DOLENTIUM HOMINUM

N. 65 – Year XXII – No. 2, 2007

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH CARE WORKERS
(FOR HEALTH PASTORAL CARE)

Editorial and Business Offices:
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Published three times a year. Subscription rate: € 32 postage included

Printed by Editrice VELAR, Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

Poste Italiane s.p.a. Spedizione in Abbonamento Postale - D.L. 353/2003 (conv. In L. 27/02/2004 n° 46) art. 1, comma 2, DCB Roma

Contents

The illustrations in this edition are taken from the book:
Al seguito di Gesù *by Dante Alimenti published by Editrice Velar, Gorle (BG)*

APOSTOLIC PENITENTIARY

Decree

Plenary Indulgences for the 15th World Day of the Sick

Since man fell in consequence of original sin which deprived him of both supernatural and preternatural gifts, God the Creator and Redeemer, in his infinite mercy, has closely united in a mysterious bond what justice demands and what forgiveness obtains; therefore, suffering that has a penal character becomes a favourable opportunity for expiating sin and for obtaining the growth of virtue, and hence, for attaining eternal salvation.

This disposition of divine Providence is fulfilled for the faithful by virtue of the Paschal Mystery of Christ, who, in dying, made himself the dispenser of life and in rising is the cause of the firmest hope in our future resurrection.

Therefore, if the very condition which subjects human beings to illness and the suffering that result from it is accepted through acts of Faith, Hope and Charity, as the subject of God's most holy Will, it is a cause of greater holiness.

It is also necessary to reflect with great attention on the fact that human remedies have a limit, and that a time will therefore come which will bring the human being to the end of his journey on this earth. Sick people in this condition must be given the most careful treatment and the greatest love so that they may be comforted in their passing from this world to the Father by divine consolations.

And therefore - as the Church's prayer for the dying implores - the face of the meek Jesus Christ appears and his voice calling them to eternal glory and happiness resounds.

Holy Mother Church, in her knowledge of this, deeply desires that the annual celebration of the "World Day of the Sick" become an effective catechesis on the teaching, recalled here, of the treasure of Revelation and the value and role of suffering.

Consequently, in order that the faithful participating in the above-mentioned celebration - which will take place in the city of Seoul next 11 February, the liturgical Memorial of the Blessed Virgin Mary of Lourdes - may be increasingly motivated by these sentiments, the Holy Father has wished to enrich it with the gift of Indulgences, explained below.

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 city of Seoul or in any other place established by the ecclesiastical Authority, in any sacred ceremony celebrated to implore from God the aims of the "15th 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 with incurable or terminal diseases, and, because of their service are unable to take part in the ceremony mentioned above, will obtain the same gift of a *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.

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 united with the Holy Father on that day, they share in spirit in the desire for the above-mentioned celebration and offer their physical and spiritual suffering to God through the Virgin Mary, "Health of the Sick".

Lastly, a *Partial Indulgence* is granted to all the members of the faithful who, from 9 to 11 February 2007, at any time, address fervent prayers to the merciful God with a contrite heart, imploring the above-mentioned benefits for the sick, especially for incurable and terminal patients.

This Decree is effective for this occasion. Notwithstanding anything to the contrary.

Given in Rome, at the Offices of the Apostolic Penitentiary, 25 January 2007, on the Feast of the Conversion of the Apostle St Paul.

CARDINAL JAMES FRANCIS STAFFORD
Major Penitentiary

FR GIANFRANCO GIROTTI, O.F.M. Conv.
Titular Bishop of Meta Regent

XV World Day of the Sick

11 February 2007
Seoul, South Korea

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

Already for ten years, you, Our Venerable Brother, have pastorally attended to the professionals of health; at the same time you have borne them witness on how to imitate Jesus Christ who, when he was on earth, displayed a special benevolence towards the sick.

The Bishop of Rome has always wanted to be a participant in these thoughts and actions on behalf of the sick, and in a patent way has confirmed this through innumerable ceremonies, prayers, greetings, and meetings.

For this reason, Our paternal feelings and pastoral obligation grow strong knowing that in a short while will be celebrated in Korea on 11 February – the Commemoration of the Feast of the Blessed Virgin Mary of Lourdes – with greater attention, the World Day of the Sick, which is usually celebrated every year in various continents.

So that Our love for the sick and the fraternal communication of the whole of the ecclesial community are not absent, we wish that there is present a person of Ours and all Our esteem. Nobody seemed to Us more suitable that you yourself, Venerable Brother, to be there Our representative, so that you will make heard Our voice, make our feelings known, and be the interpreter of the doctrine of the Supreme Pontiffs on this subject. Thus, trustingly, with these Letters We appoint you and We create you Our Special Envoy for the World Day of the Sick that will be celebrated on 11 February in Seoul in Korea.

You will be in Our place, repeating Our approach and Our words, you will inculcate strongly this pastoral care of the Church, and you will signally exhort to perseverance those who are involved in these praiseworthy works. You will comfort and you will console everyone with Our Apostolic Blessing. May your travelling companion be the most merciful Redeemer himself, who, both with words and with works, assimilated himself always to sick, weak and infirm people.

Given at the Vatican Palaces, the twelfth day of the month of January in the year 2007, the second year of Our pontificate.

BENEDICT P.P. XVI

Account of the XV World Day of the Sick

SEOUL, SOUTH KOREA, 9-11 FEBRUARY 2007

From 9 February to 11 February 2007, the fifteenth World Day of the Sick was celebrated in Seoul, the modern capital city of South Korea. Numerous meetings, conferences, pastoral gatherings and liturgical celebrations, spread over three days, helped to explore the doctrinal-scientific, pastoral and liturgical aspects of the subject of the World Day of the Sick – 'The Spiritual and Pastoral Care of Patients with Incurable Illnesses'.

In his customary message the Holy Father Benedict XVI expressed his nearness to sick people: 'the Church turns her eyes to those who suffer and calls attention to the incurably ill, many of whom are dying from terminal diseases. They are found on every continent, particularly in places where poverty and hardship cause immense misery and grief'. The Pope was present in Seoul through his Special Envoy, His Eminence Cardinal Javier Lozano Barragán, the President of the Pontifical Council for Health Care Workers, accompanied by a group of people who are part of the same Pontifical Council. This group was led by its Secretary, H.E. Msgr. José Luis Redrado OH.

The world celebration of the World Day of the Sick began with the official welcoming of the Special Envoy of the Holy Father after the opening Holy Mass, which was presided over by the Archbishop of Seoul, Cardinal Nicholas Cheong, and held in the Myeong-dong Cathedral on 9 February. Afterwards, the participants met at the congress centre adjacent to the cathedral where the proceedings then began the day devoted to doctrinal-scientific matters. In his introductory speech, Cardinal Lozano Barragán emphasised the importance of palliative care and of the questions connected with such care: euthanasia, exaggerated treatment and biological testaments. In addition to palliative care, however, as the President of the Pontifical Council observed, spiritual care based upon pastoral care centred around the sacraments and the central role of the Eucharist which, when received by a patient as Viaticum, opens him to encounter with God and with eternity, is also indispensable.

In the subsequent papers the following subjects were addressed: the status of patients with incurable pathologies in Asia, the treatment of these pathologies and experiments on stem cells, patients in a vegetative state and quality of life, and lastly the holiness of life and bioethical questions. Both the papers of the speakers and the contributions of the participants stressed the need to promote palliative care and spiritual care in the Asian context. It was observed that this kind of approach towards the gravely ill is rather at the beginning stage in most Asian countries (except Hong Kong, Singapore, Taiwan, Japan and Korea).

In order to make the work of the Catholic Church in relation to incurable and terminal illnesses known about, the Pontifical Council for Health Care Workers presented its 'Descriptive Report on the Results of Research into Palliative Care' which was an initiative engaged in with apostolic Nuncios, bishops responsible for pastoral care in health, and Catholic health centres throughout the world.

Pastoral care for patients with incurable pathologies was at the centre of the reflection engaged in on 10 February. With great interest the five hundred participants listened to the presentation in power point by Cardinal Lozano Barragán on pastoral care in health, which is directed towards the sanctification of the sick and of health care workers. Other speakers concentrated on practical questions such as hospices, cancer patients and people with AIDS. Especial interest was provoked by the questions and issues connected with palliative care which, in recent years, has become a real rediscovery in various Asian countries. One of the speakers even thanked the Catholic Church for spreading the idea of the hospice and for its constant support for palliative care centres in the East.

During the afternoon of the same day, a meeting was held

between the Special Envoy of the Pope and bishops and delegates responsible for pastoral care in health in Korea, Japan, Thailand, Malaysia, India and Taiwan. From their papers it emerged that the situation of the Catholic Church varies in these countries: its numbers vary and thus its freedom varies. Everywhere, however, Catholics are esteemed, their teaching is taken seriously and their activities, especially in the field of medicine and care for the gravely ill, are exemplary and provoke amazement.

Saturday was a day rich in appointments and ended with a musical concert for medical students and students of the nursing schools, the aim being to involve them in the World Day of the Sick. Performances by various artists and musical groups that are well known in Korea alternated with documentary films that sought to demonstrate the specificity of Catholic health care, which from being just 'cure' tries to transform itself into the more complex 'care'.

The culminating moment of the celebrations of Seoul was the solemn Sunday Eucharist of 11 February. About eight thousand people gathered together in a sports centre, the Jangchung Gymnasium, in the middle of which a large altar had been set up. In front of this altar the Special Envoy of the Holy Father, together with a conspicuous number of bishops, priests and deacons, celebrated Holy Mass. In his homily Cardinal Javier Lozano Barragán went over the fundamental points of the Message of His Holiness Benedict XVI and ended with an invocation of our Mother Mary. He asked her 'to watch over all incurable sick people and to intercede in a special way for those who need that light and tenderness that only the Lord can give'.

An evident sign of the tenderness and comfort of the Lord was the rite of the anointing of the sick. The Special Envoy of the Holy Father, together with bishops and priests, administered the sacrament of the anointing of the sick to four hundred people who had gathered in front of the altar. Tears of joy appeared on many of their faces.

In addition to the large number of participants, it is necessary to refer to the presence of three major international health care federations: the FIAMC (Catholic medical doctors), represented by its Vice President, Dr. John Lee; the CICIAMS (Catholic nurses), represented by its President, Mrs An Verlinde; and the FIPC (Catholic pharmacists), represented by Dr. Pauline La Siew Mei.

The celebration of the fifteenth World Day of the Sick in Korea was a strong moment, in particular for the countries of Asia, to call the attention of civil society and the institutions of public life to the incurably and terminally ill and to express true gratitude towards those who, like the Good Samaritan, take care of them without paying attention to cost or profit.

Rev. DARIUSZ GIERS,
Official of the Pontifical Council for Health Care Workers, the Holy See.

Angelus

ST PETER'S SQUARE, SUNDAY, 11 FEBRUARY 2007

Dear Brothers and Sisters,

Today, the Church recalls the first apparition of the Virgin Mary to St Bernadette, which took place on 11 February 1858 in the grotto of Massabielle, near Lourdes. It was a miraculous event which made that town, located in the French Pyrenees, a world centre of pilgrimages and intense Marian spirituality.

In that place, now almost 150 years ago, the Blessed Mother's call to prayer and penance resounds strongly, almost as a permanent echo of Jesus' invitation which inaugurated his preaching in Galilee: "The time is fulfilled, and the kingdom of God is at hand; repent, and believe in the Gospel" (Mk 1: 15).

Moreover, that Shrine has become the goal of numerous sick pilgrims who are encouraged by listening to Mary Most Holy to accept their sufferings and offer them for the world's salvation, uniting them to those of Christ Crucified.

Precisely because of the bond that exists between Lourdes and suffering humanity, 15 years ago our beloved John Paul II willed that, on the occasion of the Feast of Our Lady of Lourdes, the World Day of the Sick would also be celebrated.

This year the heart of this celebration is in the city of Seoul, South Korea, where I sent as my representative Cardinal Javier Lozano Barragán, President of the Pontifical Council for Health Care Workers. I address a cordial greeting to him and to all those gathered there. I would like to extend a greeting to the health-care workers of the entire world, knowing well of their important service to the sick persons in our society.

Above all, I would like to express my spiritual closeness and affection to our sick brothers and sisters, with a particular remembrance for those struck by graver illnesses and pain: to them, our attention is dedicated in a special way on this Day.

It is necessary to maintain the development of palliative care that offers an integral assistance and furnishes the incurably ill with that human support and spiritual guide they greatly need.

This afternoon, in St Peter's Basilica, many sick will gather around Cardinal Camillo Ruini, who will preside at the Eucharistic celebration. At the end of Holy Mass, I will have the joy, as last year, to spend some time with them, reliving the spiritual climate that I experienced at the Grotto of Massabielle.

I would now like to entrust to the maternal protection of the Immaculate Virgin, with the prayer of the Angelus, the sick and suffering in body and spirit of the entire world.

BENEDICT XVI

Address of Benedict XVI to the Sick at the Conclusion of the Holy Mass, Celebrated on 11 February 2007 in the Basilica of St. Peter's, on the Occasion of the XV World Day of the Sick. The Solemn Concelebration of the Eucharist was Presided over in the Name of the Holy Father by Cardinal Ruini

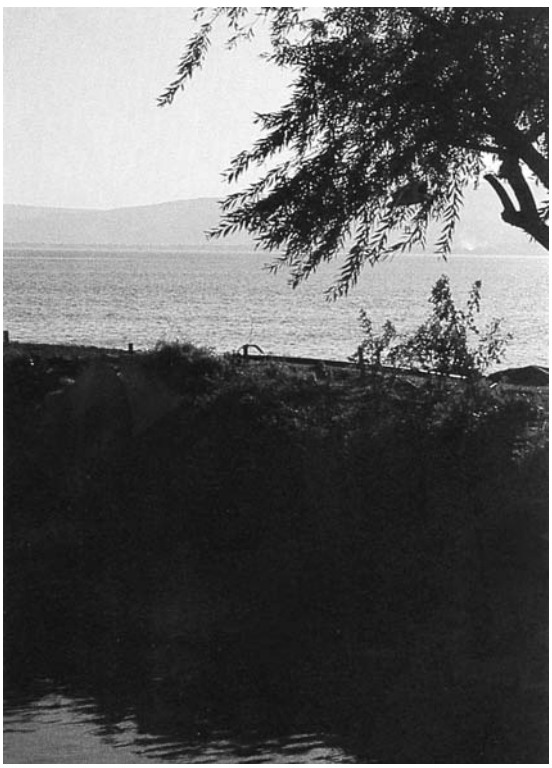
VATICAN BASILICA, SUNDAY, 11 FEBRUARY 2007

Dear Brothers and Sister,

It is with great joy that I meet you here in the Vatican Basilica on the Feast of Our Lady of Lourdes and the annual World Day of the Sick, at the end of the Eucharistic celebration presided over by Cardinal Camillo Ruini.

To him, first of all, I address my greeting, which I extend to all of you present here: to the Archpriest of the Basilica, Archbishop Angelo Comastri, to the other Bishops, the priests and religious. I greet the heads and members of the UNITALSI, who dedicate themselves to the transportation and care of the sick on pilgrimage and in other meaningful events.

I greet the heads and pilgrims of the *Opera Romana Pellegrinaggi* and those who will take part in this 15th Theological-Pastoral National Convention, both from Italy and abroad. I further greet the delegation of representatives of *Cammini d'Europa* [European Ways].



But my most cordial greeting is directed to you, dear sick people, to your families and the volunteers who care for you and accompany you with love today. Together with all of you I want to unite myself with those who today take part in the various events of the World Day of the Sick held in Seoul, South Korea. There, Cardinal Javier Lozano Barragán, President of the Pontifical Council for Health Care Workers, presides at the celebrations in my name.

Today is the Feast of the Blessed Virgin Mary of Lourdes, who a little less than 150 years ago appeared to a simple youth, St Bernadette Soubirous, showing herself as the Immaculate Conception.

Also in that apparition the Blessed Mother has shown herself as a tender mother to her children, recalling that the little, the poor are the beloved of God and to them the mystery of the Kingdom of Heaven is revealed.

Dear friends, Mary, who with her faith accompanied her Son beneath the Cross, she who by a mysterious plan was associated to the sufferings of Christ her Son, never tires to exhort us to live and share with serene trust the experience of sorrow and sickness, offering it with faith to the Father, thus completing in our flesh what is lacking in the sufferings of Christ (cf. Col 1: 24).

In this regard, I recall the words with which my venerable Predecessor Paul VI concluded the Apostolic Exhortation *Marialis Cultus*: "Contemplated in the episodes of the Gospels and in the reality which she already possesses in the City of God, the Blessed Virgin Mary offers a calm vision and a reassuring word to modern man, torn as he often is between anguish and hope, defeated by the sense of his own limitations and assailed by limitless aspirations, troubled in his

mind and divided in his heart, uncertain before the riddle of death, oppressed by loneliness while yearning for fellowship, a prey to boredom and disgust. She shows forth the victory of hope over anguish, of fellowship over solitude, of peace over anxiety, of joy and beauty over boredom and disgust, of eternal visions over earthly ones, of life over death" (n. 57).

They are words that shine light on our way, even when the sense of hope and the certainty of healing seem to vanish; they are words that I would like to be of special comfort to those who are struck by grave illnesses and pain.

And it is precisely to these our particularly tried brothers that today's World Day of the Sick is dedicated with special attention. We would like them to feel the material and spiritual closeness of the entire Christian community.

It is important not to leave them abandoned and in solitude while they try to face a very delicate moment in their life. Praiseworthy are those who with patience and love place their professional skills and human warmth at their service.

I think of doctors, nurses, health-care workers, volunteers, religious and priests who without sparing themselves stoop down to them like the Good Samaritan, not considering their social condition, skin colour or religious affiliation, but only their needs. In the face of every human being, and still more if tried and disfigured by sickness, shines the Face of Christ, who said: "As you did it to one of the least of these my brethren, you did it to me" (Mt 25: 40).

Dear brothers and sisters, in a short while, this evening, a meaningful candlelight procession will reawaken the atmosphere that is created among pilgrims and those devoted to Lourdes. Our thought goes to the grotto of Massabielle, where human sorrows and hopes, fears and trust, meet.

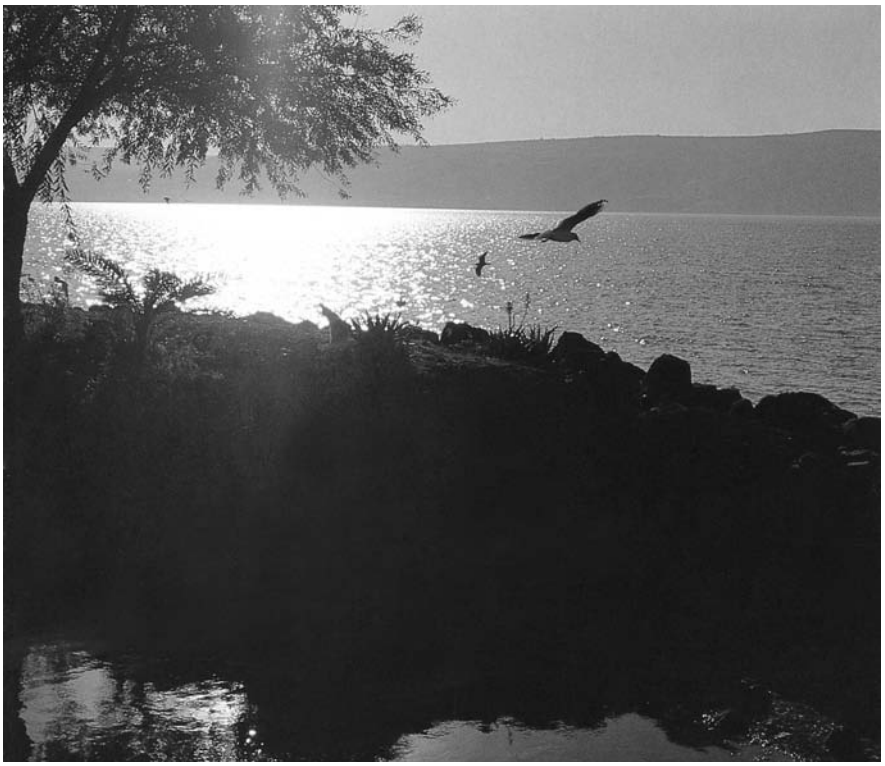
How many pilgrims, comforted by the gaze of their Mother, find at Lourdes the strength to accomplish more easily the will of God even when it costs renunciation and pain, aware that, as the Apostle Paul affirms, all works to the good of those who love the Lord (cf. Rom 8: 28).

May the candle that you hold alight in your hands be for you, dear brothers and sisters, the sign of a sincere desire to walk with Jesus, refulgence of peace, who shines in the darkness and urges us in our turn to be light and support for those near to us!

May no one, especially those who find themselves in the difficult situation of suffering, feel alone and abandoned!

I entrust you all this evening to the Virgin Mary. She, after having known unspeakable suffering, was assumed into Heaven, where she awaits us and where we too hope to be able to share one day the glory of her Divine Son, the joy without end.

With these sentiments I impart my Blessing to all of you present here and to those dear to you.



The Homily of Cardinal Javier Lozano Barragán, the Special Envoy of the Holy Father for the XV World Day of the Sick

SEOUL – KOREA, 11 FEBRUARY 2007

I have the honor of representing the Holy Father Benedict XV at this celebration of the 15th. World Day of the Sick, here in Seoul. It is true that this is a world event, however today it is celebrated in a special way in Asia, and for this purpose, Korea represents the whole of Asia in praying for sick people.

The Catholic Bishops' Conference of Korea proposed the pastoral care of patients suffering from incurable illnesses as the subject of the Day. The Holy Father Benedict XVI benevolently accepted the subject, and our goal in these three days of the World Day has been to reflect upon the situation of these sick people and pray for them. Today, in this solemn liturgical celebration, we offer to God our Father all the sufferings and pain of our brothers and sisters, and unite them to the passion, death and resurrection of the Lord Jesus.

In his message for this World Day of the Sick, the Holy Father reminds us that the Church turns her eyes to all who suffer, especially those who suffer even more because of poverty, and calls our attention to the incurably ill, many of whom are dying from terminal diseases. The Holy Father would like to be united with all of us now, in order to encourage us to show the tenderness and mercy of the Lord to the sick. The Pope affirms that the Church desires that the incurably ill and those in the terminal stage be offered support through just social policies which can help to eliminate the causes of many diseases; he urgently calls for improved care for those who because of poverty cannot afford better medical care and are dying. He stresses the need for palliative care so that they may bear these incurable illnesses and be able to meet death in a dignified way. The Holy Father praises all those in the Church who, following the example of the Good Samaritan assist, these sick people and encourage them to continue. He says that the Church, in offering assistance through its priests and all her pastoral workers, stands alongside the incurably ill, showing the loving mercy of Christ to those who suffer. He finally asks the Blessed Virgin Mary "Health of the Sick" to intercede for all those who in the Church all over the world dedicate themselves in a Gospel spirit to the care of these brothers and sisters of ours.

One reality very much related to incurable illness is death. At the beginning of his Message the Holy Father states that: "Human life, however, has intrinsic limitations, and sooner or later it ends in death. This is an experience to which each human being is called, and one for which he or she must be prepared."

Pope John Paul II, while describing some of the negative aspects of the contemporary global culture spoke of "the culture of death." It is, however, interesting to note that contemporary culture tendes to hide death, because it seems to fear death; and since it cannot overcome it despite the progress of medicine, it prefers not to think about it and hides it away. It is also paradoxical to see that contemporary culture declares itself to be absolutely in favor of life, however only healthy life without defects. It values only that life that corresponds to wellbeing, to the extent that today health is defined as a state of perfect wellbeing. And paradoxically the same culture fights life itself, right from abortion to euthanasia. This attitude is, on the other hand, a consequence of secularism. According to secularism there is no transcendence, and if there is no transcendence, one must have everything in this world so as to achieve happiness in the present life. Consequently, happiness has to be comfort and nothing more. A person seeks to be immortal, he almost deludes himself that he is immortal, and when the death of others arrives, it must remain hidden in such a way that it does not disturb him.

Within the framework of such a mentality, suffering appears to be absurd and every-

thing must be done to eliminate it; and when this is not possible, it is judged to be something unacceptable and therefore recourse is made to euthanasia. Often public opinion is induced to consider the existence of the incurably ill or of those who bear the burden of extreme suffering as useless and not worth living. If the life of a person is not considered as a value in itself, just because it does not correspond to the vision of a culture in which material wellbeing, efficiency and productivity are the fundamental "values" for existence, then the way is open for laws that favor the "culture of death."

Opposed to this attitude, the Pope exhorts us to follow the example of the Good Samaritan, employing all our efforts to alleviate the pain of terminally-ill patients, making use of palliative care. Basically, the Christian position is very distinct from that which confuses wellbeing with happiness. Certainly, wellbeing and sickness cannot coexist together. However, this is different when it comes to sickness and happiness. These, yes indeed, they can coexist together. The Pope says: "I now turn to you, my dear brothers and sisters suffering from incurable and terminal diseases. I encourage you to contemplate the sufferings of Christ crucified, and, in union with him, to turn to the Father with complete trust that all life, and your lives in particular, are in his hands. Trust that your sufferings, united to those of Christ, will prove fruitful for the needs of the Church and the world".

The spiritual fruitfulness about which the Pope speaks springs from the mystery of the cross and resurrection of Christ. Christ passed through death to resurrection. In the resurrection is full fruitfulness and full happiness. Consequently, if we are united to Christ in death we shall be united with him in the resurrection. This faith and solid hope give peace and joy to the Christian even in front of death and the "cortège that precedes death," that is in front of illnesses, especially incurable ones. In these realities of life, the Christian perspective offers one the capacity to preserve peace and happiness that are born from faith in Christ, who died and rose again.

Having happiness in illness is the fruit of the love, which the Holy Spirit emanates in our hearts. With this love we can continuously – though in a special way in the case of incurable illnesses – surrender our spirit to the hands of God our Father as Christ did on the cross, sure of reaching the joy of resurrection with him. For we Christians, death is the last stage of earthly life and the gateway to eternal life full of love and joy.

We have heard how the Holy Father invokes Mary when concluding his Message; in fact he says: "May the Blessed Virgin, our Mother, comfort those who are ill and sustain all who have devoted their lives, as Good Samaritans, to healing the physical and spiritual wounds of those who suffer." It is often the case that spiritual wounds are the deepest. Our world is wounded, physically, but also spiritually and many mental illnesses, especially depression, which is so widely spread in the world today, have their origins in the lack of hope. May our Blessed Mother, Mary, watch over all the incurably ill, and in a special way intercede for all those who need the light and tenderness that only the Lord can offer! Amen

H. Em. Card. JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Care Workers the Holy See.

Opening Mass Homily by His Eminence Nicholas Cardinal Cheong Jinsuk

MYEONG DONG, CATHEDRAL OF SEOUL, FEBRUARY 9, 2007

Dear Brothers and Sisters!

Thanks to the abundant grace of God, today we are celebrating the opening Mass for the XV World Day of the Sick 2007 here in Seoul, Korea. First of all, I would like to express my heartfelt gratitude to His Holiness Pope Benedict XVI who, even though he cannot attend this celebration in person, has sent his special envoy and has always taken the lead in calling for concern for the poor and sick and the marginalized. Conforming to his will, let us pray that through the efforts of the Church our society may pay warm attention to the sick in the world and be committed to their service. First and foremost, we believers should make efforts for this, by changing ourselves first.

On behalf of the Catholic Church in Korea, I would like to extend my cordial greetings to the papal special envoy His Eminence Javier Cardinal Lazano Barragán, President of the Pontifical Council for Health Care Workers, and the papal delegation.

I also would like to extend

greetings of peace and blessing in Christ to everyone attending this Mass, including many bishops, priests and the faithful.

For this solemn and holy event to bear much fruit of the Holy Spirit in the Providence of God, I call on the Catholic faithful for incessant prayer and collaboration.

In particular, I hope that this celebration of the World Day of the Sick can become a festival for the sick, health care workers and all those serving the sick in the Catholic Church in Korea as well as in the whole world.

By a pontifical letter of May 13, 1992, His Holiness Pope John Paul II instituted a World Day of the Sick, which is celebrated every year on February 11, Feast of Our Lady of Lourdes.

The institution of the World Day of the Sick had clear purposes and causes. This day aims at enabling Catholic medical facilities to provide the best care to the sick and to assist Christian communities to be committed to health pastoral care in a special way.

In fact, the development of scientific technology and medical science has enriched the life of humanity. However, it is also true that scientific development is threatening human life, which it should serve. Moreover, the materialism prevailing in our society has caused a serious crisis in respect for human dignity from many aspect

In this regard, the Church should give priority in her pastoral concern to "protection of the dignity of human life." Whatever the case, material and wealth must not have priority over the value of human life. I have a sincere wish that the celebration of the World Day of the Sick will contribute to establishing sound and desirable views of values. For in modern society, values and conscience are very important for respect of life.

The Catholic Church in Korea has shown much interest in the study of incurable diseases, especially in the field of cell therapy. In this context, we actively support adult stem cell research, which is safe from the perspective of bioethics and free from the danger of destroying human life. I believe that adult stem cell research sooner or later can produce a useful result and give light and hope to the incurably ill and their families. For our Lord the Healer always accompanies all those who are suffering from illnesses and those who take care of them.

The right to the dignity of human life first and foremost should be guaranteed for the sick. Therefore, we took as our subject for the XV World Day of the Sick 2007 "The Spiritual and Pastoral Care of Patients with Incurable Illnesses." For it is the most fundamental mission of the Church to proclaim the teaching of Christ that the human life must not be used as an instrument.

In his message for the XV World Day of the Sick, His Holiness Pope Benedict XVI, consoling the sick, wished them to recognize the true meaning of suffering and to be freed from the overwhelming shadow of suffering. So we chose as the biblical theme for the World Day of the Sick 2007 "The prayer of faith will save the sick person" (Jas 5:15). This is because Jesus always said to the healed "your faith has saved you" (Mt 9:22). Indeed, without faith there is no healing or salvation. For we believers, what matters is faith which leads us to entrust everything to Jesus. Even during the suffering of illnesses, we can receive grace only if we approach our Lord and entrust everything to him with the firm faith in him.

Let us recall the Gospel that we have just read. When people brought to Jesus a deaf man, Jesus healed him with the saying, "*Ephphatha*!" that is "Be opened!" Today Jesus also says to us "*Ephphatha*!" to open our closed minds, eyes and ears. When we open ourselves to Christ the Healer and trust in him, we human beings can be saved from every sort of suffering and unhappiness, from trivial illnesses to serious illnesses at the terminal stage.

Therefore, I hope that this World Day of the Sick can become a good opportunity for our society to remember the sick and help them, on the foundation of respect for human dignity. We should always pray for the sick and their families and should not close our eyes to their suffering. We do not need to say that medical research and study can have true meaning and value only when they have their foundation in human dignity.

I also hope that with this Day we can more actively practice love for our neighbors, not being confined to our nation but extending our love to those in various countries in the world. In fact, there are so many people in the world who are poor and sick. First of all, we can think of so many brothers and sisters in North Korea who are poor, sick and starving. Praying that the real-

ity there may be improved soon with the grace of God, we should try to convey the affectionate touch of God to our North Korean brethren.

Beginning with this opening Mass, the World Day of the Sick 2007 will proceed with many meetings, academic conferences, pastoral gatherings and liturgical rites. All the events should be the place where the Church gives hope and courage to those suffering from various illnesses and encourages many Christian communities that are dedicated to conveying the love and mercy of our Lord.

In addition, the Church should constantly appeal to society and the government to establish just social policies which can improve care for the sick. Of course the Church will make her best efforts to promote policies which create conditions where human beings can bear even incurable illnesses and death in a dignified manner.

Concluding my words, I once more call on everyone to pay attention to the sick on the occasion of the XV World Day of the Sick.

And I also promise that the Church will renew her efforts to establish sound values to respect life through this celebration of the World Day of the Sick.

In this way, we all can mature our faith by finding anew the image of Jesus who always accompanies the sick and suffering. Amen.

H. Em. Card. NICHOLAS CHEONG JINSUK,
Archbishop of Seoul and Apostolic Administrator of Pyong-yang

Let Us Accompany the Sick in the Spirit of the Gospel! Homily by H. E. Msgr. Lazzaro You Heung-sik

MYEONGDONG CATHEDRAL OF SEOUL, FEBRUARY 10, 2007

Jn 3:9-24
Mk 8:1-10

Jesus our Lord showed preferential love for the sick and the weak. He also performed mighty deeds by healing the sick and feeding the hungry. We, the children of the Church instituted by Jesus, inherited what Jesus said and acted. Throughout history, the Catholic Church has always been at the forefront in taking care of, and helping, the suffering and needy. With deep concern for the healing of the poor and sick, the Benedictine brothers studied the writings of Hippocrates. In the late Middle Ages, when epidemics spread along with the growth of cities, Pope Innocence III established the first charity hospital for the sick and poor. Following the example of this charity hospital, many hospitals of this kind were established in Christian countries. Furthermore, Mendel (1822-1844), the father of modern genetics, was a religious priest. After Mendel opened the door of genetics, the discovery of the molecular structure of DNA in the 1950s gave rise to the new field of genetic engineering, which has advanced to date. Today, we face many unexpected challenges and threats with regard to life and ethical issues. Therefore, it is urgent for us to return to Jesus the Lord of life and healing and to think about our identity as health-care workers in the field. I would like to share my reflections on Jesus' mission for healing in five categories.

1. Jesus saw a disease as an evil which severs the relationship a person has with God and with others in the community and destroys communion in the family. Thus, he healed and struggled against a disease, perceiving that it was his mission to free man from diseases.

2. Jesus liberates us from the punitive logic of the Old Testament which regards a disease as the result of personal evils. To the disciples who asked him "Rabbi, who sinned, this man or his parents, that he was born blind?" (Jn 9:2), Jesus answered, "Neither he nor his parents sinned; it is so that the works of God might be made visible through him" (Jn 9:3). Jesus did not respond in words to Pharisees who disputed whether the cause of sin is the sick themselves or their parents, but responded to them in the very act of healing.

3. Jesus met with the suffering, especially the poor, through the act of healing. He offered everything for man and the value of life beyond economic or utilitarian considerations. He did not turn his back on the cry and solicitation of those who suffered in misery as well as because of that of their neighbors. He was radically present in the place of their life. In many parts of the Bible we can recognize his just indignation and sympathy for the suffering and illnesses which oppressed humanity.

4. The healing of Jesus was the holistic recovery of the human person. His healing was

something more than physical recovery from illness, like that of doctors, and meant the invitation to the coming salvation (and to the Kingdom of God). The physical healing of illness has limits of temporality and partiality. Beyond the simple healing of illnesses, Jesus let us anticipate the eternal world of new heaven and new earth. Therefore, for him, healing and salvation are not different in their implications.

5. Jesus' healing aimed to let the healed return to their daily life with a healthy body and a sound mind. It was to free them from the place of suffering and lead them to the place of peace. It was not a simple rehabilitation but assumed a new dimension of returning to the beautiful order created by God.

In this light, there was a striking contrast between Jesus and his contemporaries. Regarding the sick and the handicapped as the condemned by God, the Jews in his times eliminated them from the community and deprived them of the right to partake in divine holiness. In this way, they demonized illness and the sick. However, Jesus presented us with a new vision. Even though he disapproved an illness as an evil, he had sympathy towards the sick and the suffering and invited them to become the people of the Kingdom of God. This means that he treated everyone as the beloved children of God. Today, we, the followers of Jesus Christ, in order to carry out the mission of healing entrusted by him, firmly declare "no" to the personal, structural and social evils that cause illness and "yes" to sharing our neighbors' suffering. In this sense, the celebration of the World Day of the Sick is significant. The late Pope John Paul II expounded the purpose of this day as follows: "The annual celebration of the World Day of the Sick has the evident scope to remind the People of God and, of consequence, many catholic health care institutions and the civil society itself, of the necessity to ensure the best assistance to the sick; to help the sick appreciate the suffering on the human dimension and especially on the supernatural one; to involve dioceses, Christian communities, and religious families in the health pastoral work in a particular manner; to favour the ever more precious labour of volunteers; to recall the importance of the spiritual and moral formation of health care workers; finally, to help understand better the importance of religious assistance to the sick from the part of diocesan and regular priests, as well as of those who live near to the suffering and serve them."

Hopefully, in celebrating the World Day of the Sick, ecclesial communities and Christians can offer the suffering along with the sick who suffer from illness and recognize in the faces of their suffering neighbors the face of Christ who achieved the salvation of humanity through his passion, death and resurrection. I also hope that on this occasion we can appreciate our health and be more committed to helping the sick and weak. Christians should make every effort to cure illnesses and pay more attention to hospice activities which help the sick to die in dignity and happiness in the embracing love of God.

Whenever in great difficuly, Pope John Paul II asked the sick and children to pray a special prayer. It was because he knew that God listens to the prayer of the sick who are sincere amid their suffering and of children who are pure and innocent. On this World Day of the Sick, let us pray together sincere and pure prayer for the sick and suffering.

H.E. Msgr. LAZZARO YOU HEUNG-SIK,
President of the Committee for "Caritas Corea" of the CBCK

The Spiritual and Pastoral Care of Patients with Incurable Illnesses Opening Address

9 FEBRUARY 2007

It is for me a great honour to represent the Holy Father Benedict XVI at this XV World Day of the Sick, which is celebrated here in this great nation of Korea, and especially here in your beautiful capital city of Seoul.

I thank with all my heart the Catholic Bishop's Conference of Korea and all Korean Catholics for the warm welcome and for the great work you have done in preparing with great precision the various activities of this World Day of the Sick.

At the beginning, we implore the indispensable help of the Lord of Life, the divine physician, Jesus Christ, and the intercession of Our Lady '*Salus infirmorum*', so that we may be blessed with an efficacious Day for the good of sick people in the whole world, and especially in Asia and in Korea.

As you know, the World Day of the Sick involves activities that cover three consecutive days, during which we shall reflect on the spiritual and pastoral care of patients with incurable illnesses. The first day, which is today, will be dedicated to scientific and theological problems; the second day, tomorrow, to the pastoral situation of these sick people; and finally we shall offer our study and reflections to the Lord in the liturgical climax of 11 February.

As a framework for this scientific and theological day on the spiritual and pastoral care of patients with incurable illnesses, allow me in this brief opening address to highlight in summarising form some points of Christian teaching which will serve as references for us in what we are reflecting upon today. I am referring here to our understanding of illness, euthanasia, aggressive therapy, palliative care, and the biological will. These are issues that would require a wider discussion; however, due to the time limit, allow me to present them briefly.

To speak adequately about these issues requires full anthropological knowledge. The position that one adopts on fundamental issues such as life, suffering and death will depend on the vision of man that one has. For any correct way of thinking, human life is untouchable, since it is to be identified with the dignity of the human person. For the Christian, life is a gift from God, of which we are the administrators and not the masters. Death is the maturity of life. It is the conclusion of a very important stage, which is but transitory; it is the beginning of true life, it is the day when authentic life is born. If pain is very acute, it is very propitious because it is symptomatic and helps in diagnosis. If it is chronic, it must be dealt with following the example of the Good Samaritan. But, whatever the case, suffering subsists because it belongs to the progression of death. Suffering united with that of Christ associates us to Christ, who redeems us with His passion, death and resurrection. Uniting ourselves to Christ in this way does not give us wellbeing in pain, but happiness.

Euthanasia is every deliberate action or omission meant to terminate the life of an innocent terminally ill person, with the intention of eliminating pain. Aggressive therapy consists in the use of useless or disproportionate therapies on a terminally ill patient which, in the face of imminent death, do nothing else but prolong painful agony. Hydration and nutrition are not part of aggressive therapy. Palliative care consists in treatment aimed at alleviating pain in a terminally ill patient. It does not heal; it mitigates pain. The biological will is the expression of the personal wish of an individual regarding the last moments of his earthly existence.

Euthanasia is homicide and it is never permissible. Aggressive therapy should not be practiced. Palliative care should always be used, even if in mitigating pain one may arrive at the unconsciousness of the patient, with the presupposition, however, that the person has fulfilled all his end-of-life duties. Palliative care helps the sick person to live with greater fullness the hour of death as the most important moment of his life. The biological will is acceptable not as service to euthanasia but as help in avoiding aggressive therapy.

With regard to aggressive therapy, we may note that it contains terms whose meaning keeps on changing. It regards disproportionate and

useless treatment. It is obvious that the uselessness and disproportionateness depend on the progress of medicine, although not totally. The problem is: who is to judge uselessness and disproportionateness? The answer is: the patient, the physician, the family and the bioethics committee.

In the biological will one should pay particular attention to the following points: not to confuse euthanasia with aggressive therapy and vice versa; above all one has to keep in mind that aggressive therapy applies useless or disproportionate treatment that is of no help other than that of prolonging painful agony. In the biological will the freedom of the testator, who may change the will when and how he likes, must be guaranteed. It must be remembered that the uselessness and disproportionateness of the treatment is not fixed; this changes with the progress of medicine. The biological will presupposes a 'trustee', and the trustee(s) has to make sure that in no way should euthanasia take place.

In this way, we offer a framework for the topics that will be treated during the day: sacramental care of these patients, their state and treatment, the quality of life, ethical problems, the sanctity of life and bioethics

I thank all of you for the honour you have given me, to open in this way these precious days of study, pastoral care and prayer for the sick people of the whole world.

H. Em. Card. JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Care Workers the Holy See.

I. Beyond Palliative Care

9 FEBRUARY 2007

When we speak of patients who suffer from incurable illnesses it is logical to think of palliative care. In fact, palliative care offers treatments that do not cure the sick person, but relieve pain in such a way that the patient suffers less and lives in a better way the most important moment of his earthly existence, that is death. With the help of palliative care, the sick person prepares himself more consciously for this passage. Very often pain does not leave room for a serene attitude, which is necessary for a personal dominance of this overwhelming moment of death.

We know that there are various types of palliative care; the physical, psychological, family and social, as well as the spiritual. All these are necessary; however, I will deal only with spiritual palliative care.

When it comes to Christian spiritual palliative care, this is truly more than just "palliative care"; it goes beyond, it does not only alleviate pain, it turns it into happiness. Christian spiritual palliative care realizes the paradox of converting illness and death into a source of life. Through this spiritual care, one arrives at the apex of life, where all the vital desires of the person are satisfied.

These wonders are realized especially through the Sacraments of the Church, above all through the sacraments of Anointing of the Sick and the Sacrament of the Eucharist received as Viaticum.

After a brief comment on the Sacrament of the Anointing, allow me to present some reflections on the Viaticum, since in the Eucharist received as Viaticum the mystery of overcoming the paradox of death, becoming life and happiness, fully comes true. After a brief presentation of the doctrinal points, I will, in line with the Second Vatican Council, address three points: Viaticum as life, as communion and as eternity.

I will begin with three sections taken from two Constitutions of the Second Vatican Council: *Lumen Gentium* and *Sacrosanctum Concilium*.

As regards the sacrament of the Anointing of the Sick, the Dogmatic Constitution on the Church *Lumen Gentium*, tell us that 'by the sacred anointing of the sick and the prayer of the priests the whole Church commends the sick to the suffering and glorified Lord, so that He may heal them and save them (Ja 5; 14-16) and also exhorts them, so that by uniting themselves freely to the passion and death of Christ (Rom 8:17; Col 1:24; 2 Tim 2:1-12; Pt 4:13) they contribute to the good of the people of God (*LG* n. 11)'.

In the same Constitution, we are further told that "participating in the Eucharistic sacrifice, which is the source and summit of the whole Christian life, they offer the Divine Victim to God, and offer themselves along with him…They manifest in a concrete way that unity of the people of God… which is wondrously achieved by this sacrament" (*LG* n.11).

In the Constitution on the Sacred Liturgy *Sacrosanctum Concilium*, it is stated: 'and the same apostle exhorts us to constantly bear mortification in our bodies so that the life of Jesus is also manifested in our mortal lives (Cor 4, 10-11). It is for this reason that we ask the Lord in the sacrifice of the Mass that in 'accepting the offering of the Spiritual Victim, he may make of us an eternal offering for himself' (Roman Missal, Secret for Monday within the octave of Pentecost; *SC*, 12).

In the following reflections we shall begin with the contemporaneous character that the mandate of the Lord: "Do this in memory of me," realizes in the Viaticum, especially at the moment of our death. In every Eucharist our concrete time and that of all centuries is inserted into the highest event of history in which everything achieved its culminating point: the paschal Supper, the death and resurrection of the Lord; or, to be more all-embracing, the whole meaning of the mystery of the Incarnation in its completeness, from the eternal Decree of the Father, concealed before all centuries, until the current eternal presence of Christ at the right hand of the Father.

Following this guiding thread, I will seek to refer to certain ideas about life, communion and eternity that are implied in the reception of Viaticum.

1. Life

Viaticum is the apex of life. The Eucharist is the actual source of life because it is the simultaneous presence of the whole mystery of Christ. We are dealing with the recreation of a new creature. In the Eucharist one always partakes of the medicine of immortality. However, in the Viaticum, taken at the brim of death, there is the contemporaneity of the fullness of life and the reality of death; medicine is received to defeat death by the highest explosion of life.

Our death is this – death as the ultimate end. But in union with Viaticum our death ceases to be the final point. It is converted from a burial mound into a cradle in an authentic rebirth.

On the cross, Christ abandoned himself into the hands of the Father and surrendered his spirit to Him. This surrendering of Love, the Spirit, is the power by which the Father converted the death of Christ into a source of life, or rebirth.

Our abandoning of ourselves to the Father at the final moment is like a total loving embrace in the Spirit; an embrace with the hands of Christ nailed on the cross; and with Christ in the Viaticum, our mortal embrace is converted into the special immortality of the resurrection. Christ spoke about his last hour as the hour of his glorification; in the Viaticum Christ ensures that our final hour is also the hour of our glorification.

In the Viaticum our death is united to the death of Christ and thus completes what was lacking in the passion of Christ for the salvation of the whole world. The highest event of our existence reaches that culmination when we are in synchrony with Christ and with Christ we offer our life for the salvation of the world. Thus we come to give a full meaning to suffering, sickness and pain, which are accepted so that they may complete in our bodies what was lacking in the passion of Christ so as to give them full meaning, exactly from our death. A paradox that converts suffering, sickness and pain which instead of a funeral procession that accompanies us throughout our lives become a triumphal procession of merits that through the only true merit of Christ obtains for us unending new life.

This union of the painful precedents that come before death, as well as death itself with all its suffering, and in union with the very powerful death of Christ, is what we call the Eucharist as Viaticum. In a summary: Viaticum offers us the contemporaneity of the whole of our life and the totality of the life of Christ, and makes us heirs of the true eternal life.

2. Communion

People talk about the terrible loneliness of death because nobody can take the place of anyone else, and we all have to die individually. This is true, however for a Christian, through the Viaticum, this loneliness is not as terrible as it would appear at first sight.

In the Eucharist received as Viaticum, we are in full and intimate union with Christ who dies in each one of our deaths; not in the shadows of annihilation but in the luminosity of the resurrection. This luminosity is the company of the personal Truth of the whole existence which, lived in Christ, brings with it the merciful and benevolent judgment of our Saviour. It is the merciful love of the eternal Father that lives in the person who dies, because of the Eucharist, and which is the all-powerful Love of the Holy Spirit. In the Viaticum we enter the communion of the Trinity as the last step of the ladder of the perfection of our earthly life, so as to open ourselves to the supreme perfection of heaven.

In Christ, the Head of the total Church, we enter into communion of the saints with the Most Holy Virgin Mary, with St. Joseph, with all the saints, with all those who are in the state of purgatory and with all the Christians with whom we are in communion. All of them accompany us at the definitive moment of the passing over and help us to take the fundamental leap towards absolute happiness.

In Christ, Alpha and Omega, the first born of the universe, the whole creation is virtually found. And at the moment of death, with the Eucharist received in Viaticum, the whole of creation hopes for its redemption through the dying person. This is the moment to enter into the inheritance of the whole universe, each one of us uniting ourselves to Christ, the centre of the universe, the first born of the whole creation. Especially at this moment, each person shares in this central quality of Christ and also becomes in Christ the centre of the universe and the first born of all creation (Col 1:1-20).

Thus with the Viaticum for each Christian arrives the culminating moment to which St. Paul refers in his Letter to the Ephesians: the Lord has called us ‘For he has made known to us in all wisdom and insight the mystery of his will, according to his purpose which he set forth in Christ as a plan for the fullness of time, to unite all things in him, things in heaven and things on earth. In him, according to the purpose of him who accomplished all things according to the counsel of his will, we who first hoped in Christ have been destined and appointed

to live for the praise of his glory' (Eph 1: 9-12).

The experience of the loneliness of death involves privation for those who do not have faith. In the Viaticum, faith sustains us through the definitive presence of Christ. The Viaticum is the crowning of the individual, the triumph of solidarity, communion, brotherhood, friendship, total love, and self-giving of future happiness. The proportion of loneliness to faith at the moment of death is inverse, i.e. greater faith means less loneliness and greater loneliness means less faith.

3. Eternity

The definitive presence of Christ in the Eucharistic host offers us a foretaste of eternity. Christ appears independently of conditions of time and space. His dimension transcends all imagination, which is always conditioned by material measurements. This reality that is given in all Eucharistic acts takes place, in a very special way, when crossing the threshold of eternity in the Viaticum.

In a classic way, Boetius defied eternity as *'Interminabilis vitae tota simul atque perfecta possessio'*: the unending, simultaneous and perfect possession of life. In this definition we can perceive a trace that allows us to unveil, though stuttering, the participation in divine life.

Indeed, the frontier, so to speak, between what is of the divine and what is of the creature, is movement. God is immutable; the creature is mutable. This is certainly not only a quantitative movement that can be measured with the coordinates of time and space, but is also an essential movement that becomes perfect progressively. Divine immutability is not a state of static quietness that is lacking in dynamism, but a fullness of activity that means omni–perfection. This omni-perfection is not only the concept of 'immobile engine' (*Motor inmobilis*) but also the fullness of passing over in the infinite giving of love that is the Most Holy Trinity. It is a dynamism that does not wish to possess because in itself it is everything. This is because it is loving self-giving without decrease, loving reception without increase: God is love. He is not only infinitely lovable but also infinitely loving. This immutability of perfect joy in loving self-giving is the authentic divine immutability, the very nature of God.

To share in the nature of God is to enter this community that is full of love; it is to enter the circle of the Trinity, defeating the mutability of desire and progressive growth, in the full satisfaction of the creature through the filling of his capacities to the brim. This is true life, and thus this supreme communion of love constitutes true health, which is usually called eternal health.

The Eucharist achieves this wonder. Thus Christ says: 'if one eats of this bread, he will live forever…He who eats my flesh and drinks my blood abides in me, and I in him. As the living Father sent me, and I draw life from the Father, so he who eats me will also draw life from me' (Jn 6:51; 54-57). As we know, this is the Eucharistic bread that was given to us and the blood that was shed on the cross (Lk 22:14).

Such is Viaticum: to share in the body of Christ who handed himself over to death and in his blood that was shed on the cross, so as to then enter into eternity. The frontier of the mutability of the creature is crossed in death with Viaticum. This is because the frontier between the divinity and the creatureliness is crossed through that bridge, the cross. Viaticum is Christ who died and rose again, as the fullness of the times of the individual life of each one of us. Thus death is no longer darkness that is feared and rejected, but the loving embrace that conforms us to the Lord Jesus. In the Viaticum, our death becomes full giving to the Father through the total love of the Spirit in the Lord Jesus. In the Viaticum, our death becomes full self-giving to the Father through the total love of the Spirit in the Lord Jesus. This giving is the sum of all the daily acts of giving by which we wish to demonstrate to the Lord God our devotion in our own lives. This is because in this giving we do not give something to the Lord – we give everything. We place life itself in its totality in the hands of God. We then begin to truly live and the paradox of death in life is solved.

Conclusion

Let us state the paradox: the fullness of health is death. But not any death: only death in Christ. That is to say: death experienced intimately united to the death of Christ and thus with his resurrection. The achievement of such a death is the Viaticum.

It was for this reason that I said at the beginning of this paper that spiritual care of those suffering from incurable illnesses goes beyond palliative care. All spiritual care comes from the Eucharist as its fountain. Therefore the Eucharistic care of the sick is the principal spiritual care. This is the core of pastoral care in health, and the Viaticum is its most complete exponent. This is because it is the only horizon towards which the health of mankind can really advance.

With Pope John Paul II health was defined as 'tension towards physical, mental, social and spiritual harmony.' The Viaticum is not tension towards harmony but the achievement of harmony, where the disharmony of death leads back to the harmony of the resurrection.

In the Viaticum the disorder of death is converted into the greatest order; anxiety is converted into the greatest tranquillity. One finally reaches the wished for peace in dying because this is especially what peace is: 'tranquillity in order'.

H. Em. Card. JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Care Workers the Holy See.

II. Patients in a Vegetative State and the Quality of Life

Introduction

Theresa Marie "Terri" Schiavo (December 3, 1963 – March 31, 2005) was a woman from St. Petersburg, Florida. Schiavo, then 26, collapsed in her home in 1990 and experienced respiratory and cardiac arrest. Within three years, she was diagnosed as being in a persistent vegetative state. In 1998, Terri's husband and guardian Michael Schiavo petitioned the courts to remove her gastric feeding tube. But Terri's parents, Robert and Mary Schindler, opposed this. The courts found that Terri Schiavo was in a persistent vegetative state and that she should not be kept alive. In 2003, the matter began to receive United States national attention. By March 2005, the legal history around the Schiavo case included fourteen appeals and numerous motions, petitions, and hearings in the Florida courts. Despite intervention by the other branches, the courts continued to hold that Schiavo was in a persistent vegetative state and would want to cease life support. Her feeding tube was removed a third and final time on March 18, 2005. She died thirteen days later of dehydration at a Pinellas Park hospice on March 31, 2005, at the age of 41.[1]

In 2004, Pope John Paul II stated that health care providers are morally obliged to provide food and water to patients in persistent vegetative states. A Vatican Cardinal, Renato Martino, the head of the Pontifical Council for Justice and Peace, opposed removing the feeding tube keeping Terri Schiavo alive. Cardinal Renato Martino told Vatican Radio February 24, 2005 that if Michael Schiavo (Terri Schiavo's husband) "legally succeeded in provoking the death of his wife, this would not only be tragic in itself, but it would be a serious step toward legally approving euthanasia in the United States."[2] Bishop Elio Sgreccia, President of the Pontifical Academy for Life, told Vatican Radio March 11, 2005 that withdrawing Schiavo's gastric tube would not be a matter of allowing her to die, but would "inflict death." Bishop Elio Sgreccia said: "Terri Schiavo must be considered a living human person…whose juridical rights must be recognized, respected and defended. The removal of the gastric tube used for nourishing her cannot be considered an 'extraordinary' measure or a therapeutic measure. It is an essential part of the way in which Terri Schiavo is nourished and hydrated. As far as we are concerned, denying someone access to food and water is a cruel way of killing someone. The removal of the gastric feeding tube from this person, in these conditions, may be considered direct euthanasia. For these reasons we regard as illicit the decision to remove the gastric feeding tube from Terri Schiavo."[3]

Nowadays, we observe that patients in a vegetative state are increasing in number due to the development of medical science, especially life-sustaining treatments. The condition known as 'vegetative state' is one in which the person is still alive but is permanently unconscious even though the patient gives the outward appearances of being alive. We have also observed a strengthening in the concept of quality of life and a weakening of the concept of sanctity of life and of the strength of solidarity. Added to limitations or a lack of sufficient support to families to cover the costs of prolonged care for patients in a vegetative state, this has caused a gradually increasing pressure to remove burdens. Therefore some argue that life-sustaining medical treatments for patients in a vegetative state could be withheld or withdrawn if the treatments were burdensome.

The ethical issues connected with patients in a vegetative state are expressed in the following question: if a patient is competently and securely diagnosed to be in a vegetative state, does the continuation of life support efforts become ethically optional? Of special concern is the question of artificially delivered nutrition and hydration.[4] The relevant criteria for determining whether the artificial feeding of patients is morally required are clear. Such feeding is obligatory unless it is either useless or excessively burdensome. But applying these criteria to persons said to be in a "vegetative state" is a matter of serious controversy. Some contend that such feeding is futile and hence not obligatory. Others maintain that, unless the contrary can be clearly shown, such feeding is neither futile nor unduly burdensome and is therefore morally obligatory as an ordinary means of preserving life.

In this paper, I will try to show that the latter position is correct. I will firstly provide an accurate description of the vegetative state; secondly summarize the Catholic teaching on prolonging life; and lastly provide the arguments that artificially feeding is morally obligatory unless it can be clearly shown to be futile.[5]

What is the Vegetative State?

The vegetative state itself is a form of deep unconsciousness. The upper part of the brain (the cerebral cortex) gives evidence of impaired or failed operation. Since this part of the brain is neurologically involved in such activities as understanding, willing and communicating, patients

in a vegetative state are not able to engage in these activities. But the brain stem, which controls involuntary functions such as breathing, blinking, circulating blood, cycles of waking and sleeping, etc., is still functioning. As a result, patients in a vegetative state may open their eyes and sometimes follow movements with them or respond to loud or sudden noises (although such responses will not be long sustained nor are they apparently purposeful).[6] It is commonly held that patients in a vegetative state have no consciousness experience and are incapable of experiencing pain, and that it is unlikely that patients in this state will recover consciousness. However, their condition has stabilized and they are not in immediate danger of death so long as they are given appropriate 'food,' and this can be provided them by various artificial means made possible by modern medical technology.[7] Therefore, patients in a vegetative state are not comatose. A coma is a state of "unarousable unresponsiveness" which may last as long as six months but will inevitably resolve itself into another state.[8]

Here is a definition of the persistent vegetative state that is understandable in layman's terms: "Condition in which the patient is awake without being aware. In this state the brain stem is functioning but the cerebral cortex is not, and the patient lies with his eyes open, looks around, but has no meaningful interaction with the environment."[9] G. L. Gigli and M. Valente hold that "there is no clinical difference between vegetative state (plain) and persistent vegetative state and it is actually impossible to predict, on an individual basis, those patients who are candidates to recovery. For these reason, the use of the term persistent, meant to imply the irreversible nature of vegetative state, has been discouraged. However, more recently, the term permanent to imply an irreversible state has been recommended. A patient in vegetative state would be defined permanently vegetative when the diagnosis of irreversibility is established to a high degree of clinical certainty, that is when the chance of regaining consciousness becomes extremely unlikely."[10]

Since patients diagnosed as being in a vegetative state are by no means imminently in danger of death, and since their lives can be protected, perhaps for several years, the ethical question in caring for them is whether providing them with food and nourishment by tubes is morally obligatory or "ordinary" or whether withholding or withdrawing food so provided is "extraordinary". It is important to note that patients in a vegetative state can, in fact, be fed orally in the beginning. However, those caring for them will usually prefer not to feed them orally because this is quite time-consuming, particularly if there are other patients for whom they must care. Thus feeding them by means of tubes is far more convenient. If not fed orally, the ability of patients in this state to take food orally gradually atrophies.[11]

The Historical Development of Catholic Teaching on Prolonging life

Catholic teaching on prolonging life has formally evolved over the course of five hundred years from the foundational works of certain sixteenth- and seventeenth-century theologians to recent statements issued by the moral Magisterium of the Catholic Church.[12] The first explicit treatment of what one is obliged to undergo to prolong life came from the great sixteenth-century Spanish Dominican theologian, Franciso De Vitoria (1486-1546). In his *Relectiones Theologiae*, Vitoria considers whether one violates the natural-law obligation to protect and to preserve life if one fails to eat certain foods when sick. Vitoria replies: "If a sick man can take food or nourishment with some hope of life, he is held to take the food, as he would be held to give it to one who is sick. [However], if the depression of spirit is so low and there is present such consternation in the appetitive power that only with the greatest of effort and as though by means of a certain torture can the sick man take food, right away that is reckoned a certain impossibility, and therefore he is excused, at least from moral sin, especially where there is little hope of life or none at all."[13] Vitoria also addressed the issue of the use of medicinal drugs. Here, too, he pointed out that one is not obliged to use every possible means to prolong life: "One is not held, as I said, to employ all the means to conserve his life, but it is sufficient to employ the means which are of themselves intended for this purpose and congruent. Wherefore, in the case which has been posited, I believe that the individual is not held to give his whole inheritance to preserve his life… From this it is also inferred that when one is sick without hope of life, granted that a certain precious drug could produce life for some hours or even days, he would not be held to buy it but it is sufficient to use common remedies, and he is considered as though dead."[14]

Another Dominican theologian from Spain, Domingo Bañez (1528-1604), played an important part in the historical development of Catholic teaching on prolonging life. He introduced the terms 'ordinary' and 'extraordinary' into the discussion of morally obligatory and morally option-

al means of preserving life. Bañez remarks: "He is not bound absolutely speaking. The reason is that, although a man is held to conserve his own life, he is not bound to extraordinary means but to common food and clothing, to common medicines, to a certain common and ordinary pain."[15]

Subsequent theologians were quick to pick up on the ordinary-extraordinary means distinction articulated by Bañez, and in a short time the distinction became firmly established in the Catholic moral tradition. In fact, the distinction is still operative today, even though some contemporary commentators have challenged its practical relevance.

In a 1950 article, Gerald Kelly (1902-1964) examined the Catholic tradition on the moral responsibility in prolonging life decisions and summarized the traditional definitions of ordinary and extraordinary means: "Speaking of the means of preserving life and of preventing or curing disease, moralists commonly distinguish between ordinary and extraordinary means. They do not always define these terms, but a careful examination of their words and examples reveals substantial agreement on the concepts. By ordinary they mean such things as can be obtained and used without great difficulty. By extraordinary they mean everything which involves excessive difficulty by reason of physical pain, repugnance, expense, and so forth."[16] In a 1951 article, Kelly proposed the following modified definitions: "Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations, which cannot be obtained and used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. With these definitions in mind, we could say without qualification that the patient is always obliged to use ordinary means. On the other hand, insofar as the precept of caring for his health is concerned, he is never obliged to use extraordinary means."[17]

In an address delivered to the International Congress of Anesthesiologists on 24 November 1957,[18] Pope Pius XII (1876-1958) confirmed the foundational teaching on prolonging life and Kelly's specification of the meaning of ordinary and extraordinary means. In discussing one's moral obligation to use mechanical ventilation to preserve life, Pope Pius XII outlined some of the major features of the ordinary-extraordinary means distinction as it had developed since Vitoria. Pope Pius XII declared: "Natural reason and Christian morals say that man has the right and duty in case of serious illness to take the necessary treatment for the preservation of life and health…But normally one is held to use only ordinary means - according to circumstances of persons, places, time and culture - that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty." By situating the discussion of the means necessary to prolong life against the backdrop of one's ultimate end in God, Pope Pius XII specified even more precisely the meaning of ordinary and extraordinary means. He implied that medical treatment must be evaluated in the light of the patient's overall medical condition and the patient's ability to pursue spiritual goods. Thus ordinary means are those that are morally obligatory because they offer a reasonable hope of benefit in helping one to pursue the spiritual goods of life without imposing an excessive burden; and extraordinary means are those means that are morally optional because they do not offer a reasonable hope of benefit in terms of helping one to pursue the spiritual goods of life, or because they impose an excessive burden on one and profoundly frustrate one's pursuit of the spiritual goods of life.

The Congregation for the Doctrine of the Faith provided further confirmation of the traditional teaching on the moral responsibility in prolonging life in its 1980 *Declaration on Euthanasia*.[19] Addressing the issue of whether all possible means must be used to preserve life, the Congregation for the Doctrine of the Faith noted that the means "ordinary" and "extraordinary" are less clear today, and that perhaps the terms "proportionate" and "disproportionate" are more accurate. In order to assess the proportionality of means, the Congregation for the Doctrine of the Faith noted that one should "study the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and [compare] these elements with the result that can be expected," taking into account one's overall medical condition and physical and moral resources. The Congregation for the Doctrine of the Faith also remarked that one need make do only with the normal means that medicine can offer, without having recourse to established medical treatments that carry a risk

or disproportionate burden. It made clear that one's refusal of disproportionate treatment "is not the equivalent of suicide"; rather, "it should be considered as an acceptance of the human condition," a desire to avoid excessive burdens, or a wish not "to impose excessive expense" on one's family or the community. It also specified that when death is imminent, one may withhold or withdraw certain forms of medical treatment that "would only secure a precarious and burdensome prolongation of life". The *Declaration on Euthanasia* establishes that Catholic teaching on prolonging life has continued largely unchanged from the time of Vitoria to today. Introducing the terms "proportionate" and "disproportionate" did not significantly change the traditional teaching.

Two other Catholic reports on moral responsibility in decisions prolonging life have been advanced by pontifical agencies. First, the Pontifical Council Cor Unum issued a report in 1981 dealing with the ethical aspects of providing medical care to person at the end of life.[20] Second, the Pontifical Academy of Sciences issued a report in 1985 dealing with the moral obligation to use life-sustaining medical treatment and the criteria necessary for determining the exact moment of death.[21] These reports seem to indicate that medically assisted nutrition and hydration should be considered "ordinary or proportionate" means of prolonging life and thus should be used unless death is imminent or they impose an excessive burden on the patient. But these reports lack the authoritative doctrinal status of papal teaching and of statements of the Congregations. These reports were actually given to the Pope but they have not been "officially promulgated by him to date or made part of authoritative teaching".[22]

Providing Food to Patients in a Vegetative State is Obligatory

Nutrition and hydration should always be provided to all patients, including patients in a vegetative state, unless they cannot be assimilated by a person's body, they do not sustain life, or their only mode of delivery imposes grave burdens on the patient or others. The consequence of decisions on nutrition and hydration withdrawal is the death of patients in a vegetative state. Death by starvation and dehydration "denies the respect we have for the dying person. Even a dead person is treated with respect and we would not carry out acts on a dead body simply because they would not be felt."[23] Gigli and Valente maintain that "We believe that, although unintended, the withdrawal of nutrition and hydration to patients in vegetative state…can actually turn out to be, in the long term, the Trojan horse to make active euthanasia acceptable to societies and health professionals."[24]

The United States Pennsylvania bishops issued a document dealing with artificially providing food to patients in a vegetative state on January 14, 1992. This document concluded by declaring: "As a general conclusion, in almost every instance there is an obligation to continue supplying nutrition and hydration to the unconscious patient. There are situations in which this is not the case [for example, when patient can no longer assimilate the food and its provision is hence useless], but these are exceptions and should not be made into the rule." In their judgment artificially providing food to patients in a vegetative state is "clearly beneficial in terms of preservation of life," nor does it, in almost every case, add a "serious burden." Consequently, it is morally obligatory.[25]

On March 24, 1992, the Administrative Committee of the United States Conference of Catholic Bishops (USCCB) authorized the publication of a substantive document prepared by the Committee for Pro-Life Activities of the USCCB. This document surveyed, somewhat extensively, relevant medical literature dealing with the issue and the different positions adopted by moral theologians. In their view of the theological opinions, the authors of this document explicitly state that they do not find persuasive the rationale of some theologians that since patients in a vegetative state can no longer pursue the spiritual goal of life, feeding them artificially is futile and unduly burdensome. In the conclusion of their paper, the authors have this to say: "We hold for a presumption in favor of providing medically assisted nutrition and hydration to patients who need it, which presumption would yield in cases where such procedure have no medically reasonable hope of sustaining life or pose excessive risks or burdens."[26]

The view, like that of the Pennsylvania Bishops and the Pro-Life Committee of the United States Conference of Catholic Bishops, holds that artificially providing food to permanently unconscious persons (patients in a vegetative state) is to be regarded ordinarily as morally obligatory insofar as it is neither useless nor unduly burdensome. In Directive no. 58 of the Ethical and Religious Directives for Catholic Health Care Services (November 1994), the bishops of the United States hold that "There should be presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to out-

weigh the burdens involved to the patient."[27]

Some argue that the expense entailed in feeding patients in a vegetative state must realistically be regarded as terribly burdensome in our society. But, no one, we can presume, would want his or her family bankrupted in order to provide patients in a vegetative state with tubally assisted feeding. Therefore, the costs of taking care of patients in a vegetative state must be increasingly covered by insurance or other programs. Now we should legitimately strive to avoid excessive expense without abandoning care for the patients in a vegetative state and without bringing about their death by starvation and dehydration.[28]

The total cost of caring for patients in a vegetative state (providing them with a heated room, nursing care, etc.) could be quite great, but it would be unfair and unjust to deprive the patients in a vegetative state of their fair share. Germain Grisez develops the truth that another human good served by feeding patients in a vegetative state in this way is the good of human solidarity.[29] In another work Grisez expresses this idea as follows: "life-sustaining care for the severely handicapped does have a human and Christian significance in addition to the one it would derive precisely from the inherent goodness of their lives. This additional significance is…profoundly real, just as is the significance…which continues to benefit not only the person being cared for but the one giving care."[30]

The entire story of withdrawal of nutrition and hydration is a turning point for our civilization, it is paradigmatic of the direction in which we want to orient our mutual relationships, of the way in which we want to care for and relate to elderly, handicapped and unconscious people for the years to come. There is the concrete risk of further weakening the ties of solidarity inside families and inside the social body.[31]

Some moralists profess a certain uneasiness with granting that food and water can ever be regarded as medical treatment.[32] If we define "medical treatment" as "an action or group of actions performed to alleviate or neutralize some sort of pathological condition or disease",[33] the logical question arises: if food and water are medical treatment, what precisely do they treat? Patients can be weaned from respirators, to be sure, but they cannot be taken off nutrition and hydration. Because there is a distinction between tube feeding and other forms of life-sustaining treatments such as ventilation or dialysis, tube feeding for patients in a vegetative state is not a medical treatment but basic care.

Conclusion

Patients in a vegetative state have been challenged from the ethical point of view with the proposal to withdraw assisted nutrition and hydration. However, this ethical point of view can be very dangerous. Patients in a vegetative state are not in fact dying of some fatal pathology. They are simply persons who are seriously impaired. If tube feeding is removed, patients in a vegetative state will die from starvation and dehydration. In other words, death is the inevitable consequence of the withdrawal of assisted nutrition and hydration. Obviously, the purpose of removing the feeding-tube is to hasten the death of patients in a vegetative state. Nutrition and hydration is not a form of medical treatment, which, in analogy to other forms of life-sustaining treatments such as the use of the respirator, may be discontinued in accordance with the principles and practices governing the withholding and withdrawal of other forms of medical treatment. Nutrition and hydration is a form of basic ordinary care, which should always be provided to all patients, including patients in a vegetative state.

Gigli and Valente criticize the current discussion about quality of life. They maintain the following: "In our opinion, the discussion about quality of life often hide a kind of evaluation typical of the interpersonal relationships in our society, based on the ability to produce and to be useful. In this society, not only the lives of patients in vegetative state, but also those of gravely disabled patients and of every person marginalized out of the productive system are considered less worthy."[34] Therefore E. Sgreccia and I. C. de Paula "have made a positive proposal. The concept of quality of life, which is often used as a pretext for the propagation of euthanasia and eugenics, has been declared to be positive, on condition, however, that it is considered in the light of a person in his or her entirety, and with reference to the hierarchy of values within each person and those of our society. In other words, the quality of life must favour within each person a balance between what is beneficial at a corporeal, emotional and spiritual level, each aspect being considered as part of the harmony and hierarchy of values; at the same time, the good of society and the development of the environment must be the result of the commitment of every individual for the good of all people in the context of justice and of a new and greater solidarity. Therefore… quality of life can depend only on respect for life and the right to life… it must be a quality which is founded on the inviolability and dignity of each person, where the notion of dignity and inviolability is extended to include a person's corporeal dimension, which is a fundamental value of one's own personal existence."[35] Therefore the quality of life of a patient in a vegetative state must be a quality which is founded on the inviolability and sanctity of his or her life.

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Notes

[1] *http://en.wikipedia.org/wiki/Terri_schiavo*

[2] W. A. Moore, "Vatican official en-

ters Schiavo feeding tube fray," St. Petersburg Times online, Feb. 26, 2006. *http://sptimes.com/2005/02/26/Tampabay/Vatican_official_ente.shtml*

[3] C. WOODEN, "Vatican bioethicist says removing Schiavo's tube 'direct euthanasia'," Catholic News Service, March 11, 2005, *http://www.catholicnews.com/data/stories/cns/0501419.htm*

[4] P. J. CATALDO, A. S. MORACZEWSKI ed. *Catholic Health Care Ethics: A Manual for Ethics Committes,* (Boston, Mass.: The National Catholic Bioethics Center, 2001), Ch. 17 Ethical Considerations Concerning Persistent Vegetative State.

[5] WILLIAM E. MAY, *Catholic Bioethics and the Gift of Human Life* (Indiana: Our Sunday Visitor Publishing Division Our Sunday Visitor, Inc., 2000), pp. 263-270.

[6] R. CRANFORD, "The Persistent Vegetative State: The Medical Reality," *Hastings Center Report* 18 (1988), pp.27-32.

[7] WILLIAM E. MAY, *Ibid.,* p. 264.

[8] Council on Scientific Affairs and Council of Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," *Journal of the American Medical Association* 263 (1990), p. 427.

[9] *Dictionary of Medical Terms for the Nonmedical Person* (3d ed. Hauppage, NY: Barron's Educational Series, 1994).

[10] G. L. GIGLI and M. VALENTE, "Quality of life and vegetative state," in Pontificia Accademia Pro Vita, *Quality of Life and the Ethics of Health* (Libreria Editrice Vaticana, 2006), p. 239.

[11] WILLIAM E. MAY, Ibid., p. 264.

[12] M. PANICOLA, "Catholic Teaching on Prolonging life: Setting the Record Straight", *Hasting Center Report* (Nov.-Dec. 2001), pp. 14-25.

[13] F. DE VITORIA, *Relectiones Theologiae* (Lugdini, 1587), *Relectio IX, de Temperentia,* n. 1 (translated as in D. A. Cronin, *Conserving Human* Life (Braintree, Mass.: Pope John Center, 1989), p, 35).

[14] F. DE VITORIA, *Relectiones Theologiae* (Lugdini, 1587), *Relectio X, de Homicido,* n. 35 (translated as in D. A. Cronin, Ibid., p, 37).

[15] D. BAÑEZ, *Scholastica Commentaria in Partem Angelici Doctoris S. Thomae* (Duaci, 1614-1615), Tom. IV, *Decisiones de Jure et Justitia,* in II:III, q. 65, a. 1 (translated as in D. A. Cronin, Ibid., p, 42).

[16] G. KELLY, "The Duty of Using Artificial Means of Preserving Life," *Theological Studies* 11 (June 1950), pp. 203-220.

[17] G. KELLY, "The Duty to Preserve Life," Theological Studies 12 (Dec. 1950), pp. 550-556.

[18] POPE PIUS XII, "The Prolongation of Life," in *Critical Choice and Critical Care,* ed. K. W. Wildes (Netherlands: Kluwer Academic Press, 1995), pp. 189-196.

[19] Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," in *Quality of Life: The New Medical Dilemma,* ed. J. J. Walter and T. A. Shannon (New York: Paulist Press, 1990), pp. 259-264.

[20] Pontifical Council Cor Unum, "*Questioni etiche relative ai malati gravi e ai morenti*," in D. A. Cronin, *Ibid.,* pp. 286-304.

[21] Pontificia Accademia delle Scienze, *Dichiarazione circa il prolungamento artificiale della vita e la determinazione esatta del momento della morte,* 21 ott. 1985.

[22] A. S. MORACZEWSKI, "The Moral Option Not to Conserve Life Under Certain Conditions," in D. A. Cronin, *Ibid.,* pp. 233-275.

[23] K. ANDREWS, "Euthanasia in chronic severe disablement," *British Medical Bulletin* 1996, 52, pp. 280-288.

[24] G. L. GIGLI and M. VALENTE, *Ibid.,* p. 245.

[25] Pennsylvania Conference of Catholic Bishops, "Nutrition and Hydration: Moral Considerations," in *Origins: NC News Service* 21 (1992), pp. 542-553.

[26] Committee for Pro-Life Activities, United States Conference of Catholic Bishops, Nutrition and Hydration: *Moral and Pastoral Reflections* (Washington, D.C.: United States Catholic Conference, 1992), Publication No. 516-X, p. 7.

[27] WILLIAM E. MAY, Ibid., p. 263.

[28] WILLIAM E. MAY, Ibid., p. 269.

[29] GRISEZ, "Should Nutrition and Hydration Be Provided to Permanently Comatose and Other Mentally Disabled Persons?" *Linarcre Quarterly* 57 (1990), pp. 30-43.

[30] GRISEZ, *Difficult Moral Questions* (Quincy, IL: Franciscan Press, 1997), p. 223.

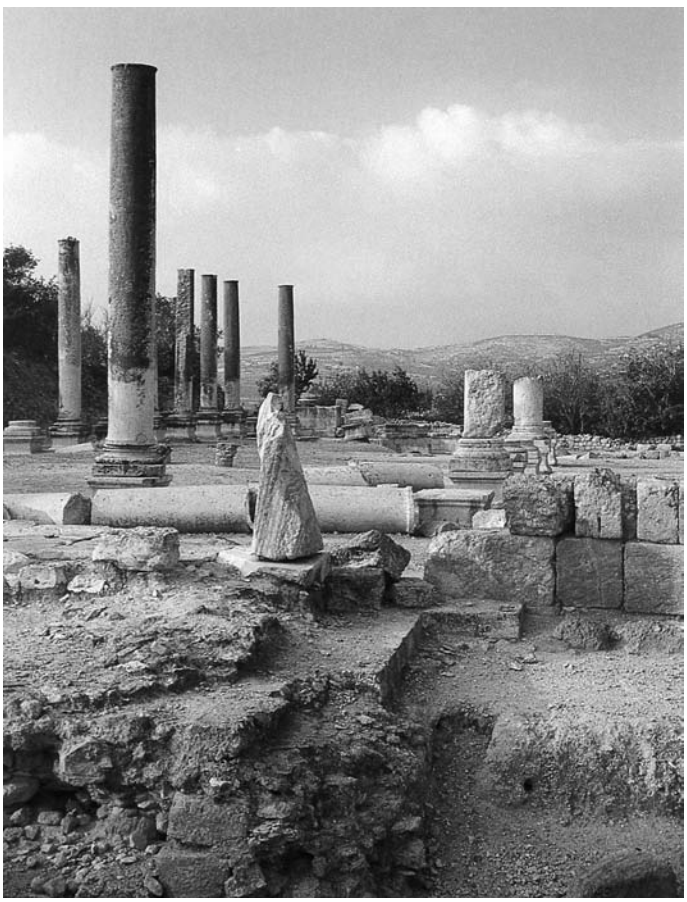
[31] G. L. GIGLI and M. VALENTE, *Ibid.,* p. 248.

[32] P. J. CATALDO, A. S. MORACZEWSKI ed., *Ibid.,* ch. 17 "Ethical Considerations concerning Persistent Vegetative State".

[33] S. J. HEANEY, "'You Can't Be Any Poorer Than Dead': Difficulties in Recognizing Artificial Nutrition and Hydration as Medical Treatments," *Linacre Quarterly* 61,2 (1994), p. 79.

[34] G. L. GIGLI and M. VALENTE, *Ibid.*, p. 240.

[35] E. SGRECCIA, I. C. DE PAULA, "Presentation," in Pontificia Academia Pro Vita, *Quality of Life and the Ethics of Health* (Libreria Editrice Vaticana, 2006), pp. 6-7.



III. Ethical Issues in Nursing Care at the End of Life

Introduction

Respect for human life and *respect for human rights* are two basic values which the organized nursing profession has urged its members to adhere to in their service to mankind.[1] To nurse at the end of life, we need to be more conscious of how value-laden the choice of medical and nursing interventions can be. We practice nursing in an ethical minefield. Ethical conflicts can be caused by the most ordinary nursing measures, such as turning, feeding and bathing.[2] In many cases, physicians, patients and their families should take certain decisions. Nurses are also asked to carry out their value-laden choices. In performing tasks, such as eliminating tube and lines, or overseeing morphine intake, nurses are faced with critical moments when they have to execute value judgments. Physicians have sometimes ordered nurses, without discussion, to intervene in ways that may cause permanent unconsciousness, or in cases where a patient's life will end. In these cases, their value-laden choices induce great moral confusion in nurses. "Nurses experience moral distress when they are unable to translate their moral choices into moral action or when they feel that nursing virtues are undermined",[3] or when they know how they should act morally but that act is deemed impossible: among other restraints are those of the individual's beliefs and self-worth.[4]

Therefore, naming and clarifying ethical issues is a permanent nursing role at the end of life. Nurses must constantly ask the question: "Are we doing good for this person and his or her family? Is this what the person wants?' These are questions that the nurse must ask in order to gain moral courage and not fall into despair.

There are a variety of clinical problems; and the focus of this paper will be on beneficence, respect for autonomy and veracity in particular. In addition, moral principles, duties and conduct related to palliative care are also analyzed.

Moral Principles and Duties

1. Doing good, beneficence

Doing good to others involves being virtuous and extending goodness to them. At the end of life, beneficence is expressed through attentive listening, knowing the patient as a person, inquiring about well-being, and persistently trying to relieve suffering. In relation to a dying patient's suffering and severe pain, the U.S. Bishops' Conference says that "what is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness." "One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying."[5] "Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason."[6] The Pontifical Council Cor Unum declares: "Drugs can diminish anguish but, more often than not, are powerless to relieve it completely. It is only a human presence, discreet and attentive, that can procure the relief so much needed, by allowing the sick person to express his thoughts and by giving him human and spiritual comfort."[7]

However, nurses are often confronted with fear about interfering with this goal. For example, when a nurse stops listening attentively to patients, it may be thought that the nurse is afraid of alleviating the patient's suffering. We might be afraid to comfort because we are afraid that the medication to relieve suffering will kill the patient. Therefore, beneficent nursing practice requires courage to confront our own fears. If a nurse is afraid to listen to a patient talking about how much he or she is in pain, the nurse will not be able to access and relieve pain. If a nurse is afraid of calling the physician to request more pain medication, he or she will not be able to relieve pain. Such fears render us unable to practice beneficence.[8]

2. Respect for Autonomy

Respect for autonomy usually belongs to the moral sphere of the patient's right to self-determination.[9] Autonomy is closely linked to the notion of respect for persons and is an important principle in cultures where all individuals are seen as unique and valuable members of society. Autonomy implies that each person has the freedom to make decisions about personal goals. It is a state in which each of us is free to choose and implement our own decisions, free from lies, restraint, or coercion.

The ICN *Code of Ethics* (2001)[10] states: "the nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment." In

the Korean Nurses' *Code of Ethics* (2006),[11] which was revised very recently, section 4, "the right to know and respect for autonomy", states "the nurse has the duty to explain in detail to patients with accurate information in order to make their own decision about their medical and nursing care (treatment), and nurses have to respect patients that they have their rights to choose or deny the treatments." Offering food and nutrition becomes merely a biological event. That is, the very core of human relationships have to do with the sharing of food and offering nourishment should symbolize concerning and care. Moreover, offering food can be offering care, which is synonymous with treatment on some levels. When a patient refuses to eat, it could mean that they are "giving up on life" but looking at this from the perspective of keeping one's health, one cannot dismiss it with the pretext of preserving the patient's autonomy. Nurses should understand that "in order to advocate the autonomy of the patient, the patient must be informed of and understand the nature of treatments and results." Also, only under voluntary consent can the patient be administered treatment or care.[12] For example, when an ethical dilemma is presented by a patient refusing his or her food, and "when the patient's autonomy is respected, there is no intervention in part by the nurse and the situation is left alone."[13] The nurse's dilemma lies in his or her duties connected with the patient's autonomy and liabilities stemming from failure to provide care for the patient. In this instance, the nurse should assess the reasons why the food was refused and offer other means of nourishment to improve the patient's quality of life. Similar to this, other instances where a nurse's morality has been questioned have occurred in doctors' orders relating to transfusions, antibiotics, diet and supplements. A nurse might experience complicated emotions in a situation where, from the nurse's point of view, the patient may not want what the doctor orders; however, the nurse cannot go against the doctor's order. A doctor who does not agree with the patient or his or her family as regards treatment may make the nurse find himself or herself in a more difficult situation. With respect to "ordinary and extraordinary means to prolong life", a nurse also recognize and defend a patient's right to refuse "extraordinary" means, namely means which provide no benefit or which involve too grave a burden. In cases where patients cannot speak for themselves, we urge family members and physicians to be guided by these fundamental moral principles.

The study by Um (1994)[14] showed that the values nurses gave greatest importance to were "saving life" and "maintaining care", and the next most important value was "respecting the patient's autonomy/self-determination'.

I will now examine challenges to respect for autonomy at the end of life.

Challenges to respect for autonomy at the end of life

For a person to act autonomously he or she must have truthful information, be free from controlling influences, and possess the capacity to make deliberate decisions.[15] There are many challenges to this ideal at the end of life which pose ethical dilemmas for nurses and other health professionals. These challenges include uncertain and denied truth, informed consent, decisional capacity, non-compliance, advance planning, and surrogate decision-making. Despite these challenges, however, nurses should play an active role in promoting autonomy at the end of life.[16] With regard to *uncertain and denied truth*, the truth about illness and prognosis always has an element of uncertainty. It is common for providers to disclose only incomplete information, while emphasizing positive aspects. Without complete information that includes their terminal condition, patients are unable to make decisions about their last days. Autonomy is denied.

In recent years there has been a growing awareness that the patient must also take part in medical decisions. The patient must be able to take decisions according to his or her own values and priorities, which could differ from those of the doctor. This is the right that informed consent seeks to establish. The *informed consent* of the patient is the rational acceptance of a medical intervention or a choice between different possible alternatives. In other words, it is the patient's voluntary and conscious acceptance of medical intervention and of possible alternatives with their respective benefits and risks.[17] To give such consent, certain conditions need to be met: having sufficient information,

adequate understanding of the information, being free to decide according to one's own values, and competence in taking decisions.

In order to make an autonomous decision, a patient must possess and understand the necessary information relevant to that decision. The doctrine of informed consent has two dimensions. First, the physician is expected to truthfully disclose diagnosis, prognosis, treatment possibilities, risks, benefits, and the consequences of accepting and refusing treatment. Second, the patient must have the mental capacity to understand this information and the consequences of accepting or refusing it.[18] The nurse frequently ends up by asking the patient to sign papers indicating informed consent and is often asked to witness this process. Sometimes he or she must question whether the patient comprehends the decision he or she is making and whether he or she possesses the mental capacity to decide.[19] It is the nurse's responsibility as an advocate for the patient to ensure that all the criteria for autonomous decision-making are met. If the nurse believes that the patient does not understand the implications of any part of the process, including non-treatment and alternative options, or that the patient is unable to deliberate on, and reason about, the various choices, it is the responsibility of the nurse to intervene.[20]

Therefore, the nurse must judge whether or not the patient has the ability to make rational decisions. When a patient has the ability to make rational decisions on life-sustaining treatments involving resuscitation, artificial respiration, diet, transfusion, dialysis, chemotherapy, operations or antibiotics, decisions on the refusal of such treatment should be taken in consultation with the patients' family and caregivers.

Decisional capacity usually deteriorates at the end of life, due to illness and medication, and evaluating decisional capacity entails asking the following:[21]

1) Can the person understand and communicate information?

2) Is the person able to deliberate on, and reason about, the decision?

3) Can the person identify personal values and goals?

When the patient's decisional capacity is impaired, family members or legally appointed surrogates make decisions about the patient's decisions in the patient's stead.

But in the Christian perspective, autonomy does not have the first or the last word: it exists thanks to "creatural" solidarity and is a necessary condition for the fulfillment of this solidarity.[22]

3. *Veracity*

The term veracity relates to the practice of telling the truth. Truthfulness is widely accepted as a universal virtue. Communication with dying patients raises the moral question of their right to know the truth. Nursing literature promotes honesty as a virtue and truth-telling as an important function of nurses. We can support the practice of nurses telling the truth in many ways. Truth-telling engenders respect, open communication, trust, and shared responsibilities. It is promoted in all professional codes of nursing ethics.[23] Lying or deception creates a barrier between people and prohibits both meaningful communication and the building up of relationships. In recognizing that communication is the cornerstone of the nurse-patient relationship, an arrangement can be made for a nurse to be truthful in order to communicate effectively with patients.[24] The hospice nurse is sometimes "the first person they can talk to about the issues that happen". Dimensions of speaking truth include asking difficult questions, saying difficult words, speaking truthfully when the truth is in transition and often uncertain, and facing the normal human tendency to avoid and deny the truth.[25] Violating the principle of veracity expresses lack of respect. Telling lies, or avoiding disclosure, implies that the specific function of the nurse or of another person involved takes precedence over the patient or, at the very least, the autonomy of the patient.

To inform someone that they are dying is always a difficult task. However "this difficulty is not to be mistaken as a right to bypass the duty to be truthful. Death is too essential an event for the envisioning of it to be avoided."[26, 27] Would depriving end-of-life patients with their rights to know the truth be in their best interests and respect the patient's dignity? Do you think it is acceptable to deceive a patient in order to prevent unnecessary suffering?[28]

However, to what extent can nurses answer end-of-life patients' questions directly? To what extent do nurses provide a context in which patients can ask these questions? In addition, in clinical settings the reality is that the responsibility of informing the patient of the nature of his or her illness lies with the doctor, and in a case where the doctor has not informed the patient of his or her prognosis, the nurse is not in a position to inform the patient.[29] Actually, self-determination is not possible without knowing the truth. At any rate, whoever is nearest the patient must inform him or her of the possibility that he or she will die. The family, the chaplain, and the group providing medical care must assume their share in performing this duty. Each case is different, depending on the sensitivities and capabilities of all concerned, and on the condition of the patient and his or her ability to relate to others.[30]

Training for the Nursing of the Incurably Ill

I would like to quote from the document of the Pontifical Council Cor Unum "Training for the Nursing of the Incurably Ill": "The familiarization of hospital personnel with the demands made by death and by the care of the dying, does not take place at the intellectual level. The actual face-to-face encounter with suffering, with a patient's anxiety, with death, can be a source of great anguish. Here is one of the main reasons why many professional people today are beginning to avoid having anything personal to do with the incurably ill, and are abandoning them to their loneliness. Thus must be added to the teaching of the theory and study of professional ethics, an education in how to relate to people, and especially to the incurably ill. If this is not taught, then any teaching of ethics is in danger, in the long run, of not being applied to the real situations encountered professionally."[31]

The Importance of the Responsibilities of Nurses

In this paper, I would like to emphasize the words of Cor Unum: "Despite the fact that many doctors tend to look upon them as purely auxiliary, nurses have a fundamental role of mediation between doctors and patients. Although nurses are, it is true, by no means free of danger of avoiding the patients during the final stages of his illness, they are nevertheless responsible for actions that can be often be of crucial importance. They must decide, for example, whether or not to call the doctor when they find that the patient has suddenly become worse; or must decide whether or not to give the patient a calming substance the doctor has left it up to their judgment to use appropriate moment, etc.... Therefore doctors and nurses' close collaboration is essential to the relief and proper care of each patient."[32]

"The nurse must possess as well a no less imposing array of moral qualities: an unassuming, sensitive and fine tact, which can understand the sufferings of the sick and forestall their needs, which can distinguish what must be said from that which is better unspoken; tactful, too, in the relations with the doctor, whose authority must always be respected and upheld, and with fellow nurses, particularly those who are younger, who must never be embarrassed or shamed, but rather aided when the need arises."[33]

Conclusion

In this paper I would like to conclude with humanization goals: "Humanization Goals, to identify nursing goals that humanize the dying person and deliberately counter the dehumanizing forces described." Zerwekh,[34] the best writer on nursing care at the end of life, listed "Humanization Goals" in the following way:

1) Learn who the dying person is. Listen to his or her story.

2) Honor the dying person's wishes.

3) Question emphasis on complicated medical intervention that ignore the reality of approaching death.

4) Question inappropriate technology that is burdensome and futile.

5) Create a comforting person-centered environment for caring.

6) Insist on physical, emotional and spiritual comfort.

7) Refuse to participate in a conspiracy of silence about dying.

8) Prevent isolation and abandonment of the dying. Encourage providers and loved ones to draw near.

Nursing practice at the end of life intimately influences the quality of life in a patient's final days. Nurses can make a difference between a dehumanizing experience for a dying patient and a family that ensures comfort and guidance for him or her toward closure.

To highlight the unmet needs of dying people, it is important to grasp the context of death and dying today. After all, it is important that nurses advocate, comfort, and, care for dying patients and their families.[35]

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Notes

[1] YOUNG-RHAN UM, 'Ethical problems experienced by nurses in the care of terminally ill patients'. Ph.D. Dissertation. Seoul National University, 1994, pp. 18-19.

[2] JOYCE V. ZERWEKH. (2006). *Nursing care at the end of life Palliative care for patients and families*. F.A. Davis Company.

[3] VOLBRECHT, R. (2002). *Nursing ethics: Communities in dialogue*. Upper Saddle River, NJ: Prentice-Hall.

[4] JAMETON, A. (1993). 'Dilemmas of moral distress: Moral responsibility and nursing and nursing practice. *AWHONNS's Clinical Issues in Perinatal and Woman's Health Nursing*, 4, 542-551.

[5] *Ethical and Religious Directives for Catholic Health Care Services*, 4th. ed.. 2001, United States Conference of Catholic Bishops, p. 22.

[6] *Ibid*.

[7] ROURKE, KEVIN D. and BOYLE P. (1993). *Medical ethics: Sources of Catholic teachings*. 2nd ed. Georgetown University Press/Washington, D.C., p. 224.

[8] JOYCE V. ZERWEKH (2006). *Op. cit*.

[9] GREIPP, M.E. 'Undermedication for pain: an ethical model'. *Adv. Nurs. Sci*., 1992. 15(1): 44-53.

[10] International Council of Nurses (ICN), *Code of Ethics for Nurses*. 2001.

[11] Korean Nurses' Association (KNA), *Code of Ethics for Korean Nurses*. 2006.

[12] WHEDON, M.. and FERRELL, B.R. (1991). 'Professional and ethical considerations in the use of high-tech pain management'. *Oncol Nurs Forum*, 18(7): 1135-1142.

[13] WATSON, R. (1993).' Measuring feeding difficulty in patients with dementia: perspectives and problems', *Journal of Advanced Nursing*, 18:25-31.

[14] YOUNG-RHAN UM (1994). *Op., cit*.., pp. 257-259.

[15] ERSEK, M. (2004). 'The continuing challenges of assisted death'. *Journal of Hospice and Palliative Nursing*, 6(1), 46-59.

[16] JOYCE V. ZERWEKH. (2006). *Op. cit*., p. 186.

[17] KIM, M. 'Informed Consent. Bioethics in patients' rights'. The Second Conference of the Catholic Institute of Bioethics. 2006. 10. 57-64.

[18] GLANNON, W. (2005). *Biomedical ethics*. New York: Oxford University Press.

[19] JOYCE V. ZERWEKH. (2006). *Op. cit*., pp. 188-189.

[20] BURKHARDT, M.A. and NATHANIEL, A.K.. *Ethics & Issues in contemporary nursing*. 2nd ed., Delmar, 2002.

[21] DALINIS, P. 'Informed consent and decisional capacity'. *Journal of Hospice and Palliative Nursing*, 7(1), 52-57.

[22] WILDES, K.W. ABEL, F. HARVEY, J.C. *Birth, suffering, and death. Catholic perspectives at the edges of life*. Kluwer Academic Publishers. 1992.

[23] BURKHARDT M.A and NATHANIEL A.K. 2002. *Op. cit*.

[24] *Ibid*.

[25] JOYCE V. ZERWEKH. (2006). *Op. cit*., p. 13.

[26] Pontifical Council for Health Care Workers, *Charter for Health Care Workers*. Translated by Pastoral Department of Catholic Medical Center. Catholic University Publication. 1998, p. 106.

[27] Pontifical Council Cor Unum, 'Questions of ethics regarding the fatally ill and the dying', 1981. *Samok*, 79 (1982), 125.

[28] BURKHARDT M.A and NATHANIEL A.K. (2002). *Op. cit*.

[29] YOUNG-RHAN UM (1994). *Op. cit*., pp. 42-44.

[30] ROURKE, KEVIN D. and BOYLE, P. (1993). *Op. cit*., p. 330.

[31] Pontifical Council Cor Unum, 'Questions of ethics regarding the fatally ill and the dying'. 1981. *Samok*, 79 (1982), p. 125.

[32] Pontifical Council Cor Unum,.*Op. cit*.

[33] ROURKE, KEVIN D. and BOYLE, P. (1993). *Op. cit*., p. 212.

[34] JOYCE V. ZERWEKH. (2006). *Op. cit*., pp. 7-8.

[35] JOYCE V. ZERWEKH (2006). *Op. Cit*., p. 4.

IV. The Bioethics of 'Quality of Life' and 'Sanctity of Life'

Prologue

After World War II, the term 'quality of life', which came from social and economic development in the West in the 1950s, slowly extended its domain to the medical field. The term 'quality of life' was not only used as a concept of requiring a life without illness but also as one with social welfare as its basic requirement.[1] However, as the medical field and scientific field used improved technology, new problems arose in the field of human life and 'quality of life' expanded itself to become the standard to judge these problems.

The term 'quality of life', and more specifically attempts to fix the standards of 'quality of life', naturally entered the question of deciding whether to use all kinds of technological means and resources in the treatment of patients at the last stage of incurable illnesses and the activities to find the answer to that question, According to the 'quality of life' that scholars and doctors deliberately decided, some lives are classified as lives not valuable enough to be carried on, and in some countries mercy killings are considered to be a legal answer to lives that are painful and no longer needed.[2]

In law in Korea the problem of 'quality of life' plays a very important role as a legal guide. The Bioethics and Safety Act (BSA) which was passed in 2005 indicates the improvement of 'quality of life' as a goal of the law and numerous life-destructing practices are connived with under this law. For example, even though most life scientists insist that the law (BSA) should endeavor to be suitable for life ethics and safety, and not violate the dignity and value of human life, yet it allows research that destroys the human embryo, which is a perfect human being, for the improvement of the 'life quality' of patients with incurable illnesses.

As stated above, 'quality of life' in our society has become a yardstick that measures a 'good life', a 'happy life', a 'fun life', and a 'valuable life', and this yardstick has turned the lives of patients with HIV, handicap or vegetative state into worthless lives that exist in pain.

Pope John Paul II warned that the term 'quality of life' is at the center of economic efficiency, intemperate consumption, physical appearance, and pleasure, and when this 'quality of life' becomes the center of our lives, the profound dimension of spirituality, the religious dimension of human mutuality, are ignored.[3]

As pain seems inevitable and hope about the near future seems to be lost, all lives are considered meaningless and this connects to the demands for rights to control that life.[4] Therefore, this writer would like to state that the 'quality of life' cannot be a means to judge and compare the value of life. And in particular that the standard called 'quality of life' as stated in the Korean Bio-ethics and Safety Act neglects and destroys life, and that the 'sanctity of life', which is the basic view of Christian life ethics, comes before 'quality of life'. When emphasizing 'quality of life', the ontological value that human life bears is neglected and errors in judging the value of life and in ranking lives take place.

1. 'Quality of Life'

1.1. As stated above, the term 'quality of life' became the main term to assess human life and changed rapidly after World War II. Just as various forms of, and desires for, the happy life are represented by the 'well-being' of today, so lifestyle has made attempts to change itself to more of a happy life with a healthy physique rather than simple survival; and these attempts to pursue a life involve living a nature-friendly life mediated by organic foods or raw foods.

As above, the core point located in the very center of the desire to change lifestyle into various forms of life is 'quality of life'. The desire for well-being behind the lives of modern people is used as a representation of happiness, welfare, peace, etc., but the term 'quality of life' emphasizes more the subjectivity side of well-being.

Therefore, the term 'quality of life' is recommended in relation to satisfaction or discontent about psychological, physical or social conditions which makes a division into high or low 'quality of life' so that to have a higher quality of life painful or miserable conditions should be eliminated.

Generally speaking, we can easily see that productivity and usefulness is in the background to the 'quality of life' argument. This is something we can witness everyday in our society: unconscious patients lying in bed for a long period of time; patients with AIDS being alienated because they are not useful to society; or people who can not enjoy their lives being undervalued because they are no longer valuable in the process of mass production. Therefore, for a higher quality of life some insist that it is much more reasonable and advisable to eliminate the condition of being alienated and

miserable. This opinion is already emphasized in our medical world very naturally.[5]

In addition, as the term 'quality of life' triggers many problems related to a healthy life, the area has widened. The content of the healthy lives of patients now gradually includes direct and indirect economic values related to everyday life, as measured by production, labor conditions, free time etc., and has enlarged itself to include the quality of nature which contains a very large range involving ideal happiness, the possibility of leisure, participation, harmony, and social agreement.

As 'quality of life' remains in economic and materialistic views and pushes itself towards individualism, pragmatism and Epicureanism, the ethical and spiritual dimensions are undermined. As Pope John Paul II stated: "the term 'quality of life' is preferentially and exclusively interpreted as economic utility, intemperate consumptionism, physical beauty and pleasure, ignoring much more profound dimensions of the being interhumanist, spiritualistic and religious".[6]

1.2 The Measurement of 'Quality of Life'

At this point, we need to see how 'quality of life' can be defined objectively. That is, as quality of life is emphasized in the subjective dimension, people fall into some kind of relativism and finally deny all objective evaluations. Therefore in measuring the quality of life by certain abilities on which many scholars place emphasis, I would like to present an objective basis. While many authors, including Engelhardt, understand these abilities as brain skill,[7] self-awareness and the perfection of reasonableness, some other authors, including Fletcher, think that quality of life lies in human life including a minimal amount of intelligence, self-awareness, self-restriction, relationship ability, interest in others, time awareness, communication ability, interchange ability, a balance between rationality and sensibility, and the abilities of the cerebral cortex.[8]

Because of the need to share the same view on what should be the typical ability of a human, there have been many attempts to examine quality of life. However, these attempts cannot provide an answer to questions about whether the lives of people who cannot express or do not possess those abilities have values or not and whether we have duties to care for and save these lives. That is, whether we rate people through the ability to reach happiness and enjoy good, or the ability to demonstrate the abilities and activities of a typical human being; the category of quality of life, after all, overlooks the core ontological, non-utilitarian dimension itself.[9]

Given that attempts to measure quality of life and the meanings of quality of life cannot include the whole of the existence of human life but remain in a simple quantitative dimension, it eventually makes errors by assessing human life within the quantitative dimension. However, if quality of life relies not only on the social and economic part of human life but also on the ethical and spiritual side, it definitely remains a proper concept based on the dignity of the human being and the unified calling of human existence. This human dignity is, of course, not dominated by certain characteristics such as self-regulation, self-consciousness or the ability to communicate within relationships; instead, it is something natural which does not disappear when one or a part of those characteristics disappear.

Whatever the case, the concept of quality of life can never be a standard by which to judge and compare the values of each life, as if some lives have much higher quality and some others do not. This comparison can bring errors by ignoring the values that lie in human life. Because of this very reason, judging and ranking the values of a life is sort of a utopian idea.[10] This attempt would eventually bring discrimination in relation to people who have lost intellectual ability, people who are considered to be useless, or people who seem to not have the ability to enjoy their lives. Clearly, when emphasizing ethical standards by utility and pleasure, when the meaning of life cannot be found in pain, or when considering life as meaningless or full of pain and not a contribution to society, the requirement of ending life comes to be seen as justifiable.[11]

When quality of life is understood in this way, discrimination in relation to human beings at the level of dignity and rights of necessity follows. The equality of all human beings on this earth should be the shared basis and an absolutism for our lives, and an essential principle underlying democracy. However, when quality of life is used as the standard to measure the value of human life, the natural and cultural basis of equality is denied and instead the ethics of discrimination are established.

2. The Ethics of 'Quality of Life' and Negligence of Life

The fact that ethics using the 'quality of life' include errors of discrimination is clear because the term 'quality of life' measures the value of life by numbers, insisting that some lives have higher quali-

ty and some have lower quality. However, our society already has 'quality of life' as its standard in many fields, for example policies and norms that are based on the practical materialism of utility and productivity, and ultimately in the principal concepts of our national law and the main norms of our society.

I would like to take a brief glance at the relationship between judging the standard of quality of life and the negligence of lives through the Code of Medical Ethics published by the Korean Medical Association in 2001 and the Bio-Ethics and Safety Act enacted in 2005.

2.1 The Code of Medical Ethics of the Korean Medical Association (2001)

"As the standard of living of people improves, the demand for medical service increases, as does the demand for the ethical practices of doctors as the consciousness of consumers increases. As medical science and the life sciences rapidly progress, new medical ethical problems have arisen."[12] This statement tells us why the Code of Medical Ethics was needed. Before drawing up this code, the administrative workers in charge of enacting the code polled 1,000 doctors about the awareness of medical ethics of doctors. The results show that, excluding the guarantee of patients' secrets, there were no impulse of doctors in favor of medical ethics, and positive answers were shown especially in relation to the questions of mercy killing, scientific reproduction, and organ transplants. Half of them answered that problems such as the discontinuation of the treatment of patients with incurable diseases or doctor-assisted suicide are possible, and half of them answered affirmatively on abortion in terms of family planning. Not only that, but affirmative answers were given on the subjects of surrogate mothers, the donation or selling of sexual cells, and commerce in organs.[13]

This ethical awareness of doctors can be seen in the Code of Medical Ethics as it can in the poll. Because of this Code, the purpose of providing a safety net for doctors to practice medicine ethically has changed into the level of ethical awareness most doctors have. Moreover, in some clauses, the lives of human are handled according to utility and productivity, as is the case with quality of life. Let us now take a look at some of the details.

Article 30, n. 3: "When the patients or representatives of the patient such as the family require medically useless or unprofitable treatment, after enough explanation and persuasion the doctor does not have to fulfill this requirement."

Article 57, n. 2: "The doctor can provide help for the patient to take their deaths".

Article 58, n.1: "Mercy killing exists to end an incurable illness and pain that the patient cannot endure, by using injection or anything to give death in an intentional and direct way before the natural death, given by someone other than the patient."

The point in the basis of the Code of Medical Ethics is also 'quality of life'. The standard of a doctor's treatment towards patients with no prospect of recovery is to no avail and uselessness, and treatment for these people is thought to be a waste of time. However, the lopsided judgment of the doctor can harm the right of the patient to receive proper treatment. Of course, the doctor's decision to cease proper treatment after all sorts of treatment is based on the professional intellect and medical technology, but sometimes that decision can grow into mercy killing.

As was seen above, the Code of Medical Ethics has provided direct mercy killing as mercy killing (article 58, clause 1), and by not stating that the stopping of treatment at the last stage of illness is a part of mercy killing it supports passive mercy killing. Not only that, the statement that "doctors can provide help for patients to have a dignified death" in article 57 shows that doctors can sometimes be helpers of mercy killing, while at the same time it emphasizes that doctors should not support mercy killing.[14]

The fact that in this Code of Medical Ethics the lives of human beings should always, in any circumstance, be protected with the doctors' faith in human life, means that the protection of all lives should always be emphasized. With the object of this code clarified, doctors should try their best to "extend the right to life and the health of people"[15] and in all circumstances engage in their practice ethically. But this Code defames doctors' noble duty by dividing the value of all patient's lives.

The standard of 'quality of life' established by the Code of Medical Ethics of the Korean Medical Association can be seen as below. When the thought that patients who are considered useless at the level of utility and productivity, and people who are considered useless in terms of value as a human, is applied to the health and medical side, the idea of providing treatment for chronic patients appears a waste of resources and the idea of investing in the system for the cure or at the least independence of patients who can be cured are already sited deeply in our society.

Especially in rich countries, where most of the population relies on medical help, the fact that expenditure on health is becoming the object of hatred has become main principle behind changing the social system.[16]

2.2 *The Bio-Ethics and Bio-Safety Act (2005)*

The law enacted four to five years after the argument about life ethics began in Korea,[17] is the Bio-Ethics and Bio-Safety Act (2005). Many professionals from various fields made efforts for a long time to enact a proper bioethics law, but the present

Bio-Ethics and Bio-Safety Act has disappointed people who participated in that process.

Even though the name of the law is the Bio-Ethics and Bio-Safety Act, the main purpose of this law is 'to improve the health and quality of people's lives', which, indeed, demonstrates most of the contents of this law.

Article 1 (Purpose)

"The purpose of this Act is to contribute to enhancing the health and quality of life of the people by ensuring bioethics and bio-safety in biotechnology to prevent infringement on human dignity and value and to prevent harm to the human body, and to foster conditions in which biotechnology can be developed and utilized for preventing and curing human illnesses."

We can easily understand from the purpose of the law emphasizing the improvement of quality of life that most of the contents of this law judge the health and happiness of people as something that is materialistic and phenomenal. The core meaning of an original bioethics law should contain efforts to protect and secure bioethics and safety problems, but in reality this law specifically clarifies quality of life as its purpose and under that name it allows research to destroy human embryos by cloning them through cloning somatic cells. Not only that, it allows the cloning of embryos of different kinds for the treatment of illnesses. Below are the related clauses.

Article 2, clause 2 (definition): "The term "embryo" includes a fertilized egg and any differentiated cell group in the period between the time of fertilization and the time when all organisms are formed ontogenetically".[18]

Article 2, clause 4: "The term "somatic nuclear transplantation" means a transplantation of a nucleus of a human somatic cell into an enucleated ovum of a human being or an animal."

Article 17 (research on residue embryos): "A residue embryo whose conservation period referred to in the provisions of Article 17 has expired may be used in vitro, only before the ontogenetic appearance of a primitive streak, for one of the purposes referred to in the following sub-paragraphs: provided, that in a case where a person intends to use a residue embryo whose conservation period is less than 5 years, the person should receive new consent to the use for the corresponding purpose from the person entitled to consent:

1. Research for developing the medical treatment of infertility and contraception technology;

2. Research for treating muscular dystrophy and other rare or incurable diseases specified in the Presidential Decree;

3. Other research which is subject to the deliberations of the Deliberative Commission and are specified by the Presidential Decree."

Article 22, clause 1: "No person shall, except for the purpose of researching on treatment for rare or incurable diseases in accordance with the provision of sub-paragraph 2 of Article 17, perform a somatic nuclear transplantation."

According to the above law, the BSA considers a human embryo as a simple mass of cells and takes an open position on all research that uses it. This contradicts the position of the Catholic Church which sees a human embryo as a whole human being. A human embryo should not be degraded as a simple object and because it should be a subject in itself the law is trying to destroy human dignity by degrading the embryo as a biological material under the name of the improvement of the quality of life. That is, by treating a human embryo as mass of cells and not as a life, the intention of avoiding ethical problems at the root can clearly be seen.[19] Not only that: under the name of the improvement of quality of life, the BSA allows the hybridization of the ovum of an animal and human nucleus. The embryo made in this way is a monster embryo that is half human and half animal and the ethical problems created by this genetic mutation rise above our imagination.

2.3. The Vatican has made its views clear on the prohibition of cloning and the production of embryos in its *The Position of the Vatican on Cloning Human Embryos*. The main ideas are below. "Cloning for 'reproduction' and cloning for 'research' have their difference only at the level of purpose. Cloning for 'reproduction' (so called therapeutic cloning) transplants the cloned embryo into the womb and the baby grows, while cloning for 'research' uses the cloned embryo only to destroy it. Prohibiting only cloning for 'reproduction' while not prohibiting cloning for 'research', allows producing a human life to destroy a human life so as to study a human life. The early stage of the human embryo that has not yet been transplanted into the womb is also a human life and a self-regulating being which would develop into a perfect human fetus. Therefore, destroying these embryos is killing an innocent human being intentionally which is an ethical disorder."[20] Therefore the Vatican urges a perfect prohibition on all technologies of making human embryos through cloning, including the transplantation of somatic nuclear cells, the division of embryos and all the technologies that might be developed. This prohibition definitely includes

making a half man, half monster by hybridizing various creatures. We should not only remove the possibility of deformed monsters or monster humans but also dangerous and irresponsible research cannot be justified when the effects of the protoplasm of animals on humans has not been explained.[21]

3. 'Quality of Life' and Catholic Bioethics

3.1. Therefore the ethics of 'Quality of Life' will inevitably be connected to the discrimination of humans related to the dignity of rights of human, and most likely would use humans as the material of biology by materializing them as stated above. The ethics of 'quality of life' approves that the discrimination between humans can exist while premising qualitative standards. In contrary fashion, Catholic bioethics does not rely on the evaluation and recognition of inequality of value in life but basically emphasizes the fact that all of that is just a human life. However, in finding sanctity in all human beings by approving equality, it does not deny a variety of intact human beings. Also it does not deny the fact that life is not always perfectly happy or intact for some or a majority of people. It is just as opposed to the fact that the value or dignity of those who are much weaker or in pain is less important.[22]

The starting point of this basic awareness is the point of view on the value of each human life. That is, instead of giving value to human life itself, we should take the fact of humans with dignity and the value of inviolability as it is. That is, "the expression of the value of human life should be the value of living humans because of the fact that we are alive".[23] Life is not a good that humans possess and destroy when it seems to be undesirable or useless but should be understood as something that is living with various forms of experiences of existence.[24]

3.2. The key conception supporting the outlook of Christian bioethics is the dignity of human life. That is, humans should be dignified because of the fact that they are human. We now should take a look at how the Christian tradition understands human dignity.[25]

The tradition of Christian on human dignity can be explained as below. First, human dignity is original, natural and cannot be transferred. Also it is a present, something that is taken for granted. Genesis 1:26-27 states that God created the human in his image and likeness. According to this, human existence is God's created words, and something living that makes the world full of God's figure and love. This is the dignity created directly from God and no one can disturb this dignity. When created, a human is a being that surpasses everything else created in the universe in his value and dignity because of this natural existence. As the Constitution of Theology of the Second Vatican Council states, a human is "the only creature that God wanted for its own existence".[26] Especially in today's scientific studies which should be for all scientists and the subjects of research, this dignity should be very importantly considered in relation to the subject of research. This fact is the basic ethic of all bio-scientific research on human beings.[27]

The second tradition is also original. However, this is not something that is taken for granted but is understood as some kind of achievement. This is the dignity called a free human living life with the ability of intellectuality and interior by free will. This dignity is given to us by freeing our acts and choices by the truth. As the Second Vatican Council teaches us: "man has his own law which God carved, and dignity is given in obeying this law"; the conscience and free will of human beings is another mark that of dignity. Similarly, this dignity has a very close relationship with the subject and the research in the field of bioscience, and this is especially important for the researcher.

Third, this is not an achievement but something beyond human nature; it is the natural dignity of the sacred human being. It is a jewel of the innocent favor of God, and therefore this should be protected and fostered by humans. This dignity has an intimate relationship with every activity of humans and is the subject of ethical activities. Therefore this means that humans can lose dignity through the acts of humans, the subjects of activity.

The proposition of human dignity is a core principle that should be respected at a basic level in the field of bioscience. Pope John Paul II once said: "The standard of judging ethics should be based on human dignity and every result made by this should be examined and applied at every stage of research."[28]

3.3. In this approach, when recognizing human life, the value of a human does not come from an activity or expression but from the fact of the existence itself and the fact that God created humans as a gift. The value of every human being, whether they are old or young, healthy or unhealthy, embryo or newborn, intelligent or limited, is irrelevant to their value or ability, but has its importance in the fact that a human is something related to God directly. The body of a human cannot include all human values and cannot express the best good that God gave us – eternal life. This is the basis of the right to life that every human possesses in any condition ('from the womb to death') and is a mark and requirement of inviolability.[29]

Christian bioethics starts with this kind of outlook of life, emphasizing the sanctity of human life. Even though some bio-scientists ignore the sanctity of life and consider

human life simply in terms of scientific value, the sanctity of life cannot be understood just as part of the chain of religion.[30] What is clear is the fact that a human is different in his excellence and incomparable value and he transcends characteristics of the scientific dimension.[31]

End Statement

The argument of 'quality of life' started from health and involved the private view of happiness, and this developed into qualitative difference in expressive lives, and ended at the point that 'sanctity of life' can be differentiated with the opposite of bio-ethics. In addition, along with the concerns about the negligence of life brought about by 'quality of life' as the standard of bioethics, this paper has emphasized the 'sanctity of life', which forms the basic bioethics of the Catholic Church.

The argument of 'quality of life' should be attentive to the fact that the point of departure for overall awareness about health and illness has gone wrong. This means that the fact that health and illness are intimately related is denied. Humans cannot be contracted into a simple biological dimension and because of the natural variety in humans, the health of humans, too, cannot be contracted into one dimension but must be related to the harmony and integration of the physical and spiritual dimensions and human energy. Therefore, improving one's health means helping one to live one's life by starting to improve the most truthful path of one's physical and spiritual condition.[32] Therefore, finding the harmony of the objective standard of life and the subjective consciousness, and the harmony of social and economic living conditions and spiritual values, is the most important things. To achieve this, an overall understanding of man and his destiny is needed. Also we need to embark on the improvement of social welfare for all human beings, their families, and the original dignity of all human beings.

Health is not a right for those who have a planned and fixed quality of life. All people have a right to a healthy life and this right comes from the right to live given by God who has and is the root of every life. Because of this, taking care of the health of another person or of oneself is an ethical responsibility given to all of us, and through this we address others as our neighbor, a humans like ourselves and a creature of God formed in God's image and likeness.[33]

I would like to end this paper by stating that all human life has the same quality of value; and the dignity of a human life is not simply a matter of physical numbers or conditions of health.

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Notes

[1] Cf. PACCINI RENZO, "Qualità della vita" in Pontificio Consiglio per la Famiglia, *LEXICON Termini ambigui e discussi su famiglia, vita e questioni etiche* (Edizioni Dehoniane, Bologna, 2003), pp. 763-768.

[2] In fact, article 30, clause 3, of the Code of Medical Ethics which was announced on November 2001 by the Korean Medical Association states that "when a representative or a family member of a patient with incurable disease alleges treatment that is medically not useful or even harmful for the patient, the doctor does not have to accept that"; and this means that the 'Quality of Life' already became an important standard for medical judgment.

[3] *The Gospel of Life*, clause 23.

[4] *Ibidem*.

[5] More will be discussed in the next section on the Code of Medical Ethics (2001) and the Bio-ethics and Safety Act (2005).

[6] *The Gospel of Life*, clause 23, by Pope John Paul II

[7] Cf. ENGELHARD H.T., *The Foundations of Biothics*, Oxford: Oxford University Press, 1966, p.239.

[8] Cf. FLETCHER F.J., 'Indicators of Humanhood: a Tentative of Man', *Hastings Center Report* 1975, 2(2): 1-4.

[9] FAGGIONI M., 'The quality of life and health in the light of Christian anthropology', in Elio Sgreccia and Ignatio Carrasco (eds.), pp. 26-27.

[10] However, preparing a standard by which to measure quality of life is never a useless attempt. The attempt in the area of health would help to define 'life' much better and to understand the primary factor of a decision. On this point, the book referred to below is helpful. LEPLEGE A. AND COSTE J., (eds.), *Mesure de la Sant Perceptuelle et de la Qualitè de vie: methodes et applications*, under the direction of Alain Leplge and Joel Coste (De Boeck, 2002), p.336.

[11] SIMARD N., 'Quality of life and patients with AIDS', in in Elio Sgreccia and Ignatio Carrasco de Paula (eds.), *Quality of Life and the Ethics of Health* (Pontificia Academia pro Vita, Ed. Libreria Vaticana, Vatican City, 2006), pp. 215-217.

[12] HWANG SANG IK, 'The process of establishment of the Code of Medical Ethics and its plan of practical use', The Korea Medical Association, 44th (2001) article 10, p. 1067

[13] HWANG SANG IK, *ibid*.

[14] The Korean Medical Association, Code of Medical Ethics, (2001), article 58 clause 2.

[15] The Korean Medical Association, Code of Medical Ethics, (2001) article 1.

[16] Cf. GIGLI G.L. and VALENTE M., 'Quality of life and vegetative state', in Elio Sgreccia and Ignatio Carrasco de Paula (eds.), *Quality of Life and the Ethics of Health* (Pontificia Academia pro Vita, Ed. Libreria Vaticana, Vatican City, 2006), pp. 240-241.

[17] The Bio-Ethics And Bio-Safety Act published by the Advisory Committee of Bio-Ethics, the Ministry of Science and Technology, in August,2001 constitutes the very first attempt to enact the bioethics law.

[18] "When based on the perfect biological analysis, a living human embryo at the moment of combining reproductive organs is a human subject with identity, and from this moment it develops synthetically and gradually which can not be considered as a cluster of cells at any other stage after that. Therefore this subject gets all the right of its life as a human existence and all the intervention not for the embryo is the intervention of the right." (The Pontifical Academy for Life, 'The produce of human embryo stem cells and its use of scientific way and treatment', Aug. 2000).

[19] 'The produce of human embryo stem cells and its use of scientific way and treatment' which was published Pontifical Academy for Life in 2000, states as below. "When based on the perfect biological analysis, the living human embryo at the moment of combining reproductive organs is a human subject with identity, and from this moment it develops synthetically and gradually and can not be considered as a cluster of cells at any other stage after that. Therefore this subject gets all the right of its life as a human existence and all the intervention not for the embryo is the intervention of the right. Ethical theology has always taught that for the "very perfect right (jus certum tertii)" the theory of probability does not apply."

[20] The State Department of the Vatican, 'The Position of Catholics on the Cloning of the Human Embryo', July 17, 2003

[21] These incidents do not come from science fiction anymore. The Nation Academy of Science of the U.S. stated that experiences of chimeras from human-animal experiments would increase and that therefore an index on the research on chimeras would be compiled. Some bioethics experts are also preparing new ethics regulations because of the new emergence of chimeras. This research will threaten the biological condition of humans under the name of human development. In injecting the essential elements of *homo sapiens*, they can merge some species into the human genome and make an 'inferior human being' or 'superior human being'. The widely known scholar, Jeremy Rifkin, said in an interview with *The LA Times*: "In my point of view, the price we need to pay for this would be too much. We need to stop at this stage of making a chimera. Making a chimera out of human and animal cells should be stopped." (*Chosun Daily*, Apr. 22).

[22] Cf. FAGGIONI M., 'The quality of life and health in the light of Christian anthropology', in Elio Sgreccia and Ignatio Carrasco (eds.), *op. cit.*, p. 29.

[23] Cf. CARRASCO DE PAULA, 'Dignità e vita umana nell'etica medica', *Medicina e Morale* 45(1945), pp. 213-222. (reference p. 220).

[24] Cf. FAGGIONI M., *op. cit.*, pp. 29-30.

[25] Cf. WILLIAM E. MAY, 'Human dignity and biomedical research: the respective positions of the subject of research and the researcher', in Juan de Dios Vial Correa and Elio Sgreccia (eds.), 'Ethics of Biomedical research in a Christian Vision: Proceedings of the ninth assembly of the Pontifical Academy for Life' (Vatican City, 2004), pp. 172-176.

[26] *Gaudium et spes*, n. 24.

[27] The Gospel of Life n.4 states: "The body of human itself that starts a specific life in this world can not include all of the values of human nor express the supreme good of humans called to an eternal life. However in some sense, the human body contains the 'basic value' as well".

[28] JOHN PAUL II, 'Address to the Representatives of the Italian Society of Medicine and the Italian Society of General Surgery', (Oct. 27, 1980), in *Insegnamenti di Giovanni Paolo II*, III, 2 (Libreria Vaticana, Vatican City, 1980), p. 1009. n. 3.

[29] Congregation for the Doctrine of the Faith, *Donum vitae*, preface, n. 4.

[30] The outlook of life in Eastern ideology also starts from sanctity. The Chinese character myung (命) comes from everything from the sky and the world and not from the land. This myung (命) has a comprehensive meaning and does not just refer to breathing but to every rule of the whole universe. It includes not only the lives of humans but also the rule of nature, the ethics of human behavior, etc. Therefore myung (命) should not be limited to life but is something given by the sky (天). This will of God is absolute. This is not something that can be removed by humans. Therefore the life of humans does not belong to humans but to the sky who gave that life to humans and this means that life is absolute. Dong-Ik Lee, *The Manager of Life*, 1994, the Catholic University Press, pp 36-38.

[31] Clause 14 of the Second Vatican Council's' Constitution of Theology explains the problem very well. "The human that is a single existence by the body and soul, has all the essential elements in his body through the physical condition. Just like this the material world gives praise to God through humans."

[32] Cf. EDMUND D. PELLEGRINO and DAVID C. THOMASMA, *Helping and Healing: Religious Commitment in Health Care* (Georgetown University Press, Washington, D.C., 1997), pp.26-38. Recovering health does not just mean being cured of an illness. The word 'cure' has the same meaning as 'care' and means psychological and spiritual help. It comes from the Latin word '*curare*'. This means that recovery of health means perfect recovery of both one's physical and one's psychological condition and not just the physical condition of eliminating the illness

[34] Cf. FAGGIONI M., 'The quality of life and health in the light of Christian anthropology, in Elio Sgreccia and Ignatio Carrasco (eds.), *op. cit.*, pp. 29-33.

I. Hospice Palliative Care in Asia and the Experience in Korea

In most Asian countries, except Hong Kong, Singapore, Taiwan, Japan and Korea, hospice palliative care is just at the beginning stage, or if it is not, it is planned only in a small part of the country. And because hospice palliative care originated in countries of the western part of the world with a strong background of Christianity, direct application of the idea of hospice palliative care to Asian countries may evoke problems associated with the differences in culture and religion.

In 1996, there was an international hospice symposium in Singapore where hospice workers from most of the Asian countries were present, and this was the second international hospice symposium held in Singapore after the one of 1992. At that time, the representatives of each country gathered together to talk about adequate hospice system for the Asian countries with a similar cultural background. So they decided to hold an Asia Pacific hospice symposium every 2-3 years, and the city which held the next symposium was Hong Kong, followed by Taipei, Taiwan, and Osaka, Japan.

The Current Status of Hospice Palliative Care in Each Asian Country

Japan

Hospice palliative care in Japan was initiated by an Organized Care of Dying Patient (OCDP) team in Yodogawa Christian Hospital in 1973. They started the reimbursement for the Palliative Care Unit (PCU) which meets with the criteria in 1990. And the Japanese Ministry of Health provided the guidelines for the approval of the PCU in 1998. In 2004, there were more than 131 PCUs with 2,449 beds, a death in a PCU is about 4.4% of all cancer deaths. The figure of the 'certified expert nurse' (CEN) was started in 1998 in Japan and by 2004 100 had been approved for hospice palliative care, 157 for cancer pain management, and 68 for cancer chemotherapy. An education course for physicians was started in 1999. And in 2005, the figure of the 'specialist nurse for hospice homes' was started with a view to gaining approval.

Taiwan

The Taiwan Hospice Foundation was established in 1990 and the first hospice ward was started in the Mackay Memorial Hospital in the same year. The Taiwan Hospice Organization was launched in 1995 and the Taiwan Academy of Hospice and Palliative Care was started in 1999. There was a large-scale nationwide study for the cost of hospice palliative care in Taiwan, comparing the cost of taking care of terminal cancer patients in oncology units, palliative-care units and home hospices. The cost in home hospices was 35.8% of that in oncology wards and this result accelerated the reimbursement of national medical insurance for hospice palliative care in Taiwan. The Natural Death Act was passed in Taiwan in 2000.

Hong Kong

A hospice was started in 1981. In 1986, the Society for the Promotion of Hospice Care was established. In 2003, 65% of cancer death were helped by hospice care. The average number of home care patients per day reached 1,000 in 2003.

Singapore

The first hospice in Singapore was started in 1985. And in 1995 the Singapore Hospice Council, the umbrella body of hospice organizations, was formed with eight charities providing community hospice services. In 2004, there were four services providing hospice home care which accepted 2,802 referrals and visited 32,801 patients. And there were also four services providing in-patient hospices which accepted 921 admissions with 129 beds. It was estimated that community hospice services covered 74.9% of cancer deaths and 19.4% of total deaths.

Korea

The first activity in Korea was started in 1964 by the Sisters of the 'Little Company of Mary' who came from Australia with home hospice. But no more activity was started until the early 1980s. The first hospice ward was started in 1988 with ten beds in Kangnam St. Mary's hospital. It was in 1995 that 'the WHO Collaborating Center for Hospice and Palliative Care' was established in the Catholic Nursing College. The Korea Hospice Association led by the members of the Protestant Church was started in 1991

and the Korea Catholic Hospice Association was begun in 1992. The Korean Society for Hospice and Palliative Care was launched in 1998 with the participation of physicians, nurses, pastors, social workers, pharmacists and volunteers regardless of their religion, and it now has more than 600 members. There are about 125 hospice activities, but still only 7.5% of terminal cancer patients are being cared for by hospices in this country. In 2003 there was a pilot study for hospice models sponsored by the Korean Ministry of Health and Welfare (MOHW). Drug availability has very much improved over the last 10 years. Now the MOWH is preparing for the hospice law.

New Frontiers of Palliative Care in Asia

This region is an area of diversity in terms of population, race, language and wealth. There are now more than 600 palliative care services in the region but a great variation in the level of services provided.

There are many obstacles to the development of hospice and palliative care in Asia. Difficulty in economic conditions, problems in drug availability, a lack of specialists in hospice palliative care and their education, and a lack of legislation and law for hospice palliative care are common, major challenges in the development of hospice palliative care in this region. In 2001, the Asia Pacific Hospice Palliative Care Network (APHN) was launched to accelerate the development of hospice palliative care in this region as well as to develop hospice palliative care suitable for Asian culture. Fourteen sites have been accepted as members up to now and the APHN is encouraging many other countries in Asia to develop the hospice system by supporting education systems and specialists to train the trainers in each country.

In Pakistan, the Shaukat Khanum Memorial Cancer Hospital has a well established palliative care program, but they need a palliative care physician. In Nepal, there is the Nepal Hospice in Kathmandhu and there is a hospice building in Bharatpur and Kathman Cancer Hospital in Bharatpur. Myanmar has a forty-bed hospice unit in Uanggon and Mandalei, and another hospice unit is under construction in Taungi. In Sri lanka, there is a hospice unit in Colombo and they need palliative care specialists and volunteer educations.

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II. Evangelization in Medicine

As we can see in the Gospel, Jesus went around the land of Palestine to preach the news of the salvation promised by God and he began his public life in the synagogue of Nazareth by saying: "The Spirit of the Lord is upon me. He has chosen me to bring good news to the poor. He has sent me to proclaim liberty to the captives and recovery of sight to the blind, to set free the oppressed and to announce that the time has come when the Lord will save his people" (Lk 4:18-19).

At all times and in all places, Jesus preached the message of liberation and proved it by healing the illness and wounds of the many poor people who came to seek relief from their suffering. His whole life was devoted to the challenge of healing, both physically and spiritually, and was the outer expression of his deep love and compression for all people, especially the poor.

When the early missionaries came to Korea, it was still underdeveloped. They established clinics in places where there were no medical facilities in order to provide relief for the many suffering people. In their missionary work, they combined the teaching and healing ministry of Jesus, and, in imitation of the Jesus portrayed in the Gospels, they were firmly convinced that preaching the Good News must be accompanied by efforts to heal people from physical, spiritual and social pain.

Since 1980, the Korean economy has made rapid progress. With the resulting reduction of physical hardship, we are very much aware of our obligation to share medical help now with countries which are still lacking in proper medical facilities and care.

The Korean Association of Catholic Hospitals and the Catholic Physicians' Guild have provided medical support for the underprivileged and deprived people in Palmar, Ecuador, Latin America since 1988. There we came to see again the pitiful poverty which our people experienced in the past. The majority of the indigenous people live in primitive housing, in large, poor, families. Employment is very difficult to find. There is no doctor at all in this district. There is only a medical visitation of 2 or 3 weeks from Korea once each year to treat the

sick. The team provided clinical laboratory testing equipment and a portable X-ray machine, and taught the people how to use them. We also provided many of the pharmaceuticals the people needed. We built a dispensary for them to administer themselves.

In 1992 we adopted a plan to help poor people in rural areas of Kenya and the Central African Republic. We visit Chesongoch, a small mountain village 450km from Nairobi, the capital of Kenya. About 20,000 poor people live here by farming and raising livestock. In the center of the village there is a Catholic Church and a dispensary run by Benedictine Sisters, and volunteers work together in this dispensary. There is no doctor. Only nurses treat the sick.

From 1992 to the present, our team has treated the sick for whom a Korean Sister, Josepha, has operated a mobile clinic for a long time. She is especially making great efforts to educate the local people in the generation and treatment of parasitic diseases. To support her work we have provided $30,000 in aid.

Since 1997, we have visited rural areas in Mongolia and also in Colombia and have been providing medical support for the poor.

It must be strongly emphasized that there is a great urgency for us, in the medically developed nations, to provided all the help we can to our brothers and sisters who are suffering from all types of disease and misery in many parts of the world. Even if there are risks involved, we must be determined to send more and more doctors and skilled personnel and to provide free medical services for people in destitute areas. This aid must be continued for years to come.

Especially for us Koreans, when we freely provide medical services to poverty-stricken people we are following the command of Jesus to his disciples "to give freely what you have freely received." (Mt 10:8)

As we move towards the third millennium of Christianity, we do so with the brief that evangelization must walk hand-in-hand with the healing power of Jesus which is exemplified through our God-given medical skills.

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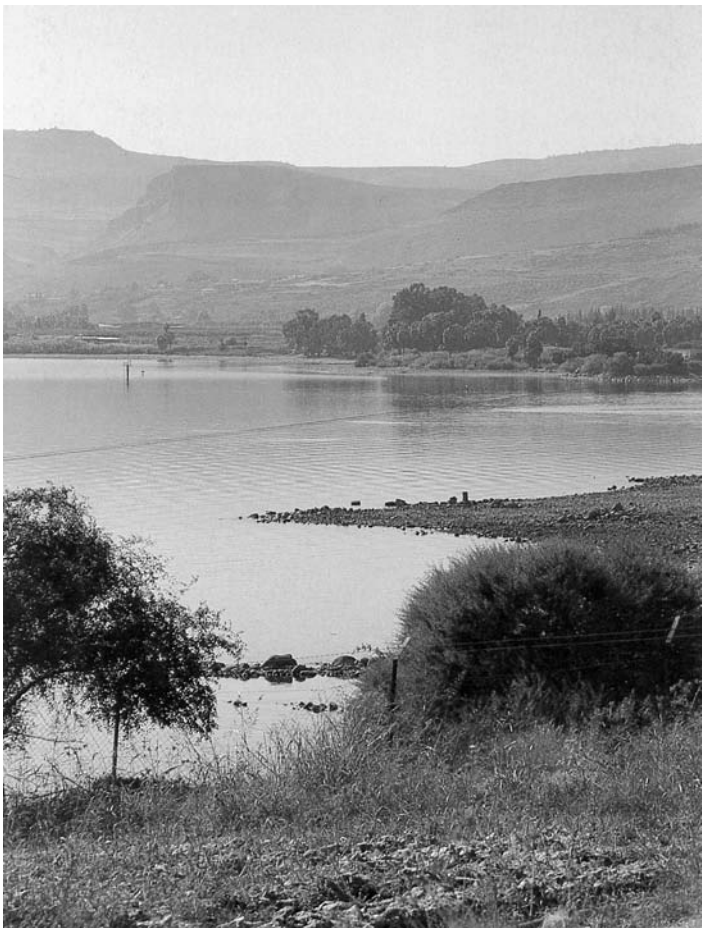


Descriptive Report on the Results of the Research of the Pontifical Council for Health Care Workers on Palliative Care

The Pontifical Council for Health Care Workers, on the occasion of the XV World Day of the Sick 2007 which will be celebrated at Seoul (South Korea) on the subject 'The Spiritual and Pastoral Care of Patients with Incurable Illnesses', in order to broaden the knowledge horizon of the work of the Church in the world of suffering and in particular of the incurably ill, has thought it advisable to present in this Descriptive Report[1] an up-dating of a study[2] that was presented to the XIX International Conference on Palliative Care on Catholic health-care centres that are specialised in palliative care.[3]

This survey was carried out at the beginning of 2004 in 121 countries of the five continental areas of the world (Africa, America, Asia, Europe, Oceania), after a number of months spent in drawing up a questionnaire with the help of an *ad hoc* study group on the question. The questionnaire was filled in by the heads of some of the most representative Catholic health-care centres for palliative care in these five continents that had been indicated by 127[4] bishops who at that time were responsible for pastoral care in health in various countries of the world.

I would like to thank for their valuable help the apostolic nuncios that allowed contact to be made with bishops with offices for pastoral care in health, the bishops responsible for pastoral care in health who offered their help during the preliminary stage of the survey and indicated the most representative Catholic health-care structures of their country dedicated to palliative care, as well as all the heads of health-care centres for palliative care who with competence and care filled in the questionnaire and thereby allowed us to know about the very many aspects of the service they provide to suffering sick people.

In particular, I would like to thank the local Church of South Korea which this year has offered us their hospitality to celebrate the World Day of the Sick as testimony to a Church that is alive and committed in the field of health as well. There are very many Catholic health-care structures working in this country, some of which are dedicated in a particular way to palliative care, bearing witness thereby to a strong role and constant care at the side of suffering sick people.

The attention that this Pontifical Council has always paid to the world of suffering grows greater in the light of the debates and the ethical questions and issues raised by the end of life and in particular by the accompanying of the dying. As I observed in my book *Metabioethics and Biomedicine*: 'the right to life expresses itself in the terminally-ill patient as a right to die with serenity, with human and Christian dignity'.[5] With palliative care, medical science places itself at the service of life because, even though it is known that a grave pathology cannot be eliminated, it dedicates its capacities to alleviating the suffering of terminally-ill patients. On this point Pope Benedict XVI has emphasised 'the need for more palliative care centres which provide integral care, offering the sick the human assistance and spiritual accompaniment they need. This is a right belonging to every human being, one which we must all be committed to defend'.[6]

I would like to end by emphasising that this document does not seek to describe all the work of the Church in the field of palliative care but it does allow us to know the contexts in which Catholic health-care structures work, the questions and issues that they have to face, and their daily activity intended in an overall way for the person.

H. Em. Card. JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Health Care Workers

Notes

[1] Drawn up by the statistics and data section of the Pontifical Council for Health Care Workers.

[2] FIORENZA DERIU, 'The Catholic World and Palliative Care: A Survey carried out by the Pontifical Council for Health Care Workers, in *Dolentium Hominum* n. 58. XX, 2005 n.1, pp. 20-23.

[3] The definition of palliative care adopted in this study is that of the National Council for Hospice and Palliative Care Services of the World Health Organisation of 1990, modified by the Ministerial Committee for Palliative Care of 1999. Thus palliative care is care intended to improve the quality of life of the patient but care that does not act on the developmental process of the illness.

[4] The number of bishops responsible for pastoral care in health was greater than the number of countries because in some of these countries there were two bishops responsible for pastoral care in health.

[5] J. LOZANO BARRAGÁN, *Metabioethics and Biomedicine* (Editrice Velar, 2005), p. 187.

[6] BENEDICT XVI, Message for the World Day of the Sick 2007, in *www.vatican.va/holy_father/benedict_xvi/messages/sick/documents/hf_ben-xvi_mes_20061208_world-day-of-the-sick-2007_it.html*

A DESCRIPTIVE ANALYSIS OF THE SURVEY

In all, 75 questionnaires were sent back. The distribution in percentages of the questionnaires that were returned in terms of geographical areas was as follows:

Europe	56%
Asia	12%
Africa	10.7%
America	18.7%
Oceania	2.6%

Below is a list of the countries that replied to the request and the corresponding number of centres that filled in the:

List of Countries	*Number of Centres that Replied*
AFRICA	
Ghana	2
Kenya	3
Malawi	1
Uganda	1
Zambia	1
AMERICA	
Bolivia	2
Brazil	3
Ecuador	1
El Salvador	1
Guatemala	2
Peru	2
United States of America	3
ASIA	
Korea	4
India	2
Pakistan	1
Thailand	2
EUROPE	
Austria	1
Belgium	3
Czech Republic	3
France	3
Germany	2
Holland	5
Ireland	2
Italy	2
Poland	15
Slovakia	3
Spain	3
OCEANIA	
Australia	2

STUDY AND ANALYSIS OF THE QUESTIONNAIRE

Structure and organisation

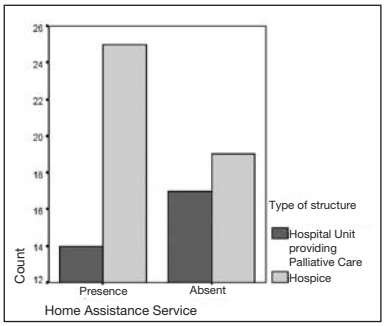
Question 2) Indicate the kind of structure

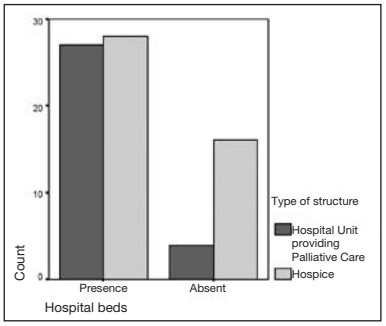
Type of structure

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	Hospital Unit providing Palliative Care	31	41.3	41.3	41.3
	Hospice	44	58.7	58.7	100.0
	Total	75	100.0	100.0	

Those who answered could choose between two types of structure, namely between operative hospital palliative care units and hospices. From a study of the data it emerged that 58.7/% of the health-care centres providing palliative care that filled in the questionnaire are hospices and 41.3% are operative hospital palliative care units.

Question 3) Specify if the structure has a Day Hospital, Hospital Beds, Outpatient's Dept, Home Based Care





As can be seen from the two graphs, 64.1% of the hospices provide a home care service and 50.9% have beds. 49.1% of the operative hospital palliative care units have beds and a clinic is present in 68.4% of these structures.

Question 5) Indicate the professional figures involved, and express your opinion on the adequacy of the resources that are available compared to the needs of the context in which the structure operates:

Professional figures involved

	Name	Count	%of Responses	%of Cases
Medical doctors	D_5A	71	13.9	94.7
Nurses	D_5B	73	14.3	97.3
Psychologists	D_5C	47	9.2	6.7
Social Workers	D_5D	54	10.6	72.0
Volunteers	D_5E	65	12.8	86.7
Auxiliary Technical Operators	D_5F	43	8.4	57.3
Physiotherapists	D_5G	51	10.0	68.0
Catholic Spiritual Assistant	D_5H	70	13.8	93.3
Spiritual Assistant of Other Religions on Request	D_5I	35	6.9	46.7
Total		509	100.0	678.7

In the centres that filled in the questionnaire, the predominant professional figures are women nurses (indicated by 14.3% of the answers and 97.3% of the centres that filled in the questionnaire), followed by medical doctors (13.9% of the answers given by 94.7% of the centres). These were followed by the figure of the Catholic spiritual assistant (in-

dicated in 13.8% of the answers by 93.3% of the centres that filled in the questionnaire). The presence of voluntary workers and social workers is also notable.

Opinion on the adequacy of medical doctors compared to the needs of the context in which the structure operates

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	Insufficient	19	25.3	27.9	27.9
	Just sufficient	39	52.0	57.4	85.3
	More than sufficient	10	13.3	14.7	100.0
	Total	68	90.7	100.0	
Missing	Not applicable	4	5.3		
	No answer	3	4.0		
	Total	7	9.3		
Total		75	100.0		

85% of the centres declared that they have just a sufficient number of medical doctors in their structures. Of these, 28% declare that they do not have a sufficient number of medical doctors. In general, the other professional figures are considered just sufficient for the needs of the structure and this points to problems concerning the availability of human resources.

Question 6) Indicate the sources of finance of the structure

	Name	Count	%of Responses	%of Cases
Public	D_6A	52	28.6	70.3
Private	D_6B	44	24.2	59.5
Donations	D_6C	61	33.5	82.4
Others	D_6D	25	13.7	33.8
Total		182	100.0	245.9

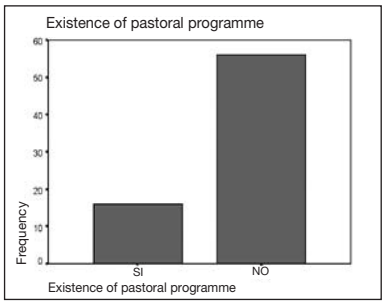
In general, the Catholic structures that filled in the questionnaire finance their activities with resources that come from donations (this was indicated in 33.5% of the answers by 82.4% of those who filled in the questionnaire). This could be a reason for the relative shortage of human resources employed in these structures.

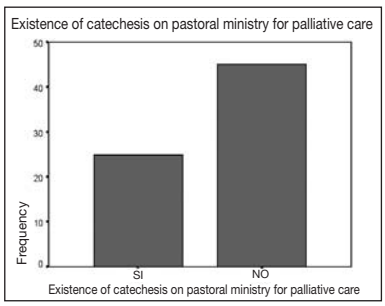
Pastoral activity and the Local Support Networks

Question 7) Does a pastoral programme of the local Church dedicated specifically to the subject of palliative care exist?

Question 16) Indicate if there exists a specific catechesis for pastoral care in relation to palliative care:

Question 23) Does a body responsible for the co-ordination of pastoral care which deals with palliative care exist in your structure?





Body responsible for the co-ordination of pastoral care

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	YES	22	29.3	31.9	31.9
	NO	47	62.7	68.1	100.0
	Total	69	92.0	100.0	
Missing	No answer	6	8.0		
Total		75	100.0		

77.8% of the centres that filled in the questionnaire complained about a shortage of specific pastoral programmes of the Church in palliative care: 68.1% referred to an absence of bodies for the co-ordination of pastoral care; 64.3% mentioned the question of an appropriate catechesis.

Question 10) Indicate if spiritual resources are employed and indicate which ones in particular:

Spiritual Resources

	Name	Count	%of Responses	%of Cases
Sacraments	D_10A	70	27.5	93.3
Pastoral Visits	D_10B	68	26.7	90.7
Funerals	D_10C	53	20.8	70.7
Help during mourning	D_10D	64	25.1	85.3
Total		255	100.0	340.0

With respect to Catholic worship, a minister for the sacraments is available in many centres (this was indicated in 27.5% of the answers from 93.3% of the centres), as well as pastoral care visits, of which 92.6% are carried out by priests, although religious and secular people are also engaged in such activity. The structures also organise funerals which are generally held inside these centres; the pastoral care service actively co-operates in providing help at the moment of bereavement (indicated in 25.1% of the answers by 85.3% of the structures that filled in the questionnaire).

Question 11) If in answering question '10' you indicated 'sacraments', specify which sacraments are celebrated

Sacraments

	Name	Count	%of Responses	%of Cases
The Eucharist	D_11A	68	31.3	97.1
Anointing the Sick	D_11B	67	30.9	95.7
Reconciliation	D_11C	56	25.8	80.0
Baptism	D_11D	26	12.0	37.1
Total		217	100.0	310.0

As can be seen from the analysis of the data, in nearly all the centres a minister for the sacraments is available (the Eucharist, anointing of the sick, reconciliation). The administration of the sacrament of baptism is less frequent (indicated in 12% of the answers by 37.1% of the centres).

Question 17) In your structure, do you organise training courses in health pastoral care that pay specific attention to palliative care?

Question 18) What form do they take in general?

Question 19) How often do they take place?

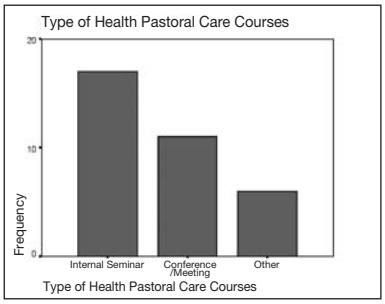
Question 20) For how long do they last?

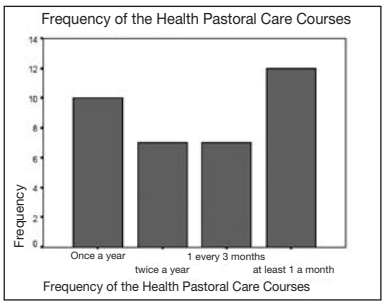
Question 21) In these courses is specific attention paid to the pastoral questions and issues connected with palliative care?

Question 22) In your structure are the ethical questions connected with the following subjects addressed?

Courses in pastoral care

		Frequency	Percentage	Valid percentage	Cumulated percentage
Validi	SI	36	48.0	51.4	51.4
	NO	34	45.3	48.6	100.0
	Totale	70	93.3	100.0	
Mancanti	Non risponde	5	6.7		
Totale		75	100.0		

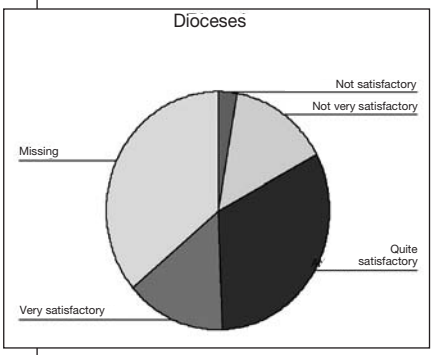


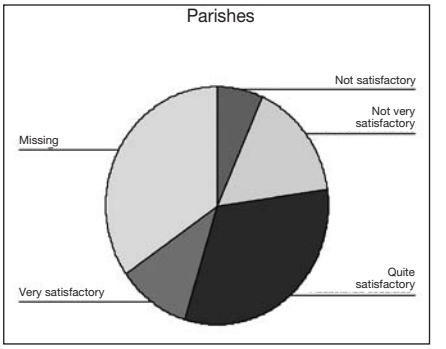


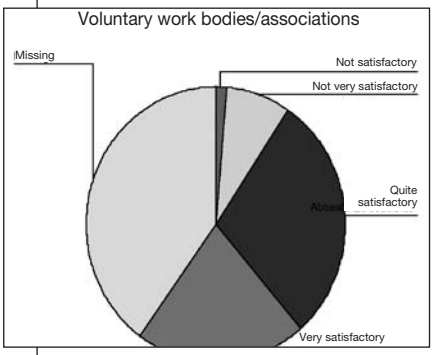
51.4% of the centres that filled in the questionnaire organise training courses for pastoral care in health, principally on the subject of palliative care. In general, these courses take the form of an internal seminar and are mainly organised at least once a year and last from two to three days. During these courses, pastoral questions and issues connected with the end of life (89.9%), the patient approach (92.8%) and the use of pharmaceuticals (81.5%), are addressed.

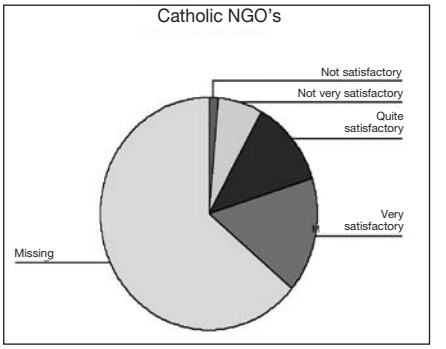
Question 25) Indicate the realities with which forms of pastoral link-up in the local area have been experimented and the level

of satisfaction experienced in relation to the results of such forms of collaboration:









In cases where forms of co-operation with realities of the local area have been experienced, these were found to be very satisfactory in the case of Catholic NGOs (44.4%), and in the main forms of co-operation with dioceses, parishes, health-care structures, voluntary work and secular associations were found to be quite satisfactory.

Activity Involving Assistance

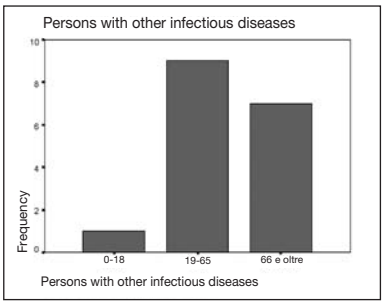
Question 28) Indicate the kind of medical services offered by your structure during 2003

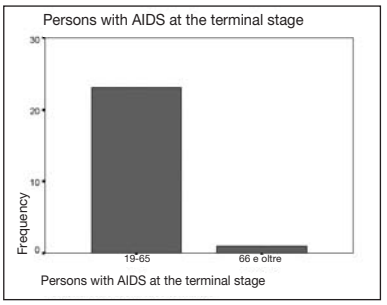
Kind of medical services

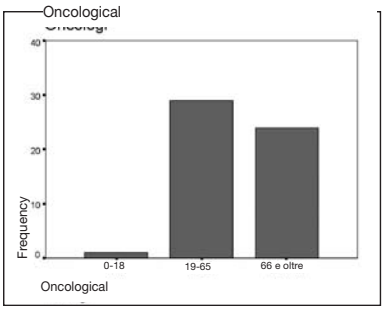
	Name	Count	%of Responses	%of Cases
Pharmacological treatment	D_28A	70	10.7	94.6
Pain-killing treatment	D_28B	72	11.0	97.3
Nutritional support	D_28C	65	9.9	87.8
Physiotherapy	D_28D	56	8.5	75.7
Rehabilitation	D_28E	49	7.5	66.2
Support for the family	D_28F	68	10.4	91.9
Telephone/computer home assistance	D_28G	34	5.2	45.9
Caregiver training	D_28H	51	7.8	68.9
Relations with the family doctor	D_28I	42	6.4	56.8
Support for the family relatives in managing mourning	D_28J	59	9.0	79.7
Assistance in an overall approach with a single project of assistance shared by the whole team	D_28K	40	6.1	54.1
Involvement of the family relatives in the programme of assistance	D_28L	50	7.6	67.6
Totale		656	100.0	886.5

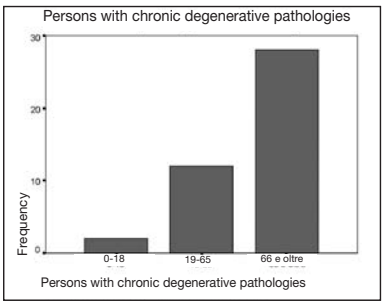
The medical services that are offered privilege anti-pain treatment (indicated by 11% of the replies of 97.3% of the centres that filled in the questionnaire), followed by pharmacological treatment. In many centres (10.4% of the answers expressed by about 92% of the structures) support for families is offered and a good percentage of centres also offer nutritional support as a medical service.

30) For each category of patients indicate the age band of most of those who have had access to the services provided by the structure during 2003









As can be seen from the graphs, the age band in which most of the AIDS patients at the terminal stage of their illness, those with other infectious diseases, and cancer patients are located is the 19-65 age band, whereas the people with chronic degenerative pathologies are over 66 years of age.

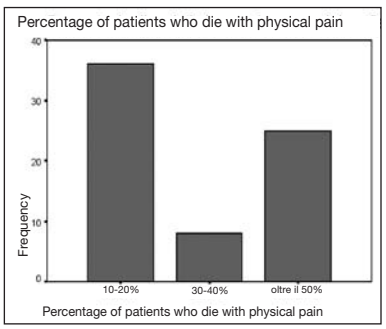
Question 32) The therapeutic intervention lays emphasis on:

Therapeutic intervention

	Name	Count	%of Responses	%of Cases
The pharmacological aspect	D_32A	65	46.1	94.2
The aspect of psychotherapy	D_32B	46	32.6	66.7
The aspect of rehabilitation	D_32C	30	21.3	43.5
Total		141	100.0	204.3

It is certainly the case that therapeutic action privileges the pharmacological aspect (indicated in 46.1% of answers by 94.2% of centres), even though the psycho-therapeutic and rehabilitative aspects are present in a sizeable percentage of centres.

Question 33) What percentage of your patients die with physical pain that requires palliative care?



52.2% of the centres replied that the percentage of people who die in physical pain is 10-20%. Unfortunately 36.2% of the structures declared that over 50% of patients die with physical suffering.

Question 34) Indicate in order of importance, beginning with the most important (1) and ending with the least important (3), the first three components that in your experience help to reduce the overall suffering of a dying patient (put the numbers 1, 2, or 3 in the empty boxes next to your choices in order to indicate the scale of importance):

Pain-killing treatment

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	1 position	31	4.3	64.6	64.6
	2 position	5	6.7	10.4	75.0
	3 position	12	16.0	25.0	100.0
	Total	48	64.0	100.0	
Missing	not applicable	24	32.0		
	no answer	3	4.0		
	Total	27	36.0		
Total		75	100.0		

64.6% of the centres that filled in the questionnaire affirmed that anti-pain therapy is the most important element in helping to reduce the overall suffering of the dying. This was followed by the support of faith and the support of the family.

Question 35) Which of the definitions listed below is closest to your idea of 'exaggerated treatment'?

Definitions listed below is closest to your idea of 'exaggerated treatment'

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	What is done against the will of the patient	21	28.0	29.6	29.6
	What does not improve the quality of life of the patient	35	46.7	49.3	78.9
	What does not improve the life expectancy of the patient	13	17.3	18.3	97.2
	Other	2	2.7	2.8	100.0
	Total	71	94.7	100.0	
Missing	not applicable	2	2.7		
	No answer	2	2.7		
	Total	4	5.3		
Total		75	100.0		

For 49.3% of the centres that filled in the questionnaire, the definition that comes close to the idea of exaggerated treatment is*: "What does not improve the quality of life of the patient"*.

Question 36) With whom do you discuss how to address the death of the patient?

	Name	Count	%of Responses	%of Cases
In general it is discussed with the patient	D_36A	45	31.5	64.3
It is rarely addressed with the patient	D_36B	21	14.7	30.0
In general it is only discussed with the relatives of the patient	D_36C	45	31.5	64.3
It is only discussed by the health workers	D_36D	17	11.9	24.3
It is left to the priest	D_36E	9	6.3	12.9
It is left to the psychologist	D_36F	5	3.5	7.1
It is not discussed with anyone at all	D_36G	1	0.7	1.4
Total		143	100.0	204.3

In many centres, how to face the death of the patient is discussed above all with the relatives but also with the patient himself or herself.

Question 37) Indicate who prescribes the pharmacological treatment:

Question 38) Indicate which category forms the basis of the use of the pharmacological protocol:

Who prescribes the pharmacological treatment

	Name	Count	%of Responses	%of Cases
Medical doctors who are experts in the treatment of pain	D_37A	48	43.2	70.6
Medical doctors who belong to a specific team	D_37B	37	33.3	54.4
The Medical doctors of the hospital when a specific team is not present	D_37C	26	23.4	38.2
Totale		111	100.0	163.2

Pharmacological therapy is generally prescribed by medical doctors who are specialists in pain therapy (43.2% of the answers expressed by 70.6% of the centres that filled in the questionnaire). The pharmacological protocol is largely based upon the use of weak opiates or strong opiates, together with anti-depressives and general adjuvants.

Question 39) Is the prescribed pharmacological protocol communicated to other people?

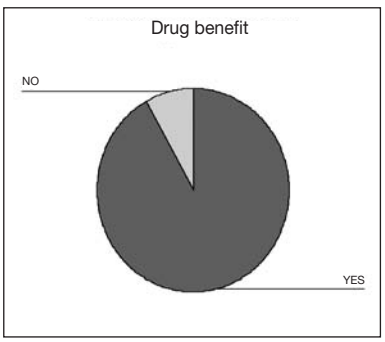
Question 40) If 'yes', indicate whom the prescribed pharmacological protocol is communicated to:

	Name	Count	%of Responses	%of Cases
It is explained to the patient	D_40A	57	45.2	95.0
It is explained to the "family leader"	D_40B	45	35.7	75.0
It is communicated to the medical doctor of the local area	D_40C	24	19.0	40.0
Total		126	100.0	210.0

83.3% of the centres provided information on the pharmacological protocol that is prescribed. 45.2% of the answers expressed by 95% of the structures that filled in the questionnaire indicated that this protocol is explained to the patient. In many of the centres this protocol is also explained to the family head.

Question 42) Do the pharmacies and the ways in which they are administered benefit the patient?

Question 43) If 'yes', indicate the kind of benefit they give to the patient:



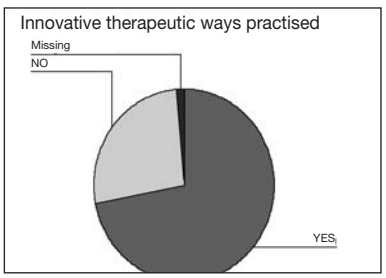
Improvement in pain levels

		Frequency	Percentage	Valid percentage	Cumulated percentage
Valid	presence	66	88.0	95.7	95.7
	absence	3	4.0	4.3	100.0
	Total	69	92.0	100.0	
Missing	not applicable	6	8.0		
Total		75	100.0		

92% of the health-care structures that filled in the questionnaire explained that the pharmaceuticals and the ways in which they are administered are of benefit to patients. In particular, 95.7% of the centres declared that there is an improvement in terms of pain relief. In addition, their administration helps in the retrieval of the affective sphere of patients.

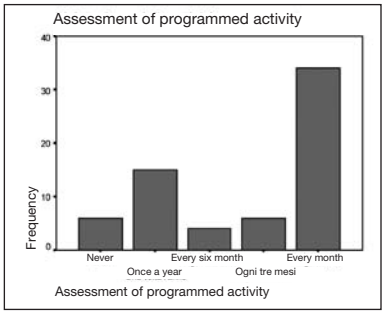
Question 44) Are innovative therapeutic ways practiced?

Question 45) If 'yes', which ones?



73% of the centres that filled in the questionnaire implement innovative therapeutic ways such as physiotherapy associated with music therapy.

Question 46) Specify if occasions for the assessment of programmed activity are envisaged:

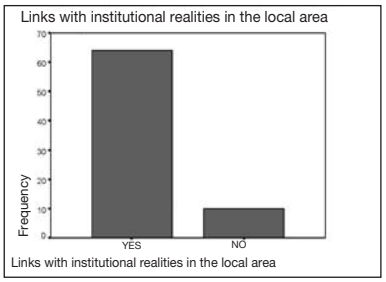


52.3% of the Catholic health-care centres every month organise moments for the assessment of the activities planned within that structure.

Question 47) Does your structure have links with institutional realties in the local area?

Question 48) If 'yes', indicate the level of formal help received from the such institutional bodies:

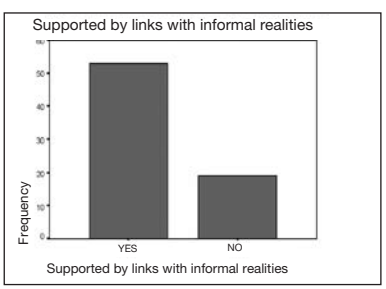
Question 49) Indicate the level of usefulness of such forms of collaboration:



86.5% of the centres declared that they are linked with institutional realities in their local areas (formal networks). In particular the most significant level of help comes from hospice/palliative care associations, followed by the third sector, public hospitals, and religious Orders and Congregations.

Question 50) In your daily work are you supported by links with informal realities?

Question 51) If 'yes', indicate the level of informal help received from the following individuals:



73.6% of the structures that filled in the questionnaire stated that they are supported by links with informal realities. In 55.6% of cases by family heads, followed by other family relatives and neighbourhood friends.

Some theological – pastoral principles underlying the research

a. General considerations

1. The structures that replied to the survey are composed as follows: hospices, 58.7%; hospices; operational hospital palliative care units, 41.3%. Over 50% of the centres that replied work in European countries, even though there are excellent structures also in other countries of the world.

2. The centres that filled in the questionnaire are of various sizes: this goes from the smallest, generally a hospice, capable of providing home care to about ten patients a day, to medium size centres, which are generally operational hospital palliative care units that can register more than two hundred clinic and home visits a day. However, few of the structures which filled in the questionnaire have day hospitals.

3. Overall, the waiting time to access palliative care is not excessively long: this ranges from three to ten days for admissions and home care, and three to eighteen days for clinic visits.

4. In the centres that filled in the questionnaire, traditional professional figures are present: medical doctors, nurses and auxiliary technical staff. Next to these figures, the presence of volunteers and Catholic spiritual assistants and spiritual assistants of other religions is effective, even though the majority of the centres that filled in the questionnaire stress that their number is only just sufficient in relation to the needs of the context in which the structure operates.

5. The shortage of sources of funding from the public sector and having to finance themselves above all from private donations, certainly makes the administration of human and material resources difficult, and this could be a cause of the low level of the numbers of professional figures available.

6. In general, the typology of medical services offered by these structures involves anti-pain treatment and pharmacology. Support for families is offered in many centres and a good percentage of centres also offer nutritional support as part of their medical services. Patients for the most part have a clinical profile characterised by cancer or chronic-degenerative pathologies. The pharmacological protocol, which is generally communicated to the patient or the family leader, is based prevalently on the use of weak opiates or strong opiates together with anti-depressives and general adjuvants.

7. The activity at the level of assistance of centres providing palliative care is not limited to the medical and supportive approach. Indeed, the personnel, according to the specific character of their mission, work to support the family and the faith of the patient. All of this is translated not only into the reduction of physical pain but also into the recovery of an affective life.

8. Despite all these efforts, a notable percentage of the centres state that over 50% of their patients die in physical suffering. However, in order to improve the quality of life of patients, in the majority of the centres that filled in the questionnaire innovative therapeutic ways such as physiotherapy associated with music therapy are also implemented.

9. From an analysis of the system of formal and informal help received by patients, it emerges that the satisfaction of the patient and the utility that he or she receives from the system of informal help, above all the help received from the family leader and other family relatives, is higher than the satisfaction generated by the help offered by the formal support structures of local areas, even though amongst these the level of help received above all from the hospice/palliative care associations is high.

10. As regards Catholic worship, in almost all of the centres that filled in the questionnaire the ministry of the sacraments, such as the Eucharist, anointing of the sick, reconciliation and baptism, is assured, even though in many cases the number of Catholic spiritual assistants is just sufficient to carry out this service. One notes the need to promote pastoral programmes of the local Church that are specifically dedicated to palliative care and to the need to promote an appropriate catechesis. However, when a pastoral programme has been drawn up, a priest or a religious is responsible for it, with whom lay people work in a significant way. In general, the principal objectives of pastoral programmes concern the overall accompanying of patients, with special attention being paid to care for their spiritual dimension.

11. Even though most of the centres that filled in the questionnaire complained about the inexistence of a body for the co-ordination of pastoral care, when such a body does exist it is oriented in the direction of the spiritual guidance of workers, fostering periodic meetings with other structures in the local area, with chaplains, with volunteers and with patients.

12. In those cases where forms of local pastoral networks have been tried, they have proved to be very satisfactory with the Catholic NGOs (44.4%) and the collaboration with dioceses, parishes, health-care structures, volunteers and secular associations was found to be sufficiently satisfactory.

13. The various realities that emerged in this survey show that there is still a great deal to be done but the path that has been undertaken is the right one. A commitment is necessary at all levels to foster and support centres and palliative care units which, beyond any logic of exaggerated treatment and in opposition to every temptation of euthanasia, assure overall assistance for sick people and their right to a dignified natural death.

b. Theological – pastoral principles

1. Every human being is unique and unrepeatable. Therefore, his human life is a value in itself and must be respected from conception up to its natural end.

2. The human being (human person) is a unity of body and

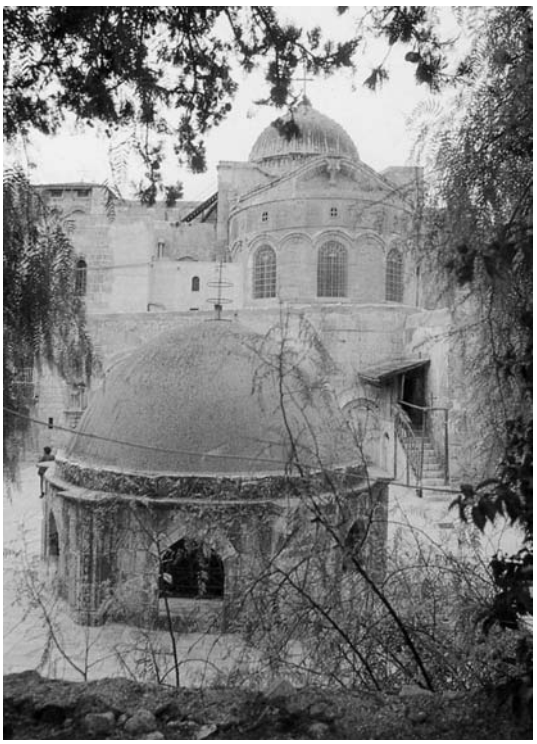
spirit. Every illness and all suffering and pain have repercussions on this whole unity. Hence the necessity to make sure that all treatment and care takes into consideration the totality of the human person, even if the illness could be localised in a part of the body.

3. The human being (human person) is by nature a social being (social animal according to Aristotle). And the Bible states: "It is not right that man should be alone. I shall make him a helper who is similar to him" Gn 2, 18. Hence the fundamental characteristic of the doctor–patient relationship, which is necessarily an interpersonal relationship of trust, as well as the importance of the necessary involvement of the family and friends.

4. The death of a person is a "passage." Spiritual care cannot, neither should it be considered "optional," something that one can do without, an irrelevant practice for the believer. Therefore, it is not to be confused with psychological support and other similar aids. The sacramental life and spiritual accompaniment should be done with much care and diligence, especially when it concerns accompanying someone to cross the threshold towards the meeting with the Lord.

5. In carrying out its mission, the Pontifical Council for Health Care Workers, entrusted with the duty of manifesting "the Church's concern for the ill, assisting those who render services to the sick and suffering, so that the apostolate of mercy they carry out will increasingly respond to the new demands" (*Pastor Bonus,* art. 152), is always inspired by these principles, reiterating their fundamental goodness, in that they respect and promote human dignity, especially in the case of people who suffer or are seriously ill. Testimony to this are the themes of its annual international conferences and various publications, especially the *Charter for Health Care Workers*.

VII Plenary Assembly of the Pontifical Council for Health Care Workers



20-21-22 March 2007
Domus Sanctae Marthae
Vatican City

Address of Homage

Most Blessed Father,

The members and some of the consultors of the Pontifical Council for Health Care Workers, together with the staff of our Pontifical Council, have come together for our plenary assembly. Our meeting has had as its purpose that of assessing the work plan that was drawn up five years ago, which your predecessor, the Servant of God John Paul II, approved, and which Your Holiness benevolently accepted. This work plan was planned in the year 2002 for a five-year period. Half way through this period, in 2005, the previous plenary assembly was held to assess the performance of the work plan and to add to or to correct what had been established. Today, in taking into consideration what was established at that plenary assembly, we have carried out the latest revision of the work plan, and we give thanks to God that we have been able to complete the fifty-three programmes of which this work plan was made up in a reliable way.

This plenary assembly has had another purpose: to draw up a draft of study for a new work plan for another five years. We have discussed and formulated the general goal, the specific objectives and the programmes and their actions to be engaged in of this work plan. We have formulated the general goal as follows: 'To promote, to direct and to coordinate pastoral care in health within the Church according to the directives of the Holy Father'. As specific objectives we propose, in the area of the word: 'To direct pastoral care in health within the Church in line with its Magisterium'; in the area of sanctification: 'To promote the specific spirituality of pastoral care in health in line with the directives of the Supreme Pontiff'; and in the area of communion: 'To coordinate and promote pastoral care in health within the Church in the name of the Supreme Pontiff'. In this work plan, as well, there are fifty-three programmes, divided according to these specific objectives.

We have the great honour to be collaborators of Your Holiness in the specific field of pastoral care in health. Thus what will be done in the future in the Pontifical Council for Health Care Workers will be exactly what Your Holiness indicates. Thus this draft which we present in its totality only briefly, contains what the members, the consultors, the officials, the under-secretary, the secretary and myself propose to Your Holiness, thinking that we interpret your wishes in relation to the future work of our Pontifical Council, but subordinating ourselves totally to your approval and endorsement.

Thanking you once again, Holy Father, for the great honour that you have granted to us in working with you in pastoral care in health, we prepare ourselves to listen to your illuminated words and we humbly implore you apostolic blessing.

His Eminence Cardinal JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Health Care Workers, the Holy See.

Address of His Holiness Benedict XVI to the VII Plenary Assembly of the Pontifical Council for Health Care Workers

THURSDAY, 22 MARCH 2007

Your Eminence,
Venerable Brothers in the Episcopate and in the Priesthood,
Dear Brothers and Sisters,

I am pleased to welcome you on the occasion of the Plenary Assembly of the Pontifical Council for Health Care Workers. I address my cordial greeting to each one of you, who have come from various parts of the world as an effective expression of the commitment of the particular Churches, the Institutes of Consecrated Life and the Christian community's numerous institutions in the health-care sector. I thank Cardinal Javier Lozano Barragán, President of the Dicastery, for the courteous words with which he has expressed your common sentiments, describing to me the current goals you are working to achieve. I greet with gratitude the Secretary, the Undersecretary, the Officials and Consultors present and the other collaborators.

Your aim is not to examine a specific theme at this meeting, but rather, to check on the implementation of the programme you established previously and consequently, to determine your future objectives. Thus, meeting you on an occasion such as this gives me the joy, so to speak, of making each one of you actually feel in your ecclesial service the closeness of the Successor of Peter, and through him, of the entire Episcopal College. Indeed, the pastoral care of health is a typically evangelical context, which immediately recalls the work of Jesus, the Good Samaritan of humanity. When he passed through the villages of Palestine proclaiming the Good News of the Kingdom of God, he always accompanied his preaching with signs that he worked for the sick, healing all those who were prisoners of every kind of disease and infirmity. The health of the human being, of the whole human being, was the sign chosen by Christ to manifest God's closeness, his merciful love, which heals the mind, the soul and the body. Dear friends, may this always be the fundamental reference of your every initiative: the following of Christ, whom the Gospels present to us as the divine "doctor".

It is this biblical perspective that enhances the natural ethical principle of the duty to care for the sick, on the basis of which every human life must be defended in accordance with its own particular difficulties and with our practical possibilities of providing help. Going to the aid of the human being is a duty: both in response to a fundamental right of the person and because the care of individuals redounds to the benefit of the group. Medical science makes progress to the extent that it is willing to constantly discuss diagnosis and methods of treatment, in the knowledge that it will be possible to surpass the previous data acquired and the presumed limits. Moreover, esteem for and confidence in health-care personnel are proportionate to the certainty that these official guardians of life will never condemn a human life, however impaired it may be, and will always encourage endeavours to treat it. Consequently, treatment should be extended to every human being, meaning throughout his or her entire existence. The modern conception of health care is in fact human advancement: from the treatment of the sick person to preventive treatment, with the search for the greatest possible human development, encouraging an adequate family and social environment.

This ethical perspective, based on the dignity of the human person and on the fundamental rights and duties connected with it, is confirmed and strengthened by the commandment of love, the heart of the Christian message. Christian health-care workers therefore know well that there is a very close and indissoluble bond between the quality of their professional service and the virtue of charity to which Christ calls them: it is precisely in doing their work well that they give people a witness of God's love. Charity as a task of the Church, which I made the object of reflection in my Encyclical *Deus Caritas Est,* is implemented in a particularly meaningful way through the care of the sick. This is attested to by the history of the Church, with countless testimonies of the men and women who either individually or in groups have worked in this field. Thus, among the saints who practised charity in an exemplary way, I was able to mention in the Encyclical emblematic figures such as John of God, Camillus de Lellis and [Giuseppe] Cottolengo, who served the poor and suffering Christ in the person of the sick.

Dear brothers and sisters, allow me, therefore, to present to you in spirit the reflections I proposed in the Encyclical with the relative pastoral instructions on the charitable service of the Church as a "community of love". And I can now add to the Encyclical the recently published Post-Synodal Apostolic Exhortation, which in a broad and structured way treats the Eucharist as the *"Sacrament of charity"*. It is precisely from the Eucharist that health pastoral care can continuously draw the strength to relieve human beings effectively and to promote them as befits their proper dignity. In hospitals and clinics, the Chapel is the vibrant heart where Jesus ceaselessly offers himself to the Heavenly Father for the life of humanity. The Eucharist, distributed to the sick in a dignified and prayerful way, is the vital sap that comforts them and instils in their souls the inner light with which to live the condition of sickness and suffering with faith and hope. I therefore also entrust this recent Document to you: make it your own and apply it in the field of pastoral health care, drawing from it the appropriate spiritual and pastoral guidelines.

I offer you my best wishes for the success of your work in these days and accompany it with a special remembrance in prayer, as I invoke the motherly protection of Mary Most Holy, *Salus infirmorum*, and with my Apostolic Blessing, which I cordially impart to you who are present here, to all those who work with you in their respective departments and to all your loved ones.

Topics

Treating and Caring

Cancer Pain, Death and Dying

Treating and Caring

Introduction

In his message for the World Day of the Sick, Benedict XVI pays especial attention to the incurably ill, above all those who are living out the last stage of their existence. The Supreme Pontiff extended an invitation to promote 'fair social policies that can contribute to the elimination of the causes of many illnesses' and called for the provision of 'better care for those who are dying and those who cannot rely upon medical treatment'. In the words of the Pope emphasis is placed on the need to 'promote policies that are able to create conditions in which human beings can bear incurable illnesses as well and *face up to death in a dignified way*'.

Amongst the various initiatives that are able to meet in a more adequate way the needs of the dying, Benedict lays emphasis above all on centres for palliative care, and hopes that their number will grow so that a growing number of sick people will be offered the 'human help and spiritual accompanying that they need'.

The Debate on the 'End of Life'

The Pope's appeal for overall care for a person at the terminal stage of his or her life occurs at a time when Italy is involved in a keenly-felt debate about the questions and issues connected with the *end of life*. Recent cases, where chronically ill people have asked to be helped to die, have helped to bring to the fore subjects that have been discussed for a long time, such as exaggerated treatment and euthanasia.

The mass media pay great attention to these situations and call upon public opinion to take a stance in relation to these questions and issues, often appealing more to people's emotions than to their feelings. In all pronouncements on the subject appeal is made to the unbearable nature of the suffering that is endured and to the dignity of the person.

Understanding

As citizens who are believers, what attitude should we adopt towards this phenomenon, a sign of the establishment of a culture that is opposed to Christian values? It seems to me that the first approach to be adopted is the good expressed in a phrase of the philosopher Spinoza: do not cry, do not laugh, understand!

This is a matter first of all of understanding that at the roots of the policies of euthanasia and exaggerated treatment there is an established tendency of contemporary culture which leads to the *removal of death*. This process of removal has always been present in the experience of human beings. In fact it finds its origins in the psychology of the human person, as Freud pointed out at the beginning of the twentieth century when he stated that 'in basic terms, nobody believes that they will die, or, which is the same thing, each person is unconsciously convinced of their own immortality'.

If the tendency to remove death is something that is natural, and thus to be observed in every epoch, it nonetheless takes on particular connotations in different historical periods. With respect to our times, it is sufficient to read what Giovanni Arpino writes in his novel *Passi d'addio*, to have an idea of the limits reached by the process of the removal or concealment of death. 'It is a grave sin of our world, of our years', he writes, 'not to want to speak about death anymore. We hide it, we camouflage it as an accident that should be immediately eliminated. Whereas death was always honoured in times that were truly human, times that were perhaps terrible but human, now it is seen as an offence, an outrage. A person who dies is almost accused of betraying those who stayed behind…This is our frightening blasphemy: wanting death to die. We have expelled death from the sphere of our thoughts, and thus we have become the ridiculous puppets of a mechanical vitality that requires us to ignore its final destiny. We are unhappy, cowardly, and specifically at a time when we speak repeatedly about safety and energy'.

Secondly, the question should be posed: what image of man emerges from the approach that is in favour of exaggerated treatment and euthanasia? 'That of the absolute master', answers Dionigi Tettamanzi, 'that of the arbiter against whom there is no appeal of the self, its decisions, its choices, the realities of its life, and thus also of that special reality – death'. The same author points out that exaggerated treatment and euthanasia 'are apparently different but in reality identical ways for man to address the reality of death'. The hypothesis of Tettamanzi is confirmed by Prof. Malherbe, a medical doctor and philosopher of the University of Louvain. In the view of this scholar, there is a logical continuity between exaggerated treatment and euthanasia because in them both there is also a man who does not allow himself to be measured in a human way by death: with exaggerated treatment man does everything to postpone death, to delay its arrival, and with euthanasia man does everything to bring forward death. And thus in both cases man wants to exercise his command over, his domination of, death.

This vision of reality finds support in a certain kind of scientific-technical progress which confirms what is to be found in *Gaudium et Spes*: 'there is the danger that man, trusting too much in his daily discoveries, will think that he is sufficient unto himself and

will no longer look for higher things' (n. 57). What is written in this Constitution of the Second Vatican Council makes an implicit reference to the fact that the question of health, life and death have been removed from the metaphysical sphere, as a result of which questions about the end of life move from the terrain of meaning and value to the terrain of increasingly powerful means. In facing up to death and in helping the dying the *words* that death utters about the human condition, and which are expressed in the cry that is uttered by those who are at the end of their lives to those who are near them, are no longer heeded.

The words spoken by a dying person reveal a gap between what he or she is and what he or she would like to be clear to him or her. This is because suffering is always a wound for human narcissism. Through suffering, the real irrupts into the imagination. And this 'real' of death, which is made present in suffering, shakes and breaks the suffering of our imaginary 'egos'; it makes us feel the reality of the subject that lives in us, this other who is more intimate to us than we ourselves and who can never be conceived adequately as the image that a man has of himself.

Continuing in the sphere of *understanding*, it should be observed that the rejection of death has consequences for our approach both to the process of dying and to dying people. People are now much less exposed to the sight of dying, which in the past was a part of people's ordinary experience. Most people still die in health-care institutions which regulate the sequences of that process with detailed prescriptions intended *to isolate* both the event of the dying person and the corpse of the dead person. The period that precedes death is thus *desocialised* because society, which is sick with the removal of death, is powerless to take on the last moments of the life of those who die. A dying person is often abandoned to a heavy loneliness, a loneliness that is more psychological and spiritual in character than physical because it is brought about by a lack of the communication of the truth, the so-called 'conspiracy of silence', by the tendency to provide prevalently technical answers to suffering, and this impedes the meaning of suffering being understood.

Responding

Given that a patient needs his appeal – which refers to the finiteness and mortal condition of the individual – to be listened to and the emotions that accompany him (disquiet, fear, hope) to be taken on board, what approach that is an alternative to exaggerated treatment and euthanasia should be proposed?

In the humanistic and Christian domain this alternative way of addressing a dying person takes the name of 'accompanying', and has as its aim helping the individual to live until his or her end.

In the anthropological approach to accompanying, the dying patient, on the one hand, bears witness to the precariousness of the human condition, which should not be rejected, which, however, happens in the case of exaggerated treatment. As the Pope observes in his Message: 'human life has intrinsic limits, and, sooner or later, ends with death'. For that matter, the dying patient is not seen as a mere 'biological residue for whom nothing can any longer be done, a being to be narcotised and eliminated through the intervention of euthanasia. On the contrary, he remains a person 'in whom the values of intelligence, will, conscience and brotherhood excel' (*Gaudium et Spes,* n. 61), and as such he is capable until the end, if placed within a *relationship*, to make of his own life an experience of growth and *completion*'.

Caring

This experience of growth requires that side by side with t*reatment* there is also *care*, and this within a creative synthesis. The verb 'to care for' expresses the *personal involvement* of a health-care worker with the person who is suffering, an involvement that is expressed through compassion, concern, encouragement and emotional support. In the concept of caring, therefore, are included both professional expertise and scientific training and that personal involvement that leads to a centring of attention on the person of the patient, whose experiences, even though they may not be fully penetrated by us, can, nonetheless, touch us deeply because we share the same humanity. Caring for a patient is thus a *synthetic* act in which intelligence, no less than the heart, has its role and its place.

In a significant book written at the beginning of the 1980s entitled 'In a Different Voice', the American Carol Gilligan expressed in a very significant way what this synthesis re-

quires. The 'different voice' to which the author refers is made up in the world of health and health care of drawing near to people with an approach of participation rather than detachment, and of harmony and compassion rather than abstract rationality. A voice that stresses the primary place of the person, his or her singularity, in that he or she asks to be taken into consideration for what he or she really is. A voice that has been spoken down the centuries for the most part by women, but a voice that is not only of women, even though our tradition has relegated this voice to them.

In moving from treating to *caring* one goes beyond professional conduct based only on the rights of sick people and the duties of those who are responsible for them. One comes, that is to say, to experience what it means to listen to the appeal that comes from the special condition lived out by a person who is near to his or her death. In responding to this appeal, therefore, one does something more than one's simple 'duty'. Within the concreteness of a specific human relationship are implemented not only the rules that structure the health-care profession. At a deeper level one gives form to the specific moral identity of people. In this way, the experience of the health-care professional makes possible the epiphany of otherness, to which Levinas refers, which involves making the essence of moral experience specifically encounter with the other, with the *face* of the other.

The accompanying of a dying person in the terms that have just been outlined occupies an essential place in palliative care, to which, indeed, the Message of the Pope refers. As the *Oxford Textbook of Palliative Medicine* observes: 'palliative care upholds life and see dying as a natural process; it neither speeds up nor delays death; it offers relief from pain and other unpleasant symptoms; it takes into account the psychological and spiritual aspects of treatment; and offers practical conditions that help the patient to live as actively as possible until his or her death and help the family to address the suffering of the patient and then of mourning'.

The etymological root of the term 'palliative' is to be found in the Latin noun *pallium* which means a 'cloak'. From this comes the idea of *spreading a cloak over a body*, which provides a concrete idea of a protective and curative action that is able to provide benefit, that is to say warmth, but at the same time, from a spiritual point of view, to provide comfort and protection to those who are in a condition of suffering.

Dialogue and Discussion

At the present time the position of the believer clashes in a strong way with the position supported by a significant part of the Italian population, which in turn is influenced by pressure groups of undeniable effectiveness. The position to be adopted in this situation is to be defined through dialogue and discussion. Dialogue is necessary in order to really understand what those who promote exaggerated treatment or euthanasia experience and intend – for example the suffering experienced by a person who has to face up to death without the support of faith and openness to *hope that does not disappoint*.

Discussion is directed towards illuminating reason with the light of faith so that it can interpret in a more just way the great subjects of the dignity of life at its final sage and the right sense of personal autonomy.

As regards the *principle of autonomy*, for example, it is important that the patient is examined with greater attention and honesty: 'is this question really free? Is it listened to carefully? And deciphered correctly? What is its precise meaning? Careful listening and correct deciphering are required above all else when one takes into account the state of physical, psychological and spiritual vulnerability in which the patient in the terminal stage of his or her illness finds himself or herself.

Who is the subject that asks to be helped to die? Is it the patient or the environment that surrounds him or her? What is the goal of the request: is it the right to act autonomously in relation to one's own death or is it, rather, the right to be helped and looked after until the end without feeling that one is a burden and without being ashamed?

The Force of Love

Dialogue and discussion acquire a particular force when they are advanced by gestures that visibly transmit, as the Pope states at the end of his Message, the desire of the Church to help the dying and 'be at their side…making the loving mercy of Christ be present'.

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Cancer Pain, Death and Dying

CLINICAL, THERAPEUTIC AND ETHICAL-THEOLOGICAL ASPECTS

The authors of this paper, in addressing such an important and sensitive subject, wish to establish points of reference that are very clear and also shared from a terminological point of view in relation to the definition of: life, health, pain-symptom, pain-illness, illness, cancer, treatment (therapy), palliative care, proportionate and disproportionate therapies, euthanasia, death, and dying.

Life is a good that cannot be disposed of at will and is a good that is inviolable because it belongs to God and is therefore sacred (*Charter for Health Care Workers*, n. 43, Pontifical Council for Health Care Workers, Vatican City, 1995).

Definition of the term 'health'.

World Health Organisation, 1978. Health must been seen as a state of complete physical, mental and social wellbeing and not only the absence of afflictions and illnesses.

Definition of the term 'health'.

The Pontifical Council for Health Care Workers, Vatican City, 2000. Health is a tension towards physical, mental, social and spiritual health and is not only the absence of illness; it makes man able to carry out the mission that God has entrusted to him, according to the moment in his life in which he finds himself. This definition of health was formulated by His Eminence Cardinal Javier Lozano Barragán and was confirmed by His Holiness John Paul II at the time of the World Day of the Sick (Vatican City, 11 February 2000).

Definition of the term 'pain'.

Sub-committee of the International Association for the Study of Pain for the Taxonomy (I.A.S.P., 1982). Pain is an unpleasant sensorial and emotional experience associated with a real and potential damage to tissue or described with terms that refer to such damage. Sub-committee of the International Association for the Study of Pain for the Taxonomy – I.A.S.P., 1982. 'Pain Terms: a List with Definitions and Notes on Usage', *PAIN*, 6 (1979) 249; 14 (1982) 205.

Definition of the term 'pain'.

The Algologic School of Florence, 1983. Pain is a psycho-physical entity of universal meanings in the perception of which different individual, cultural and religious factors are at work and in the definition of which take part not only the disciplines of medicine and biology but also those of the human sciences (philosophy and psychology). Zucchi, P.L., Vivaldi Forti, C., Milaneschi, E., and Obletter, G., 'Definizione del termine dolore', in 'Test di personalità proiettivi (Rorschach, T.A.T.) e non proiettivi (M.M.P.I.) nella cefalea psicogena e nella cefalea da tensione muscolare. Indirizzi terapeutici', *Algologia*, 1 (1983) pp. 41-82.

Symptom pain (acute pain).

This is the symptom *par excellence,* with a very acute outbreak, with a single clinical sign, often involving safeguarding, of the set of symptoms underway (acute appendicitis, cluster headache, myocardial heart attack) which creates a relationship of alarm such as to induce an immediate remedial therapeutic action. This situation is to be identified with acute pain and with its organic parameters.

Illness-pain (chronic pain).

This is the pain that emerges as a primary element from the framework of illness and loses its characteristic of being a symptom which is useful for the patient and the medical doctor. The emergence is gradual and a recurrent sub-continuous development.

Illness-pain is to be identified with chronic pain which lasts for months or years and often induces syndromes or anxiety and/or depression (rheumatic pain, post-herpetic pain, causalgic pain, arthrosis and osteoporosis pain, cancer pain).

Definition of 'illness'.

The interruption of balance (homeostasis) in the organism which leads to a physical and/or mental and/or social alteration which in English is well expressed with the terms 'disease', which refers to the organic component of the illness (algos); 'illness', which refers to the moral suffering (pathos) of the individual; and 'sickness' which refers to the illness as a social perception (ethos).

Definition of 'cancer' (or 'terminal illness').

A state of illness whose presence induces in the minds of the medical doctor, the patient and the family an expectation of the individual's death as a direct consequence of the illness itself (Lasagna, 1970). Lasagna, L., 'The prognosis of death' in Levine, S, *The dying patient* (Russel Sage Foundation, New York, 1970).

Definition of 'therapy'.

(Therapy = to cure = the carrying out of a therapeutic action; *therapeia* = to care = to take care of). By medical therapy should be understood that health-care, medical and/or paramedical act that links the administration of treatment (therapy, to cure) in its various (pharmacological, surgical, physiotherapeutic) to forms of taking caring (*therapeia*, to care) of the patient in his or her most overall, mental, physical and spiritual meaning.

Definition of 'palliative care'.

(E. A. P. C.: European Association for Palliative Care,

Newsletter, n. 1, 1989). Palliative care is total care provided to a person afflicted with an illness that is no longer responsive to therapies whose aim is the cure of the patient. The control of pain, of the other symptoms and of the psychological, social and spiritual aspects is of prevalent importance. From the definition of the E.A.P.C one may stress that palliative care: 1. upholds the value of life and sees death as a natural event; 2. aims neither to prolong nor to shorten the life of the patient; 3. works for the relief of pain and other symptoms; 4. supplements the psychological and spiritual aspects of care; 5. offers a system of support for the family; 6. and helps the family during the stage of mourning.

Proportionate and disproportionate therapies.

When a health-care worker is unable to cure a patient he or she must never forgo treatment. He or she is obliged to practice all the proportionate forms of treatment and there is no obligation to engage in disproportionate forms of treatment (*Charter for Health Care Workers*, the Pontifical Council for Health Care Workers, Vatican City, 1995). Life is a good that cannot be disposed of at will and it is inviolable because it belongs to God, and is, therefore, sacred (*Charter for Health Care Workers*, the Pontifical Council for Health Care Workers, Vatican City, 1995, n. 43).

Exaggerated treatment.

'Exaggerated treatment' is that medical action which involves the application of important therapies (surgical operations, resuscitation, the administration of drugs and medicines) to a patient at the end of his or her life with the goal of prolonging life in a forced and mechanical way. *Exaggerated treatment* takes place when the intention is to prolong life by any means without there being any hope of a cure or a residual life of good quality. This is contrary to euthanasia. In bioethics the word 'exaggerated' can be replaced by the Greek word *distanasia* which means a difficult or troubled death.

Euthanasia

By 'euthanasia' is meant an action or an omission which by its very nature, or in its intentions, procures death with the purpose of eliminating all pain. This is a homicidal act that no end can justify (*Charter for Health Care Workers*, the Pontifical Council for Health Care Workers, Vatican City, 1995,. n. 147).

Hospice

Cicely Saunders, a nurse and social assistant, who then took a degree in medicine, spread a very precise philosophy about the hospice throughout the world, from which, indeed, we can take the following definition: *admission into a family environment, with constant assistance, in a multi-disciplinary approach, where all the symptoms of malaise are taken into account, with special attention being paid to manifestations of pain*.

Definition of 'death'

The concept of 'death' is defined by the total and irreversible loss of the capacity of the organism to maintain its own functional unity autonomously. In Italy the legislative decree n. 578 of 1983 defined the death of a person as the irreversible cessation of all the functions of the encephalon.

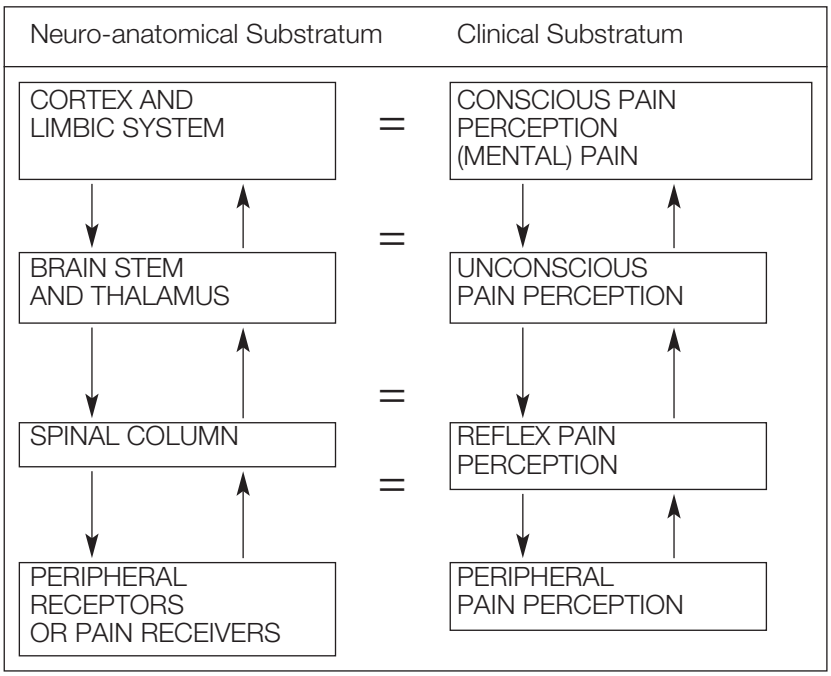
Definition of 'dying'.

An evolving process that gradually strikes the cells of the various tissues and the relative sub-cellular structures on the basis of their different resistance to a shortage of oxygen to the point of the extinction of every vital activity with the continuation of the colliquative-putrefactive enzyme phenomena alone. The process of dying ends when the whole of the organism has reached complete necrosis.

Anatomical-physiological aspects.

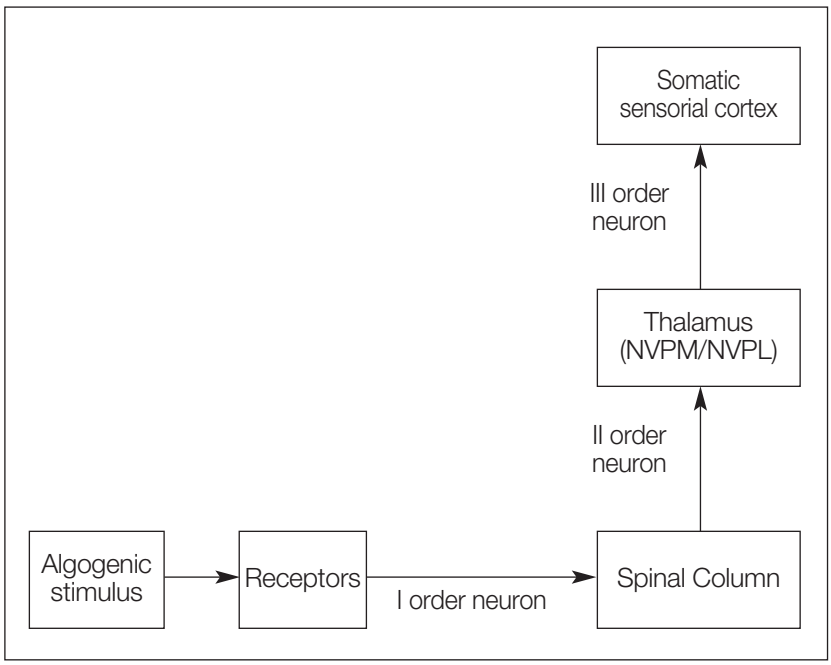
To have a better idea of the clinical aspects, a short parenthesis should be inserted here on the anatomical-physiological aspects. Pain is due to the activation of receptors (pain receptors) and the peripheral and central afferent paths that make up pain reception (fig. 1). The receptor is a structure that transforms thermal energy, mechanical energy, chemical energy and light energy into an electrical phenomenon, that is to say a sequence of action potentials. The pain receptor has a high threshold and is excited only by painful stimuli.

Fig. 1. Various kinds of pain perception with their equivalent neuro-anatomical correspondents



The algic situation creates at the level of the organism an anatomical lesion of the tissues with the freeing of algogenic substances which stimulate the reception apparatus (peripheral pain perception) which the transforms the stimulus into a pain-perceiving input which, through the order I neuron, then reaches the spinal chord (reflex pain perception). At this level, the order I neuron enters into synapsis with order II neuron which then informs the thalamus (unconscious pain perception). From the thalamus, the II order neuron projects the pain-perceiving input to the somatoestesic cortex (conscious pain perception) (fig. 2).

Fig. 2. Schematic portrayal of the path followed by the algogenic stimulus
NVPM = Ventroposteromedial nucleus of the thalamus.
NVPL = Ventroposterolateral nucleus of the thalamus.



Epidemiological aspects

Cancer pain is a problem of relevant importance from the health-care point of view because of its frequency and the psycho-physical invalidity that this symptom causes. At the present time in the world about fourteen million people suffer from cancer, of whom five million die because of it. Cancer is responsible for 8% of all causes of death and this percentage tends to increase in the most developed countries. In Europe, the percentage of deaths caused by cancer is around 23% of all deaths every year. The pain symptom in cancer-related pathologies is present in 30-40% of all cases. In the terminal stage the incidence of pain reaches 60-80% in cancer cases.

Psychological aspects.

The perception of pain. The perception of pain is provided by the pain-perceiving, discriminating, cognitive and affective component. The *pain-perceiving component* is made up of the activation of algogenic receptors (the pain receptors) and the peripheral and central afferent pathways that make up pain perception. The discriminating component refers to the capacity of the pain pathways to transmit the spatial and temporal information of the painful stimulus. The *cognitive component* refers to how the painful stimulus is likened to emotional experiences (memory of mental pain).

Assessment of pain.

In the clinical assessment of pain the points to be taken into consideration are 1. general (recent pathological, remote pathological, physiological, family) anamnesis; 2. algologic anamnesis (description of pain: the beginning, localisation), intensity (VAS), length, frequency, emotional participation, physical and/or mental malaise; 3. the general (semeiological-clinical) physical objective examination; 4. the algological examination with algometric tests: physical measurement of the pain (hyperalgesia) and mental measurement (projecting and non-projecting tests; Vs); neurological examination; and psycho-social examination.

The monitoring of pain

The monitoring of pain in a clinical context has a notable importance in the assessment of: a. intensity (VAS); b. pain-relief; c. impact on the affective and cognitive components; d. the side effects of the therapy; and e. the compliance of the patient.

Questions that arise from the relationship between the health-care workers and the cancer patient.

Faced with the pain of a cancer patient it is advisable for the health-care worker to pose himself or herself certain questions in order to enter into empathy in a better way with his or her patient. The most frequent questions are: 1) how does the patient with multicancer experience his or her pain? Pain is experienced by a cancer patient as the most concrete expression of his or her illness and to such an extent that it is referred to by 60% to 80% of samples subject to examination; 2) what role does the environmental context play in the cancer patient who has mental suffering (pathos) and physical suffering (algos)? Although pharmacological treatment is able to control cancer pain in 90% of cases, the results of pain-killing treatment are often unsatisfactory and achieve pain-relief in 50% of cases.

Reasons for an inadequate control of cancer pain

The reasons for an inadequate control of cancer pain can be connected with: 1. the patient or his or her family relatives because of the follow-

ing: a. the belief that the pain is inevitable and/or cannot be treated; b. the acceptance of pain because of the religious approach of the patient who in this case wishes to join his or her sufferings to those of Christ; c. non-compliance; and d. intolerance of the treatment. 2. the health-care workers because of the following: a. the belief that in this specific case pain is inevitable and/or cannot be treated; b. an incorrect assessment of the physical pain and the emotional responses; c. an erroneous use of pharmaceuticals in terms of molecule typology, dosages and length of administration, which are not appropriate when the chrono-biological parameters are taken into account; d. a lack of instruction by the health-care workers given to the patient and/or his or her family relatives as regards the length etc. of the administration of the drugs and medicine; and e. fear of the development of dependence; f. non-compliance.

Cancer pain as a result of physical, mental and environmental interaction.

Cancer pain should be seen as a very variegated entity obtained through the interaction of the physical and mental levels of the patient with the environmental level, giving rise to inevitable consequences such as: a. personality change; b. changes in relationships and interests; c. inability to work; d. obligations at the level of lifestyle; and e. decrease in quality of life. The painful experience of cancer tends to bring about the interaction at different moments of: a. the brain with the mind, the body with the soul in reaction whose parameters tend to unison; b. the patient with the family, with the health-care workers, and with the social, cultural and religious context. Unfortunately, however, the result is not satisfactory and leads the patient to total suffering (total pain), facilitating the appearance in those who are near to the patient (family relatives and health-care workers) the syndrome of burn-out.

Semantic diagnosis of pain.

A semantic diagnosis of pain takes place at an *oral level* through dialogue and vocalisations (groans, complaints) and at a *non-oral level* through expressions and muscular tension.

Kinds of pain (psychological).

From the description of the pain referred to by the patient and examined by the medical doctor, we can divide psychological pain into acute pain and chronic pain. From a psychological point of view, *acute pain* is characterised by a direct, visible and observable expression through the study of oral behaviour. *Chronic pain* is characterised by blocked and non-communicated expression, with oral behaviour and at times gestures that are not in conformity with the intensity of the pain; this is difficult to believe and, at times, difficult to recognise.

Psychological strategies in the treatment of cancer. There are psychological strategies (good-co-operation, bad co-operation) that the medical doctor must follow in order to obtain good results from the treatment. Good co-operation between the patient, the family and the health-care workers: a. facilitates the exchange of information; b. improves the monitoring of the therapies; c. allows the expression of needs; and d. raises the threshold of tolerance. Bad co-operation between the patient, the family and the health-care workers: a. creates depression and loneliness in the patient; b. creates difficult compliance with the treatment; c. creates closure to dialogue; d. makes the pain chronic; and e. lowers the threshold of pain

Clinical aspects

The subject of pain and of suffering from a clinical point of view has been addressed in a particular way by the School of Florence (Teodori, Neri-Serneri, Procacci, Galletti, 1973; Zucchi, Duranti, 1979). This school makes a distinction between symptom-pain and illness-pain. *Symptom-pain* is the symptom *par excellence* with a very acute emergence, a single clinical sign, often involving safeguarding, of the set of symptoms that are underway (acute appendicitis, cluster headache, myocardial heart attack) which creates a reaction of alarm such as to induce remedial therapeutic action. *Illness-pain* is the pain that emerges as a primary element of the framework of illness, losing its characteristic of being a symptom which is useful to both the patient and the medical doctor. The emergence is gradual with a recurrent subcontinual evolution. Illness-pain is to be identified with *chronic pain* which lasts for months or years, gives no truce to the patient and often induces syndromes of anxiety and/or depression. Examples of this kind of pain are: rheumatic pain, the pain of post-herpes neuralgia, causalgic pain, pain in arthrosis and osteoporosis, and cancer pain. A clear exposition of these important concepts helps to understand how pain can characterise a clinical situation that is variegated from a physical, mental and social point of view, and which English manages to express very well with the word 'disease' which refers to the organic component (algos) of the illness, with the word 'illness' which refers to the moral suffering (pathos) experienced by the patient and

his or her family relatives, and with the word 'sickness' which refers to the (painful) illness as social perception (ethos).

From this elaborate meaning which English offers us of the Italian word '*malattia*', one can understand how the (terminally ill) patient lives his or her state of total pain in all three (physical, mental and social) dimensions, involving in his or her own tragedy also family relatives, acquaintances, and health-care personnel (*Sindrome di burn-out*, Mayou, 1987). Pain in a terminally-ill patient and the suffering that accompanies such a difficult situation depends on his or her ethical-religious formation (Zucchi-Honings, 1996; Zucchi-Honings-Voegelin, 2001), cultural formation (Zborowski, 1952; Jacox, 1977; Wolff, 1985) and family formation (Waring, 1978), on his or her social context (Craig, 1978; Mc Caffery, 1979) and on expectations of recovering (Saunders, 1979). A patient afflicted by cancer encounters physical pain (fig. 3) and alterations in the emotional sphere which are characterised by anxiety and depression (mental pain) (fig. 4).

These two psychological aspects of pain, namely anxiety and depression, characterise the outbreak and the intensifications of the illness, according to its chronic levels. The causes that characterise the outbreak of the syndrome of anxiety are indicated in tab. I.

Fig 3. Stages of physical pain

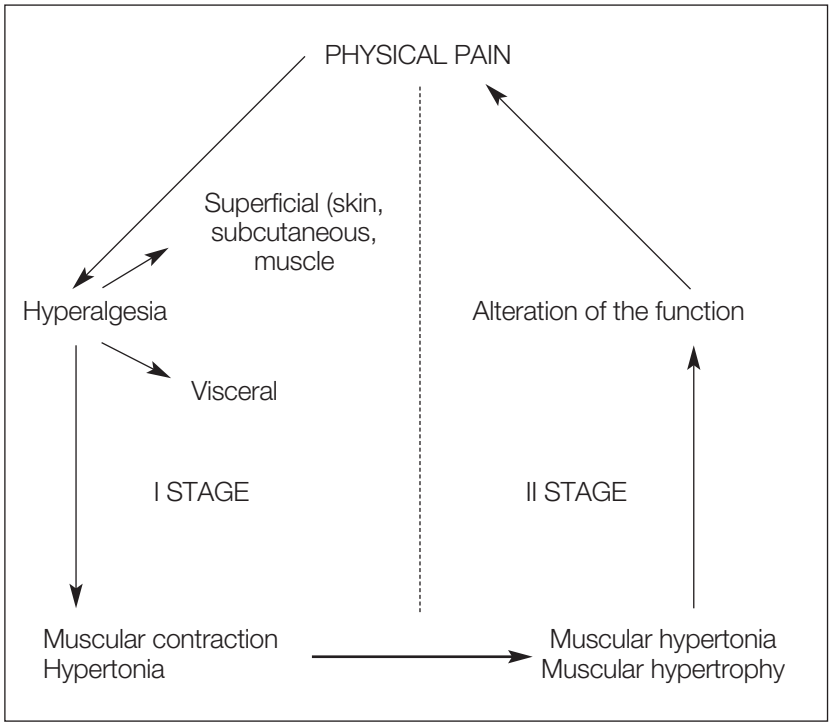
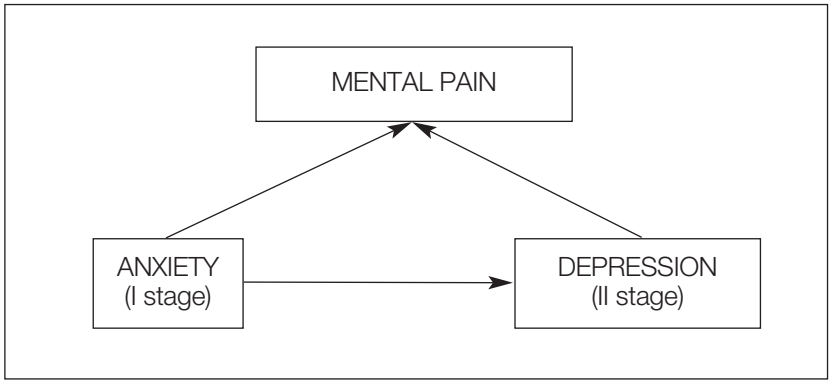


Fig. 4. Stages of mental pain.



Tab. I. Causes of the syndrome of anxiety

a) Fear of pain
b) Fear of death
c) Fear of being admitted to a hospital
d) Worry for family relatives
e) Economic problems
f) Uncertainty about the future
Scarcity of therapeutic results

The causes that characterise the syndrome of depression are indicated in tab. II.

Tab. II. Causes of the syndrome of depression

a) Loss of role within the family
b) Loss of social position
c) Loss of prestige at work
d) Loss of income
e) Insomnia
f) Asthenia
g) Dyspepsia

The syndrome of anxiety and the syndrome of depression tend to lower the pain threshold (that is to say they make the patient feel greater pain). Other factors, however, influence the level of the algic threshold, raising it or lowering it, as is described in tab. III.

Tab. III. Factors that influence the level of the pain threshold

Low Threshold
Anxiety
Depression
Fear
Mental and environmental isolation
Malaise
Asthenia
Adequate pharmacological treatment (analgesics, anxiety-reducers, anti-depressants).
High Threshold
Therapeutic relief of pain
Sleep
Rest
Affection of family relatives
Understanding of friends
Improvement in mood

A patient with cancer has different symptoms according to whether he or she is at an early or late stage of the illness (tab. IV).

Tab. IV. Recurrence of symptoms in the initial stage and the late stage of cancer pain

CANCER PAIN			
Symptoms of the initial stage		Symptoms of the late stage	
a) Asthenia	47%	a) Vomit	40%
b) Anorexia	67%	b) Diarrhoea	4%
c) Nausea	40%	c) Hiccups	5%
d) Insomnia	29%	d) Cough	50%
e) Constipation	47%	e) Dyspnea	51%
f) Incontinence	23%	f) Decubitus	19%
g) Permalleol edemas	31%	g) Dropsy	31%
h) Weight loss	77%	h) Anaemia	23%
i) Drowsiness	10%	i) Lung discharge	31%

Physical pain can give rise to hyperalgesic areas which can be on the surface, affecting the cutaneous zone, the sub-cutaneous zone, the muscular zone, and/or the visceral zone (Galletti, Duranti, Zucchi, 1979; Obletter, Zucchi, Giamberardino, Vecchiet, 1988; Wall, Mense, Cervero, Foreman, Janig, 1993). Somatic pain creates a muscular contracting beneath the hyperalgesic area (I stage) which within seven days gives rise to hypertonia and muscular hypertrophy with an alteration of function (II stage) (fig. 3). The pain tends to have a dermatomeric (fig.5), metameric or neuromeric distribution according to the sectors that are affected. From an anatomical-clinical point of view, the following definitions apply: a) the cutaneous sector that forms a part of the metamere is the *dermatomere*; b) that sector of the organism made up of the organs, the muscles and the skin that are innervated by a single spinal nerve is the *metamere*; c) that sector of the spinal column that is a tributary of the sensitive fibres of a single spinal nerve is the *neuromere*.

The action of faith and prayer on the physical, mental, cultural and social parameters of pain. The state of pain of a patient afflicted with cancer constitutes the result of the activation of the anatomical and neurochemical circuits of pain perception and is characterised by physical pain (algos) and moral suffering (pathos), parameters that are in continual interaction through cortical integration (ratio) with the environment as custom and culture (ethos).

Faith, joined to the valuable instrument of prayer, illuminates and co-ordinates the interaction between the various parameters present in the life of each man (fog. 6), raising the pain threshold (Zucchi, Honings, 1996; Zucchi, Honings, Voegelin, 2001; 2003; 2005).

Fig. 5. Dermatomeric distribution of the sensitive roots

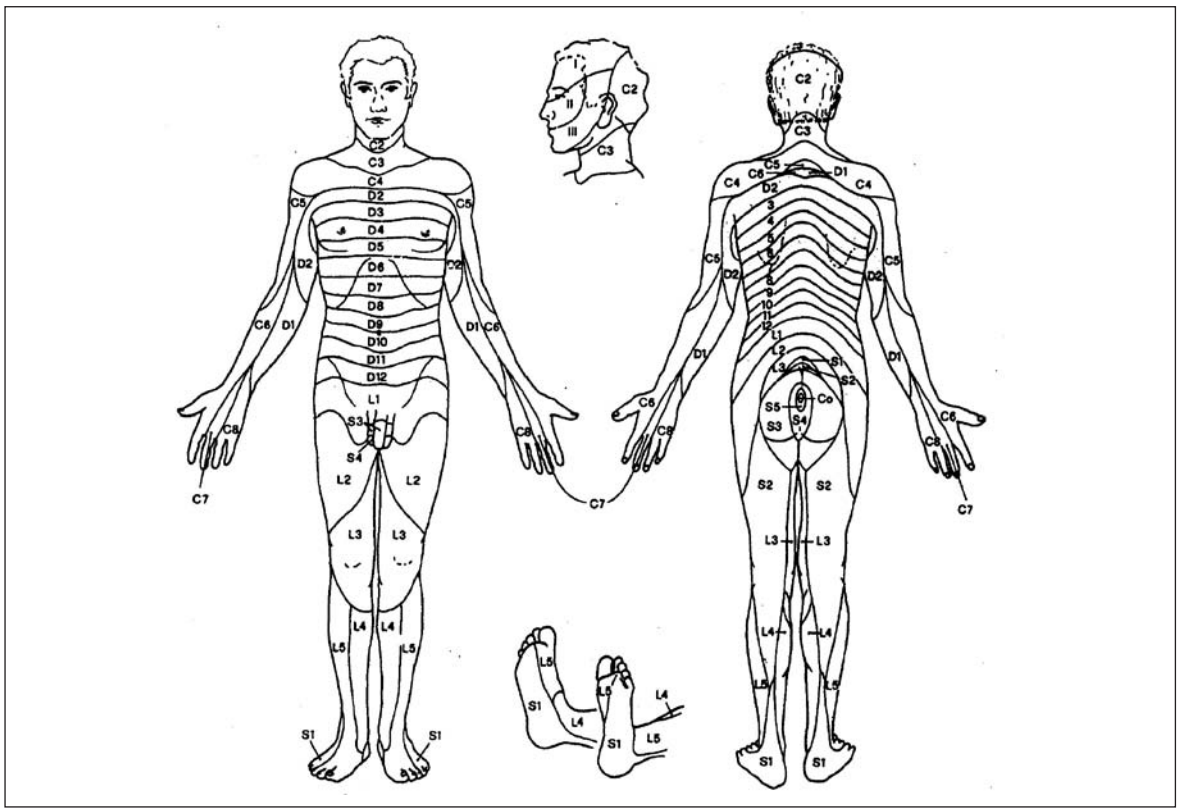
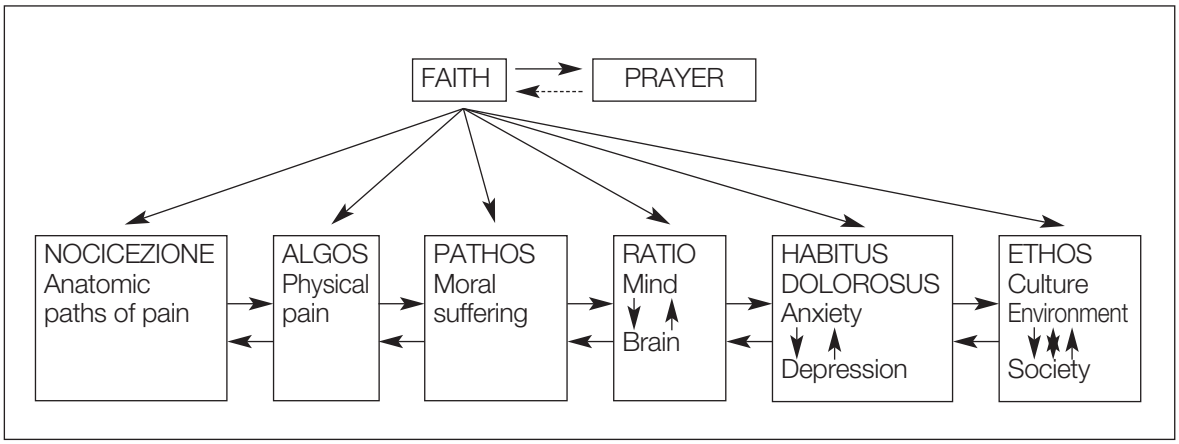


Fig. 6. Influence of faith on various (anatomical, physical, moral, rational, psychological, cultural) discriminants in cancer pain
Pain perception: activation of the receptors and the peripheral and central afferent paths.
Pain (algos and pathos): physical, moral and mental state produced by the activation of the pain-perception circuits.



PALLIATIVE CARE

Introductory aspects

Definition

Palliative care is the total care provided to a person afflicted by an illness that is no longer responsive to therapies whose goal is recovery. The control of pain, of the other symptoms and of the psychological, social and spiritual aspects, is of prevalent importance (European Association for Palliative Care, *Newsletter*, n. 1, 1989).

The term 'palliative' which marks out this therapeutic approach offered by pain-reducers, has not been very much welcomed by medical doctors or patients. The negative meaning, above all at the outset, of this term, lies in its erroneous pietistic and lacking in finality interpretation of 'having to do something' which places the health-care worker in an equivocal position given that the term 'palliative care' is interpreted as exaggerated treatment.

Palliative care, which is also supported by the *Catechism of the Catholic Church* (n. 2279) is in fact the real solution to the increasing policy of euthanasia because it provides relief from pain and other symptoms, offering the patient supports that enable him or her to appreciate the value of life, even during the terminal moments, which are experienced in this way as a pre-figuring of the *dies natalis*. The word 'palliative care' comes from the famous *pallium* of St. Augustine who with a charitable gesture helped a poor man.

In historical terms palliation has always existed but only for some twenty years has it really emerged from its obscurantist period because of that cultural positivism that tended to emphasise only the triumphant aspects of medicine and did not dwell upon its failures.

Modern pharmacology, for that matter, has not managed to suggest a therapeutic response for the relief of pain other than that of the administration of the ancient remedy of morphine and its derivatives. Unfortunately, this substance has often been used in an insufficient and inappropriate way, although remaining the best drug for the relief of pain and managing to give patients lives that are greater in quality and longer as compared to aggressive forms of anti-cancer treatment represented by radiotherapy, chemotherapy and hormone therapy.

A large number of misunderstandings have arisen around palliative care with the interpretation of this medical practice as exaggerated treatment or as a procedure of euthanasia. We can see palliative care as euthanasia if we attribute to this term the etymological or philosophical meaning of the 'good death' and not the clinical meaning of the control of pain.

The practitioner of palliative care must be an algologue with multi-disciplinary skills and with a rigorous ethical approach that allows him or her in the most difficult moments of the sensitive relationship between the patient and the medical doctor to transform himself or herself into an excellent pharmaceutical for his or her patient.

Therapeutical aspects

The treatment of cancer-related pathologies are effective and lead to a 40% recovery rate in the cases treated, whereas 60% of the population remains in an incurable state which in turn leads to an inevitable terminal stage.

Algology, which is by now twenty years old, has created a specific section of palliative care which takes care of the patient and not of the illness, which has become by now devastating for the organism. The principal goal of palliative care is the control of all the symptoms connected with physical and mental suffering which a patient in the terminal stage of his or her illness usually complains about. The approach of palliative care is not only clinical-therapeutic in character but also wants to offer psychological and social support to the patient and his or her family so that the end of the life of each patient with cancer takes place with dignity.

From an organisational point of view, multidisciplinary work in a team is required where that team is made up of a medical doctor, a nurse, a psychologist, a priest, a volunteer and above all the family of the patient.

The aim of palliative care is to follow the patient who is no longer responsive to specific cancer therapies, that is to say surgical, pharmacological (chemotherapy), radiological (radiotherapy) and immunological (immunotherapy) therapies (the healing stage), and to indicate a therapy for symptoms in order to improve the quality of life (treatment stage) (tab. V), controlling, above all else, the symptom of pain.

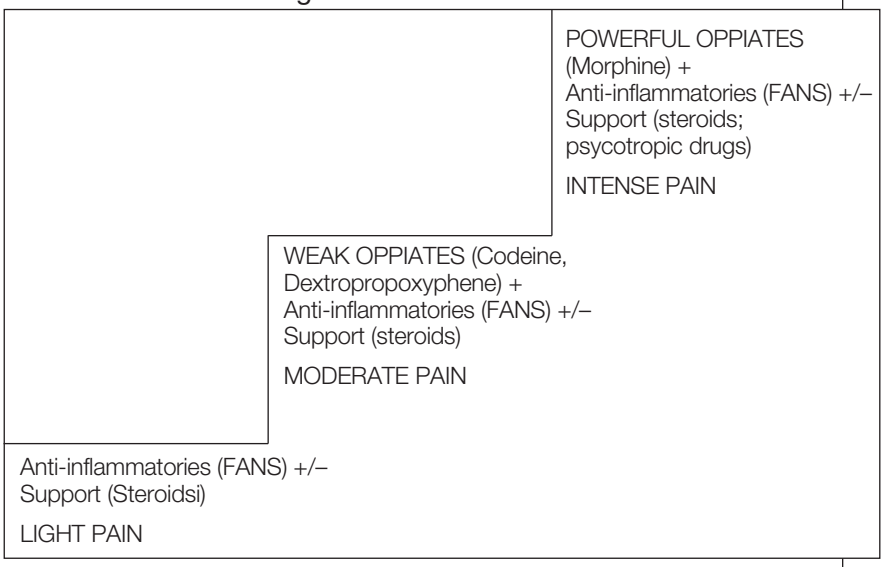
Tab.V. Therapy of the stage of healing and the stage of treating

HEALING STAGE 40%
Specific cancer therapy
- surgery
- chemotherapy
- radiotherapy
- immunotherapy

STAGE OF TREATING 60%
Palliative care
- treatment of symptoms
- improvement in quality of life
- dignified death

The WHO (World Health Organisation) has drawn up a 'three-level analgesic scale, (tab. VI) which indicates the path that a medical doctor has to follow with pharmacotherapy involving 1) FANS (non-steroid anti-inflammatory pharmaceuticals): acetylsalicylic acid, paracetamol, dyclophenac) and the help of possible support steroid pharmaceuticals: metilprednisolone, dexametasone, acetate medroxyprogesterone); 2) weak opiates (codeine, destropropoxyphene) with supports (steroids); 3) strong opiates (morphine) with supports (steroids; psychotropic drugs).

Tab. VI. Three-level analgesic scale



It should be borne in mind that the weak opiates, as opposed to the strong opiates, all have a ceiling effect, that is to say above a certain dose they do not increase their analgesic power but there is the appearance of greater side effects. This effect explains why after thirty to forty days it is necessary to move from weak opiates to strong opiates (morphine)

The supports (steroids; dexametasone, metylprednisolone, acetate medroxiprogesterone and certain psychotropic drugs -clorpromazine, haloperidol, triazolam, oxazepam) make up a group of very important pharmaceuticals that can be associated with the analgesics (FANS and drugs).

An approach of analgesic therapy organised in this way takes into account, in Italy, the needs of about thirty-thousand terminal patients with the intention of improving their conditions of quality of life. Unfortunately, because of groundless fears that lurk in the mind and in the culture both of medical doctors and patients, the use of opiates in the fight against pain is of a very low level, placing Italy in the hundredth and second place in the world as regards the use of these substances. The United States of America and Sweden are at the top of the list.

It is right, therefore, to argue that an appropriate therapy against pain represents not only the right of each person not to suffer but also lays the foundations to ensure that from the mind of each suffering man there become distant requests, which are unjustified, for assisted suicide or euthanasia.

In addition to the administration of appropriate pharmacological therapy (WHO Scale 1986), other therapies have also been reported (psychological therapy: Zucchi et al., 1983; music therapy: Zucchi, Honings, Voegelin, 2005; ethical therapy: Zucchi, Honings, 1996).

Criteria for the ascertainment of death

The criteria for the ascertainment of death have undergone a change in time in line with the evolution of scientific discoveries in the medical field. During the pre-technological age the diagnostic criteria for death were: a) *the anatomical criterion* (traumatic devastation); b) *the cardio-respiratory criterion* (stopping of the heart and breathing for a period longer than twenty minutes). The neurological criterion of brain death (irreversible primary cerebral injury with complete necrosis of the encephalon) was introduced with the resuscitation technologies (Manni, C., Proietti, R., Della Corte, F., 'La morte cerebrale: aspetti diagnostici', *Medicina e Morale*, 43 (1993) 903-917). From a physio-pathological point of view, brain death is secondary to the arrest of the cerebral flow (because of the elimination of the pressure of cerebral perfusion following

the fall in arterial pressure) or because of an increase in the intracranial pressure (usually because of cranial trauma, brain haemorrhage, or an expansive process of a neoplastic nature). From an anatomopathological point of view, brain death is characterised by the total and irreversible necrosis of the intracranial nervous structures of the brain stem-encephalon which control vegetative life and of the cortex structures which control relational life.

The diagnosis of brain death is formulated by a medical college made up of an anaesthetist, a neurologist who is an expert in electroencephalography, and by a legal doctor. The period of observation must be six hours for adults and children over the age of five, twelve hours for children between the age of one and five, and twenty-four hours for children under the age of one. Recently the proposal has been made to identify brain death with cortical death as well when necrosis of the cortical area of the central nervous system alone has been verified, even though the brain stem-encephalon structures remain whole and functioning, a clinical condition defined as the *permanent vegetative state*.

From a medical and ethical point of view one cannot identify brain death with death of the cortex because given that the centres of the paleo-encephalon remain integral the capacity to carry out the vital functions, including autonomous breathing, remains active.

Bodies and Popes especially concerned with health, suffering and therapy

The right not to suffer, which fits in very well with what has been observed in this paper so far, does not only have the meaning of distancing pain and suffering. It also means that each individual has in living the sacrosanct right to die and to die in peace without becoming a useless instrument or the victim of absurd uses of the technical which have no purpose.

Recently, various bodies have pronounced on the event of death and dying with particular reference to what can be seen as a real abuse of power that an individual or a group of individuals in a 'vertical' position exercises over a person in a 'horizontal' position who, unfortunately, is experiencing the terminal stage of his or her illness. These bodies are: 1) the Pontifical Council Cor Unum which refers to keeping a sense of proportion in therapies; 2) the Pontifical Council for Health Care Workers, which drew up the *Charter for Health Care Workers* in which it is made clear that the dying person has the right to be accompanied spiritually by a medical doctor as well because 'it is necessary to evangelise death'; 3) the Congregation for the Doctrine of the Faith which defines exaggerated treatment as being: a) useless from a therapeutic point of view because it employs extraordinary and disproportionate means; b) painful from the point of view of the patient who is subjected to useless suffering; 4) the Code of Medical Professional Ethics (art. 37) which emphasises that 'in the case of the terminally ill the medical doctor must limit his work to moral assistance…and appropriate forms of treatment'; 5) Pius XII who in his 'Speech to Medical Doctors' spoke about alleviating the sufferings of the sick person with the use of anaesthetics and the use of ordinary means – nutrition and hydration; and 6) John Paul II who in *Salvifici Doloris* emphasised living the Christian meaning of suffering and in *Evangelium Vitae* n. 65 spoke about using proportionate therapeutic means, stating that 'forgoing extraordinary or disproportionate means is not equivalent to suicide or euthanasia… but acceptance of death'.

Ethical-theological aspects

At every stage of the relationship between the medical doctor and the patient, but above all at the stage of the end of the life of the patient, the health-care worker must bear in mind certain bioethical principles represented by the principle of providing benefit, autonomy and justice.

From a historical point of view, the theorisation and the application of these principles took place in 1974 in the United States of America when research was carried out on individuals who were unaware that they were guinea pigs. To this end the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created. The result of this commission led to the Belmont Report in which three principles were formulated. It appears evident that the most important role in the principle of providing benefit is that of the medical doctor, in the principle of autonomy that of the patient, and in the principle of justice that of society.

The *principle of providing benefit* (in its two components of doing good or providing benefit and not doing harm) emphasises the obligation of the medical doctor to always have in mind the highest good of his or her patient and thus to act in a way to avoid, remove and prevent any injury.

This principle natural to Hippocratic paternalism was maintained until twenty years ago when in the context of social and individual needs the principle of autonomy was developed. The *principle of autonomy* imposes respect for the autonomous decisions of individuals who must be informed so that they can express their *consent*, which must be free and voluntary. Except in cases in which the patient is also a medical doctor, every diagnostic and therapeutic indication can only be made by the health-care worker. In every case, because of his or her dignity as a person, the patient decides

whether to accept or to refuse the medical pathway proposed to him or her thanks to a substantial assessment of his or her own case as a result of the capillary information that has been received. However, the principle of autonomy must not place the medical doctor in a neutral position or even put him or her in a condition of subordination as regards the presumed respect for the fee autonomy of his or her patient. In such a case he or she would no longer be a valuable guide at specific moments such as those of illness and pain. This approach is held to have the same negative character as that offered by the opposed position of medical paternalism in which the health-care worker alone was given the power to decide the diagnostic and therapeutic pathway to be followed by his or her patient. The *principle of justice* stresses that all people should be treated in the same way, quite apart from any difference that an individual may have at a medical, social, cultural, economic or religious level.

These three principles form the basis of the ethical approach defined as *principalism*. In 1990 principalism was flanked by *virtue ethics*, which was also called the new paradigm or the experience paradigm. From virtue ethics in an experiential sense we have passed to the *ethics of caring*. In relation to the triad of principalism, virtue ethics and the ethics of caring we should not forget the principles proposed by personalist bioethics which we can find in the teaching of the Magisterium of the Catholic Church. The most important principle, which is the fundamental condition for every other value, is the *defence of life* as an inviolable good and one that cannot be disposed of at will, from the first moment of existence, that is to say from conception until its natural end.

The physical end of man, above all in non-believers but at times in believers as well, creates fear of death and anxiety about life which are in fact two sides of the same coin. The anxiety created by the general perception of not having but above all else of not being in a continuous contrast between the ideal self and the real self in the context of a rational conscience that stresses the meaning of limit provided by: a) the poverty of material and moral wealth; b) the poverty of effective or potential power; and c) the poverty of self-sufficiency. This poverty that pervades man depends on fear of death as a result of which the power of intelligence gives way at times, if not well formed ethically, to partisan economic, cultural and political power in order to share in its privileges. It should, however, be borne in mind that the efficacy of the power of intelligence depends on the power of the will, whose engine is made up of the ethical formation of the individual who tends to accept death as *dies natalis*, that is to say the day of birth because in this circumstance man can finally behold the face of the Father.

Contemporary culture, however, tends to distance and to neglect the idea of death and to give value solely to concepts that justify the various forms of functionalism that identify man with categories in which the individual is characterised by being an instrumental object (*homo faber*), by the activity of the mind and by its functional integration at the level of the neuronal activity of the encephalon (*homo sapiens*), and by language (*homo loquax*), which represent the various expressions of the establishment in being of form on content (*Sinolo*).

Despite the cultural approach that man imposes on himself in rejecting physical pain, moral suffering and even more the concept of death and the fear of death, knowledge about death is not one of many forms of knowledge but primordial knowledge because man as such because he knows that he will die.

The human being (*antropos*) remains attracted by the influence that nature (*physis*) can have on each living cell (*bios*) and by the possibilities that each living cell can have in relation to his organism. In opposition to what pragmatic sociologism and hedonistic culturalism, which at the present time are dominant, affirm, there is no discontinuity between nature and culture, which are physiologically directed towards a bio-anthropology that is placed between man and death, for the reason as well, as Heidegger observed, that 'death is what stewards man'.

Man, in not taking into account that life is a transcendent gift, tends to come to take possession of it to the point of sharing as *extrema ratio* the euthanasia-informed idea in which the aspect of emotiveness which is adjudged philanthropic prevails in relation to pain and suffering which are no longer accepted. In these circumstances, life is no longer lived in its ontological reality as an individual gift which is unique and irreplaceable from conception until death but as a material instrument in the hands of the will of man who is an absolute arbiter of natural events.

In addition to the objective and irrevocable biological parameter, death emerges as an event characterised by a strong charge of subjectivity given that the way in which an individual dies demonstrates the way in which he or she has lived both as a subject and as a human person. However, when man in the delirium of his omnipotence accepts aggression against the transcendent gift of life to the point of the destruction of this unique and unrepeatable good, this means that he has placed himself in the condition of being defeated by the culture of violence and hatred against which he has not known how to counterpose the culture of Good which is Love above all towards his poor, sick and suffering brothers.

Only when the concept of Life-Man as a divine creature is shared as the only leading para-

meter indicated by the Creator will it be possible to lay the real, authentic and saving bases for a new Evangelisation that proposes a true path which is an alternative path to the woeful artificial selection of human lives, to an indifferent society, to a form of medical science that is often dehumanised, scientistic and mechanistic and which tends to see at times in a suicidal way the whole of mankind solely as a good to be used and to be exploited.

Conclusion

From an ethical point of view, it follows as a conclusion that above all in relation to cancer patients the activity of health-care workers is the expression of a profoundly human and Christian commitment. This is activity that should be taken on and carried out not only as a service of scientific-technical professionalism but also and above all else as a sign of dedication and love towards neighbour. John Paul II, who for years was an exemplary sick person, saw each medical-health care activity as a form of humanitarian and Christian witness.[1] This is an encounter between a trust and a conscience, or rather between a man who is marked by suffering and illness and who entrusts himself to another man, who takes on responsibility for his needs and comes to him to assist him, treat him and if possible heal him. A patient is never only a clinical case, an anonymous individual to whom should be applied the results of one's knowledge but always a human being, towards whom should be adopted a sincere approach of 'sympathy' or, to put the point in better terms, of 'empathy' in the etymological sense of the term. Medical-health care activity, as ethical action, requires love, readiness to help, attention, understanding and sharing. Pope Wojtyla affirmed in addition that 'scientific and professional expertise is not enough; what is required is personal empathy with the concrete situations of the individual patient'.[2] 'Sickness and suffering are phenomena which, when examined in depth, ask questions which go beyond medicine to the essence of the human condition in this world. It is easy to see, therefore, how important in socio-medical service is the presence… of workers who are guided by a holistic vision of illness and hence can adopt a wholly human approach to the suffering patient'.[3]

In the Christian-human vision of life and health, professional expertise, humanitarian service and love for neighbour are mutually integrated. Treating and serving the sick is thus a religious act, in an act of co-operation with God to restore health to a sick person.[4] Aware that physical evil imprisons the spirit and that evil of the spirit weakens the body, the Church has always seen medicine as a support for her redemptive mission in relation to man.

This means that the *healing ministry* of health-care workers shares in the pastoral and evangelising action of the Church.[5] Pope Wojtyla teaches here: 'The ethical norm, based upon respect for the dignity of the person and the rights of sick people, must illuminate and discipline both the stage of research and the stage of the application of the results of that research that have been achieved'.[6]

Faithfulness to the moral norm is, therefore, participation in the wisdom of the divine Legislator but also faithfulness to man and a guarantee of the sacred character of his life.[7] It is advisable to observe that the direct consequence of this value of life is its non-disposability, its untouchability, which every upright intelligence can recognise, even prescinding from religious faith.[8] This should be underlined at a time of the invasive development of biomedical technologies where there is an increasing risk of an abusive manipulation of the beginning of human life and its natural death. It is also advisable to make clear that the techniques in themselves are not called into question, indeed quite the contrary, but their purported ethical neutrality is. This is because not everything that is technically possible can be held to be morally admissible. Science and technology 'Science and technology are valuable resources for man when placed at his service and when they promote his integral development for the benefit of all; but they cannot of themselves show the meaning of existence and of human progress. Being ordered to man, who initiates and develops them, they draw from the person and his moral values the indication of their purpose and the awareness of their limits'.[9] The fathers of the Second Vatican Council observed realistically: ' All the endeavours of technology, though useful in the extreme, cannot calm his anxiety; for prolongation of biological life is unable to satisfy that desire for higher life which is inescapably lodged in his breast. Although the mystery of death utterly beggars the imagination, the Church has been taught by divine revelation and firmly teaches that man has been created by God for a blissful purpose beyond the reach of earthly misery. In addition, that bodily death from which man would have been immune had he not sinned will be vanquished, according to the Christian faith, when man who was ruined by his own doing is restored to wholeness by an almighty and merciful Saviour. For God has called man and still calls him so that with his entire being he might be joined to Him in an endless sharing of a divine life beyond all corruption'.[10]

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Bibliography

ANGELINI, F. (ed.), *Pio XII. Discorsi ai Medici* (Orizzonte Medico, Rome, 1959).

ARIÈS, P., *Storia della morte in Occidente* (BUR, Milan, 1998).

BRUERA, E., FAINSINGER, R.L., and RIPAMONTI, C., 'Rapid hypnotic discontinuation in patients with advanced cancer', *Annals of Oncology*, 7 (1996), 855-856.

CERVERO F., 'Pathophysiology of referred pain and hyperalgesia from viscer', in L. Vecchiet, D. Albe-Fessard, U. Lindblom., and M.A. Giamberardino (eds.), *New Trends in referred pain and hyperalgesia*, *Elsevier*, 7 (1993), pp. 35-46.

CICCONE, L., *Bioetica* (Ed. ARES, Milan, 2003).

Comitato Centrale della Federazione Nazionale degli Ordini dei Medici e degli Odontoiatri, *Codice di Deontologia Medica*, Rome, 3 Ottober 1998.

CRAIG, K.D., 'Social modeling influences on pain', in R.S. Sternbach (ed.), *The psychology of pain* (Raven Press, New York, 1978), pp. 73-109.

DEL TACCA, M., *L'Etica nella ricerca biomedica* (Ed. NIS, Rome, 1997)

European Association for Palliative Care, *Definizione di Cure Palliative*, Newsletter n. 1, 1989.

FOREMAN, R.D., 'Spinal mechanisms of referred pain', in L. Vecchiet, D. Albe-Fessard, U. Lindblom., and M.A. Giamberardino (eds.) *New Trends in referred pain and hyperalgesia*, *Elsevier*, 7 (1993), pp. 45-57.

GALLETTI, R., DURANTI, R., and ZUCCHI, P.L., 'Rilievi sulle modificazioni dei tessuti cutaneo e sottocutaneo nel quadro dell = iperalgesia sperimentale', *Il Dolore*, 3 (1979), pp. 111-121

JOHN PAUL II, *Evangelium Vitae*, 25 March 1995.

JOHN PAUL II, *Salvifici Doloris,* 11 February 1984.

GRACIA, D., *Fondamenti di Bioetica* (Ed. San Paolo, Cinisello Balsamo (MI), 1993).

HONINGS, B., 'Algologia e principi bioetici nella dottrina della Chiesa', in *Compendium of Pain Semantics*, (It-Engl.), 12 (2003), pp. 85-95, published by the Institute for the Study and Therapy of Pain, Florence, Italy.

HONINGS, B. and ZUCCHI, P.L., 'Diritto di non soffrire. Dovere di soffrire. La sofferenza nel mistero della salvezza', *Il Volto dei Volti*, 1 (2004), pp. 35-48.

HONINGS, B., *Iter Fidei et Rationis. Teologica, Moralia, Iura* (P.U.L., Rome, 2004).

HONINGS, B., 'Un dialogo pluridisciplinare sulla vita umana. Un presunto conflitto fra progressi medico-tecnici e norme morali', *Dolentium Hominum*, 62 (2006), pp. 36-40.

HEIDEGGER, M., *Dell'essenza della verità* (Davos, 1930).

International Association for the Study of Pain (I.A.S.P.), 'Pain terms. A list with definitions', *Pain*, 14 (1982), p. 205.

JACOX, A.K., 'Sociocultural and psychological aspects of pain', in Jacox, A.K. (ed). *Pain: a source book for nurses and other health professionals* (Little, Brown, Boston, 1977), pp. 57-87.

JANIG, W., 'Spinal visceral afferents, sympathetic nervous system and referred pain'. in L. Vecchiet, D. Albe-Fessard, U. Lindblom, and M.A. Giamberardino (eds.), *New trends in referred pain and hyperalgesia*, *Elsevier*, 7 (1993) pp. 83-98.

KOSAMBI, D.D., 'Living prehistory in India', *Sci. Amer*., 216 (1967), p. 105.

KROEBER, A., *Anthropology* (Harcourt, 1948).

LASAGNA, L., 'The prognosis of death', *in Levine, S, The dying patient* (Russel Sage Foundation, New York, 1970).

LOZANO BARRAGÁN, J., *Definizione del termine salute*, confermed by H.h. John Paul II in the Message for the World Day of the Sick, 11 February of the Jubilee Year 2000.

MAYOU, R., 'Burn-Out', *Br. Med. J.* 295 (1987), pp. 284-287.

MC CAFFERY, M., 'Sociologic effects of cancer pain', in Bonica, J.J. and Ventafridda, V. (eds.), Advances in pain research and therapy 2 (Raven Press, New York, 1979), pp 99-102,

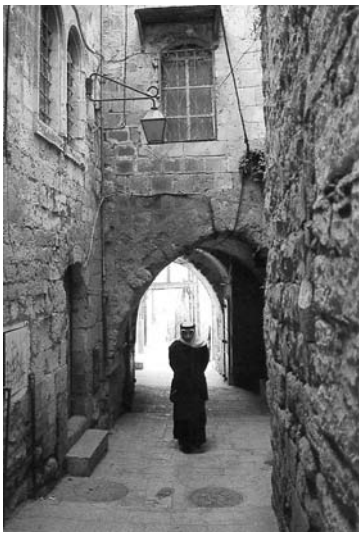
MENSE, S., 'Spinal mechanisms of muscle pain and hyperalgesia', in L. Vecchiet, D. Albe-Fessard, U. Lindblom, and M.A. Giamberardino (eds.), *New trends in referred pain and hyperalgesia*, *Elsevier*, 7 (1993) pp. 25-34.

OBLETTER, G., SCHIAVONE, C., DI COSMO, C., ZUCCHI, P.L., GIAMBERARDINO, M.A., DRAGANI, and VECCHIET, L. 'Muscle pain from eccentric contraction: echographic findings on muscle and subcutaneous tissue changes', *Schmerz, Pain, Douleur*, 9 (1988), pp. 304-308.

WHO., *Cancer pain relief* (Geneva, 1986).

Pontificio Consiglio COR UNUM, *Alcune questioni etiche relative ai malati gravi e ai morenti,* 27 May 1981 (Edizioni Dehoniane, Bologna, 1982), p. 19.

Pontificio Consiglio della Pastorale per gli Operatori Sanitari, *Carta degli Operatori Sanitari* (Vatican City, 1995).



PORTENOY, R.K., PAYNE, D., and JACOBSEN, P., 'Breakthrough pain: characteristics and impact in patients with cancer pain', *Pain*, 81 (1999), pp. 129-134.

RUSSO, G., *Bioetica e sessuologia* (Ed. Ellenici, Turin, 20049.

SAUNDERS, C., 'The nature and management of terminal pain and the hospice concept' in Bonica , J.J. and Ventafridda, V. (eds.), *Advances in pain research and therapy 2* (Raven Press, New York, 1979), pp. 635-651.

SGRECCIA, E., *Bioetica*, vols. I-II (Edizioni Vita e Pensiero, Milan, 1994).

SGRECCIA, E., CARRASCO DE PAULA, I., *Qualità della vita ed etica della salute* (Libreria Editrice Vaticana, Vatican City, 2006).

SPAGNOLO, A. G., *Bioetica nella ricerca e nella prassi medica* (Ed. Camilliane, Turin, 1997).

TEODORI, U., *Trattato di Patologia Medica* (S.E.U., Rome, 1973).

TETTAMANZI, D., *Nuova Bioetica Cristiana* (Edizioni, Piemme, 2000).

TIENGO,M., 'Nocicezione e Dolore', in M. Tiengo, *Cervello e mente nella terapia del dolore*. *Pathos*, 4 (1995), pp. 4-9.

VENTAFRIDDA, V., RIPAMONTI, C., and BIANCHI, 'A randomized study on oral administration of morphine and methadone in the treatment of cancer pain', *J. Pain Symptoms Management*, 1 (1986), pp. 203-207.

WALL, P.D., 'Neurophysiological mechanisms of referred pain and hyperalgesia', in L. Vecchiet, D. Albe-Fessard, U. Lindblom, and M.A. Giamberardino (eds.), *New trends in referred pain and hyperalgesia*, *Elsevier*, 7 (1993), pp. 3-12.

WARING, E.M., 'The relationship of chronic pain to depression, marital adjustment and family dynamics, *Pain* 5 (1978), pp. 285-292.

WOLFF, B.B., 'Ethnocultural factors influencing pain and illness behavior', *Clin. J. Pain*, 1985, pp. 1-23.

ZBOROWSKI, M., 'Cultural components in responses to pain', *J. Soc. Issues*, 195, pp. 8-16.

ZUCCHI, P.L. and DURANTI, R., *Argomenti di Patologia Medica* (Ed. Scient. Uncini-Pierucci, Florence, 1979), pp. 1-660.

ZUCCHI, P.L., VIVALDI-FORTI, C., MILANESI, E., and OBLETTER, G., 'Definizione del termine dolore', in 'Test di personalità proiettivi (Rorschac, T.A.T.) e non proiettivi (M.M.P.I.) nella cefalea psicogena e nella cefalea da tensione muscolare. Indirizzi terapeutici', *Algologia*, 1 (1983), pp. 41-82.

ZUCCHI, P.L. and HONINGS, B., 'La Fede come elemento trascendente e facilitante il risultato terapeutico nel paziente sofferente. Studio controllato in cieco su un gruppo di soggetti affetti da patologie dolorose croniche', *Dolentium Hominum*, 33 (1996), pp. 16-28 (It-Engl).

ZUCCHI, P.L., HONINGS, B., and VOEGELIN, M.R., 'Pain, Faith, Prayer', in P.L. Zucchi (ed.), *Compendium of Pain Semantics,* published by the Institute for the Study and Therapy of Pain, Florence-Italy, n.11, 2001, pp 1-383 (It-Engl.).

ZUCCHI, P.L., HONINGS, B., and VOEGELIN, M.R., 'Effetto della lettura evangelica meditata sulla area iperalgesica e sulla percezione del dolore nella sindrome algica lombare', *Dolentium Hominum*, 53 (2003), pp. 44-51 (It-Engl.).

ZUCCHI, P.L., HONINGS, B., and VOEGELIN, M.R., 'Dolore, Musica, Preghiera', *Dolentium Hominum*, 60 (2005), pp. 14-30 (It-Engl.).

ZULEHNER, P.M., *Passaggi. Pastorale delle fasi della vita* (Queriniana, Brescia, 1992), p 304.

Notes

[1] Cf. GIOVANNI PAOLO II, 'Durante la visita al «Mercy Maternità Hospital» di Melbourne', 28 nov. 1986, in *Insegnamenti* IX, 2, 1986, 1734, n. 5.

[2] Cf. GIOVANNI PAOLO II, 'Al Congresso dei Medici Italiani', *L' Osservatore Romano*, 18 October 1988.

[3] JOHN PAUL II, Motu proprio *Dolentium hominum*, 11 Feb. 1985, quoted in *Charter for Health Care Workers* of the Pontifical Council for Health Care Workers,, 1995, fourth edition, n. 3, hereafter 'Charter'.

[4] Cf. Charter, n. 4.

[5] Cf. Charter, n. 5.

[6] GIOVANNI PAOLO II, 'Ai partecipanti a un Congresso di chirurgia', 19 feb. 1987, in *Insegnamenti* X/1 (1987), 375 , n. 3.

[7] Cf. Charter, n. 6.

[8] Cf. Charter, n. 43.

[9] Congregation for the Doctrine of the Faith, Instruction *Donum vitae,* 22 Feb, in *AAS* 80 (1988), 73.

[10] Pastoral Costitution *Gaudium et spes* of the Ecumenical Second Vatican Council on the Church and the contemporary world nn. 18, 22.

Testimonies

Towards the 2008 International Eucharistic Congress in the Company of Mary the Immaculate Conception

The Grace of Illness

Nicaragua: the Church and HIV/AIDS

Portugal: the Second National Congress on Pastoral Care in Health

The Life and Works of Blessed Don Luigi Monza

Towards the 2008 International Eucharistic Congress in the Company of Mary the Immaculate Conception

The Holy Father Benedict XVI, at the audience granted to those taking part in the seventh plenary session of the Pontifical Council for Health Care Workers, on 22 March 2007, said 'allow me therefore to deliver again to you at the level of ideas the reflections that I proposed in the encyclical (*Deus Caritas est*) with the relative pastoral orientations on the charitable service of the Church as a 'community of love'. And to that encyclical I can now add also the post-synod apostolic exhortation published recently which in a broad and structured way addresses the Eucharist as a 'sacrament of charity'. It is specifically from the Eucharist that pastoral care in health can constantly draw strength to come effectively to the aid of man and promote him according to the dignity that is specifically his. In hospitals and rest homes the chapel is the pulsing heart where Jesus offers himself unceasingly to the heavenly Father for the life of mankind. The Eucharist, distributed decorously and with the spirit of prayer to the sick, is the vital lymph that comforts them and infuses in their spirit inner light by which to live with faith and hope the condition of illness and suffering. I thus also entrust to you this recent document: make it yours, apply it to the field of pastoral care in health, drawing from it appropriate spiritual and pastoral indications'.

This authoritative Petrine message calls on the Pontifical Council to promote an intense and special journey of those who are involved in 'pastoral care in health' in that direction, which is already underway in the Church, and which is being prepared for by the International Eucharistic Congress, which will be celebrated in Canada, in Quebec, on 15-22 June 2008, on the subject 'The Eucharist, Gift of God for the World'.

I. 'International Eucharistic Congresses'

The institution within the Church of this strong time of research and solemn celebration of the 'holy mystery' is rather recent. The first such congress was celebrated in 1881 in Lille in France. This initiative began with a woman called Emilie Tamisier (1834-1910) who derived inspiration from St. Pier Giuliano Eymard, the Apostle of the Eucharist (1811-1868). Members of the lay faithful, priests and bishops, with the blessing of Pope Leo XIII, gave rise to the 'First International Eucharistic Congress' whose subject was 'The Eucharist Saves the World'.

The 'Eucharistic Congresses' have always been a source of spiritual revision, an opportunity of God for a renewal of the relationship of life with the Most Holy Eucharist. An instrument for penetration into the most valuable treasure left to us by Our Redeemer.

The preparations for the congress of Quebec began in October 2004 when Pope John Paul II entrusted Cardinal Marc Oullet, the Archbishop of the first diocese of Canada, with the honour and task of organising it. The Cardinal Archbishop is proud to stress that 'the congress will be celebrated during the year that commemorates the four hundredth anniversary of the foundation of the city of Quebec, the seat of the first Catholic diocese north of Mexico'. And referring to the subject of the congress, he stresses that 'the Eucharist, as we receive it from the account of its institution is witness to the gift of love that the Son makes of himself for the many, a gift of love for the Father and for us, which seals the New Covenant….It appears in this way as the gift that the Father makes to the world in his Only Son, made flesh and crucified, which draws around his table the dispersed children of God…Lastly, (it is) the gift of the Trinitarian communion for the life of the world through the action of the Holy Spirit that assures the intimate participation of the faithful in this mystery of the Covenant'.

This will be an intense week of celebrations and cultural events, catechesis and brotherly meetings, and of witness to sharing with sick and poor brethren. It would be good to be present, to take part personally and to be immerged by the healing wave that the ecclesial community will receive as a gift from the Holy Spirit during those days. One can do this spiritually, trusting in what Pope Benedict XVI promised us: ' Not only those who have an opportunity to take part personally but also the various Christian communities that are invited to join themselves to it at the level of ideas will be able to benefit from the special graces that the Lord will dispense at the International Eucharistic Congress. In those days the Catholic world will fix its eyes on the heart of the high mystery of the Eucharist in order to draw from it renewed apostolic and missionary drive. This is why it is important to prepare oneself well and I thank you, dear brothers and sisters, for the work that you are carrying out to help the faithful of every continent to understand ever more the value and the importance of the Eucharist in our lives…How much need mankind has to rediscover in the sacrament of the Eucharist the source of its own hope! I thank the Lord that many parishes, side by side with the due celebration of the Holy Mass, are educat-

ing the faithful in the adoration of the Eucharist and I hope, in view of the next International Eucharistic Congress as well, that this practice will become increasingly widespread'.[1]

2. Let us Answer the Invitation

The 'delivery' of the Holy Father finds this Pontifical Council strongly involved in calling the attention of those who are pastorally involved in the field of health care and health to the potential value of 'suffering' for the whole of the human community because 'Christ *has also raised human suffering to level of the Redemption*. Thus each man, in his suffering, can also become a sharer in the redemptive suffering of Christ[2]…In the body of Christ, which is ceaselessly born of the Cross of the Redeemer, it is precisely suffering permeated by the spirit of Christ's sacrifice that is the *irreplaceable mediator and author of the good things* which are indispensable for the world's salvation. It is suffering, more than anything else, which clears the way for the grace that which transforms human souls.'[3]

And it will do this following the pathway indicated by the *Sacramentum Caritatis*: 'Most Holy Mary, Immaculate Virgin, ark of the new and eternal covenant, accompany us on this pathway of encounter with the Lord who comes. In her we find realised the essence of the Church in the most perfect way. The Church sees in Mary, 'Eucharistic woman', as the Servant of God John Paul II called her (cf. John Paul II, encyclical letter Ecclesia de *Eucharistia* (17 April 2003), 53: *AAS* 95 (2003), 469), its most successful icon and contemplates her as the irreplaceable model of Eucharistic life' (n. 96).

3. 'Mary Eucharistic Woman'

Ancient Fathers and theologians always proclaimed in the Church that 'the flesh born of Mary, coming from the Holy Spirit, is bread descended from heaven[4]…her womb has made a fruit flower, bread that has filled us with angelic gift. Mary has restored to salvation what Eve destroyed by her sin[5]…That body that the most blessed Virgin generated, nourished in her womb with maternal care, that body, I say, without doubt and not another, we now receive from the sacred altar, and we drink its blood as the sacrament of our redemption. This is held by the Catholic faith, this the holy Church faithfully teaches'.[6]

The Blessed Virgin is not only a 'mother' but is also existentially involved in the 'Eucharistic Mystery' and thus John Paul II states that 'Mary is 'Eucharistic' woman with her entire life'.[7]

Where the smallest Christian community sings the praises of the Most Holy Mary, the Eucharist is at the centre of the fraternal encounter as the unique and absolute principle of the generative force of the unity of the Church.[8]

The words of the consecration said on the separate 'signs' of the bread and the wine make Christ present in the act of his offering to the Father on the Cross. 'Let us place ourselves above all *to listen to the Most Holy Mary*, in whom the Eucharistic mystery appears, more than in any other, as a *ministry of light*. In looking at her we know the transforming power that the Eucharist possesses…In the humble sign of the bread and the wine, transubstantiated into his body and his blood, Christ walks with us, as our strength and our viaticum, and makes us all witnesses to hope'.[9]

We have affirmed and seen that the Blessed Virgin Mary is existentially involved in this 'Holy Mystery'. Historically, Holy Scripture demonstrates that 'she has been personally associated with the Sacrifice of the Cross, with her consent, with her motherly love, with her faith, with the offering of herself into the hands of the Father. With this complete personal union with the unique sacrifice of Calvary, Mary perfectly lived what the Church has continued to live down the centuries in the sacramental celebration. By means of the Eucharistic Consecration, Christ gives himself to us by offering himself to the Father in an act that is the re-actualisation of his sacrificial offering on Calvary. Now, Mary was present at this sacrifice and was intimately associated with it'.[10]

It is in this prerogative of '*Mater Dolorosa*', who with dignity is at the foot of the cross (cf Jn 19:25) that the '*sensus fidelium*' strongly involves her when the Ecclesial Community gathers around its 'limbs' that bear in its body the signs of the '*infirmitas*' of Man.

The Church feels and believes that 'finally, bearing with a strong and trusting spirit her immense pains, more than all the Christian faithful, as true Queen of martyrs 'completes what is lacking in the sufferings of Christ…for his Body, the Church' (Col I:24)'.[11] And one can well say that 'the divine Redeemer wishes to penetrate the soul of every sufferer through the heart of His Holy Mother, the first and most exalted of all the redeemed'.[12]

4. The 'World Day of the Sick'

The Pontifical Council which received the pressing invitation of the Holy Father to apply 'to the field of pastoral care in health, drawing from it appropriate spiritual and pastoral indications' sees in the next 'World Day of the Sick', which is centred round the Liturgical Memorial of the Blessed Mary of Lourdes, the providential celebration of creating a 'mystical bridge' between the Marian little town of the Pyrenees and Quebec in the sign of the 'Eucharistic woman', making available to the community of men 'human sufferings (which), united to the redemptive suffering of Christ, constitute a special support for the powers of good, and open the way to the victory of these salvific powers'. [13]

For a hundred and fifty years Lourdes has been a privileged place for the sublimation of human suffering in the Eucharist passing by way of Mary the Immaculate conception.

A 'holy place' which for John Paul II from the early years of his pontificate was the geographical point *par excellence* in which was to be found the 'Reality of faith, of hope, and of charity. A reality of sanctified and sanctifying suffering. Realty of the presence of the Mother of God in the mystery of Christ and his Church on earth: a presence especially living in that chosen portion of the Church, which is made up of the sick and the suffering…The sick discover in Lourdes the inestimable value of their suffering. In the light of the faith they come to see the fundamental meaning that pain can have not only in their lives, interiorly renewed by that flame that consumes and transforms, but also in the life of the Church, the mystic body of Christ. The most holy Virgin who on Calvary courageously stood at the foot of the cross of the Son (Jn 19:25) took part personally in his passion, knows how to convince ever new souls to join their sufferings to the sacrifice of Christ in a choral 'offertory' which in going beyond times and spaces embraces the whole of mankind and saves it'. This is what the Pope said at the homily of the Holy Mass celebrated with the sick in the Basilica of St. Peter's on 11 February 1980.

And it was twelve years after that day that John Paul II of venerable memory on 13 May 1992, the anniversary of the attack on his life of 1981, established the World Day of the Sick which he expressly wanted to link to Lourdes because Lourdes is 'one of the most loved Marian sanctuaries by the Christian people, it is the place and at the same time the symbol of hope and of grace in the sign of the acceptance and the offering of salvific suffering[14]…At the foot of the cross Mary suffers in silence, a participant in a very special way in the sufferings of the Son, made the mother of mankind, ready to intercede so that every person can obtain salvation (cf. *SD*, n. 25). At Lourdes it is not difficult to understand this special participation of Our Lady in the salvific role of Christ. The wonder of the Immaculate Conception reminds believers of a fundamental truth: it is possible to obtain salvation only by taking part meekly in the project of the Father who wanted to redeem the world through the death and resurrection of his only begotten Son'.[15]

5. The Message of Lourdes

In the Eucharistic celebrations with the sick, wherever these take place, one cannot but look to Lourdes and hear echo the message of the 'White Lady' entrusted to the little Bernadette. Penance and prayer for sinners she was asked by Our Lady, making her hear all the weight of the Passion of the Son during the vision of 25 February 1858. A witness who was next to her, Mrs Marie Pailhes, attested that 'it seemed that she bore all the sufferings of the world'.[16]

Bernadette carried on her body until her death the sufferings of the Passion which were invisible but burning. 'I am ground down like an ear of corn' she said one day as her

life was coming to a close.[17] Lourdes is truly 'the place and at the same time the symbol of hope and grace in the sign of the acceptance and offering of salvific suffering'. It is the place that gives the message that 'love is greater than death', as is proclaimed by the fifteenth station of the Via Crucis with the great tomb stone that was brushed aside on the morning of the Resurrection.

The water that springs from the rocks of Massabeille, which the tender and white lady indicated to Bernadette in the 'eleventh apparition' of Thursday 25 February, is 'the sign of Christ from whose rib sprung water and blood to wash away our sins. It is in memory of baptism and the celebration of reconciliation that this water acquires full meaning'.[18] The Missal of the Parish of Lourdes proposed that day for the celebration of the Eucharist the reading of this passage from the passion (cf Jn 19:34) but Bernadette did not know it. Our Lady had guided her to portray and live the Passion of the Son for sinners.

And it was only on the day of the Annunciation, Thursday 25 March, that the 'Lady clothed in white… with a blue band and a yellow rose on both her feet of the same colour of the crown of her rosary'[19] revealed her name: 'I am the Immaculate Conception'.

How can one not think of a specific decision to place in a very close relationship with the moment of the Incarnation her being 'full of grace' and the descent to Lourdes, amongst the People on the march, tired, lacking in confidence, sick, and in disorder? Immense crowds of pilgrims over the last one hundred and fifty years have come to this 'city of 'yes' to the will of God' to implore light, hope, and health of the body and of the soul.

Lourdes is a constant sign of the revelation of the irruption of our history as a People on the march of Mary the *Immaculate Conception*. Of she, that is to say, that the infinite Goodness of God, established that 'as a woman she helped to give death, as a woman she helped to give life… who gave to the world the very Life that renews everything, and was enriched by God with gifts consonant with such an office'.[20]

Of she who had already achieved in her person the overall and total health of body and soul through the merits of the Son Jesus, and is the 'image and beginning of the Church which will its completion in the future age, so that on the earth shines before the People of God in pilgrimage as a sign of certain hope and consolation, until the day of the Lord comes'.[21]

The Blessed Virgin Mary places herself at the side of mankind in pain that goes to Lourdes as '*Salus infirmorum*', and she comes as a 'sign' of certain hope because she is the 'Immaculate Conception'.

6. Our 'Lourdes' for Quebec

The Holy Father has told us that 'in hospitals and rest homes, the chapel is the beating heart in which Jesus offers himself unceasingly to the Heavenly Father for the life of mankind'.

And where there is a creature that suffers in body and soul there 'is manifested also the dignity and the meaning of human existence. The witness that my beloved predecessor John Paul II remains inscribed in our hearts: from the teaching chair of suffering he made a summit of his Magisterium. Illuminated and encouraged by such great witness, the Church is called to express solidarity and concern towards those who have to address the trial of illness, first of all helping them to see illness and death itself not as a negation of the human but as a pathway which, in the wake of the suffering, death and resurrection of Jesus, leads us to true and eternal life'. [22]

Every chapel in public or private places of care can live out its 'little Lourdes for Quebec'. But also each parish with the whole of its local community, in whose territory today are to be found 'invisible and anonymous wards' of human suffering as a result of the global trend of the shortening of the times spent in hospital, can frequently celebrate its 'little Lourdes' directed towards the great Mystery of the '*Sacramentum Caritatis*' in the company of the Blessed Immaculate Virgin Mary.

The Christian people, which has always perceived the providential motherhood of Mary in its own existence, experiences it especially in the 'sacred table – the liturgical celebration of the Mystery of the Redemption – in which Christ becomes present, his real body born of the Virgin Mary'. Rightly the piety of the Christian people has always seen a profound link between devotion to the Holy Virgin and the cult of the Eucharist… Mary guides the faithful to the Eucharist'.[23]

In our small and domestic 'Lourdes', with one's eyes and heart directed towards Quebec, one can, one must, involve the whole local community, the 'pained' part and the part of the 'Good Samaritan', so that the next 'International Eucharistic Congress' will light up in the whole of the Church a new fire for the Holy Mystery given by the Redeemer… set in motion a radical revolution in every ecclesial community, so as to arise as a rampart against 'the sin of the world' that every say becomes more burning and devastating.

The suffering of man is a mystery. John Paul II, who was an incomparable Teacher on the subject for the whole of his pontificate, taught us that it can be bent and channelled for the salvation of the world.

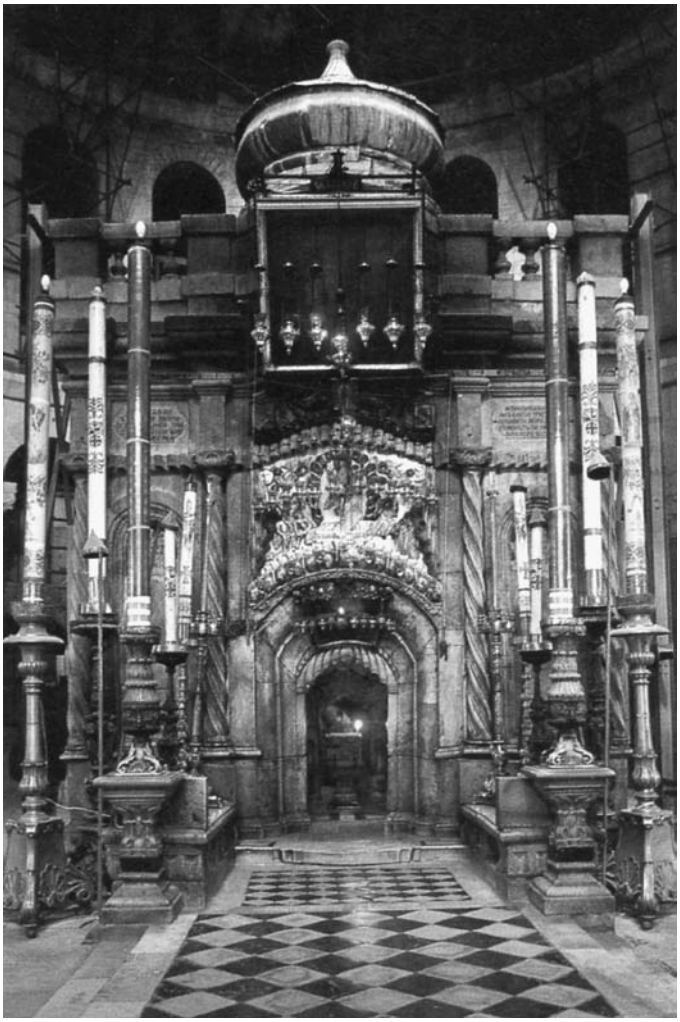
With his '*Lectio Magistralis*' that he gave us during the last month of his life, Pope John Paul II bequeathed to us the right and healing direction to follow in the company of Mary the Mother of the Word made Flesh, providing broad witness that what he had written was experienced intensely: 'it was on Calvary that Mary's suffer-

ing, beside the suffering of Jesus, reached an intensity which can hardly be imagined from a human point of view but which was mysteriously and supernaturally fruitful for the redemption of the world… In the light of the unmatchable example of Christ, reflected with singular clarity in the life of His Mother, the Gospel of suffering, through the experience and words of the Apostles, becomes an inexhaustible source for the ever new generations that succeed one another in the history of the Church. The Gospel of suffering signifies not only the presence of suffering in the Gospel, as one of the themes of the Good News, but also the revelation *of the salvific power and salvific significance* of suffering in Christ's messianic mission and, subsequently, in the mission and the vocation of the Church[24] …*Together with Mary*, Mother of Christ, *who stood beneath the cross* (Jn 17:11, 21-22), we pause beside all the crosses of contemporary man'.[25]

Rev. FELICE RUFFINI MI,
Under-Secretary
of the Pontifical Council
for Health Care Workers,
The Holy See.

Notes

[1] Speech to those taking part in the plenary assembly of the Pontifical Committee for International Congresses, Sala Clementina, 9 November 2006.
[2] JOHN PAUL II, apostolic letter *Salvifici doloris*, 14 February 1984, n. 19 (hereafter *SD*).
[3] *Ibid*., n. 27.
[4] HILARY OF POITIERS (+367), in *Testi Mariani del primo millennio* (Città Nuova Editrice, Rome, 1990), vol. 3, p. 125, n. 18 (hereafter *TMPM*)
[5] Sacramentarlo Bergomense, manuscript of the ninth century, 'Prefatio della Domenica VI di Avvento', in *TMPM*, p. 969.
[6] ST. PIER DAMIAN (+1072), in *TMPM*, p. 872, n. 6.
[7] *EdE*, n. 53.
[8] Cf. JOHN PAUL II, *EdE*, chapter II, 'The Eucharist Builds the Church'.
[9] *Ibid*., n. 62.
[10] AMATO ANGELO SDB, 'Eucaristia', in *Nuovo Dizionario Mariano*, edited by S. De Fiores and S. Meo (Edizioni Paoline, 1986), p. 535, col. Ia.
[11] PIUS XII, encyclical letter *Mystici Corporis*, 29 June 1943, 'Conclusion'.
[12] JOHN PAUL II, *SD*, n. 26.
[13] *Ibid*., n. 27.
[14] JOHN PAUL II, letter to Cardinal F. Angelini establishing the World Day of the Sick, 13 May 1992, n. 3.
[15] JOHN PAUL II, letter to Cardinal J. Lozano for the World Day of the Sick 2004 in Lourdes on the occasion of the 150th anniversary of the definition of the dogma of the Immaculate Conception, 1 December 2005.
[16] J. BORDES, *Lourdes – Seguendo i passi di Bernadette* (MSM, 1991), p. 23.
[17] *Ibid*., p. 55.
[18] *Ibid*., p. 84.
[19] *Ibid*.,p. 15.
[20] The Second Vatican Council, Dogmatic Constitution *Lumen gentium*, n. 56.
[21] *Ibid*., n. 68.
[22] Message to the Italian Bishops at Assisi for the fifty-fifth general assembly – Assisi, 14-18 November 2005.
[23] JOHN PAUL II, encyclical letter *Redemptoris Mater*, 25 March 1987, n. 44.
[24] *SD*, n. 25.
[25] *Ibid*., n. 31.



The Grace of Illness

MSGR. EUGENIO ROMERO POSE WROTE THIS TESTIMONY DURING LENT IN THE YEAR 2006. IT WAS PUBLISHED IN THE REVIEW MAGNIFICAT.

'Your grace is worth more than life' are words of the psalmist that are experienced as truth when one is blessed by illness and one touches the limits of one's own precariousness. To feel the chill of the weakness of one's body that becomes consumed, of one's mind that darkens, and of the corruptibility that takes possession of what one thinks one possesses, acquire a new meaning when one opens one's eyes to the truth of pain. And one can only look forward and exit from the spiral of the absurd when in prayer one allows one's heart to receive the light of he who suffered and tasted the bile of suffering unto the final extreme.

In feeling the inexorable inability of illness that involves feeling that you are the master neither of life nor of death, then, and only then, do you raise your eyes to on high and receive the balsam that makes existence sweeter. You look inside and find he who, the first of all, did not deny giving of himself for a non-definitive end that opens the doors to a life in fullness.

Illness is prophecy of death. Death when it arrives is an experience that makes us touch to the depths our smallness so that we can wait for a new life, and in waiting for it we give thanks to it. One cannot appreciate life if one does not accept death. To wait for the fullness of life means to ensure that fear and death do not imprison one's soul and one's heart. To live illness and not to kill the tenderness that is born with it, means to ensure that one speaks the truth about life and says 'no' to falsehood. To conceal and not to contemplate illness means that true speech is silenced for ever.

Good Father who gives to everyone and to all people life so that we may know Your love. Father the Creator you have given me Your love; so many times my inability to hold You and to hold in my hands the gifts that You offered me from Your hands, distanced me from You. I know that although You distance me, You will never allow me to escape from Your creative hands.

The sweetness with which You directed Your face to Adam who was sick and lost in a paradise that he thought belonged only to him reached to my ears. I know how Your servant Job in the silence of being abandoned, kept himself alive thanks to Your support. The nearness of Your being and remaining next to the sick, the poor and the weak that Your Son, Jesus Christ, encountered and healed in the roads of Galilee, Samaria and Judea, reached my ears. I still feel the healing hand of the Nazarene who, more than any other, tasted suffering, the darkness of pain, and delivered it unto death as a manifestation of the glory of God.

Yours, Lord Jesus, is the glory of the Father, that glory that illuminates the flesh that suffers, that glory that opens up unending horizons, and that glory that gives the communion that saves and offers incorruptibility. Thanks to your Cross, Humanity is transformed by the Spirit of Life.

I pray to you Lord that I may know in pain to ask you for the Spirit so that my life, on this pilgrimage which one day will die, and my death, be on your Cross; reach out your hand to me so that despite the darkness of my journey I may have the sincere certainty of one day opening my eyes and seeing you at the right hand of the Father with the Holy Spirit.

During many sunsets, in moving towards sleep, I hoped to meet you in that morning that has no end. But only you, Lord of my life and illness, know when that day will come that has no sunset. In the meantime allow me never to leave you and I give thanks because every moment is a miracle while I await another, greater miracle – eternal life, living with you.

I abandon myself, sick and weak, to your arms, which made me, and to those of your brethren who on the journey of pain communicate to me your warmth. Your hands are full of mercy. In them do I take refuge and in them do I hide with all those who feel the announcement that earthly life is the announcement of that other life in which illness and death are always defeated.

Thank you, Lord, for my life and my illness because you have taught me that you grace is worth more than life, that the cold of death will not allow the fire of your love to be extinguished.

Alpha and Omega, 29.3.2007

Msgr. Eugenio Romero Pose was the auxiliary bishop of the diocese of Madrid. He died during the dawn of the fifth Sunday of Lent, 25 March 2007.

Nicaragua: the Church and HIV/AIDS

'The pandemic of HIV/AIDS is one of the gravest health, socio-economic, security and human-development crises that the planet is facing. It is killing millions of adults with its full force. It breaks up and impoverishes families, weakens the workforce, transforms millions of children into orphans, and endangers the social and economic tissue of communities and the political stability of nations' (CELAM, letter on AIDS letter).

In the year 2005 more than 5.5 million people were infected by HIV/AIDS and three million people died from it. In Nicaragua this threat is silently growing.

The Approach of the Church

We encounter the problem of stigmatisation which condemns these people to social death before the disease has provoked their physical death. Many infected people live in fear of being distanced from their families and marginalised by society. We turn to you, their relatives and friends: do not distance them from their families, thereby making the cross that they bear even heavier. Accompany them with understanding and love. In these moments they have greater need than ever.

We invite you, our infected brothers and sisters, to put all your trust in the God of Life and to say with the psalmist: 'God is my refuge and my strength, in You I trust' (Ps 91:1). Offer your sufferings and worries to the Lord and master of every living being.

In addition, it is an absolute requirement of your love to live a disciplined life so as not to infect other people.

Promoting the Civilisation of Love

The Church demonstrates her concern and compassion with concrete facts, the need for which encourages us to act with greater commitment every day. At a world level, 27% of cases of care are in the hands of the Church and in Central America this figure reaches 75%. We thank the religious and all those who look after these sick people with self-denial. To deal with these matters and problems in a more effective way, Caritas in Nicaragua in March 2006 formed a commission made up of members from various parts of the country.

Drugs and Medicines for the Sick

The compelling need to treat these sick people can be met with the advance of medical science. Unfortunately, the cost of medical treatment is high and it is often beyond the reach not only of the poor but also of the middle classes. This economic problem is made worse by legal questions, for example the contentious interpretations of intellectual property rights.

As a Church, we join in the requests made by other organisations and we request universal access to the drugs and medicines that this disease requires. This need must be transformed into a public policy for all countries. The absolutisation of intellectual property rights, which obstructs access to the drugs and medicines that are necessary to millions of infected people, is immoral, as indeed are the exaggerated profits of the international pharmaceutical laboratories.

Faithfulness in Marriage

In order to achieve effective prevention of this epidemic it is important to emphasise the value of faithfulness in marriage and conjugal commitment as fundamental factors in containing the pandemic of AIDS: 'abstinence and faithfulness are not only the best pathway by which to avoid being infected by HIV/AIDS, or infecting others, they are also the best pathway by which to obtain a long and happy life' (CELAM letter on AIDS).

'Remedy for AIDS: a man with a woman for the whole of life' (slogan of the Bishops' Conference of Argentina).

To protect our young people, education in values is indispensable. As a Church we must preach with strong public pressure that true happiness lies not in libertarianism and hedonism but in a life that is led according to the will of God where abstinence and sacrifice are the signs of inner freedom which leads to true happiness. To be free means to free oneself from all the forms of slavery that imprison one.

Education in Values

Information on condoms is a simplistic response to what young people need. It does not transform immaturity into maturity. Education, and not only information, is what is required. More than talking about condoms, it is much more effective to provide parents and educators with suitable knowledge so that they can educate their children and students about the value of sexuality, deep human relation-

ships, and dialogue between people and not only between bodies, even though it is true that one expresses oneself through one's corporeity. The need for love and tenderness has been banalised, with its reduction solely to a question of genitals and what is purely biological.

Necessary Changes

Just as the Church defends the rights of people who are afflicted with this pandemic, so also does she look with concern at the right of other people to be protected against it. In order to avoid the stigmatisation of infected people, their situation is kept in complete anonymity so that they do not infect other people in an uncontrolled way. HIV/AIDS should be classified like any other infectious disease, such as tuberculosis. At the present time in prison systems, for example, where there are certainly people infected with HIV/AIDS, a test for tuberculosis can be requested, but a test for AIDS is usually carried out only with the express permission of the individual concerned.

One of the principal causes of this disease is an inadequate concept of 'gender' by which the international and national organisations, which have major funds at their disposal, are seeking to change the fundamental values of our people who believe – for example the family. The Church remains faithful to the concept of the Creator: 'God created man in his image, in his image he created them; male and female he created them' (Gen 1:27)

Thus it is an inescapable mandate of the commandment of love to eliminate the discriminatory condition of those who suffer from this disease, something that makes the cross that they bear even heavier. For that matter, we ask ourselves whether the time has not come to move out of the secrecy and the aim of silencing the grave causes and consequences of this epidemic and to declare that it is like any other contagious disease, both for reasons of justice towards those suffering from HIV/AIDS and for their environment and its relationships, and to declare that it must be addressed with full responsibility. Curiously, those who are opposed to analysing its causes are also opposed to identifying it.

Called to Conversion

The Church does not seek to be a judge of her brothers and sisters, but she does feel the responsibility to point out everything that attacks the original truth of man.

'Mary, Mother of the Church, teach us to be at the side of those who suffer with the solicitude and generosity that are specific to a mother. Her silent nearness to the dying Jesus suggests to us perhaps the only pastoral presence that is possible in the face of early death' (CELAM letter on AIDS).

Managua, 24 January 2007.

The President of the Department of Social Pastoral Care of the Bishops' Conference of Nicaragua

Portugal: the Second National Congress on Pastoral Care in Health

THE SECOND NATIONAL CONGRESS ON PASTORAL CARE IN HEALTH ON THE SUBJECT 'AT THE SERVICE OF THE PERSON – TREATING AND CARING' WAS HELD IN FATIMA (PORTUGAL) ON 1-3 FEBRUARY 2007.

1. Pastoral Care in Health in Portugal

On 18 April 1985 the Bishops' Conference of Portugal established the National Commission for Pastoral Care in Health, responding thereby to the appeal of John Paul II, who in his apostolic letter *Salvifici doloris* and his Motu Proprio *Dolentium hominum* created a new pastoral dynamic in the field of health and health care, to which the contemporary world is very sensitive.

Following this direction, pastoral care in health has engaged in very intense action not only in caring for sick people but also in education in health; the training and accompanying of health care workers; the humanisation of care and treatment, relationships and structures; and in working with all those who in the field of health and health care are concerned to engage in an ethical evaluation of treatment, scientific research, clinical experimentation, and research into drugs and medicines. It is in this context that pastoral care in health in Portugal has a constant relationship with the Ministry of Health with which, indeed, it works conjointly where this is necessary. One could say that pastoral care in health in Portugal constitutes a form of new evangelisation. It helps in a spiritual way sick people and health care workers, it takes care both of hospitalised people and those at home, it is present in hospitals and clinics through chaplains, and it is present in parishes through parish units for pastoral care in health.

2. The Factors of Pastoral Dynamics

From the outset, pastoral care in health has striven to mobilise agents who could implement organised action in an overall way. One of the most important factors of this pastoral dynamic has without doubt been the national meetings on pastoral care in health. Twenty major meetings have been organised which have allowed people to reflect on the problems raised by society. Beyond the ethical reflection, on the basis of which subjects have been studied such as the right to life, the right to health care and health education, the right to family health, and the duty to engage in responsible fatherhood, healthy motherhood, these national meetings have allowed people to engage in a profound reflection on health policies in Portugal with special attention being paid to assuring health for everyone, solidarity, and the spiritual accompanying of patients during the whole of the treatment, with respect being paid to the religious freedom of everyone.

Every ten years, after these national meetings, a national congress on pastoral care in health is organised. The first such congress took place in 1995 and this had a subject of notable importance – 'service to life'. In 2007 another congress was held, this time on a fundamental subject for the humanisation of medicine – 'at the service of the person – treating and caring'.

3. The Second National Congress on Pastoral Care in Health

a. The goals of this scientific and pastoral congress were clearly defined: to recognise the importance of health in people's lives; to define the concrete area where the Church has to act; to humanise medicine; to promote solidarity for the poor; to accompany sick people and health care workers at a spiritual level; to support the actions promoted by health units and parish communities; to energise the Christian life; to guarantee that everyone has religious support, with respect for the creed of everyone; to foster the action of the Church above all in supporting motherhood and accompanying the elderly and the sick, especially during the terminal stage of life; to promote in all the dioceses of Portugal a new pastoral dynamism in the health care field.

b. The congress was organised into three parts. The first studied the human person and his or her right to health. The second part involved a survey of the pathologies that most frequently afflict the person from the physical, psychological and social point of view.

In the third part an attempt was made to define clearly the mission of the Church through new forms of evangelisation, beginning with the observation that to humanise, to accompany and to take care of, are an expression of the preaching of the Gospel which invites us 'to preach good news to the poor… to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord' (Lk 4:18-19).

c. Some of the most significant moments of the congress deserve special reference:

– The 'magisterial lecture' given during the inaugural session of the congress by the President of the Pontifical Council for Health Care Workers, Cardinal Javier Lozano Barragán, provided a working outline for subsequent reflections by analysing in a deep way the evolution of those

philosophical currents that over the centuries, and progressively, have given rise to a radical rationalism that has compromised personalist ethics, the only ethics that always allows respect for the human person. The title of his paper was 'Beyond Science' and in it the Cardinal emphasised that science is insufficient at the level of defending and promoting the human person in all his or her dimensions and that contemporary culture, permissivism, principialism, liberalism and ethical contractualism

are all currents of thought that strongly influence behaviour and lead to the sacrifice of the human person rather to taking care of him or her.

– Various experts in medicine and philosophy during the congress made their contribution in the form of a reasoned reflection on the human person, his or her identity, his or her rights and his or her duties, concluding that health is a right of the person which must be adopted as a value in contemporary culture. From this reality is born the need to educate people in health and to promote the health of children, young people, elderly people and adults and to provide support to families and elderly people.

– During the congress it was observed that there are numerous threats to health and that some of these come from illnesses that are often contracted because of behaviour at risk, such as, for example, HIV/AIDS, hepatitis, drug addiction, obesity, cancer, and Alzheimer's. For this reason, today, the need is felt to sensitise people and health care structures so as to adopt forms of behaviour that are suited to responding in an adequate way to these challenges. Society, too, has many responsibilities in this field and the Church itself has to the duty to make its contribution to improving the health of the population.

– The congress chose seven subjects which were the starting point for conclusions. The fields where the Church has to the duty to intervene in a systematic form are certainly the following: training and education at various levels; support for associations of sick people; the creation of ongoing and palliative care units; the prevention of drug addiction; family planning; parish assistance for home assistance; and the collaboration of religious congregations with specialised clinics, above all in the area of psychiatry.

– At the end of the congress, stress was laid on the importance of faith in care and treatment. The promotion of health, with initiatives of support in the most difficult areas, allows intervention in contexts where the quality of the health service is poor. There was also discussion of the humanisation of medicine, medical ethics and spiritual accompanying. The congress emphasised the importance of the active participation of Christians in denouncing situations that compromise the health of the person and promoting suitable proposals to make health care structures more effective and efficient.

4. Conclusions

The approximately one thousand and two hundred people taking part in the congress, who came from the whole of Portugal to participate in the second national congress on pastoral care in health, attempted to provide responses to the great questions that were analysed and emphasised. They were as follows:

The importance of health in the contemporary world which must be expressed in the desire to 'give more years to life' and 'more life to years' and in the need to defend and promote the quality of life of the human person during the whole of his or her life cycle.

The duty of the Church to intervene in pastoral care in health without confining itself to condemning errors and comforting people with prayers and requests for sacrifices.

The challenge of the new evangelisation which requires new methods and new expressions at a pastoral level, with innovatory dynamisms which respond in an adequate way to the new problems of man and the world.

Pastoral care in health is one of the areas where initiatives at the level of training, treatment or accompanying must be improved with new forms of evangelisation, animated by the creativity that comes from the 'creativity of charity'.

The urgent need to create in every diocese of the country a permanent group for pastoral care in health that brings together medical doctors, nurses, pharmacists, chaplains, social workers, administrative auxiliaries, other health workers and voluntary workers, and which is present in health care structures and in parishes and seeks to energise initiatives in this field.

To this end the following policies are proposed:

1. *The adoption of necessary initiatives* so that pastoral care in health creates in every diocese a work group/committee that brings together chaplains, medical doctors, nurses, voluntary workers and other health care workers in order to create a diocesan commission for pastoral care in health.

2. *The training of priests, deacons, religious and members of the lay faithful that are specifically trained* for engaging in pastoral activity within hospitals, clinics and parish communities.

3. *The promotion of the training of workers in pastoral care in health*, sensitising them to the concrete problems of pastoral care in health and encouraging them to engage in formation and updating in the pastoral field through courses such as the course on 'ethics, spirituality and health' which is organised by the Catholic University of Portugal, the outcome of co-operation between pastoral care in health, the hospital order, the Faculty of Theology and the Institute of Health Sciences of that university.

4. *Responding to the pastoral challenges that have emerged from the reflections of this congress* and which are expressed in various proposals, privileging the following three actions to be developed in all dioceses: a. *the creation of centres for the support of life* where pregnant women are received, accompanied, guided, after giving birth as well, with help being provided to families with problems; b. *the better organisation at a diocesan level of pastoral care for elderly people* so as to transform some homes for elderly people into ongoing and palliative care units, without forgetting about day hospitals and home help for sick people; c. *the development of connections with institutional realities that can foster work within a network*, which is in short supply at the present time, in mutual co-operation between parish communities and local health institutions such as hospitals, health centres and family support units, so as to provide information and education in the field of health lifestyles and facilitate the accompanying of sick people and above all elderly sick people.

These conclusions about the various aspects of pastoral care in health require the involvement of all Catholic health care workers.

Within the horizon of the New Evangelisation, a new time is envisaged for pastoral care in health, aware that, as was the case at the time of Jesus, the Good News of 'life in abundance' is preached through service to the human person, and this pastoral care is expressed at a concrete level in gestures and words and requires as its protagonist the whole of the Church and everyone within the Church.

Msgr. VITOR F.X. FEYTOR PINTO,
National Co-ordinator of the National Commission for Pastoral Care in Health, the Bishops' Conference of Portugal, Portugal.

The Life and Works of Blessed Don Luigi Monza (1898-1954) Pioneer in Care for Children with Disabilities

When he opened a new home of 'Our Family' in 1953, Don Luigi Monza summarised the activities of the association that he had founded in the following way: 'Now by choice we welcome disabled and retarded children with the aim: 1) of removing from them what is injurious to them and other people; 2) of reintegrating them into society, able and self-reliant. To do this it is necessary to provide them with effective means so that they can achieve their goal; and hence the specialist doctors [external consultants]… hence our graduates and specialists who look after the children with an individual method'. At the same time he addressed to the 'Little Apostles of Charity' who belonged to the lay institute that he had founded, the following suggestions: 'It is essential that the children in contact with you must never feel their limitations. The Little Apostle must take on not only their trials (and they have these even though they are little, but for them these acquire a disproportionate size), but equally she must feel and bear with them their burdens, including learning. She must make this increasingly easy for them with all the instruments that modern technology makes available. Here, too, you have to excel, discovering and multiplying those talents that you have received from the Lord. You must show great love to the children; draw near to them with great sensitivity, softness, delicacy, with a capacity for sharing pain in a way that has never been done with them before'. On another occasion, when speaking about the natural aptitude to deal with such children he expressed himself in the following way: 'This is a very beautiful inclination which wonderfully helps our institution with the first apostleship of the dear children that the Lord has given us and whom parents hand over to us with the greatest trust. Thus it is necessary to become mothers for these children who bring with them the finest blessings of the Lord'.

Don Luigi Monza and the two works founded by him (the 'Our Family' Association and the lay institute of the 'Little Apostles of Charity') began to deal with the neuro-psychic disabilities of children in 1946 when the director of the Neurological Institute of Milan proposed the re-education of children who were abnormal in mental terms as a possible field of activity. Subsequently, the two institutions that were led by Don Monza extended their work from the medical-pedagogic field to the rehabilitative-motorial field by receiving into their homes children afflicted by the results of cerebral paralysis as well. Over the years such activity was progressively strengthened above all at a scientific level as a result of the specific training of the Little Apostles and the action of external workers and consultants, with the creation of an approach to disability that envisaged the interaction of various disciplines (from physiotherapy to psycho-movement, from pharmacology to the study of epilepsy, from game therapy to psychotherapy, and from neuro-psychological rehabilitation to neuro-visual rehabilitation, etc.) The 'Our Family' Association thus came to acquire the definition of an medical-mental-pedagogic institute by placing itself within a framework of treatment and care for abnormal children which in Italy had had such distinguished practitioners during the first decades of the twentieth century as Sante De Santis, Giuseppe Montesano and Giuseppe Corberi. It was, however, only in the second part of the twentieth century that child neuro-psychiatry acquired its own autonomy through the establishment of university teaching chairs and hospital departments.

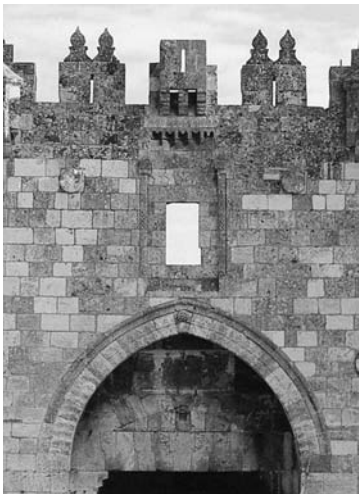
During this period the activities of the works founded by Don Monza and inspired by him further developed, even after the premature death of their founder. As a result of the organisational capacities of the guiding group led by Zaira Spreafico (1920-2004), the second Mother Superior after Clara Cucchi (1897-1950), the Little Apostles of Charity continued their care for children and young people afflicted by neuro-mental disturbance by opening new homes and creating new services. To the three homes that were active at the time of the death of Don Monza (in Vedano Olona, Ponte Lambro and Varazze) many others were added in a few decades in various regions of Italy (the first homes were in Ostuni, S.Vito al Tagliamento and Bosisio Parini). To these have been added in recent decades also homes abroad (for example in the Sudan, in Brazil and in Ecuador). In 1985 the 'Eugenio Medea' Institute for Admission and Treatment of a Scientific Character (IRCCS), with its headquarters in Bosisio Parini but organised into regional poles and outlying centres, whose principal concern was the scientific dimension of neuro-psychic rehabilitation, was created. The following lines of research have stood out in the scientific activity of this institute, which was named after the neuro-psychiatrist Prof. Medea (1873-1967) who was a supporter of the 'Our Family' Association: 1. neuropathology; 2. neuro-motorial rehabilitation and functional neuropsychology; 3. the psychopathology of the development of language and learning; 4. neuro-physiopathology and neuro-radiology; 5. neurobiology, 6. bioengineering; and 7. the organisation of health services. This IRCCS is specialised in biomedical research

but also specialises in the provision of capillary care through its residential and clinical structures, places of admission, and centres of work placement.

At the present time the 'Our Family' Association is a charitable work strongly characterised by the use of the most modern resources that medicine and biotechnologies allow to be used in the treatment of, and care for, neuro-psychic disabilities. But it is also characterised by a commitment always to have an approach of care and empathy towards the little patients and their family relatives. In addition, the lay institute of the Little Apostles of Charity has in time been flanked by other institutions (such as the 'The Group of Friends of Don Luigi Monza', the 'National Association of Parents of Our Family', and the 'Association of Volunteers for International Co-operation'). These have broadened their work beyond the initial specific field of re-educational and rehabilitative activities. For that matter, the initiator and inspiration of all these works did not immediately think of dedicating himself to the questions and issues connected with the disabilities of children but had 'simply' sought to express in the society of his times 'the charity of the apostles and the first Christians', wherever this was needed.

Don Luigi Monza was born in Cislago (VA) on 22 June 1898 to Giuseppe and Luigia Monza. He was the fifth child of a numerous peasant family and two of his brothers died when they were still very young. Luigi as a boy was not very strong and he was thus baptised a few days after his birth and confirmed at the age of only thirteen months. However, as he grew older he gained better health. At the age of six he went to elementary school and at the age of seven he had his first communion. After finishing the three years of compulsory schooling (however he had to take the exams for his second class twice) he was set to the trade of a cobbler in a shop where his older brother already worked. At the same time, however, he attended the classes of evening school in his town.

When he was fifteen years old his family was struck by a terrible misfortune – his father was paralysed after an accident at work and this had grave consequences for the already stretched family budget. In the meantime Luigi, who was an assiduous attendant of the parish oratory, had already thought about embarking on the road of the priesthood. Despite the changed family conditions, with the consent of his mother, in the same year, 1913, he was sent to the parish priest Don Vismara at the Salesian Missionary Institute at Penango



Monferrato (AT) where he remained for three years attending the middle school. In the summer of 1916 Luigi, after realising the dramatic situation in which his family found itself (his older brother had left for the front, a sister had joined a convent, and his mother was the only support that his invalid father could rely on), decided not to go back to the institute. However, the parish priest came to his aid and managed to get him accepted by the Collegio Villoresi in Monza where he began the fourth stage of middle school as a prefect (in addition to his studies he also had to watch over and help the other seminarians), and in this way there was no burden on the family budget.

In January 1917 he was called back to his home because of the deterioration in the condition of his father, who died the same month. In April 1918, after being examined twice for conscription, he had to leave on military service, and this was entirely spent behind the lines because of his by no means perfect physical state. In December of the same year his older brother also died. After being taken prisoner, his brother had been sent back to Italy by the Austrians in a bad state of health at the end of the war. In February 1919 Luigi was discharged and could thus take up again his studies at the Archbishop's College of Saronno where he finished his middle school and during the summer months passed the examination to enter high school. During his high-school years he continued to be a prefect at the College of Saranno and during the summer months he helped his mother with work in the fields, without, however, neglecting to attend the oratory.

In October 1922 the seminarian Luigi Monza began to attend courses in theology at the Rotondi College of Gorla Minore, which was not very distant from Cislago. At this institution he continued to hold the office of prefect. In October 1924 he began the third course in theology at the seminary in Corso Venezia in Milan. During the school year he had problems of health which did not, however, prevent him from being promoted to the next course. Like other seminarians who had been held up in their studies by the events of war, he followed the fourth course during the summer of 1925 and obtained a sub-deaconate on 28 June of the same year and the deaconate on 15 August. Finally, he was ordained priest on 19 September 1925 by Archbishop Cardinal Tosi and he celebrated his first Mass the next day in Cislago.

After his ordination as a priest, Don Luigi Monza was sent as a helper to Vedano Olona (VA), to the parish of St. Maurice which was in the hands of Don Pietro De Maddalena. He reached the township at the end of September, accompanied by his mother and his younger brother (who at that time was sixteen years old) and he immediately began to deal with parish matters. In particular he was responsible

for pastoral care for young people. In large measure intended for young people, such care was largely made up of initiatives promoted by Don Luigi: the 'schola cantorum', theatre, the football team and a course of French for those who were thinking of looking for work abroad. The period spent at Vedano Olona was, however, marred by certain episodes linked to the political climate of the time which was marked by the rise of the Fascist Party and the fall of democracy. After certain offences against the parish priest (who for some time had been opposed to the local Fascists) and certain provocations received by the young people of the oratory, and after an attack on the vice-commander of the town, Don De Maddalena and Don Monza were suspected of being the instigators of the episode and were put in prison on the charge of attempted murder. After four months of prison Don Monza was acquitted (although obliged to never return to Vedano Olona), and Don De Maddalena (acquitted of the specific charge but adjudged dangerous to the regime), was sent to the frontiers of Italy in Sicily).

In November 1928 Don Luigi Monza, after about a year spent as an assistant in the oratory of the Milanese parish of Santa Maria del Rosario, was transferred to Saronno to the Sanctuary of Our Lady of Miracles where he could once again be near his mother. The sanctuary was in the hands of two elderly priests but was not a parish and up to that time had not had a real oratory even though it was surrounded by a numerous population whose young people did not have any place to meet or gather. The hew helper immediately began his apostleship by welcoming children and young people, at first in his modest flat which at that time he shared with his mother, then in the courtyard annex, and finally in a field which up to that time had been used as an orchard. In addition, he was involved in creating a choir for the religious ceremonies. In his relationship with the young people he seemed to pre-date some of the characteristics of modern pedagogy, for example when he approached the maladjusted in a way that banished any form of rigidity or authoritarianism, trying, instead, to appreciate them by entrusting them with jobs that required trust. When in 1931, as a result of a decree issued by the new Archbishop, Cardinal Ildefonso Schuster (1880-1954), the sanctuary was raised to the status of a parish, Don Monza continued to be responsible for the oratory, which received an increasing inflow of young people who were now attracted by the film projector which was located in a suitable hall. As an alternative to the cinema, he also organised football games in the field which he had made out of the orchard owned by his mother, and he always tried to ensure that footballs were always available.

During his stay in Saronno Don Monza began to think about the creation of a secular association which would engage in work of apostleship in a society that was increasingly deChristianised as a result of Marxist and Fascist doctrines. These aspirations could be fulfilled when, in the early 1930s, he became the spiritual director of two young women (first Clara Cucchi and then Teresa Pitteri) who, because for various reasons that had not been able to consecrate themselves entirely to God, wanted to devote themselves to apostleship and charity. Starting in 1933, these two women and other 'young ladies' used to go to the home of Clara Cucchi for meetings on spirituality at which Don Monza often referred to the examples of the Apostles and the first Christians who were characterised above all else by their love for their neighbours. He expressed himself on the subject once with the following words: 'if they were to say to you: "I want to write the life of Christianity in a fine volume, that volume in a page, and that page in a line, and that line in one word", we would answer him by saying "write Love"'.

In 1935, given that in the meanwhile the parish priest had died, the Sanctuary of the Blessed Virgin of Miracles, together with the parish annex, was entrusted to the Congregation of the Oblates. Don Monza thought that he would not remain for long at Saronno and in addition he already had funds to begin his work. He thus managed to purchase land at Vedano Olona on the hill known as 'Lazzaretto', thanks in part to the good offices of the new parish priest, Don Ambrogio Trezzi (1881-1972). In October 1936 Don Monza was sent as a parish priest to a neighbourhood of Lecco, to the Church of S. Giovanni alla Castagna, where he arrived officially in January 1937. As soon as he had arrived he began to dedicate himself to the various duties connected with his new role (celebrations of the Eucharist, processions, preaching, confessions, doctrine, visits to the sick, etc.), and he paid especial attention to the various Catholic associations (Catholic Action, St. Vincent, brotherhoods, etc.). In the meantime the house in Vedano Olona had been built and it was officially opened on 30 September 1937 after a period of retreat by the first three followers (Clara Cucchi was appointed 'Superior' in March 1937) in the company of Don Monza. In October the work was called by its founder the 'Our Family' Institute in order to express how 'as children of the same father all men make up one family, and how all the members of the association will be fathers and mothers, brothers and sisters, for all those who draw near to them, in the same way as all the homes of the association must be a family for all those who stay in them'. Subsequently, he drew up various general indications to regulate the life of the 'Little Apostles of Charity' who were termed such to indicate that the members of the association had to give themselves to other people in humility so as to bring the Gospel message to society.

At the outset the home at Vedano Olona was used as a place for spiritual exercises and to welcome people who needed shelter. Thus it was that during the Second World War it took in a significant number of peo-

ple who had fled from the depopulated cities because of the frequent bombings. 'Our Family' had in the meantime been enlarged with the entrance of other young women and once the war had ended it began to be involved again in various activities in the area (assistance at nurseries, summer schools, spiritual retreats). Despite his heavy commitments connected with his activities as the parish priest, Don Monza found the time to visit the sisters of his work and supported them spiritually at times of difficulty. In November 1945 some 'Little Apostles' were entrusted with the running of a 'Centre for the Admission of Children and Young People, the Sons and Daughters of Prisoners and Political Victims' in Cugliate in upper Varesotto. This activity, which was moved to Campo dei fiori in Varese in October 1947, was continued until April 1949.

As was observed at the beginning of this paper, from 1946 onwards the work of Don Monza began to deal with assistance and care for children with disabilities with the admission to the home in Vedano Olona of the first two children who were afflicted by mental retardation and behaviour disorders in May of the same year. Over subsequent years these new activities ended up by utilising all the human and financial resources of 'Our Family', which at the end of 1949 suspended in definitive fashion its other activities. In addition, the home at Ponte Lambro (CO) in January 1949, and the home at Varazze (SV) in May 1952, were inaugurated and directed towards the new needs of the association.

In January 1950 the 'Little Apostles of Charity' received the juridical recognition in diocesan law of being a 'lay institute', and the next year in front of Don Monzaa the first two sisters professed their vows – Zaira Spreafico and Pasquina Sormani. In the meantime Zaira Spreafico, beginning in 1948, had acted as Superior because of the bad state of health of Clara Cucchi, who later died in February 1950. The institute of Ponte Lambro became the Mother House of the 'Little Apostles of Charity' and the headquarters of the 'Our Family' Association.

Don Luigi Monza continued in the meanwhile to run the parish of S. Giovanni alla Castagna (with all the problems connected with the difficult social situation of the post-war period), despite the advice of the Archbishop to devote himself to only one of his two jobs (given, as well, his by no means excellent state of health). In April 1954 his mother died. She had been suffering for some time from cerebral arteriosclerosis. At the end of August Don Monza, who for a number of years had complained of heart trouble without, however, undergoing medical tests, had an acute heart attack which led on 29 September 1950 to the end of his earthly existence in the parish house of S. Giovanni alla Castagna. Before dying he had words of comfort for the 'Little Apostles' who were looking after him and assured them that the work would continues to exist and would grow and develop further after his death.

His coffin was first laid to rest in the cemetery of S. Giovanni but in 1968 it was moved to the chapel of the institute of Ponte Lambro, becoming the object of veneration by the faithful and numerous admirers of the works that he inspired for children with neuro-psychic disabilities.

Don Luigi Monza was the expression of an ideal of holiness pursued in the ordinary dimension of life (he himself declared that 'holiness does not consist in doing extraordinary things but in doing ordinary things extraordinarily well') and was proclaimed blessed in the Duomo of Milan on 30 April 2006.

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This article is partly based on the memories and testimony of family relatives of the author who knew Don Monza during his period in Vedano Olona. The author expresses his gratitude to the management of the Lay Institute of the Little Apostles of Charity in Ponte Lambro and the Rector of the Sanctuary of the Blessed Virgin of Miracles in Saronno.

Bibliographical References

A.A.V.V., *La beatificazione di don Luigi Monza*, special edition of *La Nostra Famiglia. Notiziario d'informazione del Gruppo Amici di don Luigi Monza*, XLVII, n. 1, January-March 2006.

A.A.V.V., 'Speciale don Luigi Monza', in *Vedano Aperta. Informatore di vita parrocchiale*, XVII, n. 1, Easter 2006.

A.A.V.V., 'Il ministero sacerdotale del beato don Luigi Monza nel Santuario della Beata Vergine dei Miracoli di Saronno', *Quaderni del Santuario*, n. 21, September 2006.

E. APECITI, *Dare la vita. Biografia del Servo di Dio don Luigi Monza* (ITL spa, Milan, 1998).

M. BOFFI, L. MEZZADRI, and F. ONNIS, *Don Luigi Monza. Un profeta della carità* (Edizioni San Paolo, Cinisello Balsamo (MI), 1996).

M. BOFFI, L. MEZZADRI, and F. ONNIS, *Il beato Luigi Monza. La vita, la spiritualità, le opere* (Edizioni San Paolo, Cinisello Balsamo (MI), 2006).