or she needs; you will build a suitable place, intended for the sick person, the place that he or she needs. Go to the heart of the matter, look for the good of the patient and you will see how relations, communications and power change.

Look for the good of the patient and you will inject into you profession more science, more readiness to help, more dialogue, less discrimination and greater presence.

When speaking about the health-care profession, Cardinal Tarancón declared that 'medicine, education and the priesthood require something more than technical help, even though such help is necessary. They need the human warmth of those who provide technical help. For this reason, they have a special greatness and a human fullness'.

This greatness of health-care professionals is why our Pontifical Council for Health Pastoral Care has not hesitated to call health-care professionals 'Ministers of life'.

In one of its documents, the Bishops' Conference of Spain made the following observations about 'Catholics and the profession': 'The profession acquires a truly vocational and even spiritual dimension. But this will be true only if the exercise of the profession is internally animated by the spirit and supported in its development by the moral criteria of the Gospel and in imitation of Christ. These requirements must not be limited solely to an economic order, as is the case, for example, with justice in remunerations. The Christian life and Christian morality have broader requirements. Respect for life, faithfulness to the truth, responsibility and good training, hard work and honesty, the rejection of all fraud, a social sense, and generosity as well, must always inspire the Christian in the exercise of his or her work and professional activity'.

In the programme of the congress I see many subjects which emphasise with expertise what, in a rapid and schematic form, I have drawn attention to in my speech of greeting: rights, education, the various religious traditions, respect for life, evangelisation, and an infinity of testimonies which have made a reality of all of this through the practice of medicine, and a humanitarian and globalised medicine. I hope and wish that this congress will be a launching pad for, and the beginning of, a new spring for the FIAMC.

Lastly, I would like to take advantage of this celebratory occasion to extend cordial and sincere thanks to the President of the Federation, Prof. Gian Luigi Gigli, for the work of thought and reflection engaged in by the FIAMC during his presidency, and for the constant, active, expert and generous presence on his part which has characterised that work.

For this reason, on behalf of the President of the Pontifical Council for Health Pastoral Care, His Eminence Javier Lozano Barragán, we hereby give to him the medal of the Good Samaritan, the symbol and expression of our Pontifical Council, Together with that medal go our thanks and our hope, and I repeat the point, for a new spring for the FIAMC. Thank you once again.

H.E. Msgr. JOSÉ L. REDRADO, OH
Secretary of the Pontifical Council for Health Pastoral Care, the Holy See

Notes

[1] Cardinal ENRIQUE TARANCON, 'La profesión sanitaria', *Humanizar*, February 1994.

[2] Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, nn. 1-10.

[3] Comision permanente de la conferencia episcopal española, Inst. Past. *Los católicos en la vida pública*, 22-IV-1986, n. 113-114.

Pontifical Council for Health Pastoral Care

Pontificio Consiglio per la Pastorale della Salute

Pontifical Council for Health Pastoral Care

Message of His Holiness Benedict XVI for the XIV World Day of the Sick (

December 23, 2005

HEADLINES

Message for the World Day Against AIDS - 1 December 2005

Message for the World AIDS Day - 1 December 2004

Catholic Women Nurses Faced with the Challenges of Health in Africa

HIGHLIGHTED

Message of His Holiness Benedict XVI for the XIV World Day of the Sick

«Duc in altum! This invitation of Christ to Peter and the Apostles I address to the Church communities spread throughout the world and in a special way to those who are at the service of the sick, so that, with the help of Mary *Salus infirmorum,* they may bear witness to the goodness and the paternal solicitude of God.» (Benedict XVI). [View more]

WORD OF THE POPE

Message of His Holiness Benedict XVI for the XIV World Day of the Sick

Message of the Holy Father John Paul II for the XIII World Day of the Sick

Message of His Holiness John Paul II for the Twelfth World Day of the Sick

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