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Domine quo vadis?

MESSAGE OF THE HOLY FATHER ON THE OCCASION OF THE NINETEENTH WORLD DAY OF THE SICK (11 FEBRUARY 2011)

‘By his wounds you have been healed’ (1 Pt 2:24)

Dear Brothers and Sisters!

Every year, on the day of the memorial of the Blessed Virgin of Lourdes, which is celebrated on 11 February, the Church proposes the World Day of the Sick. This event, as the venerable John Paul II wanted, becomes a propitious occasion to reflect upon the mystery of suffering and above all to make our communities and civil society more sensitive to our sick brothers and sisters. If every man is our brother, much more must the sick, the suffering and those in need of care be at the centre of our attention, so that none of them feels forgotten or emarginated; indeed, ‘the true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society. A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through “com-passion” is a cruel and inhuman society’ (Encyclical letter *Spe salvi*, n. 38). The initiatives that will be organised in each diocese on the occasion of this Day should be a stimulus to make care for the suffering increasingly effective, also in view of the solemn celebration that will take place in 2013 at the Marian sanctuary of Altötting in Germany.

1. I still have in my heart the moment when, during the course of the pastoral visit to Turin, I was able to pause in reflection and prayer before the Holy Shroud, before that suffering face, which invites us to reflect on He who took upon himself the passion of man, of every time and place, even our sufferings, our difficulties, our sins. How many faithful, during the course of history, have passed in front of that burial cloth, which enveloped the body of a crucified man, and which completely corresponds to what the Gospels hand down to us about the passion and death of Jesus! To contemplate it is an invitation to reflect upon what St. Peter writes: ‘By his wounds you have been healed’ (1 Pt 2:24). The Son of God suffered, died, but rose again, and precisely because of this those wounds become the sign of our redemption, of forgiveness and reconciliation with the Father; however they also become a test for the faith of the disciples and our faith: every time that the Lord speaks about his passion and death, they do not understand, they reject it, they oppose it. For them, as for us, suffering is always charged with mystery, difficult to accept and to bear. The two disciples of Emmaus walk sadly because of the events that had taken place in those days in Jerusalem, and only when the Risen One walks along the road with them do they open up to a new vision (cf. Lk 24:13-31). Even the apostle Thomas manifests the difficulty of believing in the way of redemptive passion: “Unless I see the

mark of the nails in his hands, and put my finger in the mark of the nails and put my hand into his side, I will not believe" (Jn 20:25). But before Christ who shows his wounds, his response is transformed into a moving profession of faith: "My Lord and my God!" (Jn 20:28). What was at first an insurmountable obstacle, because it was a sign of Jesus' apparent failure, becomes, in the encounter with the Risen One, proof of a victorious love: 'Only a God who loves us to the extent of taking upon himself our wounds and our pain, especially innocent suffering, is worthy of faith.' (*Urbi et Orbi* Message, Easter 2007).

2. Dear sick and suffering, it is precisely through the wounds of Christ that we are able to see, with eyes of hope, all the evils that afflict humanity. In rising again, the Lord did not remove suffering and evil from the world, but he defeated them at their root. He opposed the arrogance of Evil with the omnipotence of his Love. He has shown us, therefore, that the way of peace and joy is Love: "Just as I have loved you, you also should love one another" (Jn 13:34). Christ, victor over death, is alive in our midst. And while with St. Thomas we also say "My Lord and my God!", let us follow our Master in readiness to spend our lives for our brothers and sisters (cf. 1 Jn 3:16), becoming messengers of a joy that does not fear pain, the joy of the Resurrection.

St. Bernard observed: 'God cannot suffer but He can suffer with'. God, who is Truth and Love in person, wanted to suffer for us and with us; He became man so that He could *suffer with* man, in a real way, in flesh and blood. To every human suffering, therefore, there has entered One who shares suffering and endurance; in all suffering *con-solatio* is diffused, the consolation of God's participating love so as to make the star of hope rise (cf. Encyclical letter *Spe salvi*, n. 39).

I repeat this message to you, dear brothers and sisters, so that you may be witnesses to it through your suffering, your lives and your faith.

3. Looking forward to the appointment of Madrid, in August 2011, for the World Youth Day, I would also like to address a special thought to young people, especially those who live the experience of illness. Often the Passion, the Cross of Jesus, generate fear because they seem to be the negation of life. In reality, it is exactly the contrary! The Cross is God's 'yes' to mankind, the highest and most intense expression of his love and the source from which flows eternal life. From the pierced heart of Jesus this divine life flowed. He alone is capable of liberating the world from evil and making his Kingdom of justice, peace and love, to which we all aspire, grow (cf. *Message for the World Youth Day 2011*, n. 3). Dear young people, learn to 'see' and to 'meet' Jesus in the Eucharist, where he is present in a real way for us, to the point of making himself food for our journey, but know how to recognise and serve him also in the poor, in the sick, in our brothers and sisters who are suffering and in difficulty, who need your help (cf. *ibid.*, n. 4). To all you young people, both sick and healthy, I repeat my invitation to create bridges of love and solidarity so that nobody feels alone but near to God and part of the great family of his children (cf. *General Audience*, 15 November 2006).

4. When contemplating the wounds of Jesus our gaze turns to his most sacred Heart, in which God's love manifests itself in a supreme way. The Sacred Heart is Christ crucified, with the side opened by the lance from which flowed blood and water (cf. Jn 19:34), 'symbol of the sacraments of the Church, so that all men, drawn to the Heart of the Sav-

iour, might drink with joy from the perennial fountain of salvation' (*Roman Missal, Preface for the Solemnity of the Sacred Heart of Jesus*). Especially you, dear sick people, feel the nearness of this Heart full of love and draw with faith and joy from this source, praying: 'Water of the side of Christ, wash me. Passion of Christ, strengthen me. O good Jesus, hear my prayers. In your wounds, hide me' (*Prayer of St. Ignatius of Loyola*).

5. At the end of this Message of mine for the next World Day of the Sick, I would like to express my affection to each and everyone, feeling myself a participant in the sufferings and hopes that you live every day in union with the crucified and risen Christ, so that he gives you peace and healing of heart. Together with him may the Virgin Mary, whom we invoke with trust as *Health of the Sick and Consoler of the Suffering*, keep watch at your side! At the foot of the Cross the prophecy of Simon was fulfilled for her: her heart as a Mother was pierced (cf. Lk 2:35). From the depths of her pain, a participation in that of her Son, Mary is made capable of accepting the new mission: to become the Mother of Christ in his members. At the hour of the Cross, Jesus presents to her each of his disciples,

saying: "Behold your son" (cf. Jn 19:26-27). Her maternal compassion for the Son becomes maternal compassion for each one of us in our daily sufferings (cf. *Homily at Lourdes*, 15 September 2008).

Dear brothers and sisters, on this World Day of the Sick, I also invite the authorities to invest more and more in health-care structures that provide help and support to the suffering, above all the poorest and most in need, and addressing my thoughts to all dioceses I send an affectionate greeting to bishops, priests, consecrated people, seminarians, health-care workers, volunteers and all those who dedicate themselves with love to treating and relieving the wounds of every sick brother and sister in hospitals or nursing homes and in families: in the faces of the sick you should know how to see always the Face of faces: that of Christ.

I assure you all that I will remember you in my prayers, as I bestow upon you my Apostolic Blessing.

From the Vatican, 21 November 2010, the feast of Christ the King of the Universe.

BENEDICTUS PP XVI

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Science and Faith: a Life Choice*

Introduction

A little time ago, Professor Nicola Cabibbo, who recently passed away, and who was for many years President of the Pontifical Academy of Sciences, stated that 'the advances in technology guided by science – which are rapidly changing our way of living and working and our relationship with the planet earth – require scientists to pay renewed attention to the 'sapiential dimension' of the ultimate meaning of human life… At the same time, the great discoveries of modern science, which open up new horizons about the structure of living and inanimate matter – as they do about the structure and the history of the universe – are of crucial importance for the world of religion'.[1] These words of this great Italian physicist express in a clear and summarising way that way of thinking about the relationship between science and faith that is typical of the Catholic Church. In these words one perceives a trust in the fertile and respectful relationship of these two distinct fields of the exercise of living of man in history. In addition, from them immediately emerges the hope that men of science and believers are unanimous on their pathway of listening to each other and against all inopportune and sterile opposition. It is certainly the case that we are do not ignore the complex history – and a history not without its shadows – of the relationship between these two experiences. But I do not want to dwell upon this here. It is preferable to point to the lights rather than to the dark aspects, because we are interested in illuminating the present and moving with serenity towards the future, in the name of the good of man and the search for truth.

To this end, my paper is organised into three parts: first of all I will indicate what meanings I will employ for 'science' and 'faith' in this paper of mine. Then I will throw light on the reasons why *science* and *faith*, albeit with their own originalities and differences, may be seen as *sister experiences and friends*, that is to say not extraneous to one another or opposed to each other. In the third and last part of my paper I will examine science and faith as allied experiences which in a reciprocal way support each other to achieve the good of man.

1. What do we Mean by the Terms 'Science' and 'Faith'?

Since the subject of my paper is often connected with a series of misunderstandings or commonplaces, it appears to me to be advisable to clarify the way in which I understand the terms of the tandem science/faith. As a consequence I will also bring out what the non-acceptable meanings of these terms are. This clarification is necessary both because we who are here today come from different educational backgrounds and spheres of expertise and in order to avoid conceptual disharmonies that would prejudice the common effort that we will be engaged in over these days of work and reflection.

The term 'science' ordinarily refers to that form of knowledge about reality or objects or situations or phenomena that are understandable in a sufficiently precise or complete way thanks to the use of reason and the instruments of analysis that have been created over time. Science refers, in common understanding, to the realm of precision, verifiability and comprehensibility.

One should observe, however, that in a rigorous sense 'science' is an *analogical* term, as a result of which it can refer to more than one subjects with a meaning that is not always the same but equally not always different. From this point of view, the concept of 'science' can refer to various spheres of knowledge, of research, of thought and of study, and *always* indicates an activity of intelligence which with rigour studies a particular (material and non-material) 'object' that is identified with precision, with a view to the drawing up of a *discourse* or a *synthesis* that can be communicated in a comprehensible way. It should be observed that the *communication* of a scientific fact is an ineluctable commitment of science itself because it offers an opportunity for verification or logic, whether instrumental or factual, by people who have a marked knowledge of the 'object' itself.

Having said this, it is advisable to observe that in common discourse the term 'science' is applied for the most part to those disciplines that in an almost exclusive way use observation and calculation. This application is not erroneous, as indeed one can easily understand, but it is certainly reductive. And it is above all else this way of understanding the term 'science' that is frequently understood as being completely irreconcilable with an experience of 'faith'. 'Science' understood as being an objective discipline which only deals with what is verifiable and concrete *a fortiori* is thought to be totally opposed to faith, differently from the experience of faith which is said to have, instead, a subjective character, and is said to concern realities or data that are not phenomenal, are ineffable, and cannot be checked.

From a correct theological point of view and according to the thought of the Catholic Church, 'faith' refers to a *human* act[2] that would not be possible without the help of God.[3] It allows, on the one hand, the establishment of a relationship of familiarity with God who freely encounters man. On the other hand, it opens man to a world of knowledge and of truth that has God Himself as its source. This experience involves man integrally; faith is not only an act of will or of love: it is also that *authentic and serious exercise of intelli-*

* Magisterial paper by H.E. Msgr. Zygmunt Zimowski on the occasion of the Tenth National Congress of the AFAR, Brescia, 27 September 2010.

gence which strives without halting to understand both He who has revealed Himself (God Himself) and what He communicates to man. It is within this framework that is located the commitment of the community of believers to communicate in an ever more effective way its own experience of faith: this is theological activity which constitutes an experience that cannot be renounced by those who believe and leads them to engage in a rigorous exercise of intelligence and constitutes an authentic *scientific* activity, even though it concerns the reality of God, His revealing of Himself, His relationship with man and history.

After these clarifications have been made, in the observations that follow I will dwell in particular on what I have defined as being the prevalent concept of science, that is to say what refers to knowledge that is connected with the dimensions of the visible, of the controllable, as happens in the sphere of medicine and disciplines connected with it; and, at least initially, by the term 'faith' I will refer to intense religious experience in a general sense, even though in most of my observations I understand faith as the Christian life or that way of being or living at whose outset there is not 'an ethical choice or a lofty idea, but the encounter with an event, a person, which gives life a new horizon and a decisive direction'.[4]

2. Sister and Friend Experiences

Although bearing in mind that in the course of time the relationship between science and faith has not always been harmonious, it is advisable not to allow ourselves to be excessively conditioned by this fact and this so that we can illuminate the opportunities that are offered today to those people who live in the first person the experience of science and/or the experience of faith.

2.1 Sister experiences

To understand in what sense science and faith can be defined as 'sisters' one must point out certain tendencies which have developed during the course of history which concern specifically the relationship between these two experiences.[5]

A *first tendency* has been that according to which science is the 'daughter' of faith in the sense that it develops beginning with the religious experience. This is the approach this is typical or most widespread in those forms of civilisation or

culture in which is privileged the reality of the sacred compared to knowledge of the world, with this last being dealt with in a strict dependence on the first. In other words, there are states and there are still contexts in which the world of the arcane, of the divine, are drawn upon in order to produce a vision of the world, of man and of reality. It should be observed that in this situation it often happens that theories or visions which in some fashion can be in opposition to what is seen as the outcome of revelation, or anyway strictly connected with the experience of the transcendent or of the divine, are avoided.

I would like to make two observations about this tendency. The first is that it is not difficult to see how this approach, which is typical of archaic cultures and religiosities, is also present in the experience itself of Israel and Christianity, at least at certain moments in their history. The second observation is that this way of understanding the relationship between *science* and *faith* in fact obscures or removes the difference that exists between these two experiences and more easily leads to the mortification of initiatives of intelligence designed to understand the world and its structure ever more clearly and in an increasingly effective way. This approach or tendency we could also define as being typical of the 'ancient' world, that world, that is to say, that preceded the so-called 'modern' world, the world when the centrality of man and his rationality were upheld and when science as knowledge developed with the help of instruments of observation.

The *second tendency* is that which developed specifically beginning with the *modern epoch*, when with the upholding of the autonomy of reason the right was upheld to develop knowledge of the world that was not conditioned by religious prejudices or by ideas present in Holy

Scripture but was only the outcome of objective observation. In this approach we find upheld such a distance between science and faith as to create an extraneousness at the level of fact between these two experiences. This extraneousness even becomes an opposition when the defenders of one or the other experiences seek to be the only bearers of truth. In other words, it happens that men of science and believers arrogate to themselves the right to be the teachers of each other in fields of knowledge that are not their competence, thereby entering into a conflict which it is difficult to resolve.

The *third tendency* is that

which recognises the originalities and the differences of these two experiences with respect to their different competences in an approach involving a peaceful relationship, one of cooperation and of integration. From a historical and cultural point of view, this third way of understanding the relationship between *science* and *faith* has been present for many centuries in the experience and the thinking of the Church, as is well borne out by Albert the Great and Thomas Aquinas who 'Although they insisted upon the organic link between theology and philosophy… were the first to recognise the autonomy which philosophy and the sciences needed if they were to perform well in their respective fields of research'.[6] This tendency was later in perfect harmony with the sensibility of the men of the twenty-first century. Today we (commonly) hear that diversity constitutes riches and not a reason for struggle, and in addition we are aware of the fact that the breadth of competences and the plurality of epistemologies impedes any claim to dominance or exclusivity or absoluteness by any kind of research. From this there comes the need for absolute respect for the independence of the various fields of research in which intelligence is exercised, without approaches involving suspicion or contempt, with an approach of listening and familiarity.

From a theological point of view, this way of understanding the relationship between science and faith is a natural consequence of believing in one God, 'creator of the heaven and the earth, of all things visible and invisible'.[7] As everything comes from Him, a 'kinship' should exist not only between things but also between things and He who is their source, their origin, their 'father'. The Jewish-Christian of the one God, the Creator, is the foundation of a grandiose vision not only of man, defined by Holy Scripture as being in the 'image and likeness of God' (Gen 1:27), but also of the relationships between man and the world. In virtue of his special identity, conferred on him by God, the human creature is in a condition to enter into a real and fertile dialogue with his Creator. God granted him an intelligence and will that project him beyond himself, making him able to reach the threshold of the mystery of the Transcendent. Man bears in himself a natural inclination to transcendent Truth and to the truths of the world which are a small reflection of it. In this sense, the experience of faith, that is to say of the relationship with God who comes to man, is grafted in a serene way and in continuity in the heart and the mind of the human creature; this does not require a suspension of reason or a forcing of the will but simply a trusting and reasonable self-giving to He who gives life to man and seduces him with His own beauty.

It is specifically to this *continuity in difference* to which St. Thomas Aquinas refers when he writes that faith supposes reason[8] or when the First Vatican Council states that faith is an *obsequium* (obedience, from *ob-audire*, that is to say voluntary listening and adherence) *rationi consentaneum*[9]. By these statements the Catholic Church expresses three facts. The first is confidence in the ability of man to find 'traces' of God both within his own interiority and in the world that surrounds him. The second fact is the belief that experience of faith, understood as openness to God who reveals Himself and as welcoming what He reveals, is not a *non-human* act; it does not involve any reduction or suspension of our intelligence. The third fact, lastly, is made up of thinking that the experience of believing is not a 'leap in the dark' (S. Kierkegaard) nor throwing oneself into the absurd but a free and loving entrusting of oneself to that God who, although He transcends us, leaves a trace of Himself in the world and in history.

There is a further fact which contributes to enriching the Catholic vision of the relationship between science and faith, and it is the following. Man, because he is in the image of God, has been placed by the Lord in the 'garden' (Gen 2:15), that is to say the world, so that he may understand it, use it in a respectful way, and transform it for his own needs, without ever forgetting that he is purely a *steward* and not an *owner* of the creatures that surround him. For this reason, he is obliged to maintain with them a constructive and peaceful relationship. For that matter, according to the Bible, the world is not simply the stage of existence and human history but also the *home* (*oikos*) in which human beings cohabit with 'brother Sun… sister Moon… brother Wind… sister Water'.[10] It follows from this that the attempt to understand the world, research directed towards a respectful use of nature, and study that helps us to understand the structure and the working of reality, so as to use its potentialities according to the design of the Creator, must be seen with satisfaction and joy, without fear and without limits, except for those that are imposed by respect for man

and the world itself. In this perspective one must acknowledge that science and faith can be seen as 'sister' experiences because they have their origin, in the ultimate analysis, in the heavenly Father, even though each is endowed with its own originality, its own mission, and its own method.

2.2. Friend experiences

I do not ignore the fact that the approach that has just been outlined may appear utopian or ingenuous. It is known, indeed, that between science and faith relationships of peaceful living together have not always existed or exist even now. Indeed, as I have already observed, beginning with the modern epoch an unbridgeable furrow appears to have been created between the two contexts of life and thought, between science and faith. Beginning with the Renaissance, indeed, with the development of the experimental sciences there took place, on the one hand, a gradual abandonment of that vision of the world that was based on the Bible, a fact that nourished by no means few disagreements between men of science and theologians. On the other hand, the gradual establishment of the experimental model gave rise to a dual phenomenon: first of all it fostered the belief, which was legitimate, in the *autonomy of research* as regards the physical world and its laws, and then established the premisses for that exaltation of reason which in its turn had two relevant consequences – on the one hand, the Kantian vision which stressed the limits of pure reason, excluding God and transcendent realities from the sphere of the exercise of reason, and, on the other, the exaltation of reason which led to a sort of 'speculative titanism' which found in Hegel its most important exponent and which tended to reduce the experience of Christianity to a simple ingenuous expression of the history of the Spirit.

These two philosophical approaches, the Kantian and the Hegelian, were pregnant with negative consequences for the relationship between science and faith. The first, in fact, tended to make *science* and the *world of phenomena* appear as being the legitimate and exclusive dominions of the exercise of rationality, and faith as being an experience of a purely *moral* character or of a character purely of the will, that is to say without any rational value or credibility. The Hegelian vision, instead, became a matrix for a minimalistic or 'liberal' re-interpretation of the doctrinal contents of Christian faith, according to which the dogmas and the truths of faith proposed in the course of history by Christianity had to be denuded of all objective value and seen as simple exemplifications or models of the relationship of man with God. As a consequence, the whole of the Christian experience came to lose any claim to universality and was reduced to a pure contingent and limited expression of the encounter of an individual with God.

As is well known, nowadays there are by no means few people who continue to think, in an explicit or implicit way, that the experience of faith is not in the least definable as an opportunity for the exercise of intelligence. It is continued to be believed by intellectuals who are not few in number that there is a substantial and insuperable extraneousness between these two levels – the level of science and the level of faith. Many contemporaries, in fact, deny the right of faith to inhabit the 'house' of science because they believe that the religious experience will inevitably pollute, through its own prejudices or its own pre-understanding, the objectivity of scientific research.

Is it possible to overcome these barriers that have been created in the course of time? The Catholic Church thinks that it is because it openly recognises the right of reason to exercise its autonomy when this concerns the phenomenal, visible and verifiable world. The Church is not scandalised when faced with a sort of *methodological a-theism* which comes into play in those fields of research where it is not necessary to resort to God as a 'working hypothesis' or criterion for comprehension. The Christian community recognises, indeed cultivates, the right of science to proceed on its journey in a rigorous and autonomous way. Indeed, it believes that the certainty of faith which leads the proclaiming of the existence of a God, who benevolently and with elegance gives origin to all things, infuses in the searcher after scientific truth an enthusiasm, an optimism and a confidence, a charge that plays a very positive role as regards the endeavour of understanding reality. In other terms, faith in the creative Trinity, if rightly understood and lived, does not reduce the thirst for knowledge about the world but instead ignites it and leads to people to look with eyes that are perennially thirsty with light at the wonders that the various sciences are committed to discovering and understanding in the course of time with their different competences.

3. Allied Experiences

The establishment of *modernity* taught believers the need not to presume that they will find the truth at any level simply beginning with the fact of faith. It is necessary to distinguish between the levels and the spheres of knowledge, using an adequate epistemology, keeping firm in the belief that an ontological and logical harmony exists in reality.

Instead, the contemporary epoch, or the *post-modern* epoch, the epoch of the *crisis of reason*, marked by the great defeats experienced during the so-called 'short century' (Eric J. Hobsbawm) has taught man, on the one hand, to forgo any kind of 'titanism' of the intellect, and on the other, it has ignited nostalgia for unity and peace that will help us in overcoming both the risk of mass globalisation and the violent opposition of identities. Science and faith, in their own ways, today are living in a dynamic towards what Paul VI called the 'civilisation of love' in which good, truth and peaceful life together should find space. And they are called

to offer their practical contribution to the service of humanity in concord, in dialogue and in mutual support. Science and faith *can* and *must* become allies, after many occasions when they have lived in an approach of distance, distrust or even of opposition.

This approach of *alliance* must achieve four kinds of *service*: to man, to truth, to life and to each other (science and faith). Science and faith first and foremost must *serve man*. They are not self-referential experiences – they are *open* experiences. For example, science that does not seek to enrich humanity and above all that does not seek to serve the weakest would be a monstrous activity, one to be feared, exposed to the risk of becoming a servant to power. In the same way, Christian faith that forget that God revealed Himself, became flesh, died and rose again *for men and for our salvation*, would be an experience offensive to God before being offensive to men. Science and faith also *serve* man together when they contest that widespread mentality that is expressed in the statement: 'I consume, therefore I am'.[11] They must make it understood that 'successful' man is not a prisoner of his own selfishness but a man who cultivates a sense of his own dignity and his own transcendence, going beyond his own 'fragmented' history.

Science and faith, as well, must *serve truth*; indeed, they must be moved by an authentic *passion for truth*. Science that is not directed to serving truth would be a blind activity, easily influenced by ideologies. In the same way, faith that did not promote thirst for truth in believers as well would be an intolerable experience. Faith that eliminated intelligence, silencing it with formulas and mortifying its questions, would be an activity unworthy of God, as well as offensive to human beings.

As I observed at the beginning of this paper, science and faith, in their own way, are activities that involve the use of reason; but 'what comes', asked St. Augustine, 'to those who know how to use reason well if not truth? It is not truth that comes of itself through reasoning but it is truth that is looked for by those who use reason'.[12] As Benedict XVI observed: 'wherever the search for truth takes place, this remains as a fact that is offered and can be recognised as being already present in nature. Indeed the intelligibility of the creation is not the outcome of the efforts of the scientist but a condition offered to him in order to allow him to discover the truth that is present in it'.[13] On the other hand, the Supreme Pontiff Benedict XVI continues, 'reason… feels and discovers that beyond what it has reached and discovered, there exists a truth that can never be discovered beginning with itself but only received as a free gift'.[14] This truth, that is to say the truth of Revelation, to which one opens in faith, 'is not opposed to that achieved by reason; rather it purifies reason and elevates it, allowing it, that is to say, to expand its own spaces in order to insert itself in a field of research that is unfathomable as mystery itself'.[15]

Science and faith must also be allied in *service to life*. In their own ways they are called to proclaim and cultivate the *gospel of life* and defend 'the *greatness* and *inestimable value* of human life even in its temporal stage',[16] rejecting all threats and violence to human life, openly professing the inviolable value of every person, at any stage or condition of his or her existence, condemning the 'culture of death… fostered by powerful cultural, economic and political currents which encourage an idea of society excessively concerned with efficiency'.[17] Men of science, in particular those who work in the field of health care, are the 'servants of human life';[18] the experience of faith confirms and strengthens this commitment: those who love the living God cannot but love life, always, above all when it is weak and threatened.

Lastly, science and faith are allies because they *provoke and help* each other. On this point allow me once again to refer to Thomas Aquinas. In a cultural context that was different from the contemporary cultural context, and with a language that was different from our own, the Angelic Doctor proposed observations of great interest for our subject that I would like to present with his own words. In *Summa contra Gentiles* St. Thomas wrote as follows: 'observation of creatures is a part of the instruction of Christian faith… Observation of the works of God is necessary for the instruction of human faith about the things of God. First, because from the study of what it has achieved we can easily address, admire and observe divine wisdom. Indeed, the things that are produced by art constitute art itself because they are achieved according to its criteria… Second, this observation leads us to admire the very high virtue of God and thus produces in the heart of man reverence for God. Indeed, the virtue of artifice is conceived necessarily as greater to that of produced things… Third, this observation ignites in the spirits of men love for divine goodness… Fourth, this observation gives man a certain likeness to divine perfection. Indeed, we have explained that God, knowing himself, knows in Himself all things. Thus, since Christian faith principally instructs man about God and with the light of divine revelation also makes him know creatures, in man is produced a certain likeness with divine wisdom'.[19]

To the conservations of Aquinas we can add that science provokes the believer to cultivate intelligence, always and above all when he (the believer) reflects on what is the most intangible and indescribable of realities: the reality of God.

In its turn, faith, for the man of science, is a permanent invitation to the ulterior, to look at man, at reality and at history in awareness that there exists beyond the world of phenomena 'a higher level that necessarily transcends scientific predictions, that is to say the human world of freedom and history'.[20] As *Fides et ratio* observes, faith helps 'to move from *phenomenon* to *foundation*, a step as necessary as it is urgent. We cannot stop short at experience

alone; even if experience does reveal the human being's interiority and spirituality, speculative thinking must penetrate to the spiritual core and the ground from which it rises'.[21]

Science helps the believer to perceive the order and the beauty of every dimension of the universe and the human; it keeps him in humility faced with the simultaneous complexity and simplicity of the universe. In this sense, science is a teacher of wonder for the believing man. As Benedict XVI observed: 'faith for its part does not fear the progress of science and the developments to which its conquests lead when these are for man, his wellbeing and the progress of the whole of mankind'.[22] Faith, and here is another aspect, helps science not to stop 'having daydreams' because it holds up a hope that does not end,[23] that promised and promoted by God Himself.

And faith helps science not to be discouraged in the face of failures, to combat resignation, to nourish confidence in a positive sense to history and the universe as a whole, to remember that above every purely technical objective, the real end of research and scientific thought are human beings; in this sense faith helps science to always remains on a 'human scale'.

Conclusion

That science and faith have their principle reference point in man, his dignity, his wellbeing and his fulfilment, is seen with greater clarity above all when one works in the field of health care. Indeed, faced with illness, before a *sick person*, more than in other circumstances, one can implement a verification of the intentions that animate scientific research, and more precisely than in other contexts, and faith as an experience that is capable of making people 'grow in humanity' is put to the test.

Reason and faith, John Paul II taught, are 'two wings on which the human spirit rises to the contemplation of truth'[24] and Benedict XVI emphasised that 'only together will they save man. Entranced by an exclusive reliance on technology, reason without faith is doomed to flounder in an illusion of its own omnipotence. Faith without reasons risks being cut off from everyday life'.[25] We can without doubt affirm the same thing about the relationship between science and faith, above all in the medical field: science and faith are like two tramways, certainly distinct and not to be confused with each other, journeying along which one proceeds towards a future of light, of solidarity towards humanity, and thanks to which man, a very noble creature amongst other creatures of the world, implements his very high potentialities, and expresses and safeguards his own dignity.

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President of the Pontifical Council for Health Care Workers, the Holy See.

Notes

[1] N. CABIBBO, 'Introduzione', in AA.VV., *L'uomo alla ricerca della verità. Filosofia, scienza, teologia: prospettive per il terzo millennio* (*Conferenza internazionale su scienza e fede. Città del Vaticano, 23-25 maggio 2000*), (Vita e Pensiero, Milan, 2005), p. 107. For a survey of this subject and observations regarding the contemporary direction of Catholic theology, of utility is a reading of the following works: G. GISMONDI, *Fede e cultura scientifica* (EDB, Bologna, 1993); P. POUPARD (ed.), *La nuova immagine del mondo. Il dialogo tra scienza e fede dopo Galileo,* (Piemme, Casale Monferrato, 1996); G. TANZELLA-NITTI and A. STRUMIA (ed.), *Dizionario Interdisciplinare di Scienza e Fede*, Urbaniana University Press/Città Nuova, Rome, 2002, 2 vols.); T. TORRANCE, *Senso del divino e scienza moderna* (LEV, Vatican City, 1992). The following web site should also be consulted: http://www.disf.org.

[2] Cf. *Catechism of the Catholic Church* (CCC), nn. 154-155.

[3] Cf. *CCC*, n. 153.

[4] BENEDICT XVI, *Deus caritas est* (Encyclica, 25 December 2005), n. 1.

[5] On this complex subject see for example R.J. RUSSEL, 'Dialogo scienze-teologia, metodo e modelli', in G. TANZELLA-NITTI and A. STRUMIA (eds.), *Dizionario Interdisciplinare di Scienza e Fede*, vol. 1, pp. 382-395.

[6] JOHN PAUL II, *Fides et ratio*, n. 45.

[7] A symbol of Constantinople (year 381): *DH*, n. 150.

[8] Cf. *Summa theologiae*, I, q. 2, a. 2, ad 1um.

[9] Dogmatic Constitution *Dei Filius,* chap. 3 (DH, n. 3009).

[10] FRANCIS OF ASSISI, *Cantico delle creature*.

[11] Z. BAUMAN, *Consumo, quindi sono* (Laterza, Bari/Rome, 2009).

[12] *De vera religione*, 39,72.

[13] Audience to those taking part in the international conference organised by the Pontifical Lateran University on the tenth anniversary of *Fides et ratio*, 16 October 2008.

[14] *Ibid.*

[15] *Ibid.*

[16] JOHN PAUL II, *Evangelium vitae* (Encyclical, 25 March 1995), n. 2.

[17] *Ibid.,* 12.

[18] *Ibid.*, 89; Cf. *Charter for Health Care Workers,* n. 1,1 (Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, 1995)

[19] II, c. 2. On the interesting subject of the use of the sciences by theologians cf. G. TANZELLA-NITTI, 'Scienze naturali, utilizzo in teologia", in G. TANZELLA-NITTI and A. STRUMIA (eds.), *Dizionario Interdisciplinare di Scienza e Fede*, pp. 1273-1289.

[20] BENEDICT XVI, Address to those taking part in the plenary session of the Pontifical Academy of Sciences (6 November 2006).

[21] N. 83.

[22] Audience to those taking part in the international conference organised by the Pontifical Lateran University on the tenth anniversary of *Fides et ratio*, 16 October 2008.

[23] Cf. Encyclical *Spe salvi*.

[24] Encyclical *Fides et ratio* (14 September 1998), n. 1.

[25] Encyclical *Caritas in veritate* (29 June 2009), n. 74.

There is Pain: the Body-the Soul

ALGOS AND PATHOS: FROM THE LEVEL OF NATURE (CREATION) TO THE LEVEL OF GRACE (REDEMPTION). ALGOLOGICAL, ALGO-PATHOLOGICAL AND PATHOLOGICAL ILLNESSES: NEW THERAPEUTIC ASPECTS.

Preface

I am very happy to publish in the review *Dolentium Hominum*, as the new President of the Pontifical Council for Health Care Workers, the medical-theological work 'Pain: the Body-the Soul', by Professor Pierluigi Zucchi, an algologue and clinician, and by Professor Bonifacio Honings, a moral theologian. These two rigorous researchers, already well known in international literature for their bridging studies between medicine and theology, wanted in this work to analyse the delicate and difficult subject of the relationship between the body and the soul in the anthropological context of pain. In this sphere they have identified three new nosological entities: algological illnesses, algo-pathological illnesses and pathological illnesses, for which they have also suggested an original therapeutic itinerary, thereby enriching both the medical and theological fields. The search for truth, which is always present in the Church, stresses that between science and faith an opposition does not exist. Instead, an integration exists for, as is pointed out in the encyclical letter *Fides et Ratio* of His Holiness John Paul II, 'Faith and reason are like two wings on which the human spirit rises to the contemplation of truth; and God has placed in the human heart a desire to know the truth – in a word, to know himself – so that, by knowing and loving God, men and women may also come to the fullness of truth about themselves'. This concept is also stressed by His Holiness Benedict XVI who, in his encyclical letter *Caritas in Veritate*, states that '*Truth*, in fact, is *lógos* which creates *diálogos*, and hence communication and communion'.

In entering this impressive work the description emerges of the physio-pathological aspects of algological illness, algo-pathological illness and pathological illnesses (cf. fig. 2), that make the algo-logical (corporeal) soul acquire the physiognomy of the patho-logical (spiritual) soul.

From this point of view, this work seems to emphasise certain points of the encyclical letter *Caritas in Veritate* of His Holiness Bemedict XVI who states (n. 76) that '*the question of development [understood in a broad sense] is closely bound up with our understanding of the human soul… Development must include not just material growth but also spiritual growth*, since the human person is a "unity of body and soul"… The emptiness in which the soul feels abandoned, despite the availability of countless therapy for body and psyche, leads to suffering. *There cannot be holistic development and universal common good unless people's spiritual and moral welfare is taken into account*, considered in their totality as body and soul'.

As I have already observed, another unprecedented aspect that appears in this original study of these two distinguished researchers is that of having created a clinical-therapeutic scale of three levels – the pharmacological, the ethical and the spiritual (cf. tab. VIII), by which a health-care worker can act in an appropriate way according to the situations that he or she encounters.

Because of the wealth of new scientific-theological data which emerge from this detailed work, I hope, through this review that I edit and which is distributed in many cultural contexts, that there will be that suitable appreciation and recognition that this rigorous medical-theological study deserves from readers.

H.E. Msgr. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers,

Introduction

The intention of this work is to study pain in the body in its unity with the soul so that it is adopted at the level of nature (*ordo creationis)* as an immanent, corporeal and human perception, and at the level of grace (*ordo redemptionis*) as a transcendent and redemptive value. To give the study a scientific, bioethical and theological approach, we begin not from a dualistic vision of man but from a dual-unitary vision. The body and the soul are not two separate elements (the dualistic vision) but distinct elements that together form the unity of the human being (the dual-unitary vision).

1. The Constitutive Elements of Man in the Order of the Creation

'Though made of body and soul, man is one. Through his bodily composition he gathers to himself the elements of the material world; thus they reach their crown through him, and through him raise their voice in free praise of the Creator'.[1] The Church for solemn ceremonies and feast days, sings at the morning lauds: 'Bless all the works of the Lord, the Lord, praise him and exalt Him in the centuries… Bless all the waters, which are above the heavens, the Lord… Bless, the sun and the moon the Lord, bless, the stars of heaven, the Lord'.[2] For this task of living praise, it is not licit for man to despise

the corporeal life, above all because he is held to see his own body as good and worthy of honour, specifically because it is created by God and destined for resurrection on the last day'.[3] The Biblical account expresses the elements of the human person with a symbolic language when it says that 'Then the Lord God took some soil from the ground and formed a man out of it; he breathed life-giving breath into his nostrils and the man began to live' (Gen 2:7). The whole of man is thus *willed* by God.[4] For our work, it should be stressed that man as at one and the same time a corporeal and spiritual being who expresses and perceives spiritual realities through material signs and symbols.[5] In the medical field, for example, clinical-semiological signs, which are the characteristics of a given pathology (for example pain in muscular-tension headaches) indicate not only physical pain that is extremely intense (algos) but also its internalisation in a moral-spiritual suffering (pathos).

1.1 The human body

It is known that modern philosophy sees the human body not only as something opposed to the soul but as the external expression of the human person in contact with the material world and other beings (Mancuso, 2007). This expressive capacity makes the body capable of a real existential relationship and of full self-fulfilment. In this way, the human body manifests not only the interiority of the soul but in a certain sense also leads it from the external towards the soul. Man, created by God, as male and female, does not have a body but is a body. This existential and personalistic direction of the soul is in full harmony with divine revelation regarding the human body of the Word made Flesh.[6] Taking up John's expression, "the Word became flesh" (Jn 1:14), the Church calls "Incarnation" the fact that the Son of Good assumed human nature in order to accomplish our salvation in it'.[7] Thus the Son of God manifests his divinity specifically in human nature because he took on not only the full reality of the human soul, with its workings of intelligence and will, but also the full reality of the human body. Everything that he is and what he does, in his human nature, and thus also in his body, derives from 'One of the Trinity'. The Son of God thus communicates to his humanity his personal way of existing in the Trinity. For this reason, both in his soul and in his body, Christ expresses humanly the divine behaviour of the Trinity (cf. Jn 14:9-10).[8] Man in all his activity, and his spiritual activity as well, is determined and conditioned by his body, an essential component of his personal unity and a point of encounter with God.[9] John Paul II observed: 'The Creator assigned the body to man as a task; man does not have a body, he is his body, and thus his vocation is to become it'.[10]

1.2 The spiritual soul united to the body

The duality of the human being implies that the unity of the soul and the body is so profound that the soul should be seen not only as the 'form' of the body: also, specifically thanks to the spiritual soul, the body, made up of matter, is a human and living body. The spirit and matter, in man, are not two conjoined natures: their union makes up a single nature.[11] Because of its unity with the soul, the 'human body of man shares in the dignity of the "image of God": it is a human body precisely because it is animated by a spiritual soul, and it is the whole human person that is intended to become, in the body of Christ, a temple of the Spirit'.[12]

The doctrine of the Church on the soul, from the Greek '*anemos*' (wind, passion), finds foundation in Holy Scripture where the term '*soul'* often refers to human *life*,[13] or the human *person* as a whole (cf. Acts 2:41). It also refers to all of what is most intimate in man[14] and of greatest value,[15] as a result of which, and this is a very important point, man is particularly the image of God. In addition, and this is equally important, 'soul' also means the *spiritual principle* of man.[16] Now, specifically on the basis of this conception of the 'soul' as the most intimate element of man, by which man is in a particular way the 'image of God', and of the 'soul' as the spiritual element of man, the Church teaches that every spiritual soul is created directly by God – it is not 'produced' by the parents – and it is immortal. Thus the soul of man does not perish at the moment of death, of its separation from the body; indeed, at the moment of the final resurrection the soul will be reunited once again with its body. Thus after death as well there remains, after a certain fashion, a relationship between these two constitutive elements, the soul and the body, of the human person. All of this is very evident in the resurrection of Christ. Indeed, the divine person of Christ remained united to his soul and to his body even after their separation at the moment of his death on the cross. 'By the unity of the divine nature, which remains present in each of the two components of man, these are reunited. For as death is produced by the separation of the human components, so Resurrection is achieved by the union of the two'.[17]

A significant confirmation of the anthropological importance of this unitary duality of the body and the soul is offered by the encyclical *Deus caritas est*: 'Man is truly himself when his body and soul are intimately

united; the challenge of *eros* can be said to be truly overcome when this unification is achieved. Should he aspire to be pure spirit and to reject the flesh as pertaining to his animal nature alone, then spirit and body would both lose their dignity. On the other hand , should he deny the spirit and consider matter, the body, as the only reality, he would likewise lose his greatness. The epicure Gassendi used to offer Descartes the humorous greeting "O Soul!" And Descartes would reply "O Flesh!"'.[18] Now to explain the relationship between *eros* and *agape*, Pope Benedict XVI makes clear that neither the body nor the soul alone *love*; it is man, the person, who loves as a unitary creature, of which the body and the soul form a part. Only when both of them are truly fused in unity does man become fully himself. Only in this way can love – *eros* – mature to its true greatness.[19] What has been said applies analogically to pain as well, precisely because it is not only the body that suffers but also the soul; in other words, man, the person, who suffers, in being a unitary creature does not suffer only physically (algos) but also spiritually (*pathos*). For this reason, pain involves not only the body but also the mind. To complete our analysis of man and pain, we will now dwell upon the dimension of human nature, upon being male and female.

1.3 A unity in two: one for the other

Created *together,* man and woman were willed by God *for* each other. 'It is not good for the man to live alone. I will make a suitable companion to help him' (Gen 2:18). None of the animals can be this 'in relation to' man (cf. Gen 2:9-20). The woman that God 'formed' with the rib that had been taken from the man and that He takes to man brings forth from the man a cry of admiration, an exclamation of love and of communion: 'At last, here is one of my own kind – Bone taken from my bone, and flesh from my flesh' (Gen 2:23). The man discovers the woman as another 'I' of the same humanity. The man and the woman are, with an identical dignity, 'in the image of God'. In their 'being-man' and 'being-woman' they reflect the wisdom and the goodness of the Creator.[20] The 'perfections' of the man and the woman reflect something of the infinite perfection of God: those of a mother[21] and those of a Father and a spouse.[22]

At this point we come to a determining conclusion of our analysis about pain, the body and the soul from a scientific and theological point of view. 'God calls man and woman, made in the image of the Creator, who 'loves everything that exists' (Wis 11:24), to share in his providence toward other creatures; hence their responsibility for the world God has entrusted to them'.[23] More concretely, this means that God makes the gift to men of being intelligent and free creatures so as to complete the work of creation, perfecting its harmony for their welfare and the welfare of neighbour. Co-operators who are often unaware of the divine will, men can deliberately enter the divine plan through their actions, their prayers, but also with their sufferings (cf. Col 1:24). They then become to the full 'co-workers of God' (1 Cor. 3:9: 1 Ts 3:2) and his Kingdom (cf. Col. 4:11).[24] The human body can, therefore, become a point of encounter between God and man, above all when he is suffering, as is borne out by our communion with the suffering of Christ, that is to say the Christian meaning of pain in the design of God.

2. The Meaning of Human Suffering in the Order of the Redemption

What Jesus did, said and suffered, had as its purpose that of re-establishing man in his primitive vocation of being elevated to likeness to God, falling, however, because of original sin. St. Irenaeus of Lyons wrote: 'When Christ became incarnate and was made man, he recapitulated in himself the long history of mankind and procured for us a 'short cut' to salvation, so that what we had lost in Adam, that is being in the image and likeness of God, we might recover in Christ Jesus.'.[25] 'For this reason Christ experienced all the stages of life, thereby giving communion with God to all men'.[26] Indeed, because in his incarnated divine person Christ 'united himself after a certain fashion to every man', he offers 'to everyone the possibility of coming into contact, in a way that God knows,

with the paschal mystery'. He calls his disciples to take up their cross and follow him (cf. Mt 16:24) because he suffers with us, leaving behind him an example for us, so that we may follow in his footsteps (cf. 1 Pt 2:21). Indeed, he wants to associate his redemptive sacrifice with those who are its first beneficiaries.[27] This takes place in an eminent way for his mother, who is associated more intimately than any other person with the mystery of his redemptive suffering (cf. Lk 2:35).[28] The Apostle also provides a moving testimony to this: 'by means of my physical sufferings I am helping to complete what still remains of Christ's suffering on behalf of his body, the Church (Col 1:24). By these words St. Paul seeks to explain the salvific value of a long journey which unravels specifically through suffering, in as far as it is inserted in the history of man and illuminated by the word of God. This discovery of the value of suffering leads him to say: 'And now I am happy about my sufferings for you' (*ibidem*). However much this discovery of the Christian meaning of suffering is 'very personal', Paul of Tarsus wants the salvific meaning of suffering to be valid

for all men who suffer. Human suffering not only provokes compassion and respect but also, in its own way, intimidates because in it is contained the greatness of a specific mystery. Thus, states John Paul II, within every human suffering there must draw near, indeed unite, in a particular way, the reasons for a particular respect from the deepest need of the heart and the profound imperative of faith. The first reason, that of the need of the heart, orders us overcome fear; the other, that of the imperative of faith, provides the contents of mystery. Indeed, in the name of and because of these contents, we venture to touch what seems in every man so intangible; in his suffering man remains an intangible mystery.[29] Now, given that man through his earthly life walks in one way or another on the pathway of suffering, we want to encounter real man on this pathway, identifiable in the anthropological context of the unity of the body and the soul of the human person, in the communal character of the human vocation in the plan of God (*ordo creationis*) and above all in the context of participation in the meaning of the suffering of the passion of Christ (*ordo redemptionis*). However, for the sake of the completeness of this study we will illustrate where pain comes from and how it is channelled.

2.2 Pain pathways and characteristics of the language of the relationship between pain and the soul

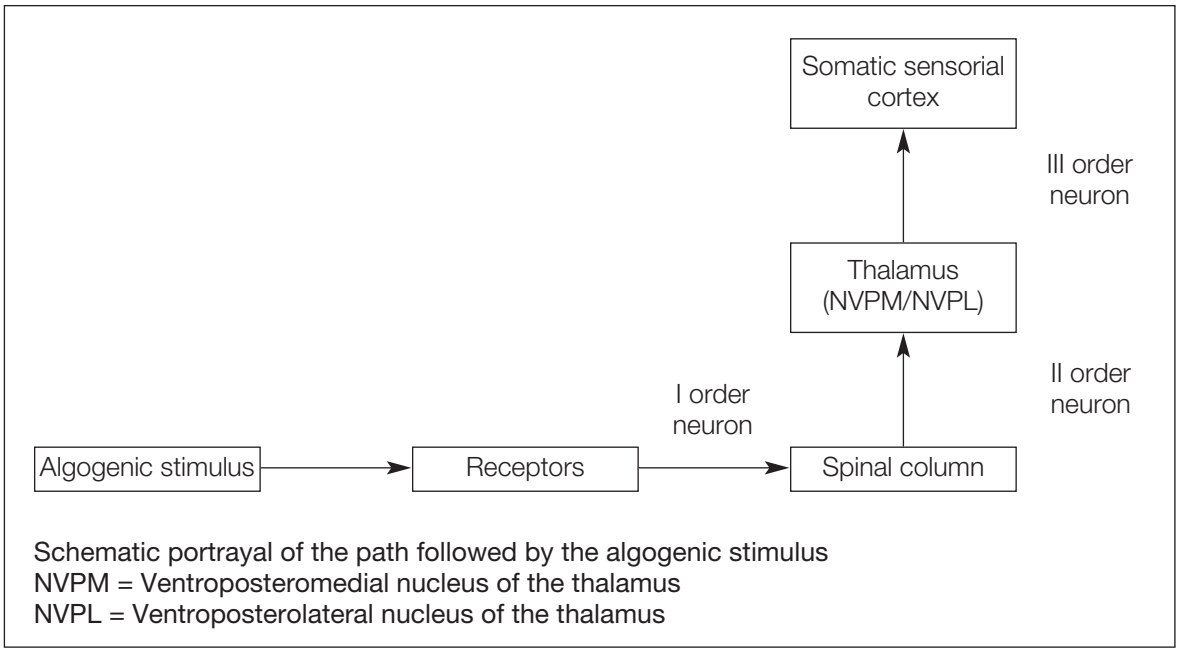
The algic system is a neuronal system made up, schematically, of four functional zones: 1. the area of reception which is characterised by the pain receiver; 2. the area of transmission made up of the afferent pathways (spinothalamic pathways: neo- and paleospinothalamic) which take the input of the pain receiver to the thalamus; 3. the area of the integration of pain made up of the cortex; and 4. the area of return made up of the efferent pathways (above all of the cortical-bulb-spinal pathways). In schematic fashion this can be expressed in the following way: reception —› transmission (afferent pathways) —› perception and integration (cortex) —› return (efferent pathways) (fig. 1).

From this model one can understand how the individual perceives pain above all when this reality reaches the cortex of our brains, the centre of the mental, motor and sensorial activities and in man the centre of thought.[30] Physical pain (*algos*) has its own language which bears upon the mind and in particular upon the soul, to which it accedes, above all through the pathway of suffering (*pathos*). Pain creates a language with the soul that leads to self-knowledge that becomes awareness in a perfect synthesis between *ratio et fides*.

Indeed, if the soul, a gift of God of life, is seen as a principle of spiritual activities, it is clear that it has in the brain the seat of the *perception* of pain and in the mind the seat of the internalisation of pain.

From what has been said hitherto we have reached the crucial point of the relationship between pain and the soul and we would like to make clear that physical pain (algos) perceived by the soul (*mens*) and received at the level of the brain (*ratio*) is defined as having a meaning that is not only immanent, connected with the pain of the body (algos), but also transcendent, connected with the pain of the soul (pathos). In this way an osmosis of the relationship between pain and soul is actuated which leads to search for algos (object) which is transformed into pathos (subject) who acquires knowledge of the algos (perception of one's own body), which becomes awareness of the pathos (perception of one's own self by the soul-mind) in a whole in the Self-Individual (immanent being with pain = algos + pathos) which is actuated, through Redemptive Grace, in the Self- Person (transcendent being, unity of the soul and the

Fig. 1. Pain pathways.



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

body) in a single projection which is ascendant towards God (*Logos*) (fig. 2), synaptic Unity of the immanent system (*ordo creationis*) and the transcendent system (*ordo redemptionis*) (the two-systems theory, fig. 2).

The interruption of the diological relationship with God (fig. 3) leads to algo-logical illnesses of the soul, with a reduction in the physical pain threshold (algos); to algo-pathological illnesses with a reduction in the threshold of mental-physical pain (algos + pathos); and to patho-logical illnesses, with a reduction in the threshold of mental pain (pathos) (fig. 2).

It is opportune to stress that when speaking about algological illnesses of the soul one means the involvement of the soul (a. algological) as the result of interactions of the receptor components beginning solely with the corporeal periphery (algos); for algo-pathological illnesses the soul is the result (a. algo-pathological) of interactions of the peripheral receptor components (algogenetic receptors, algos) and the central receptor components (limbic system and cortex, pathos); for pathological illnesses, the soul is the result (a. pathological) of the interaction of the receptor components, above all the central ones (cortex, pathos).

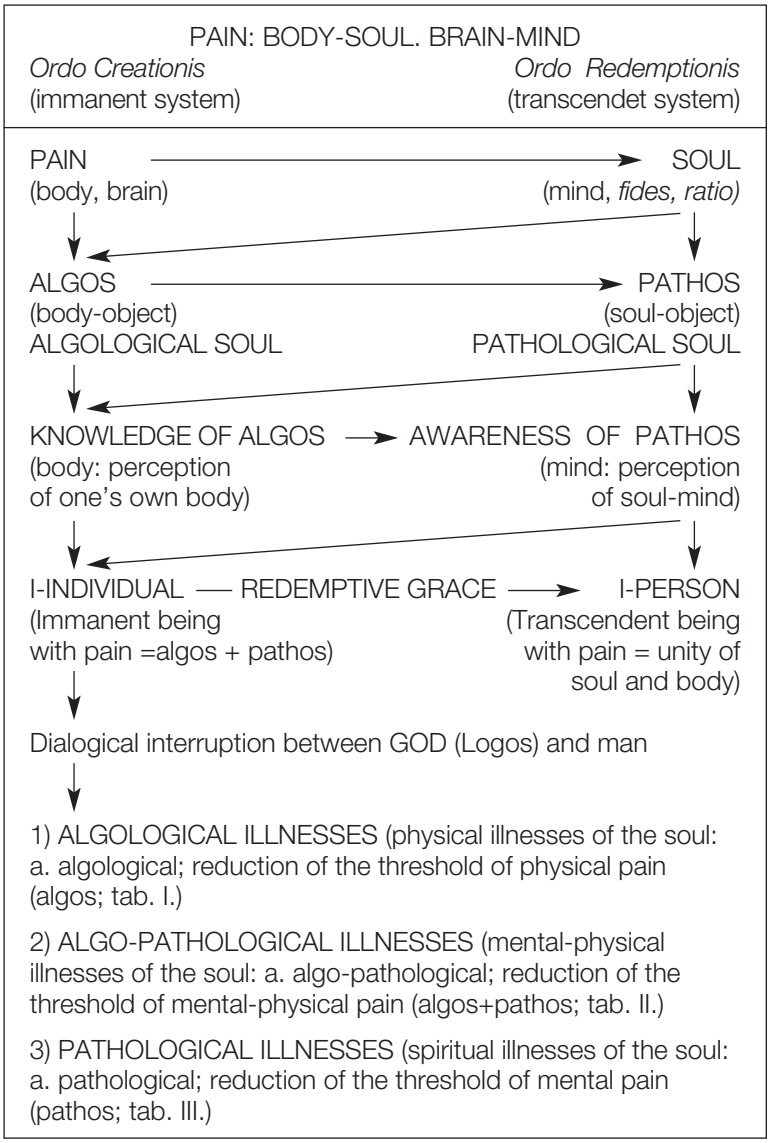
An example of algological illness could be cluster headache; migraine could be an example of algo-pathological illness; and muscular-tension headache could be an example of pathological illnesses.

In the two-systems theory that we propose, in which can be seen the synapsis between the immanent system and the transcendent system, which is actuated in the person, as a creature, unity of soul and body, of the Creator, in the sphere of neurophysiology, a drawing near occurs spontaneously with the three-worlds theory of the neuro-philosopher Karl Popper (and explained by the neurophysiologist, the Nobel prize winner, John Eccles).

Eccles posits a synapsis between *dendrons*, cells of the brain, and *psychons*, cells of the brain, through fields of quantum probability, in which waves (neurophysiological waves) are said to modulate the release of neurotransmitters in the intersynaptic space.

The criticism of this theory by some researchers, for example Changeux and the Nobel prize winner Edelman, as regards a synapsis between an organic system (the brain) and a functional system (the mind) can be overcome by the medical-theological idea of the theory of the two systems (fig. 2), identifying in the soul (mind, psyche) of the person the synapsis between the two systems, one organic (brain-dendrons-soma) and one functional (mind-psychons-psyche),explainable in the close relationship between physics and consciousness, between *ratio* and *fides*: once again, in delicate medical questions, theological science comes to the aid of medical science.

Fig. 2. The two-systems theory: *ordo creationis* (God-Logos) and *ordo redemptionis* (God-Incarnated Logos). GOD (Logos), synaptic Unity of the immanent system (Pain, body) and Transcendent system (Soul, mind).



3. The Theological Aetiology of Illnesses

Interpreting the symbolism of Biblical language in an authentic way, the Church teaches, in the light of the New Testament and Tradition, that our first parents Adam and Eve were created in a state of 'original holiness and justice'.[31] The grace of original holiness was 'participation in divine life'.[32] This participation, and this is very important for the search into the causes of illnesses, strengthened all the dimensions

of the life of man by its radiance to an improbable point. The *Catechism of the Catholic Church* states: 'As long as he remained in the divine intimacy, man would not have to suffer or die (cf. Gen 2:17; 3:19; 3:16). The inner harmony of the human person, the harmony between man and woman (cf. Gen 2:25), and finally the harmony between the first couple and all creation, comprised the state called "original justice"'.[33] This triple harmony, that is to say intra-personal, inter-personal and cosmic harmony, is thus the outcome of religious harmony, that is to say, of man's familiarity with God. From their friendship with God derived the happiness of their existence in paradise. The sin of this 'original holiness' is the fact that God places man in the garden (cf. Gen 2:8) where he lives "to till it and keep it" (Gen 2:15); work is not a burden (cf. Gen 3:17-18) but rather the collaboration of man and woman with God in perfecting the visible creation.[34]

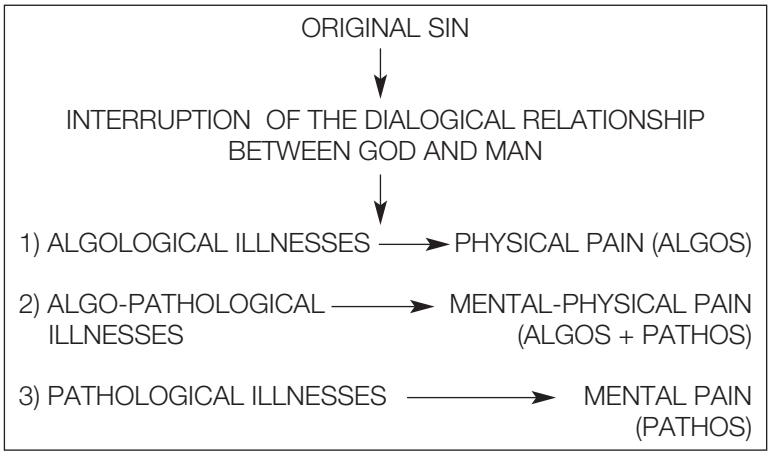
3.1 The causes of a moral order of illnesses

From the relationship between pain and the soul we should ask ourselves whether the algic perception in certain illnesses that produce not only physical pain (algos) but also, and above all else, mental pain (pathos), is the clinical result obtained not only through the stimuli of pain receptors led by afferent pathways to the central nervous system (CNS) and the hyper-production of certain chemical substances that are released at the level of the synapses of our brain, but also, and above all else, the result of an incapacity as regards dialogue with the transcendent sphere (fig. 3).

3.2 The radical cause: original sin

Because of the sin of our first parents, however, the original holiness was lost and as a consequence that original justice as well which God, in His design, had envisaged for man. Indeed, tempted by the Devil, man allowed trust in his Creator to be extinguished (cf. Gen 3:1-11), and abusing his own freedom, he disobeyed God's commandment. Holy Scripture shows the dramatic consequences of this interruption in the dialogical relationship between man and God. Adam and Eve were afraid of God (cf. Gen 3:9-10) of whom they had a false image, an image, that is to say, of a God jealous of His own prerogatives (Gen 3:5). As regards the harmonies, these, too, were destroyed: the mastery of the spiritual faculties of the soul over the body was shattered.[35] The 'dominion' over the world that God from the outset had granted to man was accomplished first and foremost in man himself as mastery over himself. Man was integral and ordered in the whole of his being because he was free of the triple concupiscence (cf. 1 Jn 2:16), but now, and this should be stressed, it is specifically this triple concupiscence that made him a slave to the pleasures of the senses, of the greed for earthly goods and self-assertion, contrary to the dictates of reason.[36] St. Thomas Aquinas observes: 'because of original justice, the reason of man was subjected to God, his inferior faculties to reason and his body to his soul. But because of original sin this balance was broken: and because his reason was no longer subjected to God, the inferior faculties rebelled against reason and his body withdrew from obedience to his soul because of death and corruption'.[37] What has been observed brings out that the originating cause of illness is original sin, precisely because in interrupting the dialogue of love with God, its effect, original justice, not having to suffer or die, was lost. But, and this is equally important, both mortal and venial sin drag the person into perdition and with the repetition of the same acts generates vice. Perverse inclinations derive from this that obscure the conscience and alter the concrete judgement of good and evil. In this way sin tends to reproduce itself and strengthen itself, even though it cannot destroy the moral sense at its root.[38]

Fig. 3. Aeitiopathogenesis of algo-logical illnesses, algo-pathological illnesses and patho-logical illnesses of the soul.



3.3 The proliferation of sin: the capital vices

Of a rather uncertain etymological origin, the word 'vice' undoubtedly refers to a heart that is not well disposed and certainly not directed towards God. A vice is a habitual inclination to sin, which has arrived totally or almost totally to the point of indifference and thus to the extinction of the remorse of conscience.[39] This applies first and foremost in the case of venial sins which do not break the covenant with God but weaken charity inasmuch as they manifest a disordered affection for created possessions. These sins obstruct the advances of the soul in the exercise of the virtues and the practice of moral good. In this sense, the vices can be catalogued in parallel to the virtues to which they are opposed or be connected to the capital sins. The Christian experience calls them capital vices because they generate other sins, other vices, and

they are seven in number: pride, greed, envy, rage, lust, greed, and laziness or sloth.[40] St. Thomas Aquinas compares the seven capital sins with the seven tendencies of vice of man, beginning from the fact that the capital vices are such specifically from a finalistic point of view. Those vices are deemed capital whose ends present attractive fundamentals designed to stimulate the appetite: and it is on the basis of their differences that the capital vices are distinguished. Now, a thing can stimulate the appetite in two ways: directly and by itself and from this point of view good stimulates the appetite as an attraction whereas evil stimulates as a rejection indirectly and as a reflection, in the case for example of those who address an evil aiming at a connected good, or in the case of those who flee from a good because of the evil that accompanies it. The capital vices thus imply a disordered desire for four possessions of the sphere that can involve concupiscence and a disordered flight from three arduous possessions. The vice of sin concerns the disordered desire for excellence as a possession of one's own spirit; the vice of gluttony concerns the disordered desire for the conservation as a possession of one's own body (food and drink); the vice of lust concerns the disordered desire for the conservation of the species as one's own corporeal possession (coitus); the vice of greed concerns disordered attachment to one's own wealth; the vice of sloth concerns disordered flight from one's own good because of the evil that accompanies it, for example the corporeal trials that accompany the acquisition of a spiritual good; the vice of envy concerns sadness at another's good, conceived as an impediment to one's own excelling; the vice of rage concerns rebellion that leads to revenge.[41] St. Thomas makes clear another important aspect: 'The process of the origin of vices is not the same as that with virtues: this is because virtues are caused by the subordination of appetite to reason, or to the eternal good of God; whereas the vices are born from a desire for transitory good'.[42] The capital vices are the cause of the proliferation of sin, and thus of the interruption, if the sin is a mortal sin, of the dialogue of love with God, and if it is a venial sin, they constitute, anyway, a con-cause of painful illnesses. Indeed, all sinners have been, and are, the authors of the passion of Christ. The Roman Catechism emphasises specifically in relation to vices: 'We must regard as guilty all those who continue to relapse into their sins. Since our sins made the Lord Christ suffer the torment of the cross, those who plunge themselves into disorders and crimes crucify the Son of God anew in their hearts (for he is in them)… Nor did the demons crucify him; it is you who have crucified him and crucify him still, when you delight in your vices and sins'.[43]

4. The Multi-Dimensional Character of Pain The algo-logical illnesses (of the soul)

The terrain of human suffering is multidimensional. The algological school of Florence defines 'pain as a mental-physical entity, with universal values, in the perception of which different individual, cultural and religious causes are at work and in the contextualisation of which take part not only the disciplines of medicine and biology but also those of the human sciences (philosophy and psychology)'.[44] From this definition emerges the importance of creating, first of all, an excellent relationship between the patient and the doctor, and three fundamental components are emphasised: 1. the sense-perception component (disease-algos), which constitutes the physical and sensorial value of pain described in terms of time (acute and chronic pain) and space (local and widespread pain); 2. the cognition-assessment component (illness-pathos), which constitutes the internally projected value of pain and the meaning that is attributed to it. This is a matter of *how* a person addresses pain and *how* it is internalised; and 3. the affective-motivational component (sickness-ethos), which constitutes the emotional value of pain described and experienced in the social context, creating culture and customs (nomos).

4.1 Pain between nature and culture

Pope John Paul II observed: '*Medicine,* as the science and also the art of healing, discovers in the vast field of human sufferings *the best known area,* the one identified with greater precision and relatively more counterbalanced by the methods of "reaction" (that is, the methods of therapy). Nonetheless, this is only one area. The field of human suffering is much wider, more varied, and multi-dimensional. Man suffers in different ways, ways not always considered by medicine, not even in *its* most advanced specializations. Suffering is something which is *still wider* than sickness, more complex and at the same time still more deeply rooted in humanity itself.' In the relationship between man and pain science, in order to combat the various painful pathologies, increasingly tends to use not only the experimental model but also, and above all else, the anthropological model, in order to counter the fracture between technology and medicine, on the one hand, and philosophy and epistemology, on the other. In all branches of knowledge, and in medical science in particular, scientific language must be *animated* by the search for the internalisation of *science in knowledge* which must, in its turn, be transformed into a *dynamic awareness* of man towards other men in the principle of service. Only in this way will science rediscover Love, as the only value that brings life.

In the perception of pain by the soul a synthesis is actuated between science, culture and wisdom, and thus a union between the neurosciences, philosophy and theology, with the acquisition by the soul of a symbiotic entity which can be defined in neuro-philosophical terms as the *algological soul*, *algopathological soul* and *pathological soul*. This percep-

tion of pain by the *algological soul* creates a therapeutic level of wisdom for health in balance with the laws of nature, where the body constitutes the point of encounter where the pathologies of the body itself come together (algological illnesses, tab. I) with those of the soul (algo-pathological illnesses, tab. II, and pathological illnesses, tab. III), transforming the physiognomy of the *algological* (corporeal) *soul* towards the physiognomy of the pathological (spiritual) soul (fig. 2), a transformation which for the Christian believer is connatural.

Given the close connections that the soul has with the body, the (therapeutic) improvement of physical pain (algos) leads to an improvement of mental pain (algos + pathos), of spiritual pain (pathos), and of social pain (ethos), creating behaviour of the person that is lifestyle and witness (nomos).

Despite the fact that pain is above all a physical, corporeal and material perception, and specifically because it is *material* it is *mater* e *matrix*, because of its dual unitary character (body-soul) it creates, in this concept, a holistic understanding of the various passages from algos to pathos, from pathos to ethos and from ethos to nomos.

This holistic understanding and these related qualitative stages correspond to the full in Christianity to personal and social anthropology and to the relationship that God has with suffering man.

4.2 Pain between nature and faith

'People who suffer become similar to one another through the analogy of their situation, the trial of their destiny, or through their need for understanding and care, and perhaps above all through the persistent question of the meaning of suffering'.[45] An important aspect of suffering is profoundly rooted in the entire Revelation of the Old and above all the New Covenant. 'Suffering must serve *for conversion,* that is, *for the rebuilding of goodness* in the subject, who can recognize the divine mercy in this call to repentance. The purpose of penance is to overcome evil, which under different forms lies dormant in man. Its purpose is also to strengthen goodness both in man himself and in his relationships with others and especially with God'.[46]

In the light of faith, bodily pain becomes, as penitence of the soul, a stage in redemption and in dialogue between the Creator and His creature in an always new form of language. From a functional point of view, pain manages to interfere in the anatomical centres of language, creating the value of a semantic entity that is always renewable and different. Language has specific anatomical seats in our encephalon which are called Broca's area and Wernicke's area (fig. 4; 4a).

Tab. I. Most frequent examples of algological illnesses (algos)

Cluster headache	Traumas
Trigeminal neuralgia	Disc hernias
Arthrosis	Arteriopathy
Arthritis	Phantom limb
Osteoporosis	Cancer

Tab. II. Most frequent examples of algo-pathological illnesses (algos+pathos)

Migraine
Fibromyalgic Syndromes
Muscular Fatigue Syndromes

Tab. III. Most frequent examples of pathological illnesses (pathos)

Muscle tension Headache
Depression
Depressive Syndromes
Psychological illnesses derived from capital vices

Fig 4. The centres of language. Broca's area and Wernicke's area (schematic vision)

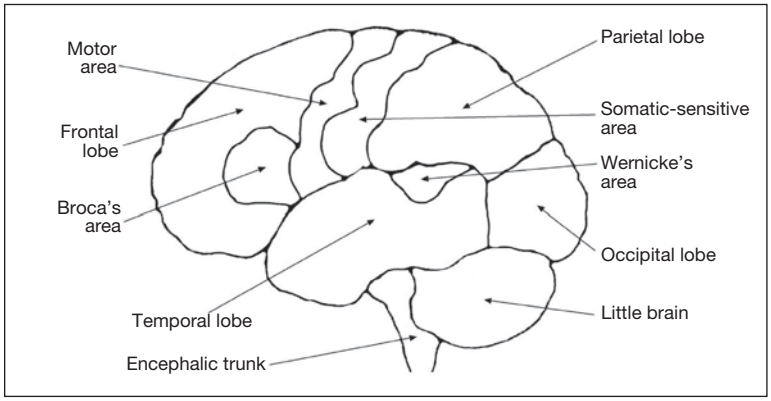
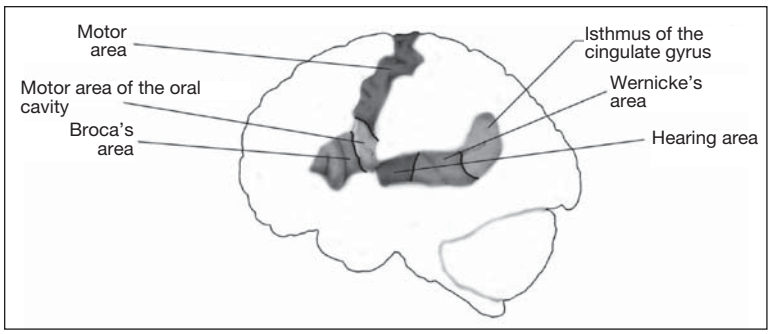


Fig 4a. The centres of language. Broca's area and Wernicke's area (anatomical vision)



The Centres of Language

Broca's area (Paul Pierre Broca: Sainte-Foy-la-Grande, 1824-Paris, 1880).

Wernicke's area (Karl Wernicke: Tarnowitz, 1848-Dorrberg im Geratal, 1905).

Language is actuated in our brains through visual and hearing systems; the motor system actuates oral and written language. The centres of language are Broca's area and Wernicke's area (fig. 1; 1a). Broca's area (discovered in 1864) is located at the foot of the third left frontal circumvolution of the motor (cortex) area and is engaged in the formulation of movements that are of use in oral speech. Wernicke's area (discovered in 1874) is located in the upper surface of the left temporal lobe (between the hearing area and the isthmus of the cingulated gyrus of the sensorial cortex) and is used for the perception of information. Between the two areas, as was posited by Wernincke, connections exist and the gravity of the two types of aphasia depends on how much the cortex is damaged beyond the perimeters of Broca's area and Wernincke's area. Lesion of these two centres is expressed in a disturbance of language called *aphasia*. There are two principal types of aphasia: Wernincke's sensorial aphasia, or perception aphasia, and Broca's motor aphasia, or expression aphasia. Wernincke's aphasia is characterised by verbal *deafness*, that is to say the patient does not understand the words that are heard, it is as though they belonged to a foreign language, and by verbal blindness, that is to say the patient does not understand written words (alexia or visual aphasia). In Wernincke's aphasia the spoken language is fluent but its understanding is compromised. Broca's aphasia is characterised by an inability to speak, even though the peripheral language apparatus is integral, that is to say phonation and articulation. The patient knows what to say but does not manage to speak. In this form of aphasia spoken language is disturbed but comprehension is relatively intact. This is the most common form of language alteration which is very often associated with right hemiplegia. At the level of clinical completeness, it is correct to add that dysphasia is a partial disturbance of the expression of language.

Every event of our lives, whether pleasurable (listening to pleasant music: the Mozart effect. Cf. Zucchi, Honings, and Voegelin, 2005) or painful (trauma. Cf. Zucchi, Honings, and Voegelin, 2003, 2004), and this includes prenatal or neonatal events (Bellieni, 2004), is configured in specific areas (fig. 5; 5a) and re-evoked in specific conditions, constituting the *phenomenon of memory*. From this one can understand how important the experience of a person is, above all *in fieri*, that is to say when he or she is in his or her mother's womb.

For the memory and learning, as well, very precise anatomical-functional seats exist in man (fig. 5; 5a).

The medial temporal lobe and three regions of the diencephalon (anterior nucleus and medial-dorsum of the thalamus and the mamillary bodies of the hypothalamus are the areas involved in the elaboration of memory and learning.

The medial temporal lobe and three regions of the diencephalon (anterior nucleus and medial-dorsum of the thalamus and the mamillary bodies of the hypothalamus) are the areas involved in the elaboration of memory and learning. At this point we ask ourselves what illnesses of the soul are, that is to say those illnesses connected above all with pathos.

Fig. 5 Areas involved in the elaboration of memory and learning (schematic vision)

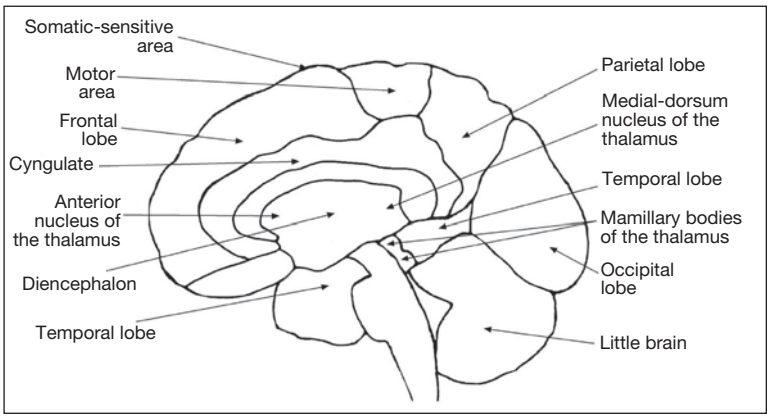
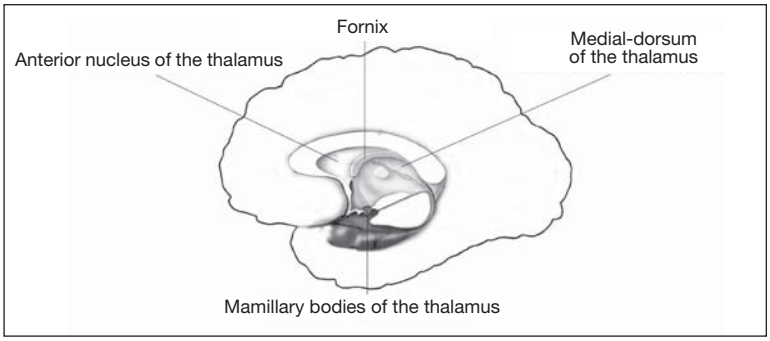


Fig. 5a Areas involved in the elaboration of memory and learning (anatomical vision)



5. Algo-Pathological and Pathological Illnesses (of the Soul)

For John Paul II: 'Suffering is something which is *still wider* than sickness, more complex and at the same time still more deeply rooted in humanity itself. A certain idea of this problem comes to us from the distinction between physical suffering and moral suffering. This distinction is based upon the double dimension of the human being and indicates the bodily and spiritual element as the immediate or direct subject of suffering'.[47] Thus, 'Insofar as

the words "suffering" and "pain", can, up to a certain degree, be used as synonyms, *physical suffering is* present when "the body is hurting" in some way, whereas *moral suffering is* "pain of the soul". In fact, it is a question of pain of a spiritual nature, and not only of the "psychological" dimension of pain which accompanies both moral and physical suffering The vastness and the many forms of moral suffering are certainly no less in number than the forms of physical suffering. But at the same time, moral suffering seems as it were less identified and less reachable by therapy'.[48]

5.1 Spiritual pain

In seeing man as a *psycho-physical* '*whole*', that great book of suffering, Holy Scripture, often conjoins 'moral' sufferings with the pain of specific parts of the organism: of the bones, of the kidneys and of the heart. One cannot deny, in fact, that moral sufferings also have their 'physical' or somatic component, and that often they are reflected in the state of the whole organism.[49] Here are some examples from the Old Testament. The prophet Jeremiah exclaims: 'My sorrow cannot be healed; I am sick at heart' (Jer 8:18). As an unhappy man but at the same time as a penitent man, the Psalmist turns to Jehovah, saying: 'Because of your anger I am in great pain; my whole body is diseased because of my sins. I am drowning in the flood of my sins; they are a burden too heavy to bear… I am worn out and utterly crushed; my heart is troubled; and I groan with pain. O Lord, you know what I long for; you hear all my groans. My heart is pounding, my strength is gone, and my eyes have lost their brightness. My friends and neighbours will not come near me, because of my sores, even my family keeps away from me' (Ps 38:4-5; 9-12). What is striking in this pain of the soul is the fact that the suffering person is before God, incapable of dialogue with God, with the transcendent sphere. The *Catechism of the Catholic Church* observes here: 'The man of the Old Testament lives his sickness in the presence of God. It is before God that he laments his illness, and it is of God, master of life and death, that he implores healing…It is the experience of Israel that illness is mysteriously linked to sin and evil'. Meanwhile we take as emblematic depression, which can be seen not only as a medical illness, but also, and above else, as one of the illnesses of the soul which in the medical sphere is most devastating and recurrent and can lead to suicide.

5.2 Depression

Depression, or rather depressive syndromes, can be also seen as authentic illnesses of the soul which not only create injury at the level of a sick individual but also at a social level, that is to say to those people with whom the patient, inevitably, comes into contact.

This pathology creates injury to the plasticity of the brain of the spiritual *patient* and those around him or her. The burn-out syndrome (syndrome of the negative internalisation of other's people's problems; Mayou, 1987) which takes place in health-care workers who are in contact with an algological patient can be explained very well from the neurophysiological point of view with reference to the plasticity of our brains, a quality that creates a functional capacity to restructure itself and thus to change on the basis of acquired experiences.[50]

The physiopathological mechanism of depressive episodes can be interpreted fro a medical-theological point of view in the following way: the experience of the interruption of the dialogue with God (fig. 3) creates an imprinting in a part of our encephalon (the plastic part) which gives rise to a functional mutation of certain areas of the brain (fig. 5; 5a) which through the *phenomenon of memory* facilitates the repetition of the pathological event. Thus the interruption of a spiritual relationship for the believer, or a relationship involving values for the agnostic, leads to a functional alteration which with the perseverance of the event leads to an authentic anatomical injury.

6. The Treatment of Illnesses

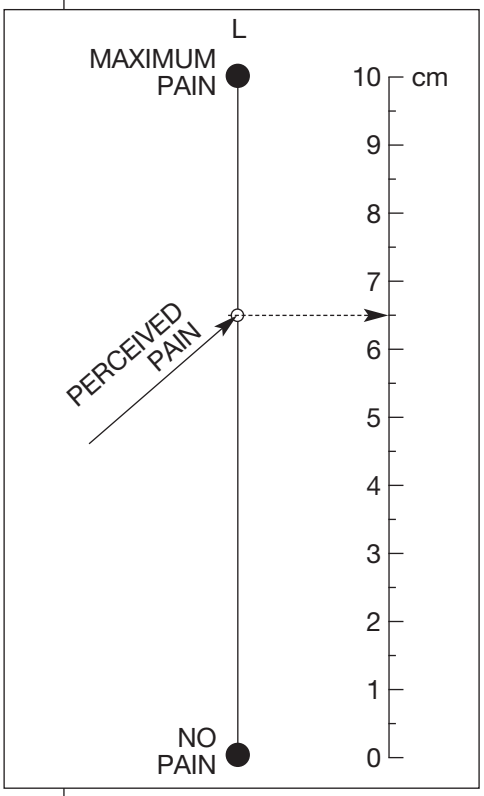
From this analysis of the causes of illnesses it emerges that algo-logical, algo-pathological and pathological illnesses have a shared origin: the loss of the original holiness of the intimate dialogue between man and God. However despite this shared aetiology, an analysis of the treatment illnesses must create a distinction between therapies that concern algo-logical illnesses, algo-pathological illnesses and patho-logical illnesses . The first (tab. I) are the responsibility, prevalently, of medical doctors; those of the second (tab. II) and the third group (tab. III) are the responsibility of medical doctors and priests. Therapies for illnesses of the body (algo-logical illnesses and algo-pathological illnesses) concern the order of the creation, the immanent order, and will be increasingly appreciated in the clinical/genetic sphere (Serra, A. 2008). Therapies for patho-logical illnesses concern the order of redemption, the transcendent order, and are also followed in the religious and not only medical sphere. The health of the body is achieved through spiritual health which creates a style of life that predisposes man to love. From this point of view, Javier Lozano Barragán defines the concept of health very well: 'health is a dynamic towards physical, mental, social and spiritual harmony and is not only absence of illness: it enables man to carry out the mission that God has entrusted to him, according to the moment of his life in which he finds himself'.[51]

Algological and pathological illnesses of the soul can be, and must be, treated as long as the patient is invited by his or her medical doctor to follow a pharmacological and ethical therapy and by his or her priest to follow a spiritual-behavioural therapy.

Pharmacological therapy constitutes an obligatory point to follow in the protocol to be followed in patients afflicted by algological illnesses where the

presence of the physical component of pain (algos) is unpleasant and impelling. In these conditions the intensity of pain is assessed according to the VAS scale of Scott-Huskisson (1976, 1979, fig. 6). The VAS scale of Scott-Huskisson has a vertical line 10cm. in length with two points at its end.

Fig.6. VAS Scale: L is a segment on which the patient marks the level of pain perceived. The segment between the marked point and the point of "no pain" is measured in centimeters.



One point, the one at the bottom, refers to the condition of absence of pain; the other, that at the top, refers to the condition of maximum pain. This scale is given to the patient who has to indicate on it the intensity of his or her own pain. Subsequently, thanks to the measuring in millimetres of the segment between the end of the scale which corresponds to the absence of pain and the point indicated, one obtains the conversion of the algic intensity into a given number which can be used in a statistical computation. At the present time the VAS scale is the most sensitive method there is for the assessment of pain (and above all acute pain) in the clinical setting. Unfortunately, this method cannot be applied to individuals in a state of confusion or with an intellectual deficit, even though in it pain is simplified in a linear representation. With this method a medical doctor has a specific measurement of pain for the algological pathology of the patient being examined and can implement a pharmacological therapy that is certainly appropriate by following the guidelines suggested by the WHO (World Health Organisation).

The Three-Level Analgesic Scale

The WHO suggests the three-level analgesic scale (tab. IV) which refers to the pathway that a medical doctor should follow according to the intensity of the pain of the patient. The lowest level (level 3) in clinical terms involves light pain which has to be addressed by following a pharmacological therapy based on non-steroid anti-inflammatories: acetylsalicylic acid, paracetamol, dicofenac, with the possible support of support steroids (methylprednisolone, dexametasone, medroxiprogesterone acetate). The middle level (level 2) refers clinically to moderate pain which is treated with a pharmacological therapy based on weak opiates (codeine, destropropoxiphene) together with FANS and possible support steroids. The highest level (level 3) refers clinically to very intense (unbearable) pain which has to be addressed with a pharmacological therapy based on strong opiates (morphine), with the possible addition of FANS and supports (steroids; psychotropic drugs).

To provide an overall picture, it must be borne in mind that weak opiates, differently from strong opiates, all have a ceiling effect, that is to say above a certain dosage their analgesic power does not increase, with the appearance, however, of greater side effects. This effect explains why

Tab. IV. Three-level Analgesic Scale

Level 3	POWERFUL OPPIATES (Morphine) + Anti-inflammatories (FANS) +/– Supports (steroids; psycotropic drugs) INTENSE PAIN
Level 2	WEAK OPPIATES (Codeine, Dextropropoxyphene) + Anti-inflammatories (FANS) +/– Supports (steroids) MODERATE PAIN
Level 1	Anti-inflammatories (FANS) +/– Supports (steroids) LIGHT PAIN

after about thirty days it is necessary to move from weak opiates (codeine) to strong opiates (morphine).

Unfortunately, because of unfounded fears which are present above all in the Latin culture both of medical doctors and patients, the use of opiates in the fight against pain is at a very low level, with Italy ranking 102 in the world in the use of these substances, whereas the United States of America and Sweden occupy the first and second positions.

The Clinical-Therapeutic Three-Level Scale: Pharmacological, Ethical and Spiritual

Similarly to the analgesic scale suggested by the WHO (tab. IV), which examines the intensity of pain above all in the oncologic field above all from a quantitative point of view, we propose the clinical-therapeutic scale (tab. VIII) which the medical doctor and priest should follow, also bearing in mind the qualitative parameter of pain (algos, pathos), on the basis of pathologies that are underway, that is to say algological illnesses (physical pain), algo-pathological illnesses (mental-physical pain) and pathological illnesses (spiritual pain).

Level 1: pharmacological therapy

Pharmacological therapy (tab. V), which is obligatory for algo-logical illnesses where there is present above all else the physical component of pain (algos), is to be suggested also in algo-pathological illnesses where there is present above all else the internalisation of physical pain in moral suffering (algos > pathos; level 2) and in pathological illnesses where pain of a spiritual kind is present (pathos; level 3).

In these last two nosological entities (algo-pathological illnesses and pathological illnesses) is to be suggested above all else ethical therapy (level 2) and spiritual-behavioural therapy (level 3).

Level 2: ethical therapy

Ethical therapy involves the health-care worker inviting the patient to engage in meditation and prayer with the aim of obtaining a strengthening of the effect of the medical therapy and an improvement in his or her condition of physical pain (algos), physical-mental pain (algos + pathos) and spiritual pain (pathos), as suggested by Zucchi, P. L. and Honings, B., 1996; Ratzinger, J. and Bertone, T., 2000; Zucchi, P. L., Honings, B. and Voegelin, M. R. 2001; 2003; 2005; 2008.

Level 3: spiritual therapy

Spiritual therapy involves opposing capital vices with the cardinal virtues of prudence, justice, fortitude and temperance (behavioural therapy) proposed by the priest and also by the medical doctor, with the support of music and ethical therapy (tab. VIII).

Tab. V. Therapies of pain for algological illnesses at a physical level: algos

F.A.N.S. (non-steroid anti-inflammatories):
(acetylsalicylic acid , diflunisal, indometacine, ibuprofen, ketoprophene, naproxen, indoprophen, diclofenac, piroxicam)

Fluorate corticosteroids
(desametasone, betametasone, triamcinolone, fluocinolone)

Non-fluorate corticosteroids
(cortisone, idrocortisone, frednisone, frednisolone, metilprednisolone, prednolene)

Anti-convulsives
(diazepam, carbamazepine, difenilidantoine, pregabalin, gabapentin)

Central antalgics (tramadol, codeine, oxicodone, morphine)

Placebo

Tab. VI. Therapies of pain in algo-pathological illnesses at the mental-physical level: algos + pathos.

1) Antidepressants
Tricyclical anti-depressants
Imipramine — Desipramine
Trymipramine — Clomipramine
Amitryptiline — Nortryptiline
Doxepine — Protryptiline
Butryptiline — Maprotyline

2) Inhibitors of monoaminoxidasis
Iproniazide
Isoniazide
Alpha-methyl-tryptamine

3) New antidepressants
Amineptine — Mianserine
Dotiepine — Noxiptiline
Trazodone — Nomiphensine
Melitracen — Fluoxetine
Viloxazine — Adenosilmetionine
Sertraline

3) Lithium salts

4) PLACEBO

5) PRAYER

Tab. VII. Therapies of pain of pathological illnesses at a spiritual level: pathos.

Classical music (Mozart effect) and placebo
Ethical therapy
Behavioural therapy

Tab. VIII Three-level clinical therapeutic scale

Level 3 Patho-logical illnesses (tab. III) Treatment of pain at a spiritual level (pathos)	SPIRITUAL THERAPY obtained by: 1) Classical music (Mozart effect) and placebo 2) Ethical therapy 3) Behavioural therapy (opposition of the cardinal virtues to the capital vices)
Level 2 Algo-patho-logical illnesses (tab. II) Treatment of pain at a physical-mental level (algos —> pathos)	ETHICAL THERAPY Antalgics and antidepressants (tab. V + tab. VI) + placebo + prayer
Level 1 Algo-logical illnesses (tab. I) Treatment of pain at a physical level (algos)	PHARMACOLOGICAL-ANTALGIC THERAPY FANS, cortisone, central antalgics (tab. V) + placebo + prayer

This therapeutic approach suggested by us and which we like to define as the *three-level clinical-therapeutic scale* must be implemented taking into account the ethical-religious approach of the patient (whether believer or agnostic) and in full cooperation with him or her.

6.1 The therapy of love

In the view of St. John of the Cross 'love of God is health of the soul'.[52] In outlining this concept this Spanish mystic (1542-1591) emphasised that spiritual health constitutes the premiss for a capacity of love, and wrote in his spiritual song: 'the soul, denied perfect love, does not have perfect health because in remaining sick it remains without health. In this way when it does not have any level of love, the soul is dead: whereas if it has some level of love of God, however small this may be, the soul is alive, but it is very delicate and infirm because of the small amount of love that it has. The more love grows, the greater will be the health that soul enjoys and thus when it has perfect love it will enjoy perfect health'.[53] Here the advice that John Paul II provided us with in his apostolic letter *Salvifici doloris* is very illuminating: we must turn our gaze towards the revelation of divine love. We must welcome the light of Revelation not only because it expresses the transcendent order of justice but also because it illuminates this order with love, as a definitive source because it is the ultimate source of meaning for everything that exists, and thus also of illnesses and their treatment. Love is also the fullest source for the answer to the question of suffering, and this answer was given by God to man in the cross of Jesus Christ.[54]

6.1.1 Jesus Christ: suffering defeated by love

In his conversation with Nicodemus Jesus declared: 'For God loved the world so much that he gave his only Son, so that everyone who believes in him may not die but have eternal life' (Jn 3:16). These words introduce us into the centre itself *of the salvific action* of God and also express the very essence of liberation from evil, which brings in itself the definitive and absolute perspective on suffering. Thus the very verb 'to give' indicates that this liberation must be accomplished by the only begotten Son through his own suffering and it is in this that is manifested the infinite love of both the only begotten Son and the Father. It is love for man, for the 'world', given that man not only 'may not die' 'but have eternal life'. Indeed, Pope John Paul II points out, 'Man "perishes" when he loses "eternal life". The opposite of salvation is not, therefore, only temporal suffering, any kind of suffering, but the definitive suffering: the loss of eternal life, being rejected by God, damnation. The only-begotten Son was given to humanity primarily to protect man against this definitive evil and against *definitive suffering*. In his salvific mission, the Son must therefore strike evil right at its transcendental roots from which it develops in human history. These transcendental roots of evil are grounded in

sin and death: for they are at the basis of the loss of eternal life. The mission of the only-begotten Son consists in *conquering sin and death.* He conquers sin by his obedience unto death, and he overcomes death by his Resurrection'.[55] At this point, and this is most important, John Paul II further makes clear that 'When one says that Christ by his mission strikes at evil at its very roots, we have in mind not only evil and definitive, eschatological suffering (so that man "should not perish, but have eternal life"), but also – at least indirectly *toil and suffering* in their *temporal and historical dimension.* For evil remains bound to sin and death'.[56] Indeed, the suffering of man cannot be detached from original sin and also from what John calls 'the sin of the world' (Jn 1:29), that is to say from the sinful background of personal actions and social processes of human history.[57]

The *Catechism of the Catholic Church* observes: 'After that first sin, the world is virtually inundated by sin. There is Cain's murder of his brother Abel (cf. Gen 4:3-15) and the universal corruption which follows in the wake of sin.[58] Likewise, sin frequently manifests itself in the history of Israel, especially as infidelity to the God of the Covenant and as transgression of the Law of Moses. And even after Christ's atonement, sin raises its head in countless ways among Christian (cf. 1 Cor 1-6; Ap 2-3). Scripture and the Church's Tradition continually recall the presence and the universality of sin in man's history'.[59] To summarise: one cannot forgo the criterion that at the basis of painful human illnesses there is a multiform involvement in sin and thus we must necessarily resort to the therapy of the divine love, to the victory of the crucified Christ over sin and the risen Christ over death. It should be said, realistically, that victory over sin and death do not abolish the temporal sufferings of human life, nor does it free the entire historical dimension of human existence from suffering. However, and this is what we would like to observe, the words of God 'For God loved the world so much that he gave his only Son' throw upon the whole of this dimension of painful illnesses and all suffering a new light, the light of salvation, the light of the Good News.

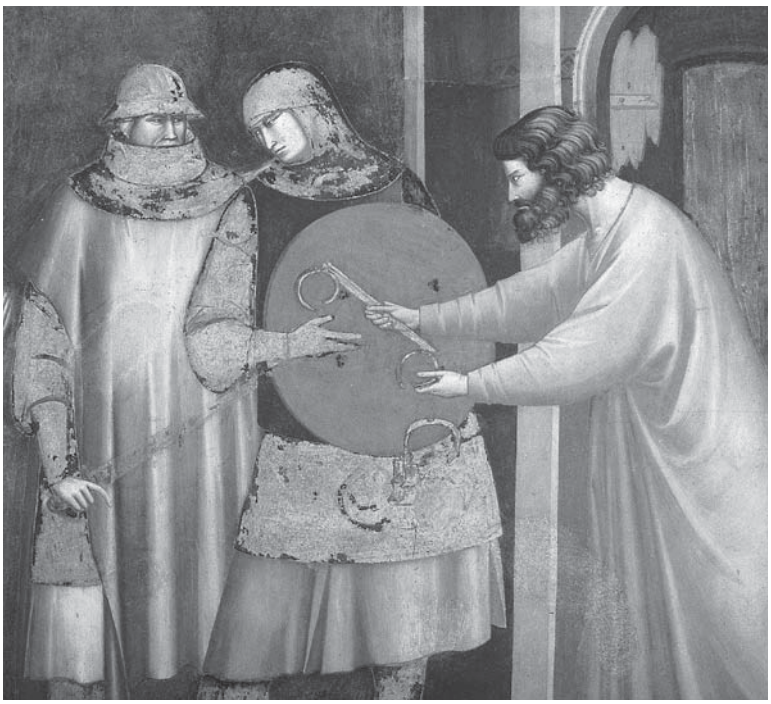
6.1.2 Therapy through the moral virtues

'In his mercy God has not forsaken sinful man. The punishments consequent upon sin, 'pain in childbearing' (Jn 3:16) and toil 'in the sweat of your brow' (Gen 3:19), also embody remedies that limit the damaging effects of sin. After the fall, marriage helps to overcome self-absorption, egoism, pursuit of one's own pleasure, and to open oneself to the other, to mutual aid and to self-giving'.[60] This divine help in defeating the proliferation of sin and thus of suffering seeks to return to man his self-mastery, which is necessary for him to give of himself and to enter the therapy of love. It should be observed, however, that however much one is dealing only with the help of marriage, the attenuation of the damage of sin is extended at the level of the creation to the whole of the being of man, soul and body. Indeed, self-mastery, in the sphere of sexuality, is the outcome of the cardinal virtue of chastity, which is a potential virtue of moderation. 'Chastity means the successful integration of sexuality within the person and thus the inner unity of man in his bodily and spiritual being. Sexuality, in which man's belonging to the bodily and biological world is expressed, becomes personal and truly human when it is integrated into the relationship of one person to another, in the complete and lifelong mutual gift of a man and a woman. The virtue of chastity therefore involves the integrity of the person and the integrality of the gift'.[61] St. Thomas Aquinas makes clear: 'chastity is that value by which man dominates and regulates sexual desire according to the requirements of reason (illuminated by faith)'.[62] The virtue of chastity has as its specific, that is to say authentic, object, sexual pleasure, which should be placed, desired, used and regulated according to a just order.[63] And thus it is evident that the virtue of chastity defeats illnesses caused, for example, by resort to contraceptive devices, to masturbation or hypsation, prostitution, homosexuality, paedophilia and all other kinds of sexual abuse. However, and this is very important, for the defeat of the capital vices as causes of a moral order of illnesses, the virtue of chastity is only a part of the cardinal virtue of temperance. The virtue of temperance, indeed, does not moderate only the disordered search for sexual pleasure at an individual and social level, it also moderates disor-

dered desire for pleasure as regards the use of alcohol and eating at an individual level. According to Catholic morality, 'Temperance is the moral virtue that moderates the attraction of pleasures and provides balance in the use of created goods. It ensures the will's mastery over instincts and keeps desires within the limits of what is honourable. The temperate person directs the sensitive appetites towards what is good, and maintains a healthy discretion: 'Do not follow your inclination and strength, walking according to the desires of your heart' (Sir 5:2: cf. 37:27-31).[64] Temperance is often praised in the Old Testament: 'Do not follow your base desires, but restrain your appetites' (Sir 18:30). In the New Testament it is called 'moderation' or 'sobriety', We ought 'to live sober, upright, and godly lives in this world' (Tit 2:12)'.[65] In this broader moral sense the Apostle writes to the Romans: 'So then, my brothers and sisters, because of God's great mercy to us I appeal to you: offer yourselves as a living sacrifice to God, dedicated to his service and pleasing to him. This is the true worship that you should offer. Do not conform yourselves to the standards of this world, but let God transform you inwardly by a complete change of your mind. Then you will be able to know the will of God – what is good and is pleasing to him and is perfect' (Rom12:1-2). As regards the illnesses caused by drug addiction,[66] by alcoholism[67] and by smoking,[68] the cardinal virtue of temperance is the most specific and proper winning force. We may add that in almost all the illnesses of the body it has by now been demonstrated that a psychological component is a co-cause and a resonance. This is addressed first and foremost by clinical psychology which in the sphere of psychosomatic medicine supports the therapeutic value of the relationship between the medical doctor and the patient. A health-care worker must attend to relationships with the patient so that his or her humanitarian sense strengthens professionalism and expertise is made more effective by an ability to understand the sick person. An approach full of humanity and love for the patient, called for by an integral human vision of illness and helped by faith, is written into this therapeutic efficacy of the relationship between the medical doctor and the patient.[69]

6.1.3 The therapy of penitence

From a theological point of view, it should be observed, as regards the subject of the treatment of illnesses, and with respect to their causes of a moral order, that further words are required on the therapeutic value of interior penitence. Indeed, 'sackcloth and ashes', fasting and mortifications, remain works of sterile and false penitence without a conversion of the heart, without interior penitence.[70] This penitence is a radical redirection of the whole of one's life, a return, a conversion to God with one's whole heart, a break with sin, an aversion to evil, together with rejection of the bad actions that we have engaged in. This conversion of the heart is accompanied by healthy pain and sadness, what the Fathers called '*animi cruciatus*' (affliction of the spirit), '*compuntio cordis*' (contrition of the heart).[71]



We are to the full in the order of redemption, that is to say in the transcendent sphere. The heart of man, heavy and hardened, requires God to give man a new heart. For this reason, the therapy of conversion, of interior penitence, is first and foremost a work of the grace of God who makes our hearts return to Him. The sacred author of Lamentations exclaims: 'Bring us back to you , Lord! Bring us back! Restore our ancient glory' (Lam 5:21). In discovering the greatness of the love of God which gives us the strength to begin afresh, our hearts are shaken by the horror of sin, by the interruption of the dialogue with God, and is converted looking at he who was pierced by our sins (cf. Jn 19:37).[72] The heart of Jesus which knows the depths of the love of his Father wanted to reveal to us the abyss of his mercy in a manner full of simplicity and beauty in the words of the merciful Father (Lk 15:11-24). The fine clothes, the joy of the father: these are the most significant features of the process of conversion, a radical treatment of the causes of illness both of the body (algological illnesses) and (above all else) of the soul (pathological illnesses).

To sum up: the authors of this article wanted to examine the following points: 1. *pain* (algos + pathos) which be-

comes of transcendent value towards God because of the physiological relationship that it has with the soul, both of which are essential constituents of the unity of the human being (the dual-unitary vision); 2. the placing in the theological and medical-scientific sphere of three new nosological entities: *algological illnesses*, which are characterised first and foremost by physical pain (algos); *algo-pathological illnesses*, which are characterised by mental-physical pain; and *pathological illnesses*, which are characterised by spiritual pain; 3. the two-systems theory (fig. 2) which explains the physiopathological aspects of algological illnesses, algo-pathological illnesses and pathological illnesses, examining the components of the immanent system (*ordo creationis*) which are internalised in the person towards the components of the transcendent system (*ordo redemptionis*). In this new theory it has been stressed that the soul (of the person) constitutes the synaptic unity of two systems (the immanent and the transcendent), overcoming in this way the criticism of Changeux and the Nobel prize winner Edelman of the science fiction explanation of the synapsis between dendrons of the brain (body) and psychons of the mind (soul), given by the neuro-philosopher Karl Popper and the neuro-physiologist and Nobel prize winner John Eccless in the three-worlds theory. 4. The placing from a therapeutic point of view of the *clinical-therapeutic three levels scale* (tab. VIII) where pharmacological therapy (level 1), ethical therapy (level 2) and spiritual therapy (level) are subject to examination.

To sum up: a) pain and body-soul can be seen as two symbiotic physiognomies of a single ontological unity of the human person (the dual vision); b) pain (algos) and its wise internalisation (pathos) in the redemptive cross of Christ belong to the full to Christian spirituality and the Catholic doctrine of the immortality of the soul; c. in the salvific plan of God pain of the body and of the soul constitute a perfect synthesis between the *Ordo Creationis* and the *Ordo Redemptionis*.

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Notes

[1] Pastoral Constitution on the Church in the Contemporary World, *Gaudium et Spes* (*GS*), n. 14.
[2] Song of Daniel, 3,57.
[3] Cf. *GS*, n. 14.
[4] Cf. *Catechism of the Catholic Church* (*CCC*), n. 362.
[5] Cf. *CCC*, n. 1146.
[6] Cf. *Dizionario Enciclopedico di Spiritualità*, Studium, Rome, edited by Ermano Ancilli, I, sub-heading, pp. 467-468, henceforth *Dizionario*.
[7] *CCC*, m. 461.
[8] Cf. *CCC*, n. 470. 'The unique and altogether singular event of the Incarnation of the Son of God does not mean that Jesus Christ is part God and part man, nor does it imply that he is the confused mixture of the divine and the human. He became truly man while remaining truly God. Jesus Christ is true God and true man' (*CCC*, n. 464).
[9] Cf. *Dizionario*, I, p. 467.
[10] In an address of 8 April 1981.
[11] Cf. *CCC*, n. 365.
[12] *CCC*, n. 364.
[13] Cf. Mt 16:25-26; Jn 15:13.
[14] Cf. Mt 26:38; Jn 12:27
[15] Cf. Mt 10:28; 2 Macc 6:30.
[16] Cf. *CCC*, n. 363.
[17] *CCC*, n. 650.
[18] Cf. R. DESCARTES, *Oevres*, edited by V. Cousin, vol. 12, Paris 1824, p. 95 ss, quoted in *Deus caritas est*, n. 5.
[19] Cf. *Deus caritas est*, n. 5.
[20] Cf. *CCC*, n. 369.
[21] Cf. Is 49:14-15; 66:13; Sal 131, 2-3.
[22] Cf. Os 11:1-4; Jer 3:4-19:
[23] *CCC*, n. 373.
[24] *CCC*, n. 307.
[25] St. Irenaeus, *Adversus haereses*, 3,18,1.
[26] *Ibid.*, 3,18,2; cf. 2,22,4.
[27] Cf. Mk, 10:39, Jn 21:18-19; Col 1:24.
[28] Cf. *CCC*, n. 618.
[29] Cf. JOHN PAUL II, *Salvifici doloris*, n. 4.
[30] Cf. *Dizionario italiano*, De Mauro, heading 'cervello'.
[31] Council of Trent, *DS*, n. 1511.
[32] Second Vatican Council, *Lumen gentium*, n. 2.
[33] *CCC*, cf. nn. 375-376.
[34] Cf. *CCC*, n. 378.
[35] Cf. *CCC*, n. 400.
[36] Cf. *CCC*, n. 377.
[37] *Super Epistolas Sancti Pauli Lectura*, in *Rom. IV*, *Lect.* 1, n. 333,
[38] Cf. *CCC*, n. 1865.
[39] Cf. B. HONINGS, *Dizionario Enciclopedico di Spiritualità*, Edizioni Studium, Rome, 2, heading, pp. 2028-2029.
[40] Cf. *CCC*, n. 1866:
[41] Cf. St. Thomas, *Summa teologica* I-II, 84, a. 4; B. Honings, heading cited.
[42] *Ibid.,* ad 1.
[43] Roman Catechism, 1,5,11, quoted in *CCC*, n. 598.
[44] Cf. ZUCCHI, PL., VIVALDI FORTI, C., MILANESI, 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) 41-82.
[45] JOHN PAUL II, *Salvifici doloris*, n. 8.
[46] JOHN PAUL II, *Salvifici doloris*, n. 12.
[47] JOHN PAUL II, *Salvifici doloris*, n. 5.
[48] JOHN PAUL II, *Salvifici doloris*, n. 5.
[49] JOHN PAUL II, *Salvifici doloris*, n. 6.
[50] Acquired experiences-learning-memory. Acquired experiences constitute the *phenomenon of learning* in man and animals which also gives rise to the *phenomenon of memory*. Eric Kandel demonstrated in the *aplisia californica*, a small sea snail, that following an acquired experience, in its neuronal structure (in this case made up of ganglion chains) molecule were released that were different from those of examples of other small sea snails which were not stimulated by the same learning.
[51] JAVIER LOZANO BARRAGÁN, Messagge for the World Day of the Sick, 11 February of the Jubilee Year 2000, Vatican City.
[52] *Cantico Spirituale*, 11,11.
[53] Cf. *Ibidem.*
[54] Cf. *Salvifici doloris*, n. 13.
[55] Cf. JOHN PAUL II, *Salvifici doloris*, n. 14.
[56] JOHN PAUL II, *Salvifici doloris*, n. 15.
[57] Cf. *Ibidem.*
[58] Cf. Jn 6:5-12; Rom, 1:18-32.
[59] Cf. *CCC*, n. 401 and *GS*, n. 13.
[60] *CCC*, n. 1609.
[61] *CCC*, n. 2337
[62] *Somma Teologica*, II-II, q. 151, a. 1.
[63] Cf. *Somma Teologica*, II-II, q. 151, a. 2.
[64] 'My child, as you go through life, keep your appetite under control, and don't eat anything you know is bad for you. All food doesn't agree with everyone, and everyone does not like the same kinds of food. Don't feel that you have to have all sorts of fancy food, and don't be a glutton over any food. If you eat too much, you'll be sick; if you do it all the time, you'll always have stomach trouble. Gluttony has been the death of many people. Avoid it and live longer' (Sir. 37, 27-31)
[65] *CCC*, 1n. 809.
[66] John Paul II observes: 'Using drugs is anti-life. "One cannot speak of 'the freedom to take drugs' nor of 'the right to drugs', because a human being does not have the right to harm himself and he cannot and must not ever abdicate his personal dignity which is given to him by

God," and even less does he have the right to make others pay for his choice' (Address to the participants at the International conference on Drugs and Alcohol, Nov. 23 1991, n. 4, quoted in Charter for Health Care Workers, Vatican City, 1995, note 195, n. 96, hereafter *Charter*.

[67] 'Unlike taking drugs, alcohol is not in itself illicit: "its moderate use as a drink is not contrary to moral law." Within reasonable limits wine is a nourishment. "It is only the abuse that is reprehensible"; alcoholism, which causes dependency, clouds the conscience and, in the chronic stage, produces serious harm to the body and the mind' (*Charter*, n. 97).

[68] 'With regard to tobacco also, the ethical unlawfulness is not in its use but in its abuse. At the present time it is established that excessive smoking damages the health and causes dependency. This leads to a progressive lowering of the threshold of abuse' (*Charter*, n. 99).

[69] Cf. *Charter*, n. 104.

[70] Cf. *CCC*, n. 1430.

[71] Cf. Council of Trent, *DS*, nn. 1676-1678: 1705: Roman Catechism 2.5.4; *CCC*, n. 1431.

[72] Cf. *CCC*, n. 1432.

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Fr. Pierluigi Marchesi (1929 – 2002): a Father and Teacher of Health-Care Policies*

Introduction

It is not easy to speak about men and religious like Fr. Marchesi who was a volcano, a man impassioned of the sick whom he loved and defended forcefully with intelligence and with great responsibility.

It is not easy to speak about Fr. Marchesi, a religious whose vision prefigured social and ecclesial questions. It is not easy to speak when a 'personage' has the charism of living hospitality and thus is a creator and an inventor, when this 'personage' was a prophet of hospitality, although recognised for this only after his death, because during his lifetime a prophet is difficult and is welcomed only outside and not inside his own country. A prophet has to die to be recognised, and this is what happened with Fr. Marchesi. Such was the case with the Prophets of the Old Testament and with the figure of Jesus of Nazareth in the New Testament. Such has also been the case with the history of the Church, at the present time as well, and so it will be in the future as well.

We are very happy that at this conference organised by Cardinal Fiorenzo Angelini space has been given to remember Fr. Marchesi. We have written this paper with a great deal of affection and with a great deal of love; with the same affection and admiration that we felt for him when he was alive.

Bibliograpical Notes on Fr. Pierluigi Marchesi

Fr. Pierluigi Marchesi was born in Cardano al Campo (VA) on 22 March 1929. Still of a young age, he became an Aspirant of the Fatebenefratelli Order in Brescia. He professed the simple vows of poverty, chastity, obedience and hospitality in 1946 and professed his solemn vows on 20 March 1953. He held the posts of Superior General, of Superior, of Provincial Adviser and of Provincial of the Province of Lombardy and Veneto, a service he gave from 1968 to 1976. At the General Chapter of 1976 he was elected Superior General and remained at the head of the Order for two mandates until 1988.

At the moment of his death he was Provincial Councillor and Director of the Centre for Studies and Formation of his religious Province. At an ecclesial level as well, Fr. Pierluigi made his wise contribution: from 1986 he was member of the Pontifical Council for Pastoral Assistance to Health Care Workers and was also the President of the Association of Catholic Hospitals and in this capacity he was a delegate of the Holy See as a representative at important international conferences and meetings.

During his service as Superior General he gave a notable impulse to the renewal that took place after the Second Vatican Council through important documents and important speeches which deeply marked the life of his Order and the world of health and health care.

He died in Milan on 2 March 2002 at St. Joseph's Hospital of the Fatebenefratelli.

I. HUMANISATION AND HEALTH-CARE POLICIES

People who leave their mark on history with their passing have the ability to discover new concepts and to formulate new ideas but in particular to manage to create connections which make their thought original and their action creative. In our case this was a matter of connecting the three concepts of humanisation, health care and policy in a theoretical/practical dialogue and pointing out their attainable objectives through a balanced harmonisation of their respective needs. In this terrain the prophetic spirit and the very life of Ft. Pierluigi Marchesi was practised, expressed and measured to the point of self-sacrifice.

1. Restoring a Human Face to Health Care

His passion was expressed in an original way in 1981 in a text that contained a programme written in the form of a letter to all the Provincial Fathers of the Hospital Order of the Fatebenefratelli. Its title was intriguing: 'Humanisation: Response of the Religious of St. John of God to a Historic Turning Point'. This text is seen today as a classic of health-care literature because of the spontaneity and the revolutionary concreteness of its proposals which could be implemented outside structures that were managed specifically by religious. A precise design which sought to involve all those who worked in health care in not going beyond man, in preventing patients from not losing their humanity, in establishing relationships of solidarity-inspired reciprocity as human, healing and healed, persons responsible for a shared destiny. The project of every man which according to Christianity is to grow, to become an adult person and to help other people to grow: a divine project endangered by the risks of illness, of suffering and of decay which is intrinsic to human beings.

For this reason, a dehumanising culture which based wellbeing solely on economic and social categories had to be opposed by a culture understood as an active process of humanisation to protect human life, to develop the intellectual faculties of man, and to reduce the aggression and the violence that threatens his very existence on the earth. If we do not live on the basis of man, we cannot manage to help those who suffer and perhaps we will not implement any project of Christian humanism – such was the thinking of Marchesi.

* Paper given at the Conference "Il volto delle creature ad immagine e somiglianza di Cristo", Rome, 9-10 October 2010

The promotion of health-care humanisation involves wise attention being paid to cultures but above all else it constitutes a decisive orientation in the direction of caring for the weak, the liberation of the poor, and the defence and the cultivation of the desire to live typical of man. All this is represented by the human face of care. Indeed, if man remains unknown, he is immediately marginalised. If the sick person is not at the services dedicated to health – Marchesi often observed – then other subjects run the risk of taking his place, but they are all usurpers.

The end and centre of every health-care institution must be the sick person to whom is dedicated the service of other people, his or her fellows, dedicated and directed towards his or her wellbeing. The dehumanisation of health care is the outcome of a separateness, which is not always a matter of chance but which can be detected in historical terms, between the healthy and the sick: an existential moral barrier which leads people to take refuge in the cold neutrality of bureaucratically conceived professions. The threats of illness that destabilise a person, that weaken him or her even in his or her own family and his or her world, must be countered by understanding man with a welcoming that is able to restore dignity to those who suffer as well as the hope of solutions to the maladies of society. In breaking down barriers, one discovers that being with a sick person is more important that doing something with him or her.

2. The Humanisation of Health Care: an Act of Justice and Charity

Following the model of Jesus, the great saints involved in social works, basing themselves on Christian principles and moral values, did not wait for law to uphold the recognition of, and respect for, man, but prefigured this through charity, in conformity with the teaching of the encyclical *Deus caritas est* (nn. 26-29) of Benedict XVI.

Charity always precedes justice and directs it. It eludes regulation and requires an interior approach and not only exterior behaviour; it is freely-given and stimulates love for the disinherited. Christian love does not make distinctions or effect exclusions but is disinterested, and thus precedes and supports justice. The cultural movement of humanisation overall has led us to see that despite the enormous advances of health care, the attention of workers and institutions has concentrated on the technical and on administration, moving from the true centre of things – man.

Thus ancient *pietas* is in crisis and it appears to be true although paradoxical that today whereas illnesses are treated better, man is less cared for. And not only this: society generates new illnesses, new forms of dependency on drugs, on technologies and on medical products, to which health care does not adapt easily. Humanisation, instead, must inspire love for the other in every situation of need to give to everyone that affection that allows sick people to meet their own moral, spiritual and supernatural, as well as their psychological and social, needs. The task of health care, therefore, is to assure justice to the sick with treatment that is rich in expertise, as well as being efficient and effective. But health care also has the task, beyond human health-care laws, to respect the sacred right of a suffering person to his or her own dignity, to an understanding of all his or her needs and to solidarity.

To the question of whether humanisation is an act of justice and charity, we reply that it is both. An act of justice because it meets a fundamental right and an act of charity because it meets a need for care that no human law can regulate. Love, charity, must enter the picture even more where human law has not yet managed to protect man as a whole, and is called to point out the pathways of justice to be followed. 'Charity is not happy with evil' (1 Cor 13:6) said St. Paul to the Christians of the first century AD, establishing a direct equation between justice and charity. The Christian revolution was *metanoia*, a revolution of hearts which led to a preferential choice for the poor and the needy, above all the suffering and the sick. The health-care revolution dreamed of by Pierluigi Marchesi consisted of giving people who suffered a sense of their own dignity and the sacredness of their lives which nothing and nobody can trample on or eliminate. Thus humanisation became a stimulus so that all workers of all professions could overcome fears linked to roles, to bureaucracy and to selfishness so as to create new ties of solidarity and friendship. There could be not true health, care or healing without authentic interpersonal relationships based upon empathy and love.

In this sense all of the formation of health-care workers had to be directed, as Fr. Pierluigi loved to repeat, by passion for man. The pathway of humanisation required specifically formed and educated people to recognise the structures of the sacredness of the human being, to interpret his or her aspirations and to assure his or her growth and fulfilment.

3. Ethics and Health-Care Policies

Although in various writings and speeches one can find points of health-care policy throughout the spiritual pathway of Marchesi, he addressed this specific subject during the last part of his activity which was dedicated to meetings and debates in which he took part, often agreeing to interact with people connected with health-care policy and management. His thinking about humanisation led him to think about the very topical subject of the relationship between ethics and health-care policies. At a time of epochal change, which was also marked by scandalous events as regards the management of health care in Italy, he spoke about ethics and humanisation with the secret hope of making the values at the level of ideals of Christian morality and those of his own religious Order enter health-care reforms. In particular, health-care policies has the task of con-

tributing to the planning of a society in which values were translated into public, personal and institutional behaviour that was transparent, verifiable and controllable. If they wanted to achieve these goals, politics had to reconnect with ethics. From the idea of a paternalistic state that provides everything and even seeks to enter individual consciences in order to decide the most intimate choices, it was necessary to move to an idea of a project-state directed towards the constant authentic exercise of rights and capable of establishing suitable spaces for the integral growth of all citizens.

The ideal of humanisation advanced by Marchesi was expressed in other forms: ethics had to assure respect for the centrality of the human person in every public activity and in political life itself. This meant respecting the wish of every man to live in good health, alleviating pain in illness, and improving quality of life. Thus as a return to those Christian ethics that were at the origins of the most aware movements of modern social Catholicism, for which the primary goal of politics is human promotion as a 'shared good'. Thus, politics had to become responsible for the health of citizens, for their education, and for environmental health care so as to construct a liveable future and create conditions for the development of the spiritual faculties of man. In other words, the idea of psychophysical wellbeing which was also adopted by the World Health Organisation was an idea involving a rule and concerned everyone inasmuch as it was a moral requirement.

Health-care policies are not immune to this logic if they want to have the right to intervene in the reality of health care which today strongly runs the risk of falling prey to a mercantilist capitalism that rejects the rules of ethics. The health-care economy, based on a healthy policy of the common good, must employ the models of healthy company management but it cannot see health care as a mere 'business' that can be governed by private investors alone. Such a health-care policy directed by values is an ideal of Catholic health care but it is also visibly constitutes the basis for an educational project for those who are involved at a professional level and for society.

Formation in values and formations in humanisation are fused in the thought of Pierluigi Marchesi in a programme of professional education and ethics of all health-care workers whom he would have liked to have involved in ongoing training to bestow a strong sense of responsibility on administrators, politicians, owners and professionals who are often been led by historical events to lose the meaning of their mission.

II. WELCOMING MAN: THE CHALLENGE FOR THE FATEBENEFRATELLI

1. Hospitality Towards the Year 2000: Listening to Man

The healthy Christian realism that animated the thought of the Fatabenefratelli looking towards the new millennium inspired a document with a programme of great breadth. In 1986 the document 'Hospitality of the Fatebenefratelli Towards 2000', which was in harmony with the previous document on humanisation which had animated the debate about health care over the previous four years, was sent to the Order of St. John of God.

Reflection on the new millennium led, from the point of view of religious hospitality, to an observation of the radical changes that had taken place within all health-care systems. Within the context of the inevitable changes in forms of providing care and pastoral care, the task of integral care based on the charism of hospitality was restated. From this point of view, religious were called to the duty to recognise the burning truth that they were no longer exclusively responsible for the sick and did not have the right to impose upon them their own religious view of life and health. Having lost the more typically professional functions of the past, a religious had to reaffirm, through a service adapted to modern times, the perennial joy of being with sick people and those in need with their own style of life, bearing witness to the sacredness of man and the real love that God feels for man himself.

In caring for man, Marchesi tirelessly repeated, we are called to listen to the voice of man who asks to be welcomed in his entire humanity and sated in his wish for care. Because never so much as today is man impoverished financially and even more in sincere and disinterested relationships. As often occurs in the documents that bear the name of Marchesi, the subject of care for man, or better of passion for man in line with the experience of St. John of God, evokes the reciprocal and complementary act of faith in the love of God. Indeed, with much courage he stated that the visible and dynamic expression of faith involves dedication to every man who is seen as a brother, a neighbour, another oneself.

Thus, even though necessarily hospitality in the future would have to change its operational models, there should never be an absence of the capacity to bear witness to the new commandment entrusted to us by Jesus as a characteristic of our identity as Christians, that mutual love which should become a true criterion of planning, administration and assessment of health-care ser-

vices in an outlook coherent with Catholicism.

2. Reconciling Oneself with the World of the Sick

As Prior General of the Fatabenefratelli, Fr. Marchesi was sent in 1983 as an observer to the Synod of Bishops which was held on the subject of reconciliation in the Church. Appointed by Pope John Paul II, he set about preparing himself to make a contribution on behalf of sick people.

I can still here his voice on the telephone from Barcelona. It was evening and he wanted help or rather wanted to share his contribution with, and make it choral amongst, the Fatabenefratelli. And soon he thought of what he had to do: a short, realistic and incisive document on 'Reconciliation in the World of Health Care'. I felt the honour of being a protagonist of that document which Marchesi sent in printed form to every father of that synod.

And then there was his speech. I will leave to your imaginations the tone, the vigour and the emotion of that brief performance of Fr. Pier Luigi Marchesi. He gave a short and direct speech on sick people, on illness, and on the pastoral care that he wanted: organised, planned and forceful. The deep insight that formed the basis of his speech took as a recurring and unstoppable theme the subject of the unity of the human person, the centre of our care. Just as medicine has often been accused of turning the sick person into a parcel and reducing him or her to his or her pathologies, it was asked whether the Church had not perhaps shared in this division by being exclusively concerned with the souls of the sick and a superficial religious sentiment without looking at the complexity of the sick person. In this context, which had been at times dramatic as regards its deleterious consequences, the Church was courageously called, through the voice of a simple hospital brother, to become reconciled with the man who suffers because of too little or too much medicine.

And please allow me to quote him. He said to the fathers of the Synod: 'It is always edifying to take sick people to sanctuaries, at least those who can do this, even though they are not always those who most need this: today it is first and foremost necessary for the Church to engage in a pilgrimage in hospitals where in many countries more people go to than is the case with parishes and where the presence of Christ who wants reconciliation is alive. And he ended his speech in the following way: 'let us not forget that we will all one day also belong to the people of the sick and the dying:

this will be an inevitable way of meeting the Christ who reconciles us and invites us to Easter'. I can still hear the echoes the applause that rang out in the hall of the synod. The Holy Father himself came down to embrace him amidst reciprocal emotion, as he himself liked to remember.

3. The Promotion of Pastoral Care in Health

The subject of pastoral care in health inside the Order was not an isolated chapter but was, rather, a part of the large movement of renewal called 'renewal of hospitality' which began specifically one year after the election of Fr. Pierluigi Marchesi as Superior General of the Order. International meetings for 'renewal of hospitality' soon began and the first took place on 26 October to 2 November 1977 in Rome. Two study commissions were appointed: the H Commission on Hospitality and the R Commission for the Organisation of Courses on Renewal.

The courses on renewal lasted from November 1978, the month when the International Meetings for the 'Animators' of Courses was celebrated, until November 1979, when the Extraordinary General Chapter began. These were moments of great enthusiasm and good results. Certainly, at that time some had more hope than others. This was a strong moment for the whole of the Order; I myself experienced this by holding a course and then teaching it in the Provinces of Spain, of Italy and of Portugal. It was an unforgettable experience. It was a moment of the Spirit who blew on the whole of the Order.

To this context should be attributed the International Commission for Pastoral Care in Health. This was another instrument in the hands of the General Curia for the service of renewal. And we set to work – this is something that I say with healthy pride. The engine was Fr. Marchesi; I was the chairman of this commission and with the other members of that commission we began our work with responsibility. The first meeting was chaired by Fr. Marchesi in Rome. At this meeting the commission and its role were organised: its goals, its structure and its methodology. Reflection, animation and the tasks of this commission were its strong points.

This first stage of the commission (1978-1983) was a moment to learn about the realities of the Order and a great stimulus for the Provinces. The commission began its work with a major meeting in Barcelona (28 April-2 May 1979): this was a historic date – new pathways were opened up for pastoral

care in health and pastoral care in health became a subject for history. This was the first international meeting where Fr. Marchesi as Superior General was present (cf. the documentation on it in the review *Información y Noticias*, n. 62/1979).

After this first meeting the courses on pastoral animation multiplied in number and they were in various languages: in English in Dublin; in German in Salzburg; in French in Paris, and then there were the courses in Los Molinos (Spain) and in Monguzzo (Italy) and also in Latin America (Mexico, Ecuador, Colombia, Peru) from July to September 1981.

After this first stage we began a second period with the Commission on Pastoral Care (1984-1988). This was a motivating stage because we became aware of the role of the commission as an 'agent of change'. The basic work had already been done and now we sought to work in relation to goals, to define in a good way the important fields of our work, such as the sensitisation and formation of agents, integration and pastoral practice.

The fruits of this work of ours, amongst others, were: the appointment in every Province of a brother responsible for pastoral animations; the course on pastoral care in Rome for the Provincial coordinators which was held in November 1984; and animation for linguistic groups…

At the General Chapter of 1988 an assessment was presented on the journey that had been taken and in comparing the positive and negative aspects we realised that the results were clearly positive. A giant step forward had been taken within the whole of the Order as regards pastoral care in health and a strong influence had also been exercised in local Churches.

The conclusions and the priorities pointed to the following ideas: a strengthening of the coordination of pastoral care; the creation of a specific style within the Order; the training of pastoral workers; the integration and motivation of members of the lay faithful; and the animation of pastoral care in health in local Churches.

All of this was a challenge; it was the seed that pastoral care had made available to renewal. Another outcome of this pastoral work was the following publications of the commission: *Cos'è la pastorale sanitaria?*('What is Pastoral Care in Health?'); *Pastorale degli Infermi nell'ospedale e nella parrocchia* ('Pastoral Care for the Sick in Hospitals and Parishes'); and *Dimensione apostolica dell'Ordine Ospedaliero di San Giovanni di Dio* ('The Apostolic Dimension of the Hospital Order of St. John of God').

These were rich and strong moments. There was no absence of difficulties, but we were welcomed and we were animated in carrying out our work. We saw in our Superiors, and especially in Fr. Marchesi, leaders, people with enthusiasm. He believed in us, he gave us confidence, and we believed in him; and this enthusiasm made our commitment to service to a common cause grow – 'the renewal of hospitality' – in which pastoral care in health occupied an important position. These were years when we felt a strong breath of the Spirit.

III. A RELIGIOUS WITH A HUMAN FACE

The approach we give ourselves to sketch the profile – if one speak thus in a more deeply human way – of Fr. Pierluigi is suggested to us by reflections offered by Cardinal Fiorenzo Angelini after the death of a man whom he described as a 'friend and fellow worker'. Attributing to his fellow work the tact of authentic intellectual and moral humility, His Eminence identified in that virtue the source both of his inexhaustible creativity and of a courageous tenacity in following the poor and suffering Christ. The Cardinal declared that 'Fr. Pierluigi, a religious and not a cleric, was both an apostle and a prophet: an apostle because he felt by vocation sent to proclaim the Kingdom of God and heal the sick (Lk 9:12); a prophet because he intuited that true and effective evangelisation involves an ecumenism of works which in the world of health care and health finds its clearest and most powerful actuation'. In this way the originality of a vocation which was not only strictly religious was identified and we wish rapidly to analyse this vocation by entering the existence of a courageous innovator as regards health care.

1. His Specific Vocation

One of the first impressions that his interlocutors had was his clear and direct identification with his own hospital religious family. He was conscious and inwardly proud of that immediate identity/belonging, as is borne out by his writings and his work over sixty years of untiring service. It was not rare to hear from him words of regret at the low level of attention that was paid both within the Church and in politics to the voice of his Order and in general to the calls of all the hospital Orders which perceived the real needs of sick people and health care. In a certain sense it seems to us impossible to establish a separation between the features/values that were characteristic of the man from those that were typical of the religious. In him these two realities coincided and in a surprising way the riches of natural talents were developed and embodied in the practical life of this hospital brother.

He was born as we know in 1929 in hard-working Lombardy and he had around him, as he loved to recall, very human models of workers and peasants who were constantly involved in obtaining a livelihood, for themselves and their families, with the sweat of their brows. His father and mother, who both worked in a factory, were for him a moral reference point and also recurred in certain reflections of his on respect for rules, honesty and ties in the company in which one works: these were all elements that came together in deciding his way of thinking about, and presenting the meaning of, membership of his religious family and its works. Even in his enthusiastic choice of his beloved football team he expressed his loyalty as an authentic sports-

man and keen former football player.

The initial direction of his personal vocation was generated by his meetings with brothers who were older than him and whom he had met when he was young. Indeed, in 1940 he entered the apostolic school of the Fatabenefratelli of the religious Province of Lombardy and Veneto after finishing elementary school where the education of this teenager were grafted onto those principles/values that helped to form the character of this man and brother: a feeling of belonging, enthusiasm in service to the sick, devotion in carrying out the role that had been assigned to him, adherence to the indication of his Superiors, something that is very different, as religious know, from mere obedience.

The originality of this adherence characterised the first years of his religious life but it also characterised his last years. Even when, still a child, together with the companions of his course, he was called to live and work next to the sick during the long nights when he was carrying out his valuable traineeship with the hospital family of St. John of God. It was specifically to that time, in welcoming, seeing and 'touching' the martyred bodies of people who were victims of the Second World War, that we can attribute the seed of the ideal of humanisation that would be clearly formulated at the end of the 1970s.

A young religious's response to the vocation to be a hospital religious often directs him while he is still undergoing formation towards care for special people in need such as the mentally ill, of whom there are a large number in the health-care institutions of the Fatabenefratelli. These were the most disinherited of the sick people who had and still have most need of humanisation in being received and cared for.

In those years there emerged his clear abilities as a communicator both through words and writing. This was because he did not like rancorous silences amongst religious or fellow workers. For him it thus became necessary to speak – where this was expected and where this was not expected (to use St.Paul's phrase) –to communicate and express his ideas, his dreams and his visions, at times sharply, although never in an unpleasant way, which, however, he did not always manage to persuade everyone to understand or accept. Once again, with this style and wish to be a communicator, one could see how this man became the instrument of this hospital religious and all of his life force was directed towards the good of the sick and to the coherent growth of his religious family.

In all of this we can recognise specific features of the special vocation of a religious who was an apostle and prophet of a different kind of health care, purified through the charism of hospitality and shaped around the project of humanisation. In him were expressed in the form of a seed the vitality of a charism that was not only a personal endowment but also a call that forced us to see gifts of another nature which would have made him a tormented, polemical and indispensable leader for our time.

2. The Service of Government of his Religious Family

From the biographical notes one can note the quantity of posts that were held by Fr. Marchesi within his own Order, in particular the Superior Generalship of 1976-1988, twelve years of responsibility as Prior General, where one can see more clearly his personality, his thought, and his 'passion' for hospitality. It is true that he reached the highest and most prestigious level but this highest level had to be expressed in better service: this is what Jesus teaches in the Gospel and Fr. Marchesi was truly a servant, an example of service.

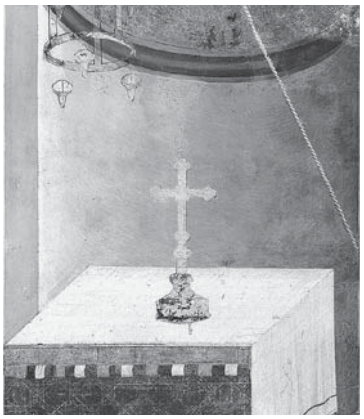
In all the positions that obedience entrusted to him, Fr. Marchesi manifested impassioned service to man, to the sick; to them he dedicated time, intelligence, words and facts.

As Superior General he placed all his energies at the service of the charism and mission of hospitality; all his energies were directed in particular to the renewal of the Order, to pastoral care, to formation, to humanisation, to alliance with the lay faithful, to looking towards the year 2000, and also great openness to the universal Church. This is particularly suggested by his appointment by the Holy Father as observer to the Synod on Reconciliation in 1983 and his protagonism, together with that of Cardinal Angelini, in the creation of the Pontifical Council for Pastoral Assistance to Health Care Workers. These were the facts and the life of Fr. Marchesi, his fundamental work as Superior General. These were moments strong in animation and he knew to take advantage of the power of slogans such as: 'renewal to humanise' or 'the sick man is our master, our school, our university'.

And thus begun a journey of service that was hard, slow, difficult, 'unpopular', not always welcomed, and this he himself knew, it was not something that he concealed. His definition of it was as follows: 'To be the Superior General of a religious Order means having the duty of prophecy, at the price of being unpopular and making enemies'(cf. *Per un ospedale più umano,* E. Paoline, 'Premessa').

Thus he interpreted his service as listening to the times and a search for innovation. After a number of years of reflection on spiritual renewal, two revolutions were indicated – that of humanisation and that of new models of hospitality. At a historic meeting in 1987 with the Camillians Marchesi offered a perfect summary of his project for government: 'The first, humanisation, has as its principal task that of transforming our relationship with patients, placing in this the same humanity that Christ 'divinised', that aspect of humanity represented by feelings, by emotions, and by the heart. 'Love your neighbour as yourself', the commandment reminds us, strengthened by that wonderful statement of Jesus 'Everything that you do for one of these little ones, you did it for me'. One is dealing with a rediscovery, a clear ideological turning point, which also involves all our fellow workers, above all those who have be-

lieved that to achieve therapeutic ends scientific culture is sufficient, technical culture with its extraordinary advances and rational knowledge. For we religious, in particular, this has been a push, a valuable opportunity to 'revisit' our charism. The second revolution of hospitality with man, which has just been announced, concerns the role of the Fatebenefratelli. How, that is to say, to be 'functional' over future years in the light of the foreseen and foreseeable transformation in the field of the demand for well-being from society to man. Foreseen and foreseeable transformations in the field of responses as well, responses which will be increasingly detailed, complex and not manageable by one person or only one function. These two revolutions were born from the increasingly evident observation of an increasing state of dissatisfaction felt by us, on the one hand, and by sick people, on the other'.



From this came a project for a new hospitality which is still of contemporary relevance as regards its contents and which was also prophetic in terms of its inspiration: 'In detail, our programme can be outlined as follows: a) the abandonment of the idea that it is enough to perform tasks of the past of a prevalently operational character so as to enrich our inner lives, cultivate our capacity for love, and embody the role of witnesses who are ready to receive the appeal that humanity addresses to us. We must always bear in mind that we became religious not to direct, not to be well in the corridors of power, but to bear witness to an authentic and total interest in those in need; b) directing our activity not so much to the function of technical leadership but to that of moral leadership in our works. This is an undertaking which is not easy for any of us; c) courageously adopting the role, which is still overly neglected in our lives, of being a critical conscience in the world of health and health care. A role that links us to the precise need to modify the contents and methods of our own basic formation so as to be able to educate in serene and constructive criticism, in lucid analysis and where appropriate without pulling any punches, in study and research; d) avoiding allowing ourselves to be dragged forward by events, by the 'vagaries' of fashion, by the peaceful tramlines of consolidated custom, so as to be forerunners, utopians (but I would prefer say prophets) in the world of health care. We must know how to identity from this moment – so as to be able to then worthily welcome – those in need at the end of this century and at the beginning of the twenty-first century. This task, as well, has too often been left to other people: we, too, were in a better condition speedily to come to the help of that part of humanity which every now and then is 'discarded', marginalised by medical science and by society itself… This is a conditionm-*sine qua non* to achieve the goals that we established for ourselves. We must, that is to say, also transform ourselves into researchers, overcoming the temptation to abandon old Europe because it is more difficult to find there the poor, the needy; in reality, we find ourselves addressing forms of poverty that do not relate so much to having as to being, and thus they are much more grave and more difficult to help: one need only think here of loneliness, of abandonment, and of a lack of affection'.

3. His Prophetic Intelligence in Understanding his Time

'In a society full of prophets of misadventure', observed Cardinal Angelini, 'Fr. Pierluigi was a prophet of hope. Who does, does not judge; who does, has the gift of everywhere discovering positive resources: who does, is not afraid of difficulties but draws an incentive from them to increase his commitment'. His personal charism had an innate sense of history joined to a prophetic vision from which came his courage as regards ideas and his impassioned hope as regards the future. A man of frontiers and not of barricades, he exposed himself to the most tiring interactions without boundaries, always directing his gaze to real problems, but with innovative wisdom. So many religious, ecclesiastic, trade unionists and lay fellow workers remember him this way and with them he prophesied that Catholic healthcare institutions had to be refounded, being monopolised as they were by old and narrow mental habits. From his concern about the future came his interior worry which prevented him from stopping at the roadside to be very happy at the results that had been achieved. Instead, it pushed him forward to look beyond the usual narrow horizons and understand the meaning of history. And he did this, even when he proposed to innovate the forms and the 'style' of the presence of religious within health care, with the certainty that this would also have improved the quality of care.

In this sense, one can affirm that he was a religious who knew how to recognise the essence of being the Church in health care, not only in owning hospitals that had to be managed but also and above all else in taking on in a responsible way the constitutive ministry of overall assistance and care for sick people as Christian witness in the health-care world.

The fact that he was a son of the Church within a hospital Order had formed in him the belief that he had an ineluctable duty to involve bishops and the top of the ecclesial hierarchy in becoming agents of health and salvation through pastoral care in health and the promotion of governance of institutions that was in conformity with the principles and values of Catholic ethics. It is worthwhile remembering that he wanted a School of Hospital Manage-

ment, a School of Bioethics, and humanistic formation for his brothers and fellow workers to provide solid bases for the constant changes that agitated, and still today perturb, the health-care world.

Indeed, his being a prophet was not reduced to simple appeals and abstract ideas but is to be defined as an interpretation and concrete response to the challenges of his time. In chronological order, the following were consigned to history: the titanic project of the renewal of his Order which involved him from 1976 to 1982; the promotion, together with other religious Orders, of the Religious Association of Social/Health-Care Institutions; the cultural campaign for the humanisation of health care; and the decision that was epoch-making for Italy to prepare, in cooperation with the public authorities, for the placing of Catholic institutions within the National Health Service. These were moments of that ecumenicalism of works invoked by Cardinal Angelini, by which one wins the 'wager of charity' (*Novo Millennio Ineunte*, n. 49) and which the Church must carry out in its capacity of yeast in the dough of health-care systems.

In particular, I am happy to stress how from his humanity emanated the prophetic charge contained in his project for the humanisation of health care. His sensitivity allowed him to prefigure the future by introducing the concept of the humanisation of the health-care and welfare world to achieve a full sharing and implementation of the charism of hospitality.

In his Order he was a strenuous promoter of an alliance with lay fellow workers, with whom he shared the values of the charism of hospitality. With vehemence he challenged members of the laity and religious with the words 'if we do not have the courage to measure ourselves with men, we cannot speak about humanisation, rather we should speak about the rationalisation of services', and in trust in being at the side of God.

His insights about the future development of the health-care world, with the passing of time, were proved to be right in the reality of the facts: history had proved him right. In the history of the Church as well – the creation of the Pontifical council for Pastoral Assistance to Health Care Workers; certain specific initiatives of Popes; certain passages in *Consecrated Life*; and the rich literature of the prestigious review, *Dolentium Hominum* – can be led back to the cultural movement that he launched and promoted with sacrifice that was also of a personal nature.

When one looks at the literary production that derived from his speeches and which were published in the volume entitled '*Humanizzazione. Storia e Utopia*' ('Humanisation: History and Utopia'), edited by the Hospital Order of St. John of God, and published by Velar in 2006, one understands, in all his positions both as Superior General and as the head of the Office for Studies, as a sick man or as a healthy man, even though outside the centres of government of his beloved religious Order, that his passion remained intact. The 1980s and the 1990s were important years when his approach of being an 'elderly man' allowed him to show his human face and in addition his strength of character. In accepting posts that he had not requested, he affirmed with determination the strength of his ideas that his ardour and his personal involvement made credible even though from certain points of view they were contestable.

CONCLUSION: ENCOUNTERING THE FACE OF CHRIST

Perhaps those who will look at him in the future will understand him better than was the case with his contemporaries, but his serene approach when faced with his final suffering and the parting caused by death compel us to reflect on what Fr. Pierluigi can still tell us. His death as an impoverishment and elimination of self, in openness to the will of God, identifies him as the righteous man of the Bible: 'at that time his deeds are revealed for everyone to see' (Sir11:28). To guide him during those dramatic moments he had two models to whom he was intimately bound: St. John of God and St. Benedetto Menni, as well as an example who was very close to him, his brother and Superior General, Fr. Mosè Bonardi. Although he spoke with modesty and timidity about his entrusting of himself to God, being afraid that he did not have suitable words to do this, his way of praying in silence and weeping before God, showed him, to those who were near to him, in his authentic humanity and patience when faced with dying.

We find an echo of this in a text that was published by the review *Fatebenefratelli* of Milan in a special edition dedicated to Marchesi and in which appear certain intimate reflections, perhaps a prayer composed in previous years as a very confidential and tender conversation between a creature and his Father: 'One should receive illness as though it was a letter, given that it is intended to reveal something to us. Illness is a weakness that tests our real strength. A forge where a sick man becomes the good creator of his character. An interval in a life of selfishness and vanity by which to change tempo as regards the earthly symphony. A crossroads where one can halt for a little while and choose the road to take and look at one's goal. A stop where one can weigh the value of things and measure the stature of men. A retreat where one can recite the miseries of sin and the litanies of patience… An altar before which one can repeat the third invocation of the Father. But hard weeks or months or years,

drops, streams or rivers, go on to the sea. The ocean always reflects the blue of the sky. And this is the time to interpret one's own illness. Thus, after contemplating the afternoon and the evening, we are pushed to the verge of that mystery that seals our brief earthly lives. Let us put it briefly… In reality, it is long enough to allow us to see, to understand and to judge ourselves. It is certain that when observing the journey that has been made hitherto, only a few gestures emerge from the greyness of years. Often our errors are of an exasperating monotony. And from the gorges, in which we are reflected with too much pleasure, there still come miasmas from stagnant waters. And now I am here, with my life behind me, at times tepid like a breath, at times far from dying. I am here, with that little that I have achieved with difficulty, and thinking of that great deal that I could have done in doing good. But the sack is empty and the road is almost at an end. This is the hour for a deeper examination of conscience. I must weigh myself and measure myself, before my judge does so. I am a grain of sand. I am a blade of grass. And this is the hour of my last wishes. Well, I would like to die in your grace, O Lord. I would like my last hour to come when I am working. I would like to depart happy at having dreamed my life'.

TO FATHER PIERLUIGI MARCHESI,
WITH AFFECTION AND WITH LOVE,

+ José L. Redrado, OH

I am moved. Your death reawakens in me feelings, memories and experiences. Your death, which was almost expected, when we learnt about your grave illness, but always with a thread of hope, thinking that it would not be so quick.

And it was so quick, almost hurried, hastened, always moving, like a bell that chimes and reminds us of an appointment. You departed knowing that you had begun a voyage with a difficult return; you left in the knowledge that you knew where you were going, with fear, with suffering, but also with joy and hope; you left with a tired and suffering body because of so many tests and so many therapies.

You have left. I almost cannot believe it. You left when in your diary there were so many projects, appointments, and so much to do. With your wish to live you wanted to carry them out with commitment, with will, with responsibility in relation to our Order, your religious Province, our dicastery for pastoral care in health of which you were one of the greatest promoters from its creation until today. Precisely a few hours before your death, when finishing the programme of the next international conference to be held in November on the subject of Catholic health-care institutions, we remembered your name and we assigned a paper to you, with the doubt, I confess to you, as to whether you would be able to come at that moment, and unfortunately such was the case. You will not be in the programme but nonetheless you will be present, a protagonist; we will remember you with affection.

You have departed, Fr. Marchesi, and you have reawakened in me feelings and experiences. I remember you with affection and with love. For me, for my vocation in hospitality, you were a point of reference, a model, because of your enthusiasm, commitment, dedication and love for our Order and the sick.

I admire your courage and your insight. For me you were a mediation that encouraged my vocation, that led it to greater service, that filled it with a great experience.

Much of the renewal that has taken place in the pastoral care in health of our Order is due to your prophetic vision! My hospital episcopate also has a great deal to do with this mysterious journey of life and the mediations that have occurred in relation to it.

For me and my vocation, for my role in the service of the Order and the Church a mediation for which I give thanks and which I remember with affection and love in my heart.

Thank you Fr. Marchesi, for your commitment, your courage, your prophecy and your idea of renewal; thank you for giving a new face to our Order; thank you for your love for our Order, the Church, the sick and our fellow workers. May all of this be for you an 'identity card' that allows you to embrace the Lord, with John of God, one of whose successors you were in its animation as its Superior General!

Thank you. So many thanks! May you ignite in us your courage, your faith, your love and may your death be for all of us a seed which produces these fruits. You have departed, Fr. Marchesi, but you will remain alive in our hearts, in my heart.

Vatican City, 2 March 2002.

TO THE SECRETARIAT OF THE *OSSERVATORE ROMANO,* VATICAN CITY

The President Archbishop, the Father Under-Secretary and all the Officials of the Pontifical Council for Health Care Workers join in Faith and prayer with His Excellency the Secretary, Msgr. José L. Redrado OH and the whole of the Order of the Fatebenefratelli, on the return to the House of the Father of the Most Reverend Br. Pierluigi Marchesi OH, member of this dicastery from its creation, and they remember his zeal and his qualified work, in particular during his time of service as Superior General of the Fatebenefratelli, made available to the Pontifical Council for the promotion of respect for sick Man and the defence of life at all times, being grateful for the expert role performed hitherto as the coordinator of the International Association of Catholic Health-Care Institutions (AISC), and they remember, edified, his witness of Christian fortitude in accepting with serenity and great Faith his sufferings of his last moments.

4.3.2002

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

Prof. Rev. PIETRO QUATTROCCHI
Associate of the Fatabenefratelli.

Mourning: Healing the Wounded Heart

One cannot conceive of life without linking it indissolubly to the presence of death. From a child being born to the dying man who utters his last breath, the whole of the trajectory of existence is marked by thousands of 'small adieus' or separations which prefigure the final detachment – death.

The death of a loved one, especially if it takes place in unexpected circumstances, is instinctively rejected because it upsets one's life and destroys a myriad of dreams and projects.

Then, slowly, the days of loss and tears are followed on the part of those who stay behind by elements of a smile and the commitment to move on.

Many people are able to manage their sorrow by drawing on their own strengths and resources; others need to entrust themselves to the help of a professional (a psychologist, a psychotherapist, a psychiatrist, a medical doctor, a priest…) in order to receive support from him or her during critical moments, and yet others resort to the use of pills such as sleeping pills or tranquillisers in order to alleviate the stress of interminable sleepless nights.

A small group of people take advantage of the support offered by mutual help groups in order to work through mourning in which they experience a release of feelings and solidarity with, and nearness to, other people in difficulty.

Recovering from Mourning: a Global Process

Mourning depends on the capacity of those who remain to find reasons and purposes so as to redesign their own life projects.

The process of a healthy working through of a loss bears upon three dimensions: the healing of the mind, of the heart and of behaviour.

1. The healing of the mind

The first step involves healing the mind. The laceration produced by a separation, and this is even more the case if that separation has been dramatic, upsets a person, interferes with his or her sleep, impedes his or her concentration, blocks his or her capacity to take decisions and often his or her wish to go on living.

The mind is inhabited by a thousand questions about why the event took place, by a need to be in contact with the person who has died, and by a search for what to do with time and silences.

Criteria by which to measure a positive working through of grief relate to the ability of those who remain to change their habits, to look at the event with a wiser and more realistic approach, to become reconciled to the precariousness of existence, to learn to take small decisions and to adopt a constructive approach towards the present.

2. The healing of the heart

Health of the mind passes by way of the mediation of the heart where the feelings and emotions provoked by the loss are located. These feelings invoke welcome and citizenship in order not to be relegated to oblivion.

Feelings that are recurrent in grief are: shock and incredulity, a feeling of emptiness and loneliness, anxiety and fear, anger and resentment, sadness and bitterness, regret and a feeling of guilt.

At times the states of mind are intense and lasting; in other circumstances they are more tenuous and transitory. Two approaches that are diametrically opposed and equally ineffective in managing these feelings are, on the one hand, the tendency to impulsiveness with a loss of control and, on the other, an inclination suffocate them, to deny them or to repress them.

Ignored feelings do not disappear but as is the case with frustrated children they return to the centre of the scene and call for attention through psychosomatic malaises, migraines, difficulties with digestion and so forth.

If, instead, these feelings are received and channelled positively, with the passing of time they tend to become weaker and to foster the healing of the heart.

3. The healing of life

The result of a change in a 'way of thinking' is reflected in a 'way of feeling' and this in its turn bears upon the 'behaviour' of a person.

Every significant loss produces a change in identity between the self of the past and the contemporary self, a change that bears upon the internal and social horizons of the person.

The itinerary of gradual healing envisages, after an initial stage of dismay and once the most intense reactions have been overcome, the person being able to recover energy, producing new projects and honouring his or her own family, social and professional responsibilities.

For some people this adaptation requires a very long time, for others a shorter period of time according to the motivations that are present in individuals, the resources that have been activated and the choices that have been made.

Pathways of Healing

In every wounded person there dwells a patrimony of human and spiritual potentialities that play a role of primary importance in healing pain. The process of gradual healing as regards mourning can follow seven pathways, according to the history, the values and the sensibility of each individual.

1. The spiritual pathway or the pathway of faith

For many people the medicine that alleviates pain is of a spiritual nature. The spiritual dimension is a part of the human being, independently of whether he or she adheres or otherwise

to a particular creed or attends a church, a synagogue, a mosque or a pagoda. It concerns the relationship with God or with the transcendent and the pursuit of values such as peace, forgiveness, acceptance, altruism, hope and so forth. At the heart of spirituality, for many people, there is the search for God and/or the need for meaning.

Every tragedy places the question of meaning at centre stage: concern at one's own powerlessness, the perception of the presence or absence of God in pain, and questions about the life beyond.

On the one hand, suffering reveals to man his fragility but, on the other, it releases his virtues.

On some occasions a detachment is accompanied by a radical change in the values that are adhered to. A person can pass from a material style of life which is shallow and selfish to the choice of genuine values, to the sharing of his or her possessions, to a social commitment that would have previously been unthinkable. In these cases, adversity is transformed into profound existential conversion.

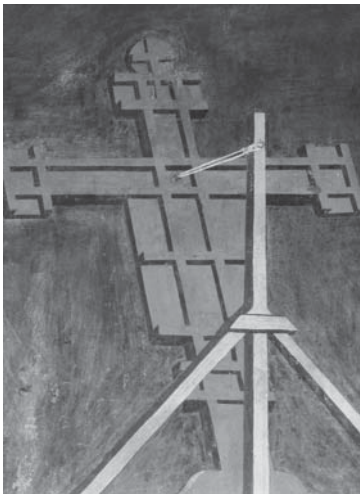
The spiritual dimension or the support of a religion perform for many people a therapeutic and healing function during events involving mourning. Spiritual comfort can be expressed through resort to prayer or meditation, abandonment to God, the need for forgiveness or reconciliation with the past, a greater involvement in the practice of one's faith, attending prayer groups or groups that listen to the word of God, taking part in pilgrimages, listening to religious programmes on television or radio, and the belief that life on earth is not a destiny but a journey that leads on to a destiny.

2. The pathway of self-discovery

A gift that is frequently ignored or concealed in the shadow of pain is human creativity. Creativity expressed down the centuries by philosophers, narrators, poets, painters and sculptors who have transformed their own grief into works of art. One may think of philosophical systems (Kierkegaard, Schopenhauer), works of music (Back, Mozart) or schools of psychology (the logotherapy of V. Frankl) which were created against a background of the personal sufferings of the artists concerned.

Just as birth pangs generate the precious gift of a new creature, so encounter with death allows some people to bring forth an unexplored dimension of themselves or unknown talents.

Nothing like melancholy or nostalgia awakens the aesthetic or imaginative potential of individuals. For some people the voyage of self-discovery finds expression in poetry, for others in the pages of a diary which narrate fragments of their own internal history, and for yet others in painting or the use of material for the externalisation of flashes of their interior landscape.



At times the introspective voyage is fostered by attending courses of psychology or courses connected with self-esteem in order to foster a more authentic understanding of themselves.

In a few words, creativity offers an opportunity to reveal oneself and fulfil oneself.

3. The pathway of affective ties

Mourning is not only awareness of what has been lost, it is also an invitation to be grateful for what has remained. For the majority of people, the family and its components (parents, brothers/sisters, spouses, children and grandchildren) constitutes the vital nucleus of reference in grief.

Every individual grows up in a different family: at times families are numerous, at others they have few members; in some families a healthy air and an air of nearness between the family members is breathed; in others there prevails coldness or interpersonal detachment; and some families are communicative and open to society whereas others tend to be closed and isolated.

The family humus fosters or impedes the process of recovery from the events of mourning.

Secondly, every individual has to opportunity to rely, in addition to their family, on their friends and those they confide in, who are often people who are not conditioned by the family dynamics and are freer to harmonise with the needs of their interlocutor. Being able to rely on friends facilitates the expression of thoughts and feelings and allows time and space for recovery and relaxation.

A third horizon of support is characterised by the support that is received from work colleagues or members of a group, the community or an association to which an individual belongs.

At times the circumstances of mourning also foster unforeseen encounters that lead to new affective ties which attenuate the loneliness that is experienced and open up new doors for tomorrow.

4. The pathway of self-care

Separation from someone, like love for that matter, embraces the physical, mental, psychic and social spheres.

Pain can lead the survivor to neglect himself or herself, to find a thousand excuses for not being involved in daily activities, to become embittered and close himself up in his or her own world, and to take refuge in an excessive consumption of alcohol or drugs to reduce his or her pain.

A reliable thermometer of health is the motivation of the individual as regards taking care of himself or herself. The commitment to caring about oneself is expressed first and foremost in the practice of a healthy diet and physical exercise, through healthy walks amidst nature or going to a gymnasium. Other forms of

caring for oneself include paying attention to hygiene and one's own image, the practice of yoga or breathing exercises, in order to obtain self-control and counter anxiety and many disturbing ideas, and engaging in some hobby or pastime in order to find areas of gratification and relaxation.

5. The cultural pathway

Many people seem to find in cognitive stimuli a fertile terrain by which to heal pain, nourishing the mind with gratifying stimuli and opening it to the opportunities of the present. The closed mind is a trap which turns out life and obscures the present. The mind, wrote Bergler, is like a parachute: it functions when it opens.

To open oneself to healing means working to ensure that mourning does not become a prison but, instead, opens up to knowledge and where this is possible leads to wisdom.

This journey is the pathway of those who strive to understand in a better way the experience of mourning though the reading of books and articles on the subject, taking part in courses involving education or information about the working through of loss, and contact on internet with other people bearing the burdens of mourning.

Openness of the mind embraces the possibility of signing up to a voyage, encountering different cultures and traditions, learning a language, attending courses for the elderly, debating current affairs, and taking part in cultural or artistic events

After a certain fashion, encounter with death forces reflection and the articulation of a new philosophy of life.

Fertile pain expands horizons and gives depth to existence.

6. The pathway of self-giving

For a myriad of people, the master path by which to heal pain is love. In truth, the best way to help ourselves lies in finding opportunities to help other people. Often, however, pain impoverishes and makes us egoists: many people are led to fold in on themselves and to interpret reality through the exclusive lens of self-reference.

A wounded heart heals when affective energy that was previously centred around a loved one who has died is channelled and invested anew in other recipients or new goals.

In practice the dismay and emptiness produced by an adieu becomes an appeal to open one's heart to a family or to a larger community that can benefit from one's time and one's solidarity.

Voluntary work is a privileged pathway for many people by which to heal pain and transform it into love. There are those who belong to an association or a group involved in visiting elderly people or sick people in institutions or at home, that gives a few hours to teach Italian to immigrants or a helping hand to the poor, or that is involved in ecological voluntary work or in ambulance services. Membership of self-help groups for losses becomes a constructive pathway by which to be helped and to help. Each group is an university of pain: one learns observing, listening, communicating and engaging in dialogue in a constant process of giving and receiving.

7. The pathway of projects

When one loses grandparents or parents the grief is about the loss of the past; when one loses a spouse, a fiancé or an intimate friend, the grief is about the loss of the present; and when one loses a child or a grandchild the grief is about the loss of the future. In general the most searing loss is the loss of a son or a daughter. Usually, children bury their parents, and it is a dramatic thing if parents bury their children, to whom they gave life.

In order to try to alleviate the intensity of their pain and use time and resources in a positive way, many couples find comfort in being able to immortalise the memory of their loved one through a project or a foundation named after them. One is not dealing, therefore, only with memories linked to a place (for example a visit to a grave in a cemetery or the laying of flowers around a tree where a child died) but of creating an initiative with a good purpose and of maintaining the memory of that person alive in time. At times this project involves giving study grants to help young people who are without economic resources to study; in other cases it involves the sponsoring of projects involving scientific research.

A project projects into the future and at the same time makes present a person who is absent.

Healing Life

Each of the itineraries proposes refers to the power of transformation contained in pain. Some people deal with grief by privileging the pathway of the mind (reflection, creativity, cultural expansion), others privilege the pathway of the heart (affective ties, altruism and gestures of self-giving), and yet others privilege the pathway of the spirit (the relationship with God and with the community, the strengthening of spirituality).

There are those who entrust themselves to a specific itinerary to heal pain and those who avail themselves of the contribution of various pathways; there are those who start with man and those who start with God. Beyond the good that has been lost and the consequences that are suffered, the indispensable conditions to heal a wounded heart require an approach open to life, the motivation to grow, a readiness to adapt to changes, the need to love and to feel loved, and the creativity to compose music with the strings that remain.

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The Hospital Chaplaincy: a Construction Site for the Church of Communion

(THE RESULTS OF DOCTORAL RESEARCH)

1. Introduction: Chaplaincies and Hospital Chaplaincies

John Paul II, on the occasion of the nineteenth international conference on 'palliative care' organised by the Pontifical Council for Health Care Workers on 11-13 November 2004, observed: 'The Church intends to continue to offer her specific contribution through the human and spiritual accompanying of the sick who wish to open themselves to the message of love of God, who is always attentive to the tears of those who turn to Him (cf. *Psalm* 39:13). Here emerges the importance of pastoral care in health in which hospital chaplaincies, *which contribute so much to the spiritual good of those who are in health-care structures, have a role of special importance*'.[1] This is an authoritative and significant statement both because of the tones that are used in relation to 'hospital chaplaincies' and their pastoral action for the sick and health-care workers, and because of its recipients, who had gathered together at an international assembly in which took part qualified men of science and people involved in pastoral care in health.

1.1 The ancient name of chaplaincies

The term 'chaplaincy' was already used, according to A. Caro, before 1566 and was defined as an 'ecclesiastical entity created for the purposes of worship'.[2] The Zanichelli encyclopaedia repeats the same definition but adds the reason for its creation: a chaplaincy is an 'ecclesiastical entity created for the purposes of worship by the will of, and because of the donations or bequests of, one or more faithful'.[3] An illustrated dictionary of the Italian language, for its part, after making the observations cited above, emphasises its particular purposes: 'a chaplaincy is an ecclesiastical entity created through the legacy or donation of a faithful, especially for the celebration of Masses at a specific altar of a church'.[4] In more summarising form, a dictionary of the Italian language defines 'chaplaincy as the ministry and office of a chaplain'.[5] As a consequence, according to what is indicated above, the term 'hospital chaplaincy' should also be understood as a religious or spiritual service that is principally cultural and sacramental and which is carried out by one or more chaplains (priests) within a health-care structure.

1.2 The new meaning of the term 'hospital chaplaincy'

The official date of the birth of the 'hospital chaplaincy' endowed with a new name may rightly be seen as 30 March 1989, a 'historic' day in the life of the Italian ecclesial community because this was the date of the document – which was defined as a 'pastoral note' – entitled 'Pastoral Care in Health in the Italian Church', which had been drawn up by the National Council for Pastoral Care in Health and approved by the Standing Council of the Italian Bishops' Conference.[6] For the first time in an official document the subject of pastoral care on health was taken into consideration and there was an – albeit brief – reference to a new pastoral body.

An essential definition of this body is given in this document: 'A hospital chaplaincy is an expression of the religious service provided by the Christian community in health-care institutions'. The document also lists the pastoral workers who can belong to it: 'It should be made up of one or more priests to whom can be attached deacons, religious and lay faithful'. The element of absolute innovation here as regards the pastoral action of hospital chaplaincies was specifically the possibility of having other pastoral figures as well as priests. Before this pastoral note, reference had never been made to hospital chaplaincies by the Italian Bishops' Conference or a pastor of a local Church.

In the subsequent sections (nn. 79-81) of this document reference is also made to the principal purposes of this new pastoral body, those that are *ad intra*, i.e. the health-care context, and those that are *ad extra*, i.e. the parish community and the local area: 'The principal objectives of a hospital chaplaincy are as follows: to have in a health-care institution an accessible ecclesial sign which makes possible missionary action; being a place where, through people, aptitudes and gestures, including sacramental ones, God reveals His tenderness, and which places itself at the service of man in order to accompany him in his tribulations, helping him to live until the end; promoting and coordinating all the forces that are present in the hospital community through suitable instruments and initiatives (pastoral advice…); and contributing to the involvement of Christians who are in the local area in the promotion of health and care for the sick'.[7]

1.3 The bibliography on hospital chaplaincies

After the publication of the above-mentioned pastoral note, and above all during the second part of the 1990s, in Italy there took place a marked increase in interest in hospital chaplaincies, understood in the new pastoral sense, not only on the part of those directly involved (hospital chaplaincies, pastoral workers, the directors of diocesan offices or other pastoral bodies),

but also on the part of the Magisterium of the Church. Both Pope John Paul II and the bishops of local Churches began to turn their attention to hospital chaplaincies in order to point out policies so that their full establishment could be achieved.[8] If one observes in greater detail the bibliographical production on hospital chaplaincies in a national context from the beginning of the 1960s until the end of the 1980s one finds writings of a varied character and varying levels of importance in which reference is made to the need to open pastoral care in health to cooperation with members of the lay faithful.[9]

This subject was already being addressed at a national conference on pastoral care in health which was organised by the Minor Capuchin Friars at S. Giovanni Rotondo (1984) when the testimony of a French lay pastoral worker (a woman) who was active in a hospital chaplaincy was listened to.[10] However, there was no lack of qualified hospital pastoral workers to pay attention to the experiences of hospital chaplaincies in European countries in order to posit experimentation with them in Italy. For example, reference should be made to the Capuchin, Rev. Stefano Bambini,[11] the Camillians, Rev. Angelo Brusco,[12] Rev. Luciano Sandrin,[13] Rev. Silvio Marinelli,[14] and Rev. Rosario Messina,[15] and one should not forget the papers given by Msgr. Elio Sgreccia[16] and Msgr. Giorgio Beconcini.[17]

Side by side with the voices of individuals, reference should also be made to the regional conferences concerned with the pastoral experience of hospital chaplaincies: that held in Calabria (April 1992)[18] and that held in Liguria (May 1993).[19] These were the beginnings of an analysis engaged in by people who were personally engaged in pastoral work and wanted to make it known about in wider contexts. At the Third Conference of the National Council for Pastoral Care in Health of 1995 a study group on hospital chaplains was established,[20] and a year later, under the auspices of the Italian Conference of Capuchin Provincial Ministers (CIMPCap), the Secretariat for Pastoral Care in Heath organised a national conference on the subject 'The Chaplaincy. A *Kairòs* for Pastoral Care in Health' (1996).[21]

In dictionaries the heading 'hospital chaplaincy' found its own interesting space. In the *Dizionario di bioetica* (1994), Guido Davanzo dwelt upon the hospital chaplain and referred to the experience of chaplaincies,[22] but the analysis of A. Brusco in the *Dizionario di Teologia Pastorale Sanitaria* (1997), although it referred to an analysis that had begun a few years previously,[23] was more detailed as regards the various aspects of pastoral realities that are addressed and was presented again[24] in the first *Manuale di teologia pastorale sanitaria* (1999) which he wrote together with S. Pintor.[25]

1.4 The need for a deeper and more overall analysis

From this summarising examination of the principal literature in the field, I drew the conclusion that at the present time Italy does not have a specific study involving an overall theological analysis of hospital chaplaincies. Certainly certain insights exist, reference is made to possible theological horizons, stress is laid on the need for, and the urgency of, a renewal of pastoral action in the health-care world, but this was not followed by the development of a study and more serious analysis of the subject.

By now the need for a broader and deeper theological analysis of this pastoral body which was beginning to advance in the health-care/hospital structures of our country was seen as ineluctable. It is true that 'orthopraxis' is important in the life of the Church but it is equally true that 'theory', that is to say reflection on pastoral experience in the light of faith, is also useful and indispensable. These are both important and element elements in daily experience and Christian tradition. Otherwise there is the very real risk that the abundance of analyses that are engaged in at a number of levels, and a variety of experiences without fundamental criteria of verification, will be matched by a lack of clarity at the level of terms, an ambiguity as regards contents, and an incorrect rooting in the pastoral reality of the Italian Church.

Thus within the context of the journey that the Italian Church has been engaged in over the previous four decades (1960-2000), and taking into account the various experiences which had been underway for a number of years in the local Churches, my doctoral research had the principal purpose of engaging in a *theological reflection on hospital chaplaincies*; a drawing up of their *Biblical foundations*; an attempt to define their identity and components; an in-depth analysis of their *evangelising mission*; and the beginning of a survey of their *openness to their local areas*. For this reason, an attempt was made to 'read' the renewed pastoral care in health of the hospital Christian communities in the light of the ecclesiology that was developed by the Second Vatican Council, to read the renewal of the universal Church which took place after the Second Vatican Council, and to read the signs of the times expressed in the evolution of the health-care world, within the horizon of team work made up of the multiple component parts of the people of God.

With the help of theological 'suggestions' made by Mario Midali (the importance of the kairological stage in theological analysis) and by Bruno Forte (the three defining elements of the Church at all times: *koinonia*, *diakonia* and *martyria*), I organised the chapters of my research on hospital chaplaincies along the following lines: chapter I – the three kairological events of the birth of the hospital chaplaincy; chapter II – the hospital chaplaincy as *koinonia*: identity and component parts; chapter II – the hospital chaplaincy as *diakonia*: vocation and mission; chapter IV: the hospital chaplaincy as *martyria*: witness. The author is happy to offer a summary of the results of his doctoral research entitled 'The Hospital Chaplaincy: *Koinonia*, *Diakonia* and *Martyria* of the Church in the

Changing World of Pastoral Care in Health' to the readers of the international review *Dolentium Hominum*, the official voice of the Pontifical Council for Health Care Workers.[26]

2. The Three Kairological Events of the Birth of the Hospital Chaplaincy

Beginning with the belief that hospital chaplaincies in Italy did not arise suddenly and that the idea of hospital chaplaincies and the need for them developed gradually over four decades (1965-2006), I analysed the slow journey of the Church in recognising *signs of the times* in this development, in line with the observations of *Gaudium et spes*: 'the Church has always had the duty of scrutinizing the signs of the times and of interpreting them in the light of the Gospel.

Thus, in language intelligible to each generation, she can respond to the perennial questions which men ask about this present life and the life to come, and about the relationship of the one to the other'.[27] I identified three signs of the times: a) the 'seeds' of the attention paid to the Second Vatican Council to the sick and to the promotion of health which grew into plants and fruit during the period after the Second Vatican Council; b) the founding 'values' of the law which created the National Health Service (n. 833/1978), which achieved practical expression in socio-cultural phenomena and ecclesial facts with an evident impact in the religious sphere; and c) the 'horizons' that were broadened by the renewal and development of pastoral care in health and which were embodied in new figures and new bodies within the hospital world. *These three events, read within the context of pastoral care in health, may be seen as special factors that led to a maturation of the need for, and the birth of, hospital chaplaincies*.

2.1 The 'seeds' of the attention paid by the Second Vatican Council to pastoral care in health

When examining the texts of the Second Vatican Council there emerges the perception of a Church already attentive to the sick and to the promotion of health, albeit in the perspective of a theology of suffering in conformity with those years. I stressed four cardinal points of this Church of the Second Vatican Council:

The ecclesiology of communion was a point of departure which had in itself the seeds that were developed during the journey taken after the Second Vatican Council. I was thus able to observe that as the people of God the Christian community is achieved in communion and lives for communion. Each member receives in baptism the mission to grow in the first person in communion to advance his or her community in the same dimension.

The icon of a Samaritan communion clearly emerges from the consciousness of the fathers of the Second Vatican Council. They imagined a Church that knew how to write in every epoch and in an original way that parable of making oneself a neighbour to those who are in need which Jesus embodied, first of all.

The countenance of a Church where 'all are responsible' in the ministry of pastoral care in health was already outlined and took on over the following years increasingly precise traits as a result of the notable contribution of John Paul II and the journey of the Italian Church engaged in by the National Council, and then by the National Office, for Pastoral Care in Health.

The two features of a community that is a *maestra and a ministra* in the originality of the insight of John XXIII were read from the point of view of the concern of the mother Church with the good of the multi-factor health of humanity and individuals. I believe that it is not difficult to see these four characteristics brought together in the pastoral agency of the hospital chaplaincy which may legitimately be defined as: unity of communion; a community of communion; a communion of the Samaritan ministry; a community of shared joint responsibility; and a community of health/salvation.

2.2 The 'values' of the founding law of the National Health Service

The creation of the National Health Service in Italy, read through the hermeneutical principle of the basic values of the first section of law 833, was seen by me as a river into whose bed flowed the essential and very important values of civil society. I am convinced that the creation of the Italian NHS 'can and must constitute a real 'sign of the times', a solicitation, a push, a privileged opportunity that should intensify and accelerate the commitment – which is already for other rea-

sons underway – to the creation of authentic local Christian communities'.[28]

I analysed these values with reference to the community of the Church. In this way I examined a) the value of health understood in its most overall sense; b) the equality of citizens as regards health-care services; c) the connecting bridges between hospital structures and their local areas; d) the recognition of the socio-political and ecclesial value of volunteers; and e) the therapeutic value of the service of religious assistance.

Indeed, the founding principles of the NHS may be seen by the Church as an authentic grace of God and a *kairòs* of the Spirit which call upon the conscience of each citizen and each Christian. With the texts in my hands, and carefully examining the sections of the founding law of the NHS, I identified numerous pastoral points which constitute a 'strong appeal to our commitment as a Church to service to life from its beginning to its end',[29] and I strove to bring out the human and religious value of each principle and to emphasise its connected horizons for opportunities a regards pastoral care.

Thus we must 'be happy at these enunciations which already in its constitutional text and now in the statements of this law are marked by the contribution of Catholic thought and are in conformity with the Christian vision of the person and human life'.[30] The task of the Christian community, today as yesterday, continues to be that of offering a specific contribution to its mission of the total salvation of man and to act so that these enunciations are not denied at a practical level. We may see these principles as strong 'pro-vocations' as well, understood as impetuses to new and original calls to embody the missionary nature of the Christian community and as challenges for a renewal of pastoral care in health both in the hospital world and in local areas as well.

2.3 The 'new horizons' of the pathway of pastoral care in health

Lastly, I considered the renewal of pastoral care in health as a third 'sign of the times' which led the Italian Church to open itself to the suitability of the idea of hospital chaplaincies. This renewal was characterised by a series of events that were connected to each other and also causally related to each other: the steady establishment of the characteristics of the identity of this form of pastoral care in health was followed by an expansion of its operational frontiers, by the discovery of new pastoral workers and the creation of new bodies of communion and animation, by the re-assessment of the person of the hospital chaplain, and by the idea of the creation of hospital chaplaincies.

I was reinforced in the belief, which was not only my own, that pastoral care in health experienced during those years a series of advances which were stressed by various theologians[31] and which deserve special attention. These 'advances' were recognised and almost ratified in the pastoral note of the Episcopal Commission for the Service of Charity and Health.[32] In a few words: pastoral care in health engaged in a large number of initial journeys which enabled it to acquire greater visibility in the Church. A concrete sign of this advance was the idea of a hospital chaplaincy which had in itself various of the proposals made by what was a renewed form of pastoral care in health.

2.4 From the signs of the times…to the time of signs

The world of health care – a complex and emblematic mirror of the broader society of our time – poses various challenges to the Church: bioethical challenges as regards research and experimentation; challenges relating to the beginning and the end of human life; challenges connected with turning hospitals into companies; and challenges involving the humanisation of health care, to mention only a few. 'The Church, in the field of health and health care as well, is called to listen to the hopes of men and to read those signs of the time that constitute a 'code and language of the Holy Spirit''.[33]

The request for health, in its various expressions and the diversity of the problems that it raises, is a 'sign of the times', a pro-*vocation*' to which the Church community is called to respond as a healing community, as an effective sign of integral salvation.[34] However, if we consider the point well, we can state that our time is not only pregnant with 'signs of the times' but can also be defined as a 'time of signs', that is to say a time that wants and believes in visible gestures on the part of the Christian community. We can state this about every field of the pastoral action of the ecclesial community and thus also about the field of pastoral care in health.

Today, the health-care world needs a therapeutic presence and a presence of healing actions that meet the deepest hopes of the human spirit. 'Health is not only a 'place' where God extends to us impelling invitations to read His presence; it is also the 'place' where Christians must create new 'signs' where the presence of God can also be read by those who do not believe, a challenge that the Church makes to the world'.[35]

3. The Hospital Chaplaincy as KOINONIA : Identity and Component Parts

After identifying the 'three signs of the times' that in-

creased consciousness of the need for the hospital chaplaincy – an expression of a Church of communion that allows a greater appreciation of the various charisms of the people of God – I addressed myself to providing a Biblical and theological foundation for this new pastoral body and to outlining the physiognomy of each of its component parts. My analysis followed four *stages*.

3.1. In the first stage I briefly analysed the phenomenological event of illness and suffering, an event seen above all else as a season of loneliness, of solidarity and of communion/charity. I embraced the belief that the interlocutor of theology today is no longer the atheist but the man who suffers. 'The partner of dialogue with contemporary theology is no longer the enlightened unbeliever' but 'the man who suffers: the individual who experiences the situation of non-salvation in its various forms…In this experience of suffering we do not encounter peripheral phenomena…but always the human condition as such…As a result a theology that acts from the experience of pain of men is not dealing with marginal phenomena but with the centre and the depths of the human being'.[36] Suffering, for that matter, 'is an experience that is clarified gradually as it is approached: it requires an approach that is measured and respectful, an approach of seriousness, because it bears upon the mystery of man and also bears upon the mystery of God. It always concerns the mystery of being'.[37]

Suffering/illness is an experience of loneliness and of division, of marginalisation and of neglect: 'illness demonstrates more than anything else that the world is divided in two. It is synonymous with separation and loneliness. People with a heart feel compassion, others feel ill at ease, and yet others are bothered and even irritated, but in these different ways they give the same message of detachment. They reassure themselves and communicate to the other that illness is an exceptional and extraneous condition, like old age, and not a common and shared destiny. And it is then that illness, in not being recognised as a form of life, becomes horribly painful and incurable'.[38] On the other hand, suffering itself enables us to live existential experiences of special solidarity and communion with the other: 'in an entire life there is nothing more important than bending down so that another person, his neck bound, can stand up again'.[39]

3.2. In the second stage I dwelt upon an illustration of the Biblical covenant seen as a red line in the history of salvation and as an event of communion between JHWH and Israel, His chosen people. In this covenant JHWH reveals above all else that He is a) a father (and mother) who cares about and takes care of His people; b) a shepherd who loves His flock; and c) a physician who heals those who trust in Him and entrust themselves to Him. I illustrated and explored these three aspects of the face of God which are significant not only in themselves but also as regards the health-care world, where the sick, their family relatives and the whole hospital community need to experience divine fatherly and motherly love; where the need is perceived for a community that requires secure guidance and to live a journey of fraternity; and where every person aspires to restore his or her health and receive divine salvation.

In the salvific event itself, the identity and the mission of Israel are presented as being in communion with its Lord, in communion within its social life, and in the joint responsibility of its members. These three horizons of communion also constitute the essential requirements of the Christian communities present within health-care institutions. Naturally, I observed how these three features of YHWH were incarnated in Jesus Christ, the visible face of the Father, the good shepherd who gave his life for his sheep, the physician and saviour both through words (preaching and parables) and through therapeutic and salvific actions in relation to sick people.

3.3. In the third stage I directed my attention to the world of health care, read through the icon of the therapeutic covenant understood both as a relationship and cooperation between the various professionals of health to achieve the same end and as a relationship between these professionals of health and their patients. I then argued that this world of health care can extend its therapeutic covenant to the Church as well, which is rightly called the 'community of the covenant' and is legitimately present in places of suffering and care above all through the action of the hospital chaplaincy. Through the evangelising work of its various members, the hospital chaplaincy can offer its qualified contribution in order to respond to the troubling questions of scientific research and the expectations of those who suffer.

3.4. In the fourth stage I focused in on the harmonious organisation of the hospital chaplaincy which was seen *as a community of the covenant and as a healing mosaic*, describing the specificity of each of its component parts with reference both to its problematic aspects and its valuable new opportunities: the chaplain priest as the representative of 'Christ the shepherd'; the deacon as the principal qualifying feature of the 'service'; the non-clerical men religious and women religious characterised by a special 'consecration'; and the (men and women) members of the lay faithful with their gift of baptism and their animation of earthly realities.

I ended the second chapter by stating that hospital chaplaincies came into being in our country through a providential shared flow of different factors or events: the ecclesiology of communion of the Second Vatican Council had an impact at the same time as the creation of the National Health Service and its reforms; the development of the theology of the lay faithful took place at the same time as the appreciation of the 'genius' of women; the ageing of hospital chaplains was accompanied by the crisis of vocations as re-

gards the priestly ministry and consecrated life; and the surprising phenomenon of social/health-care voluntary work was enriched by the discovery of Church charisms and ministries.

These anthropological, sociological, theological and pastoral factors taken as a whole created a large mosaic of 'signs of the times' which called upon the conscience of the Christian community to find new responses to the new needs of the men and women of our times: 'Attentive to the signs of the times, communities must look towards the future, trusting in the fact that the Lord precedes us in history and mission, sustaining us on our journey. Christian communities, together with the other builders of pluralist society, must seek to be bearers of the memory and the prophecy of the Spirit'.[40]

I thus defined the experience of the hospital chaplaincy as a '*building site for the Church of communion*' both from the point of view of the internal life of relationships and love and in terms of the creation of a service directed towards recipients in the world of health and health care. Its purpose is to manifest the 'most beautiful face' and 'face in colour' of the Church of Christ to the benefit of the hospital community with its multiple component parts.

4. The Hospital Chaplaincy as *Diakonia*: Vocation and Mission

After dwelling at length, through a detailed analysis, on the identity and its component parts of this ecclesial body of joint responsibility, seen as *koinonia*, that is to say as a community called to be in constitutive terms a reality of communion and to live the riches of unity in Christ, founded on baptism and a variety of charisms, in the third chapter I directed my attention to another aspect of its physiognomy, that is to say its equally fundamental dimension of being *diakonia,* understood as a service for the preaching of, and bearing witness to, the Gospel. If the hospital chaplaincy is a reality of communion and lives communion both with Jesus Christ and between its various components, necessarily it lives a missionary communion and becomes a missionary community. John Paul II stated with clarity in 1988: 'Communion and mission are profoundly connected with each other, they interpenetrate and mutually imply each other, to the point that *communion represents both the source and the fruit of mission: communion gives rise to mission and mission is accomplished in communion'*.[41]

The specific purpose of my study at this point was to outline the evangelising face of the hospital chaplaincy with respect to the features that it shares with every Christian community and its characteristic traits as a body that is present and works in the vast horizon of suffering and care. Expressed in more concrete terms: I analysed the vocation and the mission of the hospital chaplaincy in the following terms:

4.1. The mission of evangelisation inside hospitals constitutes the principal task of a chaplaincy, whose original identity and whose specific role I identified in three characteristic elements: a variety of presences and charisms; communion, joint responsibility and cooperation; and planning and intelligent coordination.

A) The defining feature of a hospital chaplaincy, which immediately emerges from its special identity, is its *variegated and overall composition*: ever since its first description in a Church document, it has been defined as a body of priests, deacons, men and women religious and members of the lay faithful;[42] and some twenty years later the second pastoral note described it as a 'variety of presences and charisms'.[43] This variety expresses in an important way the reality of the Church of communion, as is repeatedly observed in the documents of the Magiterium and in the thinking of theologians:'This diversity of services in the unity of the same mission makes up the richness and beauty of evangelization'.[44]

The various presences inside the Church are united by a single purpose: to work for the advent of the kingdom of God according to the different vocations, situations, charisms and ministries that exist. 'This variety is not only linked to age, but also to the difference of sex and to the diversity of natural gifts, as well as to careers and conditions affecting a person's life. It is a variety that makes the riches of the Church more vital and concrete'.[45]

B) Naturally, the 'variety of presences and charisms' in a single pastoral body is a great gift of the Spirit to the Church of our times but it is also a great responsibility because it requires the contribution of each of its component parts to the transformation of the hospital chaplaincy into a community of '*communion, joint responsibility and cooperation*.[46] These characteristics constitute an 'indivisible triad', the Italian bishops wrote after the national Church conference held in Verona, and they outlined in an effective way the countenance of a Christian community that goes forward together with a style that appreciates every resource and every sensibility, in a climate of brotherhood and of dialogue, of frankness in exchange, and of meekness in searching for what corresponds to the good of the whole community.[47]

C) The hospital chaplaincy, an ecclesial reality that is essentially based on communion and its multiplicity of pastoral workers, cannot but engage in the *choice of planning and project-making* for its pastoral action: its specific identity and the fecundity of its life depend a great deal on this scientific, professional and apostolic methodology. It must be concerned to 'place gospel elements in the vast sector of health care and assistance with projects of catechesis and formation', and at the same time its pastoral workers, 'by promoting projects designed to make the environments of health and health care more human, and by cooperating in those projects that are already underway, are called to offer to them the specific contribution

of their Christian vision of man'.[48]

It has been wisely stated that 'communion and cooperation cannot be effectively promoted without the move from improvised action to *engaging in projects* and without an intelligent *coordination* of the resources that are present in the community: the extraordinary ministers of Communion, pastoral and health-care workers, the voluntary workers of the various associations, the family relatives of patients, and the patients themselves'.[49]

4.2. A chaplaincy is called to be a missionary community. Thus all of its component parts are required to have the specific requisites that are needed to be effective workers of evangelisation in the vineyard of the Lord.

There was still a lack of publications and studies that point out the most important features of those who are called in a pastoral sense to be present and operative in the world of health and health care and so I pointed out certain indispensible requisites that pastoral workers in hospital chaplaincies should have. These I identified as a vocation to pastoral ministry, human and Christian maturity, specific formation, spirituality of service, and a mandate or '*missio*'. Each element was analysed in the light of the relevant documents of the universal Church or the local Church of Italy.

4.3. A hospital chaplaincy, as an ecclesial community that is present and operative in health care, in order to achieve fully its identity cannot but grow in the belief that *its essential and priority mission is specifically that of evangelising*: 'The fracture between the Gospel and existing culture in Italian society is also reflected in the world of health care. The process of secularisation has reduced the spiritual and moral sensitivity of by now means few believers as well, leading them to adopt a defensive stance if not rejection as regards transcendence and spiritual and moral values'.[50] In its commitment to evangelisation, a hospital chaplaincy begins with a certainty: '*a crossroads of humanity*, the world of health is also a *land of the Gospel*. In this setting where various pathways intersect, where generosity and selfishness, materialistic claims and the wish for spirituality, the proclamation of rights and actual injustices, co-exist, the Church is called to offer the light and the direction of the Gospel'.[51] Despite the process of secularisation that has affected health care, 'a hospital still remains a privileged place of evangelisation'.[52] If evangelisation is and remains 'a profoundly ecclesial act', it also 'calls upon all the various workers of the Gospel, each according to their charisms and ministries'.[53] Hospital chaplaincies as well, with all their component parts, (priests, deacons, men and women religious, lay people) see this responsibility to live and proclaim the Good News of the love of God according to the specific gifts and means of the civil and ecclesial status of each individual. The potentialities of this pastoral body in this field are by now enormous and constitute riches of the Spirit for the Church of our times.

The most important settings of evangelisation for hospital chaplaincies have been emphasised on various occasions and in various documents of the Magisterium. In 1989, with extreme clarity, the four pathways of evangelisation in the health-care field were already being pointed out: 'the ecclesial community, indeed, has the task of working so that the values of *life* and of *health* are respected and directed towards salvation, and the moment of *illness* and *death* can receive in addition to the support of science and human solidarity also the support of the grace of the Lord'.[54]

The evangelisation of the health-care world thus includes the four aspects of human existence: on the one hand, the proclamation of, and witness to, the Gospel of life and health; on the other, the approach and light of the Gospel of suffering and death. In the *first sphere* of the sacred and inestimable value of life, I analysed four specific roles: being ministers of life; the ethical problems and questions of being born; the promotion of the new culture of human life; and the approach of the Gospel of life. *In the sphere of the value of health* I emphasised the pathway of the promotion of health: from that of the body to that of the person, from the demand for health to nostalgia for salvation, and from the initial theology of health to the commitment to the incarnation of the gospel of health.

As regards suffering/illness, I outlined certain pastoral itineraries of evangelisation: living suffering between resistance and surrender, promoting a new consciousness as regards illness, restoring individuality to the sick person, and conjoining the Gospel of suffering to the Gospel of charity. Lastly, I dwelt upon an exploration 'of the eloquence of death and resurrection', addressing the ethical problems of death and dying, the spiritual and pastoral accompanying of the dying, the

celebration of the paschal mystery at funerals, and presence at the side of people and families in mourning.

4.4. Today at a theological-pastoral level there is an awareness of the vastness of the operational horizons of evangelisation in the world of suffering that must promote everything that can embody in contemporary society the activity of Jesus for suffering people. In referring to concrete and urgent endeavours we may cite: the defence of the health and well-being of the sick; the fight against illness and pain, its causes and its consequences; cooperation in integral care for the sick person in all his or her needs; help for families that suffer the consequences of illness; solidarity in the world of health and health care (the giving of blood, organ transplants…); cooperation to ensure that structures, institutions and technology are at the service of patients and not other interests; the defence of the rights of sick people; denunciation of abuses and injustices in the health-care world; the growing humanisation of care; and the accompanying of the terminally ill.[55]

A hospital chaplaincy has many opportunities in front of it to live its missionary and evangelising action in and for the community that works in health-care institutions. At the level of recommendations, I recommended *seven pathways* which in my own view are the most urgent and the most in conformity with its vocation and mission today: witness, the 'sacrament of presence' which is expressed in visits and effective help relationships, humanisation, proclaiming, the sacraments, charity, and ecumenicalism that also includes inter-religious dialogue.

4.5. The hospital chaplaincy holds the first responsibility for the evangelising action of the health-care/hospital instituiuion in which it is located; the proclaiming of the Gospel remains the principal mission of its constitiution; and witness to a God who loves life and the living is the heart of every one of its apostolic programmes. *The principal recipients of its evangelising vocation may be placed in three groupings*: the sick and their family relatives who are seen as the objects and subjects of evangelisation; health-care workers in their broad diversity of jobs and in particular medical doctors and nurses; and the heads of health-care structures, that is to say the protagonists of their political-social and 'structural' dimensions. It is specifically in the setting of health care that the need for 'pastoral care that is closer to the lives of people, less hurried and complex, less dispersive and more incisively unitary'[56] is most urgent.

4.5. I ended the third chapter, which was the longest, by stating that one may define a hospital chaplaincy as a 'laboratory of experiences' of the healing Church, because, like every other Christian community, it must experience in the first person the healing of the paschal mystery in order to transform itself into a community that heals those to whom it is sent with its gospel message. A hospital chaplaincy, if every day it performs well its mission amongst the sick and health-care workers can become a letter of Christ 'who wrote this letter and sent it by us. It is written not with ink but with the Spirit of the living God, and not on stone tablets but on human hearts' (2 Cor 3:3-4) and will know how, 'in ordinary experiences..to find the alphabet by which to compose words that express the infinite love of God'.[57] Of this alphabet it already possess certain verbs which by now have become consolidated in its practice and planning: listening and dialoguing, accompanying and hoping, being communion and becoming community, planning and cooperating, becoming responsible and making responsible, evangelising and humanising, preaching and caring, welcoming and celebrating, being born and growing, and living and dying in Christ.

5. The Hospital Chaplaincy as *Martyria*: Witness in Local Areas

In the last chapter of my research the aim was to dwell upon the hospital chaplaincy as an ecclesial community that opens to its local area with the tesk of being witness (*martyria*), that is to say the animation of the parish as regards the promotion of health and care for those who suffer, building bridges of communion and cooperation. 'Other forms of integration are needed and urgent to support families, joining forces and optimising the resources that are available. Here it is appropriate to remember at least the integration through adequate formation of the ministry of comfort and the ministry of communion with the sick, the fertile integration of the hospital chaplaincy with the parish community, and the coordination of Church socio/health-care associations through the National Forum of Social/Health-Care Association'.[58]

This move of pastoral care in health from the hospital to its local area does not mean, of course, neglecting or abandoning one to privilege the other; instead, it involves the strengthening of the service for hospitalised patients and at the same time the expansion of boundaries, an extension of responsibility in favour of the civil and religious community. Openness to the local area, in addition, constitutes an authentic 'provocation' for the hospital chaplaincy as well, which cannot limit the concerns of its work to the troubled wals of health-care structures: 'As health care gradually moves out of the narrow confines of a hospital and becomes rooted and expanded in the local area, so also does pastoral care at the side of suffering people lose its limited connotation of 'hospital pastoral care' and become increasingly defined as 'pastoral care in health''.[59]

Ever since the 1980s the Italian Church has perceived the problem of the extension of its pastoral care from hospitals to local areas and has called on communities to achieve this 'paschal' conversion. Indeed, in the pastoral note of 1989 it was stated that 'in pastoral care in health there emerge certain basic needs that deserve especial attention' and amongst these it placed specifically the following approach: 'the field of action cannot end with the area of hospital structures but must be extended to the whole of the local area in which the lives of citizens are lived, rediscovering the natural relationship between patients and families, families and the civil and ecclesial community. Indeed, a hospital is by now defined as a service that is integrated with other health-care structures that are open to the participation of citizens and are no longer the sole point of reference for being treated and healed'.[60]

By now a need that cannot be postponed was maturing in the conscience of the Christian community: in pastoral care in health in health-care institutions the *first step* to take was 'from the chaplain to the chaplaincy': 'this is not a matter of coining a different word but rather of pointing out a different direction in order to 'relocate' the chaplain in a service provide by the Church where the countenance of the Church is transmitted through a multiplicity of services and greater cooperation both inside and outside the hospital'.[61]

A second step was then required 'from the hospital chaplaincy to the Church community in the local area'. 'A chaplaincy that does not project itself into the local area remains half of what it is and destined to fall into isolation'.[62] By the 'Christian community of the local area' is meant the Church community that has the face of the local or diocesan Church, of the parish that is belonged to, of the vicariate or deaconate, of a possible 'pastoral unity', of the community of men and women religious, and of Church associations, groups or movements. At a more concrete level, in my research reference was made in the main to parishes. Certainly, an authentic pastoral conversion is required on the part of priests, chaplains and pastoral workers, involving mutual enrichment: in looking for pathways of cooperation, a chaplaincy works both for the strengthening of its experience and for its future as a Church that provides care and heals.

5.1 The hospital chaplaincy and the parish: an enriching relationship

In recent years Italian bishops have paid especial attention both to parishes and to pastoral care in health. In 2004 they drew up a fine pastoral note on 'The Missionary Face of Parishes in a World that is Changing'. A year later they reflected together on pastoral care in health at their general assembly and a few months after that they approved another pastoral note – 'Preach the Gospel and Heal the Sick: the Christian Community and Pastoral Care in Health' (2006). I posed two questions and I attempted to find specific answers as well. The first question was: 'what can a hospital chaplaincy offer to the parish?' The answer is: a hospital chaplaincy helps the Christian community of the local area with the ecclesial visibility of all its many members (priests, deacons, religious, lay people), with the proposal of a healing community, and with the memory of a constant role in pastoral care in health. The second question was: 'what in its turn can a parish offer a hospital chaplaincy?' The answer is: memory of communion and openness to the diocesan Church, openness to the local area and to families, and care for the old and new poor of society.

5.2 The hospital chaplaincy and the parish together for…

If the Italian Church today rightly speaks about 'integrated pastoral care', of pastoral unity, of the building of bridges, and of overcoming forms of self-reference, we can deduce that to these approaches also belong cooperation between hospital chaplaincies and parishes. These two communities, when they exist in the same local area, cannot ignore each other. Implicitly, this openness is already envisaged by the *Code of Canon Law* which states, when addressing the question of chaplains of all kinds, and thus also hospital chaplains: 'In the exercise of his pastoral function, a chaplain is to preserve a fitting relationship with the pastor' (Latin text:: '*debitum coniunctionem*')'.[63] Naturally, here reference is made to the parish priest of the local area where the chaplain engages in his ministry. In the analysis of the hospital chaplaincy it is licit to expand this 'due relationship' to all the pastoral workers of the ecclesial team with the parish community, which must evidently be filled with contents, and as a consequence, with knowledge and cooperation, with relationships and with pathways of service for health and the sick.

In addition, this 'relationship' of cooperation between two communities is further justified in the light of what the same *Code of Canon Law* states about the duties of a parish: 'In order to fulfill his office diligently, a pastor is to strive to know the faithful entrusted to

his care. Therefore he is to visit families, sharing especially in the cares, anxieties, and griefs of the faithful, strengthening them in the Lord…With generous love he is to help the sick, particularly those close to death, by refreshing them solicitously with the sacraments and commending their souls to God; with particular diligence he is to seek out the poor, the afflicted, the lonely, those exiled from their country, and similarly those weighed down by special difficulties'.[64] The hospital chaplaincy, with its experience in the sector, can offer a contribution to the parish priest, and to the community of the local area, so that it can better perform, and with greater 'diligence', one of its principal duties.

In a more specific way, the parish and the hospital chaplaincy can enrich each other in their knowledge about the identity and life of each community, in the exchange of pastoral services, in the appreciation of the World Day of the Sick, in knowing and visiting people in hospital in the local area, in the animation of associations and groups, and in the promotion and formation of voluntary workers.

5.3 The hospital chaplaincy and the parish for the health and treatment of sick people

As regards the promotion of health, the two communities have before them a broad unexplored horizon. I tried to posit certain pathways: the construction of a healed and healing community, the rediscovery of the missionary consciousness of all Christians, the formation of pastoral workers, catechesis on ethical subjects connected with life and suffering, pastoral care for the various age bands, education in health and the promotion of a healthy lifestyle, knowledge about the philosophy of health care and the organisation of health-care structures. In caring for the sick as well, the two communities can cooperate in knowing about the mosaic of illnesses and sick people, in holistic care for the person, in the pastoral care of 'signs', in pastoral care of continuity, and in the appreciation of Sunday and the celebration of the Eucharist.

I ended the fourth chapter by stressing the need for the hospital chaplaincy, gaining nourishment from the sources of prayer and the liturgy and opening itself to the new horizons of the local area with pastoral creativity, to become 'capable of great hope' and a 'minister of great hope for others':[65] an active hope that knows how to fight so that 'the world may have life, and have it in abundance' (Jn 10:10).

In this way it makes itself obedient to its Lord and implements his 'commandment' fully to perpetuate his memory. 'When Jesus ordered his community "do this in memory of me" he not only asked for the rite that he had celebrated to be remembered and repeated, he also asked for that 'self-giving' expressed in the breaking of bread and the sharing of the chalice to be translated onto an existential plane'.[66]

6. Conclusions

At the end of my long research, carried out with patience and enthusiasm, on hospital chaplaincies, which are present and operational in the 'sacred' settings of suffering and health, like a pilgrim who had reached his goal I felt the need to look over my shoulders to 'make an assessment' of the study that had been carried out.

Above I observed the three sources on which I had drawn for my work: the documents of the Magisterium of the Church; the thought of the theology of pastoral care in health contaned in the publications of authors of our times; and personal pastoral experience in the health-care world. I then in summarising form presented the most interesting results achieved by this new pastoral body. The *first result* of my research was the fact that a hospital chaplaincy may be seen as a response of the Italian Church to the voice of the Spirit which in previous decades (1960-1990) spoke in a strong and clear way through three kairological events. The *second result* was the certainty that a hospital chaplaincy is a 'Church project' in the health-care world which has a Biblical-theological basis, its own specific form, its own objectives and its own large number of individuals. The *third result* was the awareness that the identity of the hospital chaplaincy is being developed, that is to say that it is experiencing and will experience in the near future an evolution in its experience. *Other results* worthy of attention were the centrality of the person of the chaplain-priest in the life of a chaplaincy, the appreciation of all the charisms of the people of God, the vastess of the horizons of the evangelisation in health care, and the relationship between a chaplaincy and its parish which should be completely invented and experienced.

Lastly, I listed the *problems* connected with the hospital chaplaincy *that have remained unresolved* and which await an answer from pastoral experience, from theological reflection and from the Magiserium of the Church over the next years: its most appropriate name, the juridical and voluntary dimension of pastoral workers, the relationship between a hospital chaplaincy and the hospital council for pastoral care, the possibility of an ecu-

menical hospital chaplaincy, and the need for, or the possibility of, establishing a new ministry for the working members of a hospital chaplaincy.

Summarising the elements of all the definitions given during this research, I attempted to summarise and specify the most important aspects of the identity and action of a hospital chaplaincy: it is based in theological terms upon the missionary mandate of Jesus given to his Church to 'preach the Gospel and heal the sick'; it is created by a juridical mandate of the bishop of the local Church for a health-care/hospital community; it is made up of various expressions of the people of God: priests, deacons, men and women religious, men and women members of the lay faithful; it engages in ordinary pastoral action within the health-care field that is dedicated to sick people, their family relatives and workers of various professional categories and the whole hospital community; it seeks to achieve the multiple goals of pastoral care in health which are listed in the Pastoral Note of 1989 (n. 20) and the Pastoral Note of 2006 (n. 23); and it is expressed in practical terms in various forms of pastoral action and help: humanisation, human promotion, psychological support, help relationships, spiritual accompanying, evangelisation and catechesis, liturgical celebrations, sacramental grace, ecumenical and inter-religious dialogue, and the building of bridges of cooperation with the parish communities of the local area.

7. A Work of Research as Service to the Italian Church

The work of this research was very long and required special time and energy: it was experienced not only with the goal of offering a concrete contribution to the field of pastoral care in health but also and above all else with *the intention of performing a useful service for the Church in Italy*. The secret hope is that it can become a useful concrete point of reference for hospital chaplains, for pastoral workers of all forms of membership of the Christian community, and for those who care about the presence and the action of God and the Church in the season of health and suffering.

The pathway of the itinerary of study was demanding and enormously exceeded in size what had been envisaged. The initial project, set out in general and schematic terms, gradually became clear as the research progressed: I realised that the horizons were constantly expanding and becoming almost a challenge. The result that was achieved is offered to all Church communities and individuals so that they may achieve the stimuli that are needed to achieve what has been pointed out in these pages.

After reaching my goal I am aware that I have produced a work which from some points of view may be seen as being incomplete because a great deal remains to be explored in theological reflection, to be planned in individual communities and to be experienced in the field. Like the learned scribe in the Kingdom of Heaven, 'new and old things' (Mt 13:52) have been taken from the draw of the Church and harmonised into a single pastoral project. It is indispensable to stress that the limits of this research are inherent in the very nature of the work that has been carried out: this was the first time that such a subject was addressed at a national level.

These limits should not be seen as negative elements but as 'pro-vocations' and almost challenges for other chaplains, pastoral workers and theologians so that they may continue to develop that analysis that has been begun and enrich and broaden its contents and perspectives. The 'conclusion' thus remains 'open' to further horizons: the subject of hospital chaplaincies is of great contemporary relevance and of great interest for the mission of the Church.

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Notes

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[1] GIOVANNI PAOLO II, 'Evitare ogni forma di eutanasia', in *DOLENTIUM HOMINUM. CHIESA E SALUTE NEL MONDO*, review of the Pontifical Council for Health Care Workers, n. 58, XX, n. 1 2005, p. 8.

[2] M. CORTELAZZO and P. ZOLLI, *Dizionario etimologico della lingua italiana,* vol. 1/A – C (Zanichelli, Bologna , first edition 1979).

[3] EDIGEO (ed.), *Enciclopedia Zanichelli* (La Repubblica, Rome, 1995).

[4] G. DEVOTO and G. C. OLI, *Vocabolario illustrato della lingua italiana* (Selezione dal Reader's Digest, Milan, 1983) vol. 1.

[5] *Dizionario della lingua italiana* (Signorelli, Milan, 1985).

[6] CONSULTA NAZIONALE CEI PER LA PASTORALE DELLA SANITA', *La pastorale della salute nella Chiesa italiana. Linee di pastorale sanitaria* (*PSCI*), 30 March 1989.

[7] *Ibid.,* n. 81.

[8] Cf. GIOVANNI PAOLO II, 'Messaggio per la XI Giornata mondiale del malato', published with the date of 2 February 2003, in *DOLENTIUM HOMINUM. CHIESA E SALUTE NEL MONDO*, n. 51, XVII, n. 3 (2002), pp. 4-6. In this document the Italian phrase '*cappellanie ospedaliere*' is translated into the principal languages in the following ways: 'chaplaincies' (English), '*aumoneries*' (French), '*seelsorgern*' (German), '*servicio de los capellanes*' (Spanish). ARCIDIOCESI DI TORINO. CURIA METROPOLITANA, 'Cappellania ospedaliera. Orientamenti programmatici' in *RIVISTA DIOCESANA TORINESE*, February 2002.

[9] Cf. P. SCHREUR, 'I laici nella pastorale ospedaliera. Un'esperienza olandese' in AA. VV., *L'operatore pastorale nel mondo della salute oggi. Alla ricerca di una nuova identità*, (SALCOM, Brezzo di Bedero (VA) 1971); S. BAMBINI, 'Nuove prospettive di un'assistenza religiosa nell'ospedale moderno', in *Atti del VI convegno nazionale cappellani ospedalieri cappuccini*, La Mendola (Trento) 3-7 September 1973, edited by O. NALDINI.

[10] G. PEZARD, 'Verso nuove esperienze pastorali nel mondo della sofferenza', pp. 69-74 in O. NALDINI, *Uomini a servizio di uomini, Atti del convegno nazionale dei Padri cappuccini ospedalieri, S. Giovanni Rotondo 15-19 ottobre 1984*.During this conference the bases were established for the 'Associazione Nazionale Cappellani e Religiosi Ospedalieri' (ANCRO) ('The National association of Hospital Chap-

lains and Religious'), which subsequently became the 'Associazione Italiana di Pastorale Sanitaria' (A.I.Pa.S.) ('The Association for Pastoral Care in Health').

[11] S. BAMBINI, 'Cappellania ospedaliera e comunità cristiana', in *ANIME E CORPI, rivista bimestrale medico-psicologico-pastorale della sofferenza*, edited by OARI., 136 (1988), pp. 197-212.

[12] A. BRUSCO and G. BECONCINI, 'La cappellania ospedaliera: Aspetti teologici pastorali. Esperienze pratiche' in *ANIME E CORPI,* 156 (1991), pp. 381-403.

[13] A. BRUSCO and L. SANDRIN, *Il cappellano d'ospedale. Disagi e nuove opportunità* (Camilliane, Turin 1993), pp. 101-110.

[14] S. MARINELLI, *Il cappellano ospedaliero. Identità e funzioni* (Camilliane, Turin, 1993), pp. 162-170.

[15] R. MESSINA, 'La Consulta nazionale e le Consulte regionali e diocesane della Sanità', in A. BRUSCO (ed.), *Consulta Nazionale CEI, Curate i malati,* pp. 203-212.

[16] E. SGRECCIA, 'La Cappellania ospedaliera: un progetto di comunità pastorale' in *INSIEME PER SERVIRE*, 3 (1990), pp. 42 - 46.

[17] A. BRUSCO and G. BECONCINI, 'La cappellania ospedaliera: Aspetti teologici pastorali. Esperienze pratiche' in *ANIME E CORPI,* 156 (1991), pp. 381-403.

[18] CONFERENZA EPISCOPALE CALABRA, CONSULTA REGIONALE PER LA PASTORALE DELLA SANITÀ, *Evangelizzazione e testimonianza della carità oggi, in ospedale. La cappellania ospedaliera*, *Atti del Seminario di studio per cappellani ospedalieri, religiose, operatori sanitari*, Gizzeria Lido (Catanzaro) 20-21 April 1992 (Editoriale progetto 2000, Cosenza, 1992).

[19] S. BAMBINI, 'La cappellania ospedaliera', in CONSULTA PASTORALE SANITARIA REGIONE LIGURIA, *La sofferenza nel mistero di Cristo*, *Atti del convegno regionale, maggio 1993* (Tipolitografia Emiliani, Rapallo, 1993).

[20] AA. VV., *Progettualità ecclesiale nel mondo della salute, Atti del III convegno della Consulta nazionale della pastorale della Sanità della CEI, 23-25 aprile 1995*, edited by I. MONTICELLI, SALCOM (Brezzo di Bedero (VA), 1995).

[21] CONFERENZA ITALIANA MINISTRI PROVINCIALI CAPPUCCINI, SEGRETARIATO PER LA PASTORALE DELLA SALUTE, *La cappellania. Kairòs per la pastorale della salute*, *Atti del convegno nazionale, Cavallino (VE) 6-9 maggio 1996*, by edited M. STEFFAN (Mestre (VE), 1996).

[22] Cf. G. DAVANZO, *Cappellano ospedaliero*, in S. LEONE and S. PRIVITERA (ed.), *Dizionario di bioetica*, EDB-ISB, 1994; cf. also G. DAVANZO, 'Negli ospedali non solo i cappellani', in *SETTIMANA*, *settimanale di attualità pastorale* (EDB, Bologna), n. 15 (1991), 3.

[23] Cf. A. BRUSCO and G. BECONCINI, 'La cappellania ospedaliera. Aspetti teologici e pastorali. Esperienze pratiche', in *ANIME E CORPI*.

[24] Cf. A. BRUSCO, *Cappellania ospedaliera*, in G. CINÀ, E. LOCCI, C. ROCCHETTA, and L. SANDRIN (eds.), *Dizionario di Teologia Pastorale Sanitaria* (= *DTPS*) (Camilliane, Turin, 1997), pp. 165-169.

[25] Cf. A. BRUSCO, S. PINTOR, *Sulle orme di Cristo medico. Manuale di teologia pastorale sanitaria* (EDB, Bologna, 1999), pp. 209-212.

[26] This thesis was defended on 24 October 2008 and my examiner was Prof. GIUSEPPE CINÀ, dean for a number of three-year terms, and my co-examiners Prof. LUCIANO SANDRIN and Prof. MASSIMO PETRINI, respectively the current dean and vice-dean of the International Institute for the Theology of Health Pastoral Care 'Camillianum', which forms a part of the Pontifical Faculty of Theology 'Teresianum' of Rome.

[27] *GS,* n. 4. Cf. JOHN XXIII, *Gaudet Mater Ecclesia; EV* 1/55*.

[28] L. CICCONE, 'Contributi biblico-teologici al problema della salute', in AA.VV., *Chiesa e riforma sanitaria,* p. 48.

[29] *Ibidem*.

[30] E. SGRECCIA, 'Il servizio pastorale nelle nuove strutture delle unità sanitarie locali', in AA. VV., *Riforma sanitaria e comunità cristiana*, p. 66.

[31] Cf. A. BRUSCO, 'La pastorale sanitaria nell'attuale contesto sociale', in I. MONTICELLI (ed.), *Progettualità ecclesiale nel mondo della salute, Atti del III convegno della Consulta nazionale della CEI per la pastorale della Sanità, 23-25 aprile 2005* (SALCOM, Brezzo di Bedero (VA), 1995), pp. 17-46; A. PANGRAZZI, 'Pastorale della salute. Il guaritore ferito', *Il regno-attualità,* 10 (1998), 351-360; L. SANDRIN, *Fragile vita. Lo sguardo della teologia pastorale,* pp. 83-84.

[32] COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, pastoral note *"Predicate il Vangelo e curate i malati". La comunità cristiana e la pastorale della salute*, 4 June 2006. Hereafter *PVCM*.

[33] PONTIFICIA OPERA PER LE VOCAZIONI ECCLESIASTICHE, *Nuove Vocazioni per una nuova Europa* (Libreria Editrice Vaticana, Vatican City, 1997), p. 47.

[34] CEI, UFFICIO NAZIONALE PER LA PASTORALE DELLA SANITÀ, *Domanda di salute nostalgia di salvezza, VII Giornata mondiale del malato, 11 febbraio 1999*, (Camilliane, Turin, 1998), 'Sussidi e Documenti' series, n. 4.

[35] *Ibidem*.

[36] W. KASPER, *Il Dio di Gesù Cristo* (Queriniana, Brescia, 1987), pp. 216, 217.

[37] G. CINÀ, *Sofferenza e salvezza. Fenomenologia e riflessione teologica, "Camillianum". Istituto* Internazionale di Teologia Pastorale Sanitaria*,* "Sussidi", n. 1, Rome, 1997, p. 14.

[38] L. PINTOR, *Servabo. Memoria di fine secolo*, Turin, first edition April 1991*,* p. 84.

[39] *Ibidem*, p. 85.

[40] VESCOVI BRASILIANI, 'Missao e mistérios dos cristaos laigos e leigas', in *Il regno-documenti*, 17 (1999), p. 587.

[41] JOHN PAUL II, post-synodal Apostolic Exhortation *Christifideles laici* on the vocation and the mission of the laity in the Church and the world, 30 December 1988, n. 32; hereafter *CfL*.

[42] Cf. *PSCI*, n. 80.

[43] *PVCM,* n. 66.

[44] PAUL VI, Apostolic Exhortation *Evangelii nuntiandi* on evangelization in the modern world, 8 December 1975, n. 66; hereafter *EN*.

[45] *CfL*, n. 45; cf *EN,* nn. 67-73.

[46] CONFERENZA EPISCOPALE ITALIANA, pastoral note *Rigenerati per una speranza viva" (1Pt 1,3): testimoni del grande 'sì' di Dio all'uomo dopo il 4° convegno ecclesiale nazionale*, 29 June 2007, n. 23. Hereafter: *RSV*.

[47] Cf. *Ibidem*.

[48] *PSCI,* n. 21.

[49] *PVCM,* n. 59.

[50] *PSCI,* n. 21.

[51] *PVCM,* n. 18.

[52] *Ibid.,* n. 66.

[53] *EN,* n. 78.

[54] *PSCI,* n. 1.

[55] Cf. J. A. PAGOLA, 'Evangelizzazione e mondo della salute', in *DTPS*, p. 429.

[56] CONFERENZA EPISCOPALE ITALIANA, pastoral note *Il volto missionario delle parrocchie in un mondo che cambia,* 30 May 2004, n. 21. Hereafter *VMPMC*.

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

[58] UFFICIO NAZIONALE CEI PER LA PASTORALE DELLA SANITA', *La famiglia nella realtà della malattia, XVI Giornata Mondiale del Malato, 11 febbraio 2008* (Camilliane, Turin, 2007), n. 5.

[59] UFFICIO NAZIONALE CEI PER LA PASTORALE DELLA SANITÀ, *La comunità cristiana luogo di salute e di speranza, VI Giornata mondiale del malato, 11 febbraio 1998* (Camilliane, Turin, 1997), n. 2.

[60] *PSCI,* n. 21: *'L'estensione della pastorale dall'ospedale al territorio'*.

[61] BAMBINI S., 'Cappellania ospedaliera e comunità cristiana', in *ANIME E CORPI,* 136 (1988), p. 206.

[62] *Ibid.,* p. 209.

[63] *CCL*, can. 571.

[64] *Ibidem,* can. 529 - § 1; cf *CIC*, can. 530: 'The functuons enstrusted to the parish priest in a special way are the following:… 3. to administer Viaticum and annonting of the sick, with the provision of can. 1003, § § 2 and 3 always applicable, and betwoing the apostolic blessing'.

[65] *Ibid.,* n. 34.

[66] UFFICIO NAZIONALE CEI PER LA PASTORALE DELLA SANITÀ, *La sofferenza è stata redenta,* n. 4.

Priests, Pastoral Workers and Health-Care Staff: Towards Reciprocal Integration

1. The Needs of People who are Admitted to Hospital

1.1. Usually in hospitals there exists an affable disassociation between the representatives of the Church and the health-care staff, even though they care for the same people. However, today more than ever before, integration between them can be of beneficial effect in addressing the health-care world which has before it growing prospects of grave moral and spiritual consequences.

1.2. In his document *The Philosophy of the Hospital*, Dr. Chalmers of Fredericton, Canada, where he engaged in pastoral care for sick people (which he now engages in every day at the Palliative Care Unit of Algeciras (Cadiz, Spain), recognises the triple reality of the person: body, mind and spirit.

We believe that our best attempts to attend to all the needs of patients, whether they are physical, social, emotional or spiritual, are the outcome of the joint efforts of the members of our unit. Indeed, if there is an imbalance between these three components, the other two will be affected as well. I can remember cases where a physical illness or a traumatic crisis (produced, for example, by a grave accident) has made the faith of a personal vacillate when this was not sufficiently strong ('why is this happening to me?'); or how major anxiety has continued to cause digestive disorders; or when the fact of a person not forgiving her mother (justifiable from a human point of view but not from a spiritual one) led a daughter to place her mother in the psychiatric ward of my Canadian hospital, although after speaking and praying with her twice, she began, at least, to recognise that 'certainly, in the final analysis she is my mother'. For this reason, as another document of that hospital, *Programmes for Pastoral Visits*, observes: 'pastoral workers perform an integral role within the health-care team'.

2. Priests: Successors to the Apostles and Ministers of Healing

A few years ago the Spanish Bishops' Conference referred to 'healing care in the whole of the dynamic of diocesan pastoral care, with the acquisition of a more vital awareness of the salvific power borne by a Church faithful to Jesus Christ' (Spanish Bishops' Conference, 2007, pp. 103-104). In this dynamic the first instrument is the priests, the successors to the Apostles, who are called to continue the ministry of Jesus who 'sent them out to preach the Kingdom of God and heal the sick' (Lk 9:2) in their bodies, minds and spirits.

Jesus told the Irish Clarissan nun Sister Briege McKenna, whom I met in Indiana in 1978 during a seminar on prayer and healing and who exercised a great ministry of evangelisation and healing with retreats for priests (up to a thousand people in 2006 in Ars, the native town of St. John Vianney), to communicate the following to bishops and priests: 'It is not humility to deny the power of the priesthood, but it is humility to recognise that I have chosen them… not for them to be saints… but for my mercy, my love and my compassion for mankind' (McKenna, 2005, p. 92).

The apostle James, when referring to the sacrament of the anointing of the sick, which was established by Jesus Christ, says: 'Are any of you ill? You should send for the Church elders, who will pray for them and rub olive oil on them in the name of the Lord' (Jm 5:14).

How beautiful it is when a priest exhorts his faithful to turn to him when they are sick so that he can place his hands on them and pray for them, as takes place with reconciliation, one of the sacraments of healing. Some priests, indeed, exercise a powerful ministry of evangelisation and healing, and this is what the Canadian Emiliano Tardif (whose process of beatification is underway) did. I met him many years ago. In reality, however, any priest, because of his consecration, is equally invested by the Holy Spirit and, as the American Jesuit, Robert DeGrandis, who is famous throughout the world, said: 'the ministry of sacramental healing should be seen as a part of the priestly vocation' (DeGrandis, 1996, p. 62). Indeed, the Twelve were sent out to 'heal every kind of illness and infirmity' (Mt 10:1)). One testimony to the fact that our Church encourages us to exercise this ministry is the volume *Prayer for Healing* which was published in the Vatican and was the outcome of an international conference that took place there in the presence of 1 archbishop, 5 bishops, 8 priests, 1 deacon and physician, 1 woman religious and 5 lay people (the Pontifical Council for the Laity/ICCRS, 2005).

3. Health-Care Workers and the 'Christian Visit' of the Believer

When in December 1978 I was talking to Mother Teresa in her nunnery in Calcutta I said to her that I was a university lecturer in Canada and she answered me: "so try to radiate Christ as he is". Should this not be the motto of all those who care for those who suffer, that is to say: 'radiate Christ'? Indeed, one can visit a sick person in three ways: a)

as pagans, that is to say even by saying to them such foolish things as "anyway you do not deserve this", "go and understand why God has sent you something like this if you have not done anything bad to anyone", or as an aunt of a terminally-ill girl once said to me: "This is an injustice"; b) *as tepid and 'discreet' believers* who are unable to speak a word of Christian hope, are never concerned about praying with a patient or, like his brethren, are not interested in his spiritual health because it is believed that these are 'very personal things', or in how he should really be; c) through a *Christian visit*, answering the revelation of Christ: "I was

sick and you visited me" (Mt 25:36). To sum up, one is dealing here with accompanying a sick person, knowing: that we are there, humbly, but as the ambassadors of Christ (2 Cor 5:20) whose constant company, and the company of his Spirit, we must always ask for in this ministry; that, as St. Paul assures us, 'our battle is not against creatures made of flesh and blood but against… evil spirits' (Eph 6:12), because in addition to the reality that we perceive at the level of our senses, there is a spiritual reality where God acts through the Holy Spirit, although his enemy, the devil, 'a perverted and perverted being', as Paul VI well put it, inspires in sick people anxiety, fear, desperation and rebellion against God; that in their debilitated state these sick people are vulnerable to his attacks but they are also vulnerable to the grace of God, a grace that must flow through our ministry, assuring them that Jesus holds them fast to the same cross on which he died for them; that as a result we must discern the level where we must help them to encounter God, explaining to them that we come from God and that we go to Him and He Himself, even though this is not realised; says: 'Perhaps in their suffering they will try to find me' (Hos 5:15); that for this reason we must ensure that this painful experience helps to make them draw more closely to God and to make them understand that their suffering is purifying them spiritually and that this is the most important form of healing through which they, like Christ, will overcome death; that in addition to including them in our daily prayers of intercession, we must ensure that we pray with them asking Jesus to fill them with his peace and – always with discernment – ask for their healing or relief of their pain; but this should never be a solely social encounter.

Dioni, who was sixty-five years old, before dying in the Palliative Care Unit, gave me a cassette of when for the whole of Europe she was 'India', one of the top singers of the famous Pilar López company. The cassette was entitled '*Amor y espinas*', a very appropriate title, as I explained to Dioni with words that apply to all sick people: "Jesus died for your salvation, he loves you with an infinite *love* and he is at your side, allowing you to share in his *thorns*": love and thorns. Carlos, who was fifty-seven years old, was also in the Palliative Care Unit and was paralysed, after spending years obtaining his livelihood as a ferocious mercenary leading dangerous and always fatal missions. He repented the first time that he fell ill; now he knew that the Lord was with him, and he so much appreciated my prayers that at times I had to dry his tears.

4. Prayer and Sacraments in Pastoral Care for the Sick

4.1. Our prayer – a subject analysed in depth in my book entitled '*Estuve enfermo y me visitasteis*' – must always be spontaneous (even though often, according to the circumstances, we end with an Our Father, an Ave Maria and a Glory) and, naturally, change according to the person. In this way we establish that necessary intimacy that leads us to discover problems such as hopelessness, a distancing from the Church or an inability of forgive. For this reason, the famous French psychiatrist and deacon Philippe Madre – who converted after seeing the healing of a schizophrenic after two hours of prayer – says that a part of the vocation of a health-care worker is to help a patient to open his or her own heart. My personal experience is that only in this way can one achieve a beneficial non-sacramental confession that can lead to a sacramental confession with a priest.

4.2. Some people, however, live illness with true faith. People such as Harry, a Canadian

non-Catholic friend who two days before dying said to me: "How much I wish to meet my Creator!". Or Ángel, a drug addict who died of AIDS. When he was looking at his Bible (which he knew thanks to certain Evangelical friends) he said to me "I know that he is here". Other people, however, are afraid of dying or have wounds from the past that require 'inner healing'. We carry out our 'healing mission' by accompanying, by listening and by transmitting the comfort of the Word of God, as in Isaiah 43:5 'do not be afraid because I am with you', or in Philippians, on how to obtain this peace of God who 'surpasses all intelligence'.

4.3. At times, however, one should pray so that patients can forgive, a recurrent theme of the conference of the International Christian Medical Foundation, to which I was invited in 1984 by its president, the American surgeon William Reed, the author of a book on care for the whole person: body, mind and spirit (Reed, 1995). I remember the testimony of William Wilson (who held the chair of psychiatry and was director of the Christian Psychiatry Programme at the prestigious Duke University) on the total healing, five years ago, on the basis of prayer sessions, of a case of migraine that had lasted for eight years, when the woman patient could in the end forgive her husband who had betrayed her many times.

If we bear in mind the spiritual aspect of sick people we must try to know if there is someone who cannot forgive, aware that this is doing that person a great deal of harm. We know, and this is confirmed by Philippe Madre, that one of the best ways of praying with sick people for their recovery is to reawaken in them the need to forgive or to ask for forgiveness.

4.4. In addition, we must encourage patients and their family relatives who have drawn away from the Church to become reconciled with the Church, assuring them that one Holy Mass, or for the patient anointing with oil, is worth more than all the statuettes of saints, the flowers and the candles that they place in front of images.

4.5. As regards anointing with oil and the patient, the *Catechism of the Catholic Church* (n. 1516) observes: 'It is the duty of pastors to instruct the faithful on the benefits of this sacrament' – the medical doctor should offer to the patient treatment that he or she has not asked for his or her own good – and 'The faithful should encourage the sick to call for a priest to receive this sacrament'. *The Code of Canon Law* states (n. 1007): 'Anointing of the sick is not bestowed on those who obstinately persevere in manifest grave sin'. This is one of the reasons why a health-care worker enters into intimacy with a sick person and his or her family relatives.

With respect to the sacraments, one evening in Vaasa, in Finland, in a conversation with the parish priest of a Lutheran church, I spoke to him about the high level of suicides in that country and in Japan. He replied to me, with total conviction, that the level was much lower amongst Catholics because of the fact that they accede to the sacrament of confession. Indeed, those of us who care for the sick believe that to receive or not to receive the sacraments can mean their eternal salvation or their spiritual suicide.

4.6. Lastly, we do not forget to interact with a patient through the medical staff – medical doctors, nurses, auxiliary staff, that is to say through those who have to relate in some way with the patient – so that God will help them in their work and their decisions.

5. Ecumenical and Inter-religious Experience in Pastoral Care

Personally, praying with a patient greatly appeals to me, for example with an evangelical, and even better with his or her family relatives present, because this means promoting ecumenicalism. I have very grateful memories of Moroccan men and women that I looked after in the Palliative Care Unit: their affability and their gratitude as regards my visit, a kiss, an embrace (always corresponded) and praying with them to our one God, asking for His mercy, and making clear that I did this through Jesus. I liked to speak to them about the Biblical figures present in the Koran, for example: Adam (even though he repented and thus did not transmit the effect of original sin); Noah; Abraham (the father of faith, from whose son Ishmael the Arabs descend); Lot (who preached against homosexuality); Jacob; Joseph; Moses (to whom, they believe, God handed the Torah); David (to whom, they believe, God gave the psalms); Salomon; Elijah; Job; Jonah (who managed to convert Nineveh; Zachariah, the husband of Elisabeth; John the Baptist; the Virgin Mary (the woman that they most venerate, to whom the angel Gabriel announced the birth of her son); and Jesus (the greatest prophet after Muhammad), whom they believe received the gospels from God, worked miracles and healed people, ascended to heaven and will return at the end of the world (which will be marked by moral decadence, signs in the sky and the appearance of the Anti-Christ), even though they do not believe in his death and resurrection. The Archangel Michael, who for them, as for us, is a protector (for a Muslim patient it is a pleasant surprise to receive a statuette of him with a prayer in Arabic).

We do not ignore the fact that the *Catechism of the Catholic Church* (quoting *Lumen gentium* of the Second Vatican Council) states: 'The plan of salvation also includes those who acknowledge the Creator, in the first place amongst whom are the Muslims; these profess to hold the faith of Abraham, and together with us they adore the one, merciful God, mankind's judge on the last day'. (n. 841).

6. Health-Care Personnel Faced with the Whole Person: Body, Mind and Spirit

6.1. The atheist Alexis Carrel, who won the Nobel prize for medicine in 1912 (for his suture technique for blood vessels and organ transplants), converted after seeing the complete healing in Lourdes of a woman who had tubercular peritonitis, was about to die, was emaciated and had a very swollen stomach. He later wrote that prayer 'is the only force in the world that seems to overcome the so-called 'laws of nature''.

Seeing every day in the Palliative Care Unit the compassion and the affection of all of the health-care personnel, without forgetting about the cleaning staff as well, I ask myself whether they realise that it is God that places these feelings in their hearts. Philippe Madre, with his dual medical and spiritual experience, says that 'the priority for health-care staff is to exercise mercy'.

I have already referred to the surgeon William Reed and his integral care for the person – body, mind and spirit – because, as the influential Christian Swiss physician, Paul Tournier (1965, p. 61), observed: 'Man – body, mind and spirit – is a unity. The life that lives in his body corresponds to the live that lives in his mind and to the life that lives in his spirit…The spirit…is neither mind nor body. It constitutes the personal relationship of man with God, and shapes the mind and the body on the basis of this relationship'.

With respect to medical doctors, we hope that each one of them will recognise, as the Book of Sirach says, that 'he gave medical knowledge to human beings, so that we would praise him for the miracles he performs…the doctor will use them to cure diseases and ease pain…The doctor's prayer is that the Lord will make him able to ease his patients' pain and make them well again' (Sir 38: 6-7, 14).

6.2. In 1981 two student nurses of one of my courses on non-verbal communication (where we addressed the various aspects of the interaction between women nurses and patients or between medical doctors and patients) recommended to me a book of a great value by two women nurses on spiritual care in their profession (Fish and Shelly, 1978). In this book one can read that 'illness afflicts a person in his totality, not only his body or mind or spirit' and that 'the care of a nurse must be centred on the person as a unity' (p. 32). It emphasises the fact that a nurse for her patients can and must be a 'channel of the love of God' (p. 49). In this book the essay *Interpersonal Aspects of Nursing*, by a famous American lecturer on nursing, Joyce Travelbee, who died at the age of forty-seven, is quoted: 'A woman nurse does not only try to relieve physical pain or provide physical treatment, she attends to the person in a spiritual sense. She attends to the individual, not to a part of his body. The existence of physical, mental or spiritual suffering is what concerns the nurse' (p. 59).

In this book it is stated that 'one of the personal resources of a nurse is knowledge of Scripture so as to be able to use the Word of God therapeutically' (p. 110), naturally not in an indiscriminate way but always with discernment.

A Canadian friend of mine who is a nurse, Lynn Young, managed to win the favour of a very unpleasant patient who others avoided because she asked for God's help. And I can also think of the former nurse Barbara Shlemon (famous for her ministry, her books and her intercession centre in Florida) whom I met in 1978 during the course of that seminar on prayer and healing with Sister Briege McKenna. Her life changed in 1964 when a sick young woman in a comatose state with her stomach swollen as though she were nine month's pregnant, without any hair, yellow, indifferent to almost every stimulus, and already breathing very badly, after receiving one night the sacrament of anointing of the sick and after Barbara had prayed for her, the next day was sitting on a bed and eating a bowl of soup.

I remember with affection the Canadian woman nurse who looked after me when I arrived at the urgent patients' department with an attack of asthma. Years later I had the privilege of helping her spiritually and of bringing her communion when she was a terminally-ill patient. Indeed, William Reed, who always prays for his patients when he is operating on them, says in the above-mentioned book that the operating theatre 'is a place where lives are suspended between life and death. There the soul sleeps, the body is senseless, and the spirit dwells in communion with God. In the hands of the surgeon and the anaesthetist there is not only a life, but also a soul and a spirit that can be influenced, for good and evil, by words, actions and thoughts' (pp. 23-24).

And the lecturer on medicine and Italian researcher Giuseppe Moscati († 1927), who was canonised in 1987 by John Paul II, observed: 'Blessed are we doctors if we remember that in addition to bodies we have in front of us immortal souls which demand the gospel precept that we should love them as ourselves. There lies the satisfaction; and in not hearing ourselves proclaimed the healers of a physical malady' (Sicari, p. 181).

That doctor/saint, with his extenuating day as a medical doctor, also said that 'those who always take communion every morning have with them an energy that never goes away' (Sicari, p. 174). It was very beautiful to hear in the above-mentioned conference the testimonies of those medical doctors – who pray with their staff and their patients – about extraordinary and even miraculous recoveries and their conversion. I myself benefited as regards the treatment of my terrible bronchial asthma which had lasted for seven years after William Reed had prayed for me. And I was not surprised by the fact that although he was an Episcopalian he read the Book of Sirach

(one of the seven books not included in his Bible). 'My child, when you feel ill, don't ignore it. Pray to the Lord and he will make you well. Confess all your sins and determine that in the future you will live a righteous life…Then call the doctor –for the Lord created him – and keep him at your side; you need him. There are times when you have to depend on his skill. The doctor's prayer is that the Lord will make him able to ease his patients' pain and and make them well again' (Sir 38: 9-14)

7. A Ministry for the Future

There would be a great deal more to say but I will only cite here what I call my 'photographic ministry'. Only occasionally and with discernment, taking advantage of my passion for photography, I like to give family relatives something that afterwards pleases them a great deal: for example a family picture of Generosa with her husband, children and dog to remember that Sunday when they made her come down to the patio on her wheelchair; or for Andrés, a picture of him with his uncle Manolo, a simple and affectionate man from the countryside, who always accompanied him: "every time that I look at that photograph, tears come to my eyes". 'It is better to give than to receive!' (Acts 20:35). As John Paul II said: 'We begin by thinking that we give to them and we finish by realising that they have enriched us'.

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Pastoral Care: the Chicago Study*

At this time of reexamination and restructuring of health care in the United States, it is appropriate to briefly review an important aspect of Catholic health care, and that is the pastoral care of our patients. Given the economics of the Obama health-care legislation, spiritual concerns may be overlooked, but they should not be. These concerns include mandates for immoral cooperation in abortion and a lack of protection for the conscience rights of health-care workers.

A review of pastoral care is in order for three reasons: 1) the spiritual components of health and wellbeing are increasingly acknowledged as a legitimate aspect of medicine.[1] 2) Since Vatican II there has been a shift in Catholic hospital ministry from clerical domination to a lay orientation.[2] 3) Finally, the Catholic identity of our Catholic health-care system has been called into question.[3] This latter concern is not of recent origin.

Fifteen years ago Fr. Richard McCormick, S.J., wrote a seminal paper, "The Catholic Hospital Today: Mission Impossible."[4] His summary was depressing. He stated that "the circumstances of the late twentiethcentury United States have weakened and sometimes dissolved the culture of the Catholic health-care facility, the strength and transforming power of its vision."[5] Was Fr. McCormick's pessimism justified?

The Catholic Physicians' Guild of Chicago feels that the Catholic identity of our hospitals is uniquely rooted in their pastoral programs.[6] If Fr. McCormick is correct in thinking that the culture of the Catholic hospital is dysfunctional or absent, then our programs are in serious trouble. But is that the case?

Materials and Methods

The Chicago Physicians' Guild undertook to survey the twenty-one Catholic hospitals of the Archdiocese of Chicago. Its purpose was to "take the pulse" (to coin a phrase) of the Catholic mission of our hospitals. To this end, we designed a simple one-page checklist (Figure 1) which we sent to the twenty-one directors of pastoral care as identified in the *The Official Catholic Directory 2009*.[7] An introductory letter was sent to the pastoral-care directors, along with the questionnaires and mailing instructions to return the survey. To simplify analysis most questions were in a "Yes-No" format. There were five broad categories: identification, Mass, Sacraments, ethics, and natural family planning (NFP). The survey is shown in Figure 1. Since patients were not involved in this survey, institutional review board approval was not required. Responses from pastoral-care directors were voluntary with no incentives provided.

Figure 1. Hospital Checklist.

The name of your hospital: _____

1. Identification:
   a. There are Catholic images (statues, pictures, crucifixes) present. Yes___ No___
   b. The hospital is identifiably Catholic. Yes___ No___
   c. The word "Catholic" is in the mission statement. Yes___ No___

2. Hospital Chapel:
   a. Is there a chapel? Yes___ No___
   b. Is it open daily? Yes___ No___
   c. Mass is offered? Indicate times; if not offered place an X. S M T W T F S
   d. Is information about Mass times and location given to Catholic patients upon admission? Yes___ No___

3. Sacraments:
   a. How many pastoral care personnel are there? (full-time equivalents) Number_____
   b. Is the Sacrament of the Anointing of the Sick available 24 hours per day? Yes___ No___
   c. Is this provided by an in-house priest or the patient's own parish priest? In house___ Parish___
   d. Communion is available from pastoral care ministers. Yes___ No___
   e. Is confession available from a priest if the patient so requests? Yes___ No___

4. Ethics Committee:
   a. Is there a Catholic priest on the Ethics Committee? Yes___ No___
   b. Is the Ethics Committee guided by the *Ethical and Religious Directives*? Yes___ No___

5. Is Natural Family Planning available to those women who request it? Yes___ No___

If your hospital provides additional Catholic services please list them below.
Also, should you have any additional comments we would appreciate them.
Please return this form in the self-addressed stamped envelope.

Results

Response:
In all, 20 of the 21 hospitals responded. A checklist for the non-responding hospital was completed by a Catholic Physicians' Guild member on its staff. As the questions were objective in nature, this was not felt to introduce bias into the survey, and their responses are included.

Identification:
All 21 hospitals were identifiably Catholic.

Mass:
Of the hospitals surveyed, 15 had Mass daily in the chapel. Five hospitals had Mass six days a week.

One hospital had Mass two days a week.

Sacraments:
Nineteen hospitals had the sacraments available 24 hours per day, one 16 hours per day, and one not specified. There were 86 full-time equivalent pastoral-care personnel, including 52 religious.

Ethics:
Ten respondents (47.6 percent) had a priest on the ethics committee. There was insufficient data to determine whether the ethics committees were guided by the *Ethical and Religious Directives* of the United States Conference of Catholic Bishops, so this result was not included in the final analysis.[8]

NFP:
In all but one hospital, NFP was not available. Because of this, NFP was not included in our final analysis.

The results warrant some comments. Twenty of the twenty-one hospital pastoral-care programs (95 percent) replied. For a voluntary questionnaire, this is a good response. The questionnaire for the nonresponding hospital was completed by a Catholic Physicians' Guild doctor on that hospital's staff. All hospitals were identifiably Catholic. This included not only the name but also the presence of statues of saints, crucifixes, and holy pictures. Three quarters (15 of 21) of the hospitals had daily Mass in their chapels. One hospital had Mass only one day a week. Nineteen of the twenty-one hospitals (91 percent) had the sacraments available twenty-four hours a day, seven days a week. Of interest was the large number of personnel on duty. There were eighty-six full-time equivalents, or 4.1 persons per hospital. This included fifty-two religious and thirty-four lay persons. Also of note was the fact that there were twelve priest chaplains in spite of the fact that there is an acknowledged shortage of priests. About one-half of the hospitals had a priest on their ethics committees. Finally, NFP was essentially not promoted by any of the hospitals. One hospital did not have an ob-gyn department.

Discussion

Catholic health care (or at least the hospital component of that care in the United States) can be dated to 1823 when St. Elizabeth Seton and the Sisters of Charity staffed the Baltimore Infirmary, which subsequently became the hospital of the University of Maryland.[9] Many other orders of religious women founded hospitals following Mother Seton. The first hospital in Chicago was founded by the Sisters of Mercy in 1851 and was appropriately named Mercy Hospital.[10] In most instances these religious hospitals were organized to fill a need for health care for poor immigrants. The socially and economically advantaged had their own private clinics.

By 1990, 12.5 percent of hospitals, 15.1 percent of beds, and 15.6 percent of admissions were provided by Catholic health care. Given the current health-care debate, it is important to note that 14.5 percent of health care (80 billion dollars of a total of 512 billion dollars) expenses are incurred by Catholic hospitals.[11]

Statistics can tell us only so much. Of far more importance is what the sisters brought to health care. They were religious before they were nurses or administrators. They spent their formative years, even before they arrived on the hospital wards, in their novitiates and convents, becoming perfected in a religious life dedicated to God and service to their fellow men and women.

Their mission remained essentially unchanged until after Vatican Council II when diminishing members of hospital-based women religious prompted a reassessment. A decline in priestly vocations also occurred. Pastoral care prior to Vatican II consisted of a priest chaplain who conducted a sacramental ministry. He said Mass, distributed Communion, heard confessions, and administered the last rites. He was also available for spiritual advice and support. With the decline in the number of both priests and religious women there was, of necessity, an increase in what became known as lay ministers. Incidentally and relatedly, there had also been a shift in Catholic hospital board control from the respective orders' religious sisters to lay persons who oftentimes did not have the years, or decades, of religious formation that the sisters had.

The emphasis prior to Vatican II was on the sacraments: the Mass, Communion, Penance, and Extreme Unction. Since Vatican II there has, understandably, because of the decline in the number of

priests, been a shift to health-care counseling. This includes end-of-life counseling, grievance assistance, family bereavement efforts, and supportive therapy. As more pastoral-care and counseling courses and academic programs become available over the Internet, this trend will continue. Indeed, there has arisen a cottage industry of seminars, retreats, and degree programs (M.A. and Ph.D.) to provide the academic tickets for nowmandated pastoral-care certification requirements.[12]

The results of the Chicago Study suggest that pastoral care in Chicago Catholic hospitals remains strong and well supported by the boards, CEOs, and administrations of the twenty-one Catholic hospitals. We are encouraged by this. Because of this commitment to Catholic hospital identity, the Catholic Physicians' Guild of Chicago feels that, where possible, Catholic doctors should consider referring their patients to Catholic hospitals.

We must note, however, the lack of commitment to natural family planning in Chicago Catholic hospitals. This is an important aspect of health-care ministry, and we encourage its more widespread promotion.

One final point. While pastoral-care coordinators are becoming better trained and more professional (given the workshops and degree programs), they should not lose sight of the primary role of the Sacraments in Catholic health care and ultimately in the eternal salvation of our patients' souls. Pastoral care should promote the primacy of the Sacraments: Mass, Communion, reconciliation, and the sacrament of the sick. This emphasis is specifically articulated by the local bishops when they oversee "the celebration of the Sacraments for the sick in healthcare settings."[13]

It might be noted that pastoral care is not unique to Catholic hospitals. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has guidelines for pastoral care, and all major non- Catholic health-care centers have pastoral-care departments. In Chicago these include Northwestern University Medical Center, the University of Illinois Hospital, and the University of Chicago Hospital (which calls its component "Religious Care"). Catholic health care is unique in that a significant aspect of its spiritual care is in the form of the sacraments. Catholic hospitals in all probability will be confronted with expanded pastoral-care needs. They will therefore have to be even more creative in the use of their resources in this regard. Perhaps local parishes can share priests, but this would require approval by the local bishop. Recruiting motivated volunteers and then supporting pastoral-care certification for them is another option. Adequate funding must be provided by the hospital, no small feat when hospital budgets are tight.

Summary

Pastoral care is an essential component of Catholic hospital ministry. There is concern that Catholic identity has eroded with the decline in religious sisters in direct hospital administration, as well as the decrease in hospital priest chaplains. The Catholic Physicians' Guild of Chicago has surveyed pastoral care in the twenty-one Catholic hospitals in the Archdiocese of Chicago and concludes that pastoral care remains strong. Pastoral counseling and sacramental ministry are the strengths of pastoral care, and our commitment to them must remain strong. As long as it does, the Catholic Physicians' Guild of Chicago does not share Fr. Mc- Cormick's pessimism.

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The Votive Temple of the Medical Doctors of Italy: the History of a Sanctuary and its Founder

In a letter of 19 December 1941, the Bishop of Como, Msgr. Alessandro Macchi, expressed himself in the following words: 'When I think of God, my heart fills with joy. A lost town on a hill, an almost unknown time, now famous for its votive temple, raised up by a creative mind, Msgr. Cambiano, in memory of a class so worthy for its humanity, but at times whose true value is not always appreciated. Praise be to its creator, keenly-felt gratitude to all those who have helped in the magnificent undertaking of Msgr. Cabiano, sincere congratulations to he who with an intellect of love thought of illustrating the small town of Duno. May St. Luke, the patron saint of physicians, always help these great benefactors in the exercise of their most notable work and may they be, as the Holy Spirit wishes, always full of love!'.

The church to which this bishop referred in his letter was consecrated by him on 25 August 1938 and dedicated to Our Lady of the Rosary and St. Luke the Evangelist, the patron saint of physicians. On 3 October of the same year this church, called the 'votive temple of the medical doctors of Italy' was raised to the dignity of being a sanctuary. In addition, on 5 May 1940 the adjoining sacristy was inaugurated, a sacristy dedicated to all those medical doctors who had given their lives for their country and for humanity. This votive temple had in the meantime achieved a certain fame at a national level, as is borne out by the first two pilgrimages of medical doctors which were held respectively in November 1938 and June 1939.

This votive temple of the medical doctors of Italy was raised thanks to the initiative and the perseverance of Don Cambiano who at that time in Duno was engaged in the practice of his priestly ministry. Carlo Cambiano was born in Candilo, in the Province of Turin, on 6 February 1868. He was ordained a priest in 1897 and sent to Duno in 1899, in the Lombard lower Alps, as the spiritual vicar. Duno was a small town in Valcuvia, then in the Province of Como (at the present time it belongs to the Province of Varese. It is high up compared to the valley below (525m above sea level) and it was difficult to reach (it could only be reached by a mule's path or by journeying along a steep and difficult path).

From the moment of his arrival Don Cambiano began to attend untiringly to this small mountain settlement and its inhabitants, and he became within a few years a tireless engine of the religious and civil life of Duno. Amongst his initiatives we may remember the construction of a nursery school, the building of road for vehicles from the valley to the town, the public aqueduct, and an institute for the deaf and dumb.

Don Cambiano also found time to dedicate himself to literature and he published works of local interest (such as *Monografia di Duno* or *Duno e il Tempio Votivo dei Medici d'Italia*), of religious meditation (such as *Il figlio del tribune* on St. Martin), and of aphorisms of a health-care character (such as *Medicus* and *Medicus bilinguis*).

Don Cambiano, who felt feelings of gratitude and appreciation towards those who with commitment and self-denial were engaged in the medical profession, in 1937 expressed his esteem for those medical doctors who were working in the difficult context of the Spanish Civil War. When he learned that in the university world the idea was to create a sacrarium for medical doctors and students who had sacrificed themselves for their country he took the decision to build a temple that would commemorate all medical doctors, living and dead, who had been and were ready to sacrifice their existence to care for suffering humanity. In the intentions of this priest there was also the creation of a rest home for elderly medical doctors who had retired from their profession (this last project, however, never say the light of day).

To build the temple Don Cambiano thought of a using a house and its land in the centre of the village which had been donated by a woman parishioner with a clause which said that a church had to be built there. After he had the house demolished, in December 1937 he began the building work following a project drawn up by the architect, Cesare Paleni. The work was finished in May 1938 and so the new church could be consecrated in August 1938. A little time afterwards the building work on the sacrarium began, and this last was inaugurated in May 1940.

Don Cambiano, who already enjoyed the title 'Knight of the Crown of Italy' which had been conferred on him for the care that he had provided to military men who during the First World War controlled the territory of Duno, in October 1938 was appointed 'Rector of the Sanctuary', and in September 1940 he was also made 'Monsignor and Chaplain Extra Urbem of H.H. Pius XII'.

Msgr. Cambiano stayed at

Duno until his death which took place on 12 June 1943 after a long illness.

The Votive Temple of the Medical Doctors of Italy is a small and compact building, of rather classical features, located specifically in the centre of the town and surrounded by houses that are lived in. It is made up of two separate areas which are connected: the church with a circular plan and the adjoining sacrarium.

The entrance door of the church, the work of the sculpture Enrico Magrini, portrays in a summarising and symbolic fashion the human and professional characteristics of a physician; numerous specialist contexts in which the medical profession expresses itself are also illustrated. Above the entrance door there is an image of St. Luke the Evangelist, the patron saint of medical doctors. The inside of the church, which has marble tablets, has a Via Crucis made up of ceramic pictures and a wooden bas-relief portraying Our Lady of the Rosary with her child Jesus in her arms. At the sides of the altar there are two votive lamps that commemorate, respectively, living and dead medical doctors. The sacrarium, which has circular walls, has marble tablets in which are engraved the names of medical doctors who gave their lives, respectively, for their country and for humanity. The building is completed by a bell tower with its belfry and a small door which leads on to the sacrarium.

After the death of Msgr. Cambiano, custody of the sanctuary was entrusted to the Servants of Charity of the work of Don Guanella, who in December 1941 were entrusted with the running of the parish of Duno which has just been brought into being.

The Votive Temple of the Medical Doctors of Italy, despite its initial fame and a number of pilgrimages of medical doctors which took place during the first years after its inauguration, ended up by falling into a slow but steady decline. Only at the end of the 1990s (thanks to the joint initiatives of the Italian Society for the History of Medicine, the Order of Medical Doctors of the Province of Varese and the Faculty of Medicine and Surgery of the University of Insubria) was the sanctuary of Duno able to return to its ancient splendour.

In recent years this votive temple, at a time near to the feast of St. Luke (18 October), has been the location of a ceremony when medical doctors who have recently died in the practice of their profession are remembered by their biographical data being placed in a specific register and their names being engraved on a marble tablet in the sacrarium.

To go back to Msgr. Carlo Cambiano, the creator and founder of this sanctuary for medical doctors, in 1942 the journalist Giovanni Cenato wrote of him: 'Don Cabiano is not a doctor but as a doctor he has studied the soul, he has understood struggles and sacrifices. He has thought that these fight the implacable enemy and that at the decisive moment science, which is a human thing, is no longer useful. Then non-human science can intervene – knowledge of God. God can help, illuminate and infuse that extreme courage that raises up those who are about to fall. Light is also a weapon. He has believed that one had to say to physicians that Faith is a force. And he wanted to say this by raising up a church for them, dedicating it to them and offering it to them as a gift. And thus the Temple for Physicians of Duno was born. It is the house of their spirit which expresses at one and the same time hope and gratitude towards the Almighty. Nothing has been done in Italy, indeed in the world, which is similar. And not only this. This most pious of priests wanted to dedicate a sacrarium to medical doctors, he wanted that in this sacrarium would be written the names of those medical doctors who had fallen in performing their duty, both in peace and in war. It launches them into eternity without an exhibition of allegorical, grandiose and invasive monuments, which are often created more because of the vanity of those who remain than the piety of those who have left'.

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Anniversary Consultation 20 Years of European Chaplaincy 10 Years of the ENHCC (European Network of Health Care Chaplaincy)

London,
16-19 September 2010

Chronicle

LONDON, 16-19 SEPTEMBER 2010

On 9 July 2010, at the Pontifical Council for Health Care Workers, a meeting took place between Rev. Dr. Stavros K. Kofinas, an Orthodox priest, the coordinator of the European Network of Health Care Chaplaincy (ENHCC) and the coordinator of the Network for Pastoral Care in Health of the Ecumenical Patriarchate, and H.E. Msgr. Zygmunt Zimowski, the President of the Pontifical Council. Following this meeting, Msgr. Dariusz Giers, an Official of the Pontifical Council, was sent to the Anniversary Consultation of the ENHCC, which took place in London on 16-19 September on the occasion of the tenth anniversary of the creation of this network. Fifty-three participants went to London, the representatives of the hospital chaplaincies of forty European countries (amongst whom were many Catholic chaplains), both religious and lay people.

The opening ceremony took place in the famous St. Paul's Cathedral of London and was preceded by evensong. During the ceremony Msgr. Giers read out in English the address of greeting of the President of the Pontifical Council for Health Care Workers.

All the sessions of this meeting were held in the Westminster Thistle Hotel and were on the subject 'Chaplains in the Future – Giving and Receiving'.

The workshop was organised into four sessions in the following order: an initial prolusion; an introductory session with two supplementary papers; an examination in small groups of the questions addressed; and, lastly, a shared analysis of the conclusions proposed by each group.

The first session, which took place in the morning of Friday 17 September, began with a prolusion entitled 'The Chaplain and Changes in the Health-Care System' by Anne Vandenhoeck and this was followed by two papers which illustrated experiences in the French context (Pierre Bouisset/Anne Hummeau, 'The Hospital Chaplaincy in France Today', and in the English context (Richard Lowndes, 'The Chaplaincy/Spiritual Care in England. National Experiences and Envisaged De-

velopments'). During the subsequent debate the following problems were pointed out: the dual task of a hospital chaplain who, on the one hand, must understand the language of a health-care system and, on the other hand, must make the medical staff understand that within this system he performs a specific function; it is thus important for the chaplain to have an approach of openness towards health-care workers. Stress was laid upon the utility of documentation on the work carried out by the chaplain (evidence), although the difficulties of this were also pointed out (privacy).

The second session addressed the subject of 'The Chaplain and Religious Communities' (Dana Kalnina-Zake), seen from a Scottish perspective (Ewan Kelly) and a Belgian perspective (Axel Liegeois). As regards this subject, emphasis was placed on the need for awareness as regards one's vocation. A chaplain should know how to distinguish between spirituality and religion; spirituality also involves the ecclesial dimension, but there should be an avoidance of the promotion of one's own religious community. It is fundamentally important that the chaplain to concentrates on spiritual care and not on psychological counselling as such: he is called to heal rather than to treat.

The next session examined the subject 'Chaplains and Personal Growth' (Kirsti Aalto), and this was analysed in depth by a representative of Dutch chaplaincies (Anneke Kemper) and Irish chaplaincies (Kathleen O'Conor). It was stressed that in the context of a global (economic and moral crisis) and also with reference to the personal crises (burnout) of chaplains, it is important not to become discouraged, to try to advance in spiritual terms, and to grow in faith. In order to obtain balance and integrity as regards one's own personality, the help and support of colleagues and teams is essential.

With respect to chaplains who are priests, Pierre Bouisset and Anne Hummeau, representatives of French Catholic chaplaincies, emphasised that their presence in health-care centres is an important 'sign'. "Often today", they observed, "the teams of a chaplaincy do not include the figure of the priest. However, his presence is special. A priest is appointed by the bishop to accompany the team and to implement through his presence the connection with the local diocesan church. In the name of the Church he accepts what is experienced by the members of the team and expresses openness towards acceptance of the gift of God. He is a 'sacramental presence' at the side of the sick and the elderly: he reconciles people with God, anoints

with consecrated oil, and in union with the team celebrates Holy Mass, thereby manifesting how much the whole of the mission with the sick and the suffering is rooted in the Eucharist".

During the final session of 19 September the handing on of the position of coordinator of the ENHCC took place. Father Kofinas was replaced by Dr. Anne Vandenhoeck, a Belgian and a teacher of theology at the Catholic University of Louvain, who was elected unanimously by those taking part in this Anniversary Consultation. The new coordinator of the ENHCC, after expressing her thanks for the trust that had been expressed in her, accepted with gratitude her new post and presented the guidelines at the level of its programme for the future of the association. It was decided that the next consultation of the ENHCC would take place in Holland in 2012.

The meeting took place in a friendly and respectful atmosphere and seems to have achieved its goal, that is to say an exchange of experiences as regards European hospital chaplaincies, in order to assure to sick people more adequate and efficient spiritual care. Here it should be pointed out that the terms that were most frequently used during the deliberations of the meeting were training, quality of service, transparency, humility, spiritual growth, witness and faith. To strengthen their faith, the organisers of the London consultations planned daily prayer meetings in churches, in a hospital chaplaincy, and during the sessions.

More detailed information on the Anniversary Consultation 2010 can be obtained by consulting the web page of the ENHCC:
www.eurochaplains.org

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

Address of H.E. Msgr. Zygmunt Zimowski

OPEN CEREMONY – ST. PAUL'S CATHEDRAL, LONDON – 16 SEPTEMBER 2010

Dear Rev. Dr. Stavros Kofinas, Coordinator of the European Network of Health Care Chaplaincy,

Dear chaplains, representing many Churches and denominations of numerous European countries,

And all those taking part in this opening ceremony, which is taking place in this beautiful cathedral church dedicated to St. Paul, Apostle of the Nations,

At the outset let me express my deepest gratitude for the invitation to take part in this *Anniversary Consultation* in London while you celebrate twenty years of European chaplaincy and the tenth anniversary of the foundation of the European Network of Health Care Chaplaincy (ENHCC).

Fr. Stravros Kofinas, I greatly appreciate the mission and work of the ENHCC and, let me say this loudly, it was a great honour for me to receive you at my offices in the Vatican this summer. I was able to learn from you about the story and activity of the Network and also to admire your zeal and your dedication to our sick brothers and sisters. In recognition of your work I awarded you the Good Samaritan Medal, which the Pontifical Council for Health Care Workers gives to those who serve the sick and suffering in an exceptional way. Indeed as you noted 'we had an open and honest dialogue that formed the foundation for a relationship for cooperation in the future'.

The topic you have chosen to reflect upon throughout this *Anniversary Consultation* concerns the future: '*The Chaplain in the Future – Giving and Receiving'*. Nowadays many people are anxious and even scared about the future, seeing it as insecure and unstable. For those of us who are involved in pastoral care in health, we face a challenge concerning how we can continue to serve and minister to the spiritual needs of those who suffer within a society that has become secular, pluralistic, relativistic, and often hostile and aggressive towards faith and religious values.

The Holy Father Benedict XVI, who in these days is visiting England, spoke very inspiring words on the future. In a homily that he gave this year in the Basilica of Saint Paul's Outside the Walls in Rome on the vigil of the feast of the Holy Apostles Peter and Paul (28 June 2010), he said: 'The Church is young and open to the future. And I repeat this today, *close to the tomb of St Paul*. The Church is an immense force for renewal in the world. This is not, of course, because of her own strength but because of the power of the Gospel in which the Holy Spirit of God breathes, God Creator and Redeemer of the world. The challenges of the present time, the historical and social and, especially, the spiritual challenges, are certainly beyond the human capacity. It sometimes seems to us Pastors of the Church that we are reliving the experience of the Apostles when thousands of needy people followed Jesus and he asked them: what can we do for all these people? They were then aware of their powerlessness. Yet Jesus himself had shown them that *with*

faith in God nothing is impossible and that a few loaves and fish, blessed and shared, could satisfy the hunger of all. However, there was not and there is not hunger solely for material food: *there is a deeper hunger that only God can satisfy*. Human beings of the third millennium want an authentic, full life; they need truth, profound freedom, love freely given. Even in the deserts of the secularized world, man's soul thirsts for God, for the living God'.

Since its foundation, the Church has taken to heart the mission entrusted to it by its Teacher, not only to give food to the hungry but also to care for their souls and bodies. Jesus sent out the Twelve Apostles with power to cast out unclean spirits and to cure all kinds of diseases and sicknesses. He said: "as you go, proclaim that the kingdom of heaven is close at hand. Cure the sick, raise the dead, cleanse the lepers, cast out devils. Freely you received, so freely give" (Mt 10:7-8). And down the centuries the health care ministry has been an excellent example of satisfying the spiritual hunger of people, of *receiving* from God's grace and *giving* to those who suffer. And I am persuaded that there is no other future for the Church and for its ministers than freely giving what we have received from the bounty of God.

In conclusion, I would like to say that I am the head of a very special Dicastery of the Roman Curia. Its name is the Pontifical Council for the Health Care Workers. It was instituted in 1985 by the Servant of God, Pope John Paul II. The main purpose of this Pontifical Council is 'to manifest the Church's concern for the sick, assisting those who perform a service for the ill and the suffering, so that the apostolate of mercy they carry out will increasingly respond to new demands' (Apostolic Constitution *Pastor Bonus*, n. 152).

Therefore, I want to express my closeness to all chaplains, especially to those associated with the European Network. In a spirit of union and brotherly love, I bless everyone of you and your work and I pray that you will continue to be a light of hope for the future of the health care ministry in Europe and the entire world.

With respect and admiration, and wishing you a very successful meeting,

H.E. Msgr. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers, the Holy See.

Chaplains in the Future: Giving and Receiving

OPEN CEREMONY – ST. PAUL'S CATHEDRAL, LONDON – 16 SEPTEMBER 2010

It took ten years for our Network, which has now travelled for ten years, to be founded. The journey started in the Holy Land when Sten Ludgren was travelling from Sweden. Sten was then head of the Pastoral Office of the Free Church of Sweden, a staunch ecumenist and a sincere pastor, a mentor for many. As he was travelling, he encountered a chaplain from another country. They started to talk about chaplaincy and, seeing how rewarding their exchange of experiences was, they came up with the idea of calling together chaplains from Europe together so that they too could have the same joy of sharing. So it was that the first meeting of representatives from European Chaplaincies gathered in October 1990 in Berlin. After that, meetings followed in Uppsala (1993), in the Netherlands (1994), in Bath, England (1996), and in Rome (1998). There, in Rome, it was decided that the next consultation be hosted by the Ecumenical Patriarchate in 2000 and would take place in Greece.

The journey of European chaplains was rewarding, but the question that was posed in Rome was a serious one: where are we going? For the meetings of European Chaplains seemed to be a journey without a destination.

Parallel to this journey, another journey was taking place, that of the European Union! The 1990s were the decade of rapid steps toward a united Europe. With the collapse of communism across central and Eastern Europe, Europeans become closer neighbours. With the signing of the 'Maastricht' Treaty on European Union in 1992, the dreams of a Common Market materialized, emphasising:

– the strengthen and the democratic legitimacy of European institutions
– the improvement of the effectiveness of European institutions
– the establishment of economic and monetary union
– the development of the social dimension of the EU Community
– the establishment of a common foreign and security policy.

In 1995 the EU members implemented the "Schengen Agreement" which gradually allowed people to travel without having their passports checked at the borders. Millions of people were able to open up even more channels of cooperation and communication, made easier, more and more, through the rapid use and continual development of internet and mobile tele-

phones. Thus, Europeans became concerned about how to act together in areas of other common concern, including that of health care. The Treaty of Amsterdam signed in 1997 laid down new principles and responsibilities in the field of the common foreign policy, with the emphasis on projecting the EU's values to the outside world, protecting its interests and reforming its modes of action. It formed a more consolidated structural basis of representation from the Member States so as to plan and implement common strategies.

By the time the 23 representatives from 15 chaplaincies arrived on the island of Crete at the Orthodox Academy for the 6th. European Consultation of Hospital Chaplaincy, the socio-political background of Europe had rapidly changed. In the far horizon, with the developments that had taken place in Europe, the journey that the chaplains had begun in 1990 was acquiring a sense of direction. In Crete, it was clear that we were all now part of One United European Community! The question that had to be posed was: could we, should we, have a Single United Hospital Chaplaincy? It was evident that, if we were going to exist within a European framework, there was a necessity to have more cooperation between our respective chaplaincies and a need for a common standard that qualified what health care chaplaincy was and how it was practiced.

At the onset of the deliberations, the answer to this question seemed rather simple: "Yes!" "Of course!". It was commonly agreed that the time had come when the chaplaincies of Europe should come together under some sort of organization. The participants initially felt that there were more things that each shared in common than things that separated them. In fact, some of the national chaplaincies were already "networking" themselves with other national chaplaincies. There were, though, some initial concerns regarding the formation of a "united" chaplaincy due to the underlying differentiations in the administration of each chaplaincy, its relationship with its Faith group authority and the different perceptions of the meaning of spirituality. The main difficulty was the use of language in defining these differences, particularly within their specific cultural contexts. The greatest clash came in defining chaplaincy within a faith-centred context or in a secular context. Here, our discussion became intense. Until the last hour of deliberations, it seemed as though the journey toward some type of oneness would remain unfulfilled. Laistrygonians and Cyclops, the wild and angry Poseidon had surrounded our ship. Tensions rose, but our thoughts and excitement remained high. Our persistence in maintaining open communication and understanding prevailed. We all knew that if we brought these tensions along inside our souls, if our souls set them up in front of us, allowing our differences to polarize us, they would harm us. We all knew that if chaplaincy was going to survive within the socio-political and religious community of Europe, we had to reach our Ithaka, an Ithaka of mutual respect, of sharing and learning from one another, an Ithaka of high quality standards for European Chaplaincy, an Ithaka that expresses concern and care for all. On the last day, after much discussion and in the final hour, on Saturday, the 11th of November, it was agreed that the European Network of Health Care Chaplaincy (ENHCC) be formed and the Cretan Declaration was adopted.

In leaving Crete, the only thing that we had agreed on was a name. A small organizing committee was formed made up of myself, Fred Coutts, who offered to set up a website, Michael Möller-Herr of the Lutheran Church of Germany and Kirsti Aalto of the Lutheran Church of Finland, who graciously offered to host the next consultation in 2002. The main task of this working committee was to prepare a draft of the Standards for Health Care Chaplaincy in Europe. Meeting in Constantinople, today's Istanbul, at the Ecumenical Patriarchate, we collaborated, using what we had learned from the Cretan Consultation to form the draft.

Our meeting in Finland was panegyrical! The Standards were adopted, a coordinator was elected, and a network committee was appointed. Dublin, Lisbon and Tartu, Estonia, were the sites of the following consultations. During these meetings, a Constitution was adopted setting the precedent for a firm infrastructure, taking great efforts in explaining and helping others to understand who each of us was at a theological, clinical and cultural level. In Lisbon and Estonia, we began discussing special areas of concern, issuing a statement on palliative care and addressing end of life issues. More importantly, each time we met, a strong bond of professional and inter-personal relationships was formed.

After the founding of our Network, great efforts were made in establishing relationships across the Atlantic, with the American Association of

Professional Chaplains and with the Association for Clinical Pastoral Education (whose representative is attending our Consultation for the first time). We have opened pathways toward the Council of European Churches (CEC), the EU Policy Advisor for Religious Dialogue and with the Office of the EU Commissioner for Public Health, visiting their offices regularly and taking part in several EU dialogue meetings. In fact, it was because of our initiative that a special meeting was called by the office of the EU Commissioner on palliative care.

As Homer writes in the Odyssey about the journey to Ithaka, "Many cities did [we] visit, and many were the nations with whose manners and customs [we were] acquainted…"

Throughout these ten years, those that have been elected to serve the Network Committee have been in continual communication, meeting once in Dublin, once in Leuven and three times at the Ecumenical Patriarchate in Constantinople. Without the cooperation and dedication of those that served the Network Committee, we would have never progressed as we did. Here, I must underline the work done by Rev. Fred Coutts, our webmaster, who created and developed our website, making it a point of reference for us all. I can honestly say that without Fred's energetic effort and absolute commitment, our Network would have never progressed in its course of travel.

After ten years of journeying, our Network has reached a peak, or I should say a plateau, in our history. Over the past two years, some firm steps were made. One was that we established a dialogue with the Pontifical Council for Health Pastoral Care. This is important in that some 15 national chaplaincies of the Roman Catholic Church have participated in the Network. In my meeting with the members of the Council in Rome this past July, it was agreed that health care chaplaincy in Europe is entering a difficult phase due to a more secular understanding of what is termed as "spiritual", the attempt to minimize whatever is religious, particularly whatever is considered ecclesiastical. The Pontifical Council will assist us to connect with more countries in Eastern Europe, which has been difficult in the past, and to work with the Council of European Bishops' Conferences, an important body of the Roman Church.

In June of 2009, we met again with the directors of the Church and Society Commission (*CSC*), a commission of the Conference of European Churches (*CEC*), with the Deputy Secretary of the Office of the EU Commissioner of Public Health and the Policy Advisor for Religious Dialogue in the EU. What became apparent at all of these meetings was the request that we, as a renowned European organization, offer our knowledge and skills so as to enrich those who are concerned with health care in Europe. Instead of asking for recognition from EU officials, we were placed in a position where we were asked to contribute to the "Great Event of the European Union".

Following this request, the Network Committee decided that a small conclusive survey should be done so as to show how end of life issues are dealt with in each of our respective countries and chaplaincies. This was also a good follow-up from our last consultation. This comparative survey would be useful for all of us to learn from one another, while serving as a reference source for the bodies that we have been collaborating with over the past years. The survey was an important trail to test how we truly work together and contribute in a collective way. Unfortunately, this effort failed. Only eleven participating organizational bodies contributed.

The failure of this collective effort raises some basic concerns about the future of our Network. Has our journey to find Ithaca come to a standstill? Have we lost our sense of motivation? Have we become engulfed in the disenchantment of a United Europe, a disenchantment that pervades our day and time, causing us to retreat into ourselves?

As stated in the Cretan Declaration that was adopted at the onset of our journey, our Network was founded on two major factors:

1) a clear understanding of ourselves and how we relate to one another at a theological, cultural, psychological and practical/clinical level

2) the promotion of a high standard of spiritual health care within our national organizations, in Europe and the world at large.

Over the past ten years as the Network's Coordinator, it has been my firm belief that the existence of our Network depends on one more important factor: *our ability to contribute to the challenges of health care at all levels by building bridges of communication, forming relations hips of trust and cooperation and by being a expression of care.*

This last point is the denominator that can give us the incentive to move on. We cannot exist just by inertia, by remaining self-centred and self-confining in our national situations. We are professionals who proclaim the message of hope through care. Thus, our contribution to the challenges of today's European society and in health care particularly, is not a theoretical or academic one. It is a way of expressing our concern for those that are in need of a care that only

we can offer. If we retreat into our national situations and do not make efforts to look at ourselves as part of a whole and expressing care for that whole, we will dwindle, not only as a Network, but as caregivers. Our Journey will come to an end.

We are entering a difficult time in history in which all the institutions and establishments that once offered a sense of stability are being questioned. Well defined social and cultural entities of the past seem to have liquidated. In the name of "multi-culturalism" and "multi faithism", all seem to be one, but there appears that we have lost the "One", that there is not a "Someone" outside our selves that keeps us together. This poses a new challenge to chaplaincy organizations to work together: to help people, in these troubled times, to regain their faith in a Philanthropic God and to learn how to except genuine care. For, as Ecumenical Patriarch Bartholomew told us when we met with him, our mission is to be a living expression of God's Philanthropy. It is a mission that *does not know geographical boundaries, does not distinguish race, people or language, is directed indiscriminately and without exception to all men and women, who are created in God's image.*

So it is that, as at all of our previous gatherings, we are called upon to make this anniversary meeting a historic one. A new coordinator will be elected, as my term is ending. In these coming days, we will have to seriously discuss how our journey will progress in the sea in which we are sailing in a time of history that that is encountering many storms. In examining who the chaplain of the future will be, we must also define how the chaplain can be a vessel of care, an example of how one can give and receive. In doing this, we must also examine how our Network can also be a better vessel of care. How we can find better ways in giving to one another and receiving and accepting one another at a personal and cross-national level? As in Crete ten years ago and all our following consultations, I am sure that if we will keep Ithica in our mind, we will continue in our continual goal of networking.

Fr. STAVROS KOFINAS
Coordinator
of the European Network
of Health Care Chaplaincy

http://www.vatican.va/roman_curia/pontifical_councils/hlthwork/index.htm

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