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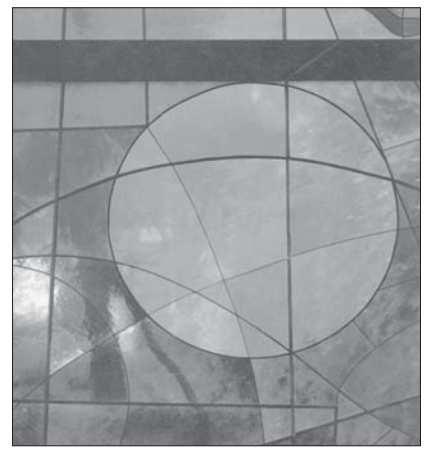
Organised by
the Pontifical Council
for Health Care Workers

Caritas in Veritate
Toward an Equitable and Human Health Care

November 18-19, 2010

New Synod Hall
Vatican City



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The illustrations in this edition are taken from the book:
Dove il cielo ha toccato la terra
by P. Girolamo Salvatico
Elledici - Editrice Velar, 2010

Message of the Holy Father Benedict XVI to the Participants in the XXV International Conference of the Pontifical Council for Health Care Workers

To my Venerable Brother
Archbishop Zygmunt Zimowski,
President of the Pontifical Council for Health Care Workers,

With joy I wish to send my cordial greetings to those taking part in the Twenty-fifth International Conference which well belongs to the year that celebrates the Twenty-fifth Anniversary of the creation of the dicastery, and offers a further reason for thanking God for this valuable instrument of the apostolate of mercy. A grateful thought goes to all those who strive, in the various sectors of pastoral care in health, to live that *diakonia* of charity which is central to the mission of the Church. In this sense, I am happy to remember Cardinal Fiorenzo Angelini and Cardinal Javier Lozano Barragán who led this Pontifical Council for Health Care Workers for twenty-five years, and I address a special greeting to the current president of the dicastery, Archbishop Zygmunt Zimowski, as well as to the Secretary, to the Under-Secretary, to the Officials, to those who work with it, to the speakers at this Conference, and to all those present.

The subject chosen for this year – '*Caritas in veritate*. Toward an Equitable and Human Health Care' – is of special interest for the Christian community, where care for man is central because of his transcendent dignity and inalienable rights. Health is a precious good for the person and society which should be promoted, conserved and defended, with an allocation of the necessary funds, resources and energies so that more people can enjoy it. Unfortunately, the problem still remains today of many populations of the world that do not have access to the necessary resources to satisfy fundamental needs, particularly with regard to health. It is necessary to work with greater commitment at all levels so that the right to health is made effective, fostering access to primary health care. In our epoch we are witnessing, on the one hand, health care that runs the risk of being transformed into pharmacological, medical and surgical consumerism, almost becoming a cult of the body, and, on the other, the difficulty that millions of people have in gaining access to minimal conditions of subsistence and to medical products that are indispensable to their treatment.

Also in the field of health – an integral part of the existence of each individual and of the common good – it is important to install true distributive justice that assures to everyone adequate care on the basis of objective needs. As a consequence, the world of health cannot avoid the moral rules that must govern it for it not to become inhuman. As I emphasised in the encyclical *Caritas in veritate*, the Catholic Church has always stressed the importance of distributive justice and social justice in the various sectors of human relationships (n. 35). Justice is promoted when one welcomes the life of the other and one takes responsibility for him, responding to his expectations, because in him one perceives the very face of the Son of God, who became man for us. The divine image impressed in our brother is the foundation of the most high dignity of every person and generates in everyone the need for respect, care and service. The link between justice and charity, from a Christian point of view, is very close: 'Charity goes be-

yond justice, because to love is to give, to offer what is "mine" to the other; but it never lacks justice, which prompts us to give the other what is "his", what is due to him by reason of his being or his acting…If we love others with charity, then first of all we are just towards them. Not only is justice not extraneous to charity, not only is it not an alternative or parallel path to charity: justice is inseparable from charity, and intrinsic to it. Justice is a primary way of charity (*ibid.*, n. 6). In this sense, with a summarising and incisive phrase, St. Augustine taught that '*justice consists in helping the poor*' (*De Trinitate*, XIV, 9: *PL* 42, 1045).

To bend down like the Good Samaritan to the wounded man, abandoned at the side of the road, is to perform that 'greater justice' that Jesus asked of his disciples and actuated in his life, because to act in conformity with the Law is love. The Christian community, following in the footsteps of the Lord, has obeyed the mandate to go out into the world 'to teach and heal the sick' and over the centuries it 'has felt strongly that service to the sick and suffering is an integral part of her mission' (John Paul II, Motu Proprio *Dolentium Hominum*, n. 1) to bear witness to integral salvation, which is health of the soul and health of the body.

The People of God, on a pilgrimage along the tortuous pathways of history, joins its efforts to those of so many men and women of good will to give a truly human face to health-care systems. Health-care justice must be among the priorities of the agendas of governments and international institutions. Unfortunately, side by side with positive and encouraging results there are opinions and lines of thought that wound such justice: I am referring to questions such as those connected with so-called 'reproductive health', with resort to artificial techniques of procreation involving the destruction of embryos, or legalised euthanasia. Love for justice, the defence of life from its conception until its natural end, respect for the dignity of every human being, should be supported and borne witness to, even when this is to go against the mainstream: fundamental ethical values are the shared heritage of universal morality and the basis of democratic co-existence.

A joint effort by everyone is needed, but what is also, and above all, needed is a profound conversion of the inner look. Only if one looks at the world with the look of the Creator, which is a look of love, will humanity learn to be on earth in peace and justice, directing with fairness the earth and its resources to the good of every man and every woman. For this reason 'I would advocate the adoption of a model of development based on the centrality of the human person, on the promotion and sharing of the common good, on responsibility, on a realization of our need for a changed lifestyle, and on prudence, the virtue which tells us what needs to be done today in view of what might happen tomorrow' (Benedict XVI, Message for the World Day of Peace, 2010, n. 9).

I express my nearness to my suffering brothers and sisters and an appeal to live illness, as well, as an occasion of grace to grow spiritually and to share in the sufferings of Christ for the good of the world, and I express to all of you involved in the vast field of health my encouragement for your valuable service. In asking for the maternal protection of the Virgin Mary, *Salus infirmorum*, in a heartfelt way I bestow upon you my Apostolic Blessing, which I also extend to your families.

From the Vatican, 15 November 2010

Inaugural Prayer

O God our Father, whose tenderness is bestowed upon every creature, to You, true love of life, we entrust the expectations regarding these days of listening and sharing; may it be a time of grace, a space of fraternity, an experience of sincere communion for the advent of your Kingdom of justice and of peace! Bless all of us, merciful Father, and make us worthy of serving you in man, willed by you in your image and infinitely loved.

Lord Jesus, Saviour and Redeemer of humanity, still today you pass amongst us doing good to everyone and proclaiming the inestimable preciousness of every human life. We recognise that we have been healed anew by your wounds, strengthened by your Spirit, sent to our brothers and sisters by the urgency of your compassion. Take us by the hand, Lord Jesus, and teach us to bend down with you before every creature who is sick in body and in spirit; make us know how to give new hope to so many of our brothers and sisters who are deprived of love, of health, of trust and of the wish to live praising your glory.

Holy Spirit of God, only from you, which you give to us without measure, do we receive abundance of life. Illuminate our minds and our hearts so that we know how to perceive the signs of your passing in the distracted world that surrounds us. Effuse your blessing on this assembly and confirm in us the intention to serve you in our weakest brothers and sisters through the humble and discreet offering of our presence; bless, O Spirit of charity, our work and our families, our consciences and the entire human community.

May we be accompanied by the maternal intercession of Mary, she, the Comforter of sorrows because she is the Custodian of hope, Prophecy of new times because Witness to your Gospel. Through total dedication to the Word made flesh, may there rise soon the dawn of that day when, every tear being dried, we know how to make shine forth in us and amongst us the beauty of your face and our dignity as your children! Amen.

Sr. MARIANNA CAPRIO
Mother Abbess of the Monastery of Monte Carmelo, Viterbo, Italy

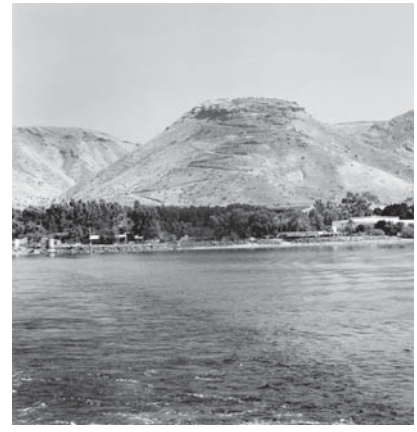
Caritas in veritate
Toward an Equitable and Human Health Care

thursday 18 november

Speech of Greetings and Opening Address by H.E. Msgr. Zygmunt Zimowski

I would like to thank Mother Marianna Caprio, the prioress of the Carmelite convent of Vetralla for this intense moment of prayer, and I greet all of you, coming from sixty different countries, at the opening of this twenty-fifth international conference organised by the Pontifical Council for Health Care Workers which is on the subject 'toward an equitable and human health care in the light of the encyclical *Caritas in Veritate*'. Indeed, you make up six hundred participants from:

Angola,
Argentina,
Austria,
Australia,
Bangladesh,
Belgium,
Benin,
Belarus,
Bolivia,
Brazil,
Burkina Faso,
Burundi,
Cameroon,
Canada,
the Czech Republic,
the Republic of China (Taiwan)
Columbia,
the Republic of the Congo,
the Democratic Republic
of the Congo,
South Korea,
the Ivory Coast,
Croatia,
Ecuador,
Eire,
France,
Georgia,
Germany,
Ghana,
Greece,
India,
Indonesia,
Italy,
Kenya,
Lesotho,
Liberia,
Luxembourg,
Malta,
Mexico,
Namibia,
Nigeria,
the Netherlands,
Panama,
Peru,
Poland,
Portugal,
Russia,
the Holy See,
Slovakia,
Slovenia,
Spain,
South Africa,
Switzerland,
Thailand,
Togo,
the Ukraine,
Uganda,
the UK,
the USA,
Venezuela
and Zambia.



And thus, at least in the most widespread languages: good morning and welcome to you all; *Bonjour et bienvenue à tous les participants*; *buenos dias y bienvenidos a todos*; *bom dia e benvindos a todos*; *herzlich willkommen*; *Sredecznie witam wszystkich uczestnikow z Polski*; *jambo na Karibu kwetu*.

On this happy and well attended occasion I have the honour and the pleasure to welcome Their Eminences Cardinal Tarcisio Bertone, the Secretary of State; Cardinal Raffaele Martino and Cardinal Peter Kodwo Appiah Turkson, respectively President Emeritus and President of the Pontifical Council for Justice and Peace; the two heads of Vatican ministries who the day after tomorrow will receive a Cardinal's hat and to whom once again I express with great joy my congratulations: His Excellency Monsignor Angelo Amato S.d.B, Prefect of the Congregation of Causes for Saints, and His Excellency Monsignor Gianfranco Ravasi, President of the Pontifical Council for Culture.

I also extend my greetings and welcome to the ambassador to the Holy See of the United States of America, His Excellency Miguel Diaz; the ambassador to the Holy See of Benin, His Excellency Loko Comlanvi; the ambassador to the Holy See of the Republic of China, His Excellency Larry Yu-Yuan Yang; the ambassador to the Holy See of Panama, His Excellency Delia Cardenas; and the ambassador to the Holy See of Togo, His Excellency Felix Sagbo.

We also have the pleasure to have here the representatives of His Eminence Cardinal Giovanni Lajolo, President of the Governorate, the Archiater, Dr. Patrizio Polisca, the Director of Health Care and Hygiene of the Vatican City, and Prof. Giovanni Minisola, Chief Consultant in Rheumatology at the Hospital of St. Camillus, Rome, as well as many other figures.

We have thus all come together in this New Hall of the Synod which on Saturday will be the setting for the much looked forward to consistory, to study and find pathways of for the implementation in the health-care field of the third and most recent encyclical of His Holiness Pope Benedict XVI, *Caritas in Veritate*.

It will certainly not be an easy task to identify and address some of the principal evils which, as is emphasised in this papal document, today threaten the health, the *salus*, of the human person, and thus to outline the basic approaches by which to promote fairness and humanisation in medicine and more in general in the field of suffering.

To help us, as we can already observe, there will be experts from all the continents of the world: ecclesiastics, men and women religious, and men and women members of the lay faithful.

We will thus focus in on the mission of the Church in favour of the sick, the promotion of 'humanised' and thus anthropocentric health care, and the role of health-care workers, civil society, institutions and private agencies in the promotion of justice, fairness and solidarity in the health-care field.

Health is recognised as being one of the fundamental human rights by the international community and it is a natural right: we are thus called to treat every person as our peer and to respect his or her dignity, giving him or her the same opportunities to grow and live in the healthiest way possible. All of this, as regards what is upheld on 'paper', encounters difficulty in being implemented: in the least industrialised countries of the world health-care institutions are still dramatically absent and basic medical products are inaccessible; in the West we run the risk of losing from sight the principles of care for the human person because of an overly 'technical' approach which ends up by ignoring the person of the sick individual in his or her entirety and his or her dignity.

Given the short time available to papers and respecting the many figures that will draw near to these microphones starting this morning, I will end my opening address by stressing that this conference has been conceived of and organised to contribute, in harmony with, and in the light of, *Caritas in Veritate*, to the mission of truth and justice that the Church is called to carry out by promoting, and where this is necessary by defending, a society that is really in harmony with man, his dignity and his vocation.

It only remains to me to entrust our deliberations to the protection of the Most Holy Mary, *Salus Infirmorum*, and to wish to everyone: good work; *bon travail*; *buenos travajos*; *bom trabalho*; *gute Arbeit*; *owocnej Pracy*; *kazi njema!*

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

Address of His Eminence Card. Tarcisio Bertone

Your Eminences,
Dear Brothers in the Episcopate,
Distinguished Authorities,
Ladies and Gentlemen,

I greet with affection all participants at this 25th International Conference organized by the Pontifical Council for Health Care Workers, on the topic *Toward an Equitable and Human Health Care in the Light of the Encyclical Caritas in Veritate*. I thank His Excellency, Archbishop Zygmunt Zimowski, President of this Pontifical Council, for the invitation extended to me to address this august assembly. My sincere gratitude goes to all who have worked closely with the President in the organization of this Conference, in particular the Secretary and Undersecretary of this Pontifical Council, and all members of the Staff. I welcome all the participants who have come from near and far, and wish you fruitful deliberations in these two days of study.

I wish also to extend my heartfelt congratulations to the newly nominated cardinals who will be speaking at this conference, His Eminence Gianfranco Card. Ravasi and His Eminence Angelo Card. Amato. Dear brothers, I welcome you to the College of Cardinals.

The topic for this Conference *Toward an Equitable and Human Health Care in the Light of the Encyclical Letter Caritas in Veritate*, puts forward the crucial issues of justice and human dignity in health care and invites us to address them from the perspective of charity in truth, which is the principle around which the social doctrine of the Church turns.

With respect to the topic, I wish to highlight four issues raised in the Encyclical, which among others, need to be taken into consideration if we are to ensure an equitable and human healthcare, namely: the prophetic mission of the Church, the duty of the State, the need for solidarity and subsidiarity, and the problem of intellectual property rights.

1. The Prophetic Mission of the Church

Pope Benedict XVI observes that "love in truth - *Caritas in veritate* - is a great challenge for the Church in a world that is becoming progressively and pervasively globalized" (*Caritas in veritate,* 9). Globalization makes people and nations inevitably interdependent, with the risk however, that this is not often "matched by ethical interaction of consciences and minds that would give rise to truly human development" (*ibid.*). Therefore, in the face of development that is not integral, that is, when it does not promote the good of every man and of the whole man, in front of a society that is not attuned to man, his dignity and his vocation, the Church has a mission of truth to accomplish.

The Church, which is God's family in the world cannot sit back and not address, for example, the persistent inequalities in the access to health care services. For indeed "the joys and the hopes, the griefs and the anxieties of the men of this age, especially those who are poor or in any way afflicted, these are the joys and hopes, the griefs and anxieties of the followers of Christ" (*GS*, 1). Though the Church "does not have technical solutions to offer," and does not claim to interfere in the politics of States, she however has a mission of truth to accomplish, so as to promote a society that is attuned to man and to his dignity and rights (Cf. *Caritas in veritate,* 9).

The deprivation of a right is a violation of human dignity and any threat to human dignity and life, must necessarily be felt in the Church's very heart; "it cannot but affect her at the core of her faith in the redemptive Incarnation of the Son of God, and engage her in her mission of proclaiming the Gospel of life in all the world and to every creature" (*EV*, 3).

2. The Duty of the State

The *Universal Declaration of Human rights of 1948* (Art. 25) listed health among those elements to which everybody should be able to have access. This paved the way to its definitive proclamation as a fundamental right in the *Alma-Ata Declaration of 1978* by the World Health Organisation. The Declaration states that: "Health… is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." At the basis of the doctrine of rights is the need to direct social organisation in order to ensure that everybody can meet their own essential needs.

Health is a social phenomenon that concerns not only the protection of individuals and their rights, but also the promotion of the common good. It is a fundamental good to which all should have access. The right to health of every human individual is a constituent element of a civil society and its legislation.[1] In other words it sets important obligations on the State. And therefore the "concern for the health of its citizens requires that society help in the attainment of living-conditions that allow them to grow and reach maturity."[2]

The right to health care demands that the state ensures equal access of its citizens, to health care services. This is in consonance with the equality of its citizens as human

beings, irrespective of their social or physical status and capability. Indeed as the Venerable, Pope John Paul II affirmed "nothing better than the right to health leads to the defence of the priority right to life and its quality, in the context of respect for the human person, created in the image and likeness of God."[3] Unfortunately, for various reasons this right is not always guaranteed for all citizens in the different parts of the world.

In the contemporary globalised world, where it seems that everything is reduced to a discussion of social questions and issues in merely economic and financial terms, a serious problem is raised when reference is made to health and the related question of economics and financing. It so happens that this right is not possible if the State does not guarantee access to health care to all of its citizens.

Caritas in veritate affirms that "if we love others with charity, then first of all we must be just to them. Not only is justice not extraneous to charity, not only is it not an alternative or parallel path to charity: justice is inseparable from charity, and intrinsic to it. Justice is the primary way of charity…. On the other hand charity demands justice: recognition and respect for the legitimate rights of individuals and peoples" (*Caritas in veritate*, 6).

Justice requires providing universal access to health care. Today it is commonly agreed that minimal levels of basic health needs must be provided as a fundamental human right. Thus in order to fully realise the right to health of its citizens the State has the obligation of adopting appropriate legislative, administrative, budgetary, judicial and promotional measures. This will include, among others, adopting a national health policy with a detailed plan for realizing the right to health. Besides, it has to ensure equal access to all the underlying determinants of health (safe food, water, housing and sanitation, and so on). Moreover, it is also the duty of the State to ensure that other providers of health care services (the private sector) conform with human rights standards, and that privatization does not constitute a threat to the availability, accessibility, and quality of health facilities, goods, and services.[4]

3. Solidarity and Subsidiarity

In general all developed countries provide all their residents with access to a broad set of public health and individual medical interventions. In these countries, access to care is assured despite income and wealth inequalities through universal coverage health systems. Though all of these health care systems assure universal access to all citizens, the services provided vary from country to country and from region to region. Moreover, in some countries, there are persistent inequalities, particularly with regard to certain disadvantaged groups, especially poor adults and children, refugees and immigrants, who for one reason or another may not be covered by the existing insurance schemes. All these need to have their rights respected and promoted.

The situation in most developing countries, especially those characterised by political instability and meagre resources leaves much to desire. Very often the respect and protection of the rights of the citizens, among which access to health care especially with regard to the common people, is far from being a reality.

To ensure access of the citizens to essential health services, one must see to it that the available resources/services are administered not only with humanity, but also with charity, having as a goal the protection and enhancement of the human dignity.

The response to situations of minimal resources is twofold: in the first place there is need on part of the political leaders, doctors, hospital administrators, and researchers, not to waste their resources which are already meagre but rather in respect of human dignity, they should use them to advance the common good. This requires practical and daily choices, which may not be easy but at the same time not impossible.

Secondly, there is need for solidarity between rich and poor nations in order to ensure universal access to medical care.[5] In *Caritas in veritate*, Benedict XVI makes a strong appeal for the "Co-operation of the Human Family." He notes that "the development of peoples depends, above all, on a recognition that the human race is a single family working together in true communion, not simply a group of subjects who happen to live side by side" (*Caritas in veritate*, 53).

In order to avoid paternalistic social assistance, which is demeaning to those in need, he urges that the solidarity of the rich nations to the poor countries be closely linked with the principle of subsidiarity.

If economic aid is to be true to its purpose, it must not pursue secondary objectives, for example being attached to specific anti-life healthcare policies, like the imposition of abortion in exchange for aid (*Caritas in veritate*, 28). Development aid ought to "be distributed with the involvement not only of the governments of receiving countries, but also local economic agents and the bearers of culture within civil society, including local Churches. Aid programmes must increasingly acquire the characteristics of participation and completion from the grass roots" (*Caritas in veritate* , 58).

At the level of each single nation, we have to remember that "there is no ordering of the State so just that it can eliminate the need for a service of love" (*Deus caritas est*, 28b). This means that even in the most just society, one can never do without *caritas*. We need therefore "a State which, in accordance with the principle of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spon-

taneity with closeness to those in need. The Church is one of those living forces" *in the health care field* (*Ibid*.).[6] Moreover, "the State which would provide everything, absorbing everything into itself, would ultimately become a mere bureaucracy incapable of guaranteeing the very thing which the suffering person – every person – needs" *(Ibid.).*

4. The Problem of Intellectual Property Rights

Lastly, in order to ensure equal or universal access to health care one has to make the required medicines not only available but also affordable. The main obstacles to this objective have proved to be the prohibitive costs and the limits caused by the patent license holders.

Thus *Caritas in veritate* denounces "the excessive zeal for protecting knowledge through an unduly rigid assertion of the right to intellectual property, especially in the field of health care" (n. 22). There is a war of interests between the owners of pharmaceutical companies and the developing countries where the economic capacity is very minimal. Moreover, the new medicines are protected by patent licenses leaving the monopoly to the holders of the same. And this usually results in high costs for the acquisition of the necessary drugs.

Profit as the exclusive goal "without the common good as its ultimate end, risks destroying wealth and creating poverty" (*Caritas in veritate*, 21). Development, if it is to be authentically human, must make room for the principle of gratuitousness, as an expression of fraternity. Definitely, the financial argument should be taken into consideration, but only as a means and not as an end. These economic imbalances and the resulting health problems can be counteracted by the growing awareness of the dignity of every human person and of radical human interdependence; which ensue in a greater sense of the need for solidarity.

Patent license holders should "never let financial gain prevail over the consideration of human values, but be sensitive to the needs of those who do not enjoy social security, carrying out effective programmes to help the poorest and most marginalized. … we must work to reduce and, if possible, eliminate the differences between the various continents, urging the more advanced countries to make available to the less developed their experience, technology and some of their economic wealth."[7] This will make them capable of providing for their own citizens, health services that are not only accessible but also qualitative.

Conclusion

Every human person has a right to health and demands absolute respect of his physical and spiritual life. By recognising health as a fundamental right, the legal system recognises and also takes seriously, the shared and equitable subjectivity of all human beings. Resources should be conformed to God's plan so that no one will feel excluded from the care owed to his person and his health, with respect for the equal dignity of all. This is a task to be undertaken by all responsible parties, on the international, national and local level, both private and public sectors, as well as individuals, who should be guided by the commitment to advance the common good in respect of the human dignity.

It is my sincere hope that during these two days of reflection the distinguished speakers will help the participants to delve more into these and many other issues raised by *Caritas in veritate*, with regard to the promotion of an equitable and human health care.

His Eminence Cardinal
TARCISIO BERTONE
Secretary of State,
the Holy See

Notes

[1] *CCC*, n. 2273.
[2] *CCC,* n. 2288.
[3] JOHN PAUL II, "Address to participants in the Plenary Assembly of the Pontifical Council for Pastoral Assistance to Health Care Workers," in *Insegnamenti* XIII/1 (1990), n.5, p.406.
[4] Cf. UNCHR and WHO, *The Right to Health*, Fact Sheet N.31, pp. 25-27 (ISSN 1014-5567).
[5] Cf. Address of John Paul II, at Ouagadougou 29 January 1990, n. 4, in Giorgio Filibeck, *Les droits de l'Homme dans l'enseignement de l'Eglise: de Jean XXIII à Jean-Paul II*, Libreria Editrice Vaticana Cité du Vatican 1992, p. 219. The Holy Father launched a solemn appeal to humanity and on behalf of humanity, in particular for the millions of African people who among others are threatened by the fact of never having good health and living in a dignified way, not to deny them their universal right to human dignity and security of life. See also John Paul II's "Address to the Constitutional and Diplomatic Corps at Yaunde in Cameroun," 12 August 1985, no. 9, in Giorgio Filibeck, *Les droits de l'Homme dans l'enseignement..,* p. 218.
[6] See also PIUS XI, *Quadragesimo Anno*, n. 79; JOHN XXIII, *Mater et Magister*, n. 53.
[7] JOHN PAUL II, *Address to the 14th International Conference organized by the Pontifical Council for Health Care Workers*, 19 November 1999, n.5.

PROLUSION

PETER KODWO TURKSON

Caritas in Veritate: Good News of Integral Health Care

I bring you all greetings and prayerful wishes for a successful conference from the Pontifical Council for Justice and Peace!

It is also my honour and pleasure to be with you at the beginning of this most promising Twenty-fifth International Conference organized by the Pontifical Council for Health Care Workers, on the topic "Toward an Equitable and Human Health Care in the Light of the Encyclical *Caritas in Veritate.* Whether one looks back, with gratitude, at the 25 years of existence of the Pontificial Council for Health; or at you, the delegates and participants from 60 countries around the world with all your rich experience; or ahead to the challenges of offering health services that are attuned to the dignity of man and his sublime vocation – it is a providential grace to take up *Caritas in Veritate* and meditate together on its significance for all the various ministries under the auspices of this Pontifical Council. May our Conference be a fitting thanksgiving for the countless blessings of the past 25 years as well as an urgent invocation for God's help to further the good health and indeed the whole good of each person – man, woman and child, – each social group and the whole of humanity (Cf. *Caritas in Veritate,* 18).

***Caritas in veritate*, a Papal Teaching**[1]

Announced in 2007 to mark the 40th anniversary of the encyclical *Populorum Progressio* of Pope Paul VI (1967) and the 20th anniversary of the encyclical *Sollicitudo Rei Socialis* of Pope John Paul II (1987), *Caritas in Veritate* was originally intended to celebrate the memory of these two encyclicals, especially for their treatment of the question of *true human development*. Since the *social issues* which beset development in the days of Pope Paul VI and Pope John Paul II have now become utterly global, *Caritas in Veritate* originally intended to take up human development in the new situation of a rapidly *globalizing world.*

The bewildering onslaught of the economic crisis of 2008-2009 motivated the Pope to address the meaning and ethics of *economics in the context of human development* in careful detail. This somewhat delayed the promulgation but, on 29th June 2009 (feast of Sts. Peter and Paul), the Holy Father signed his social encyclical addressed "to all people of good will" and promulgated it on 7th July (month of St. Benedict), just before the meeting of the G-8 in L'Aquila, Italy.

Caritas in Veritate is a social encyclical, like many others before it, beginning with Pope Leo XIII's *Rerun Novarum* (1891). [2] In it the insights of theology, philosophy, economics, ecology and politics have been harnessed coherently to formulate a social teaching that places the human person – his integral development and so his real health – at the centre of all world systems of thought and activity. The salvation of every human being was at the centre of the mission and ministry of Jesus Christ: as the *revelation of the love of the Father* (Jn 3:16) and *the truth of man's creation in God's image and of his transcendent vocation to holiness and to happiness with God.* This is the setting of the two concepts love and truth[3] which drive the encyclical. Love and truth not only lie at the heart of the mission and ministry of Jesus; they also correspond to the essential character and activity of human life on earth. The human person is a *"gift and love of God"* with a vocation, a divine calling, to *"become gift and love"* too. And this dynamic of charity received and given is what gives rise to Church's Social Teaching, which is *Caritas in Veritate in re sociale.*[4]

The *res socialis* or human society, the context and reference of the Church's Social Teaching, has changed over the years: from the misery of workers during the industrial revolution and the emergence of Marxism (Pope Leo XIII), the great depression of 1929 (Pope Pius XI), decolonization and the emergence of the *third world* (Pope John XXIII and Pope Paul

VI), political changes in Eastern Europe before and after the fall of the Berlin wall (Pope John Paul II), and now Pope Benedict XVI addressing globalization, underdevelopment, financial, economic, moral and anthropological crises.[5] In these remarkably changing situations, the Papal social encyclicals have continuously brought the Church's basic social principles up to date and re-applied them. So

"the Church's social doctrine illuminates with an unchanging light the new problems that are constantly emerging";[6] and this is precisely what the encyclical letter, *Caritas in Veritate*, seeks to do in our day.

So Pope Benedict is in full harmony with more than a century of Catholic social teaching about the human person. *Caritas in Veritate* addresses the complex conditions under which people develop integrally, in all the human dimensions and forms including illness and healing, under the challenging ideological conditions of our contemporary globalized world. Situating himself fully within the social teachings of the Popes before him, Benedict XVI refers especially to *Gaudium et Spes* (1965) of Vatican II and to *Populorum Progressio* (1967) of Pope Paul VI and *Sollicitudo Rei Socialis* (1987) of Pope John Paul II:

To underline the centrality of the human person, his well-being and total development, in all the activities of the human person (man).

To teach that man's activity, with which he builds the *earthly city*, is an anticipation of the *universal city of God* when his activity, inspired by love and justice, seeks the well-being of the human person, whole and entire.

And this is central *good news* of the encyclical *Caritas in Veritate*, the context for ever*y vocation* of the human person, including the vocation to the ministry of *healthcare delivery* as both medical and pastoral care workers.

Caritas in veritate as Good News

Let me illustrate the *good news* that *Caritas in Veritate* is even to the *"afflicted and infected"* with the real story of Rosanna. My personal secretary as Justice and Peace in San Calistro, Fr. Michael Czerny SJ, used to be the director of a Jesuit HIV-AIDS programme in Nairobi; and he shared this story with me, which I believe serves as a parable of our theme, the promotion of authentic and integral health in the light of *Caritas in Veritate:*

The Story: Rosanna is an abandoned mother in her late twenties, HIV-positive and struggling to get by in a Nairobi slum. "Six years down the line," she says, "my family has not accepted me, not my mother or sisters or husband. I've lost jobs because I'm HIV-positive." She also lost an infant daughter to AIDS, but her 10-years-old son – conceived before Rosanna got infected – is HIV-negative. Jomo is a bright, healthy boy who loves drawing and soccer. His mom tries to keep healthy, too, and says: "I want to see my son grow up".

From time to time, Catholic AIDS programmes invite Rosanna to tell groups the story of her difficult life, explaining her HIV status and encouraging young people to live well and to avoid the mistakes which lead to infection. Rosanna is grateful for help, but she seeks more. "Myself, I am young. I want to have a future even if I didn't finish secondary school. I want my son to be someone." Unable to do physically demanding work, she stands little chance of finding someone to hire her. But recently she had an enterprising idea: The landlords in her slum refused to provide water, telling the poor tenants to find it for themselves. So, with the help of a Catholic organization, she bought a storage tank and a pump and set up a water business. Things are going well, and she is paying back nearly 2% a month.

Knowing Rosanna, the Jesuit director of the programme was beginning to wonder what *Caritas in Veritate* might mean for her and Jomo when, providentially, she dropped in on him. So he gave her a four-page summary and, after an hour's careful reading, she came up with pretty clear ideas of how the Encyclical speaks to Jomo and herself.

Rosanna and Benedict XVI love life and see society much the same way. "I know the Encyclical is about the whole world," she said, "but when I read the Pope's words, he is talking exactly about Kenya, even my slum. He says that the market must not become "the place where the strong subdue the weak,' but it is." Billions of us live as neighbours to one another in our global village – or is it a global slum? – yet with too little fraternal relationship. "Kenyan authorities see the poor as a problem. If you do not have a job, they try to send

you back up-country. Our politicians feel supported by foreign aid and just take advantage of the poor." Accordingly, aid is misdirected and badly distributed; it creates dependence, generates corruption, abuses the poor and solves nothing. "Without ethics, we are in a total mess."

The Pope "is thinking in the right channel," Rosanna said, but many of us have become discouraged and, frankly, lazy. Addicted to sound-bites and ideological slogans, the local and global picture seems too complicated to understand. Ever more resigned to a fragmented world, we just let others ('the market') decide. And instead of ploughing through the Encyclical and thinking about what it means, we easily say it is too long and too heavy.

By contrast, Benedict XVI seems tireless in wanting to find the way forward. Without preaching, yet showing us how, the Pope invites us to think clearly about (our) society and (our) economy. He shows us how to put order into our thinking, keeping things in their proper places. Social science seeks the facts and the trends. Social policy implements governmental decisions about what to do; but only *we* (believing and thinking people) can weigh up the pros and the cons, only *we* can opt for the basic values and work for what is best under God for the whole human family.

For example, when Benedict XVI shows that respect for life and responsible sexuality are essential for development, Rosanna concurs. Honesty and true charity aren't born of selective or sentimental wishing; they hang on a complete picture of man which can only come from God. "In promoting development, the Christian faith does not rely privilege or positions of power," the Pope affirms, "but only on Christ," to which Rosanna adds: "So I urge the Church to show us what being a Christian is all about. Isn't it loving your neighbour; and loving him/her sincerely: in truth?"

The heart of the Encyclical is gift, gratitude, graciousness, gratuitousness. "Gift" and "gratuitousness" come up about three dozen times, and "graciousness" is Rosanna's word. To acknowledge the abundant gifts we receive is to be filled with gratitude. It is also the fundamental truth of our situation. So we are *creatures*_before we become investors, bosses or employees; each our *own person* but radically *related* to one another; *responsible,* but *not totally in charge.* Instead of doing whatever we like, as global culture cajoles us to, without reference to humanity and God, things will get better only if we each graciously, gratuitously give our best: mind, heart, goods, time, and energy even in the service of the sick, the aged, the handicapped etc.

And so, *Caritas in Veritate* is indeed very good news for society, in that the Holy Father calls upon Christians and people of good will to recall the *best* of what t means to be human, to be grateful to God for the myriad of ways in which He bestows his graces on us each day, and to use our gifts and talents, our resources: great and small, as gift to others and to make the world a better place.

So, just as *Caritas in Veritate* shed light on Rosanna's plight and prospects, I trust that her story opens up for some of its ways of addressing the issues surrounding the integral health-care of the human person, sometimes directly and often obliquely included in human development and well-being. Like Rosanna, we want to apply the Encyclical to our situation and our challenges.

Globalization is at once bringing people closer together, but ironically making us strangers (as Rosanna also observed). In spite of inventions and advance in technology millions (1/6 of the world population) go to bed hungry every night.[7] And in spite of all of the structures of international finance, development and diplomacy, wars, famines and disease rage on.

Life is the Foundation

When the Holy Father writes about his vision of human development, he reflects upon the fundamental need to respect the *right to life.*

Openness to life is at the centre of true development. When a society moves towards the denial or suppression of life, it ends up no longer finding the necessary motivation and energy to strive for man's true good (*CiV* 28).

Unfortunately, selfish and shortsighted ideologies claim to reduce harm but in fact attack life itself and violate the most fundamental components of human dignity, not do mention long-term health and happiness.

Some non-governmental organizations work actively to spread abortion, at times promoting the practice of sterilization in poor countries, in some cases not event informing the women concerned. Moreover, there is reason to suspect that development aid is sometimes linked to specific health-care policies which *de facto* involve the imposition of strong birth control measures. The British Ministry of International Aid announced, just before the Pope's visit to England and Wales, that Britain was going to *"hardwire"* the demand for reproductive health education in her aid-packages. Further grounds for concern are laws permitting euthanasia as well as pressure from lobby groups, nationally ad internationally, in favour of its juridical recognition... (CiV 28).

The truth about the human person demands that people of faith and good will recognize things for what they truly are – hatred is hatred, murder is murder, injustice is injustice – and political or ideological motives cannot serve as excuse not to recognize and to address these human problems. The long painful process of healing and reconciliation within families, between friends, and among nations and peoples can only begin when the truth has been established. New seeds of conflict are always sown when this truth is obscured or when vengeance dominates our thoughts and actions, as individuals and as a community. Only when the fundamental right to life is respected can the requirements of justice begin to be fulfilled.

Healthcare is both Physical and Spiritual

Caritas in Veritate is emphatic on the point that human develop-

ment is not reduceable to mere material and technological development. For the Holy Father, "the development of individuals and peoples is (likewise) located on a height, if we consider the spiritual dimension that must be present if such development is to be authentic. Similarly, healthcare and the wellbeing of the human person may not be limited to the "body", the merely physical component of the person. It must reckon also with both the psyche and the spiritual component of the person; and it is in this that the Holy Father goes beyond the MDG's and NEPAD's indication of disease control and access to healthcare, good governance, economic stability and growth, poverty eradication and food security as Africa's path to development and wellbeing to draw attention to the *"human heart, the seat of all that destabilizes the continent"*. It is thus the suggestion of *caritas in veritate* that healthcare delivery also include morality and a *care of the spirit/soul: the sickness of the soul.*

Healing the Sickness of the Spirit

Finally, we may describe the *good news* of the encyclical as the *healing of the spirit of man* and the *liberation of human culture.*

Shortly after the promulgation of the encyclical *Caritas in Veritate,* the Holy Father presided over the African Synod in October 2009. During the opening Eucharist in his homily, the Holy Father exhorted Africa and the Church in Africa to cherish its cultural and spiritual heritage, *"which humanity needs even more than raw material"*. *"From this point of view",* the Holy Father continued, *"Africa constitutes an immense spiritual 'lung' for a humanity that appears to be in crisis of faith and hope"*. The Pope appealed to Africa passionately to make sure that this *spiritual "lung"* was not infected by *"two dangerous pathologies":* religious fundamentalism combined with political and economic interest; and a disease already widespread in the Western world, namely, *"practical materialism, combined with relativist and nihilistic thought"*. The Pope referred to the latter as *"sickness of the spirit"* and *"spiritual toxic refuse"* which the so-called first world was exporting and thereby contaminating the peoples of other continents with it.

Just last May, at the plenary assembly of the *Pontifical Academy of Social Sciences,* eminent scholars and professionals described the *technical causes* of the current economic, technological and social crises, but also signalled very important *"remote causes"*. They identified these *remote causes* as *spiritual* and moral.[8] Though not quantifiable, the *spiritual factor* is present in every human activity, distorting it.[9] Thus the *Pontifical Academy* appeared to affirm with Pope John Paul II that *"sin and structures of sin are not categories which one applies often to the situation of the contemporary world. However, one cannot easily understand in depth the reality which stares us in the face without identifying the root of the evil which afflict us"*.[10]

Accordingly, addressing the plenary assembly of the Italian Bishops (May 27), Pope Benedict XVI also referred to the seriousness of the current economic crisis and affirmed the presence of an equally serious *spiritual and cultural crisis*[11] which should not be glossed over. And for the Pope, this *spiritual* and *cultural crisis in human.* The current crisis may be manifested in the area of economics, market, trade and business, in technology, ecology and politics; but it is ultimately anthropological in character.

This, then, for the Holy Father, is ultimately where the present crisis is to be located: in man, in the *"sickness of his spirit",* in his *culture* and *spirituality,* infected by the *"new and modern ideas"* which he calls *"spiritual toxic refuse"* and *"pathologies"*. The culture of our day, then, as the Pope affirms, *"has burdens from which it must be freed and shadows from which it must emerge"* (CiV,59); and the *Good News* is that, in the incarnation of Jesus, the *love of the Father* and the transcendent Word of God (*Logos)*, in *human culture*, every human culture, including that of our day, is offered the means of liberation to serve the well-being of humanity.

Caritas in veritate articulates this *means of liberation*; and it may be seen as an offer of a social teaching, rooted in and derived from the ministry of Jesus, who sets all things free, to continue *to fee man's culture, his state of mind and soul from burdens,* and to help them *emerge from shadows* of the so-called "new and modern ideas" which diminish man's vision of the truth and reduce his sense of healing to the organs of his body.

One manifestation of the *sickness of the spirit* is an emerging *misunderstanding of the human person, a mistaken sense of man.* The Holy Father analyzes the prevailing conception of man that in these fifty years human sciences and human engineering have produced. In the name of *science,* these otherwise beneficial fields have succumbed to a pervasive *ideology,* according to which *man is only the product of culture; and that he evolves/fashions himself independently of human nature and any universal laws inherent in his being.* Man mistakenly considers himself to be his own author, the author and master of his/her life and of his society (*CiV* 34). Man feels self-sufficient; and not only neglects or displaces God, but does away with God completely.

As a consequence of this sickness, man thinks he/she owes nothing to anyone except to himself; and he believes that he *only* has rights (Civ. 43) and no natural norms and responsibilities. The individual is thus the *master of his own existence and autonomous interpreter of its meaning.*

Indeed, there is in all of these a perverse dynamic at work in the continuous modern demand for more rights, the removal of every limit, and the progressive widening of the scope of man's action, up to contemplating the idea of self-reproduction. In fact, this dynamic, while it closes up man in a egoistic self-production, also prevents him from assuming any duties, without *which all rights are sucked into a self-referential spiral which eradicates every meaning.*[12] It is just as Pope Benedict XVI observes, *"appeals are made to al-*

leged rights, arbitrary and non-essential in nature, accompanied by the demand that they be recognized and promoted by public structures, while, on the other hand, elementary and basic rights remain unacknowledged and are violated in much of the world" (CiV. 43).

A link has often been noted between claims to a "right to excess", and even to transgression and vice, within affluent societies, and the lack of food, drinkable water, basic instruction and elementary health care in areas of the underdeveloped world and on the outskirts of large metropolitan centres (CiV. 43).

Thus disconnected from the *common good* and the *universal dimension of objective moral law* (natural law engraved on the heart of man), man now seeks in *majority opinion,* however unstable it may be, the basis for the determination of the morality of law. This has led to a moral and an anthropological deregulation, giving the impression that *norms are created solely by consensus. Moral law,* the highest instance of regulation of all laws, has been secularized and replaced by *civil law*, which is ascribed a *moral value*, by reason of the fact that it has been decided upon by *democratically-elected* governments claiming *consensus*. This has generated a lot of totalitarian points of view, position and ideologies; and the human being is himself the first victim. Denied as a reality in himself/herself, the human person is increasingly being considered *self-creating* and the *product of culture.*

Another false ideology also lead to the false *utopia of a return to humanity's original natural state.* This detaches progress from its moral evaluation and human responsibility (CiV 14), and it reveals a desire to *deconstruct conceptions about the human person and its institutions* (man, woman, family, marriage, children and their education etc.). The truth about man would then be freed of all models and moulds. Man would not be differentiated in anyway. All would be equal, and all would be the same. This introduces us into the ante-chamber of the *general theory!*

Ecological Health and the Integral Human Health

In recent years a whole new dimension of health and sickness has opened up to human awareness and now demands urgent attention. We call it *environment* or *ecology,* and it has to do with the soundness and sustainability of our habitat, the earth. Largely neglected until now, the emerging problems – or even crises – of the environment *"The* significant new elements in the picture of the development of peoples today in many case demand *new solutions*. These need to be found together, respecting the laws proper to each element and in the light of an integral vision of man, reflecting the different aspects of the human person, contemplated through a lens purified by charity" (CiV 32). In the rush to face the new urgencies, some thinking and planning go too far, elevating nature above man and seeing man as a threat to nature. In his ever balanced way, Pope Benedict addresses ecology within the larger picture of both Creation and its Creator who is Our Father. Our intelligent attention "is demanded, in any case, by the earth's state of ecological health; above all it is required by the cultural and moral crisis of man, the symptoms of which have been evident for some time all over the world. (CiV 32). In your discussions during this conference, ecological issues of pollution, lack of drinking water, agricultural livelihoods spoiled by reckless exploitation of resources and other properly environmental issues will impose themselves as important and indeed basic conditions for human health, especially of the poor and marginated.

Psycho-spiritual Health

As if to help us put all the previous considerations into their greatest context, towards the end of the Encyclical the Holy Father addresses what we might call the culminating threats to human health, namely the collective mental illness born of false ideologies and false development which threaten our human well-being. Let us listen to a longer citation and notice how Pope Benedict brings together the many strands of human development into this consideration of the health and well-being of "the whole man and of every man" (Paul VI).

One aspect of the contemporary technological mindset is the tendency to consider the problems and emotions of the interior life from a purely psychological point of view, even to the point of neurological reductionism. In this way man's interiority is emptied of its meaning and gradually our awareness of the human soul's ontological depths, as probed by the saints, is lost. *The question of development is closely bound up with our understanding of the human soul,* insofar as we often reduce the self to the psyche and confuse the soul's health with emotional well-being. These over-simplifications

stem from a profound failure to understand the spiritual life, and they obscure the fact that the development of individuals and peoples depends partly on the resolution of problems of a spiritual nature. *Development must include not just material growth but also spiritual growth [and health],* since the human person is a "unity of body and soul", born of God's creative love and destined for eternal life. The human being develops when he grows in the spirit, when his soul comes to know itself and the truths that God has implanted deep within, when he enters into dialogue with himself and his Creator. When he is far away from God, man is unsettled and ill at ease. Social and psychological alienation and the many neuroses that afflict affluent societies are attributable in part to spiritual factors. A prosperous society, highly developed in material terms but weighing heavily on the soul, is not of itself conducive to authentic development. The new forms of slavery to drugs and the lack of hope into which so man people fall can be explained not only in sociological and psychological terms, but also in essentially spiritual terms. The sense of *emptiness [or malaise]* in which the soul feels abandoned, despite the availability of countless therapies 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 (CiV 76).

Conclusion

The *good news* for integral health care grounded in *Caritas in Veritate* is best summed up by these words of our Holy Father:

In every truth there is something more than we would have expected, in the love that we receive there is always an element that surprises us. We should never cease to marvel at these things. In all knowledge and in every act of love the human soul experiences something 'over and above', which seems very much like a gift that we receive, or a height to which we are raised.

The development of individuals and peoples is likewise located on a height, if we consider the spiritual dimension that must be present if such development is to be authentic. It requires new eyes and a new heart, capable of *rising above a materialistic vision of human events*, capable of glimpsing in development the 'beyond' that technology cannot give. By following this path, it is possible to pursue the integral human development that takes its direction from the driving force of charity and truth (CiV 77).

Let me conclude in the way I began. For Rosanna, forgiving her relatives, living for Jomo and his future, teaching youth to be responsible in the face of AIDS, leading a little support group for HIV-positive women, selling water to her neighbours – all helped prepare her to read and appreciate *Caritas in Veritate* very much. I am sure she has helped us to enter into the Encyclical, too. The message is in the title, *THINK! LOVE!* We must do both if Rosanna and Jomo and we are to have authentic human development and health.

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Notes

[1] The reception of the encyclical, having something for everybody to identify with, has been great. Within 30 days of its publication, Vatican Radio counted about 4,300 articles on the encyclical in English, French, Italian, Spanish and Portuguese on the web. The *Meltwater Group,* extending its survey to other languages, counted 6,000 articles on the encyclical (cf. Gianpaolo Salvini SJ., "Enciclica 'Caritas in Veritate', in *La Civiltà Cattolica* #3822, 19 Sept 2009, 458.

[2] Counting the letter of the *Sacred Congregation of the Council* to Mons. Liénart, Bishop of Lille, on 5 June 1929; *Gaudium et Spes* and *Dignitatis Humanae* of Vatican Council II; the second half of *Deus caritas est";* and the Instruction: *Dignitas Personae, on certain bioethical questions* from the Congregation for the Doctrine of the Faith (8 Dec. 2008), one may reckon 22 official documents on the social teaching of the Church (cfr. *Le Discours social de l'Église Catholique: De Léon XIII à Benoit XVI,* Bayard Montrouge 2009).

[3] The introduction to the encyclical is devoted to the meanings of these two concepts: *love* and *truth,* their relatedness, their rooting in the life of the Triune God, their revelation to man through Christ, and their distortions at the hands of men and in human history. Jesus who reveals and shares them with is also the one to liberate and free them from human distortions.

[4] *Caritas in Veritate*, no. 5

[5] Cf. *ibid.* no. 75.

[6] Cf. *ibid.* no. 12; *Solicitudo rei socialis*, no.3.

[7] United Nations *2009 World Hunger Report.*

[8] They have to do with g*reed* and ideological/theoretical *presumptions.*

[9] Thus discourses about the human being and about his vocation lose sight of his inner being and character: *spirit (soul) and body, corporal* and *spiritual*, which is the specific nature of man (cfr. *Sollicitudo Rei Socialis*, no. 29) and economics and business life are also distorted by presumption about the infallibility of false economic theories, while, out of greed, human labour is replaced at the center of the creation of wealth by *financial activity*, carried out not as a Thought", *Plenary Assembly of the Pontifical Academy of Social Sciences,* Vatican City, 1 May 2010.

[10] *Sollicitudo Rei Socialis*, no. 36.

[11] *"...una crisi culturale e spirituale, altrettanto seria di quella economica"*. He went on to say: *"Sarebbe illusorio – questo vorrei sottolinearlo – pensare di constatare l'una, ignorando l'altra"* (Benedetto XVI, "Discorso all'assemblea della Conferenza Episcopale Italiana", 27 maggio 2010).

[12] Cf. Fontana, S., *Per una Politica dei*

GIANFRANCO RAVASI

Euntes docete et curate infirmos (*Mt* 10:7-8). The Urgency and Biblical Pertinence of the Mission for the Sick

The lips and the hands of Jesus are two capital presences in the Gospels. On the one hand, there are his words which trouble and comfort, which preach the 'gospel', the good news of salvation, which lead to conversion, to being followed, and to a commitment to build up the Kingdom of God. On the other hand, however, there are his acts of healing, his bending down over sick flesh, his 'touching' of the devastated or inert bodies of a very large number of marginalised people. Indeed, in the New Testament the Greek word '*áptein*', 'to touch' (in the 'median' form), occurs thirty-nine times, whereas the word 'hand', '*chéir*', occurs as much as 177 times.

The Hands of Jesus

Let us choose at random some examples of this. The case of the lepers is emblematic: 'A man suffering from a dreaded skin disease came to Jesus, knelt down, and begged him for help. "If you want to", he said, "you can make me clean". Jesus was filled with pity and stretched out his hand and touched him. "I do want to", he answered, "Be clean!" At once the disease left the man, and he was clean' (Lk 1:40-41). In Israel this affliction was considered to be – because of the famous 'thesis of retribution' (crime-punishment, thus illness-sin) – an unspeakable shame. A leper, therefore, was not only a sick person but also and above all an excommunicated person. It was thought that he or she had been punished by God because of a very grave sin, he or she was forced to live on the outskirts of inhabited centres, usually in ghetto-caves or, like Job, amongst refuse, and was forced to indicate his or her presence as soon as a healthy and normal citizen appeared on the horizon. Indeed, one can read in the Biblical book of Leviticus: 'A person who has a dreaded skin disease must wear torn clothes, leave his hair uncombed, cover the lower part of his face, and call out "Unclean, unclean!"…and must live outside the camp' (Lev 13:45-46). He was, as a consequence, an individual who was socially dead, repulsed with horror by the faithful who feared that they would be infected not only physiologically but also, and above all else, morally and at a sacral level.

Jesus, instead, meets this man on his journey, draws near to him, and reaches the point of touching him. Not only does he not condemn him but, as Mark observes, he is profoundly moved (*splanchnisthéis*), he heals him and he sends him to the priests, almost as a point of irony, in order to receive an official attestation of his healing and readmission to civil society. In abolishing all the taboos of the ethical-judicial case studies of that epoch, this miraculous act has the characteristics of an original and even provocative form of behaviour of Christ who privileges care for the suffering over sacral ritualism. On other occasions, instead, it is pure and simple daily routine that is entrusted to the hands of Jesus. We may think of the case of the mother-in-law of Peter who was suffering from a fever. The two hands of the Saviour and the sick women are intertwined: 'He went to her, took her by the hand, and helped her up. The fever left her' (Mk 1:31); in Mt 8:15 one reads: 'he touched her hand', almost taking her pulse as one does when one measures the accelerated heart beats of a person who had a fever).

On other occasions the gesture is even more concrete and direct, as when Christ 'put his fingers in the man's ears, spat, and touched the man's tongue' (Mk 7:33), thereby referring back to an archaic therapeutic praxis which held

that some of syndromes of saliva had an effective power. This is an act that is repeated in the case of the man born blind when Jesus 'spat on the ground and made some mud with the spittle; he rubbed the mud on the man's eyes' (Jn 9:6). On other occasions he simply 'touched their eyes' (Mt 9:29; 20:34), freeing them from an

affliction, that of ophthalmic syndromes, which was almost endemic in the ancient Near East and was caused by various factors connected with hygiene and the environment.

Christ refused to wear the clothes of a magician or of a guru of an apocalyptic approach. His

miraculous gestures, indeed, have nothing to do with resort to spells, paranormal techniques, dramatic scenes or oracular excitement, as a follower of his to celebrate his teacher would have dreamed of doing (and possibly invented) and as still today we see take place in certain exaggerated religious movements and in popular curiosity as regards the 'mysterious'. His acts were, in contrary fashion, elementary. As has already been observed, he touched people's eyes and ears, he laid on his hands, he prayed, and he engaged in dialogue with the sick person. On one occasion he does not even manage to heal a sick person immediately: this was the case of the blind man of Bethsaida who was healed in two stages (during the first stage this man managed to see 'people, but they look like trees walking around' but during the second stage he 'saw everything clearly', Mk 8:22-25). What interests Jesus, more than his personal triumph and the success of his action, is faith, individual conversion and liberation from evil, to the point that he may even heal far from a crowd in order to avoid publicity. The soul of his action is religious and not propagandistic or apologetic in character.

Christ refuses to move forward on the messianic-political enthusiasm of his contemporaries; he is concerned above all else to preach the advent of the Kingdom of God. Indeed, the miracles almost preach an action of the Kingdom, they are an effective and 'symbolic' representation of it, and they are an 'experiential' confirmation of it. In one sentence, seen by scholars as being handed down by an ancient pre-gospel Aramaic tradition, Jesus exclaims: 'How terrible it will be for you, Chorazin! How terrible for you too, Bethsaida! If the miracles which had been performed in you were performed in Tyre and Sidon, the people there would long ago have put on sackcloth and sprinkled ashes on themselves, to show that they had turned from their sins' (Mt 11:21). The miracles, in the intentions of Jesus, are intimately intertwined with his words and become a 'visible' appeal to conversion and faith, in conformity with his general behaviour, and not huge advertising and promotional signs of a political and magical messianism, as Satan wanted in the famous account of the temptation when he suggested to Christ certain dramatic and spectacular approaches (Mt 4:1-11; Lk 4:1-13). The intimate link between miracles and faith in the Kingdom of God is formalised by Jesus himself when he declares: 'No, it is not Beelzebub, but God's Spirit, who gives me the power to drive out demons, which proves that the Kingdom of God has already come upon you' (Mt 12:28).

In 'continuity' with his constant style of preaching and action in favour of the poor, the marginalised and the excluded by the 'officialdom' of his time, Christ allocated to them alone his miraculous, effective and saving words. For this reason, we should say that the Kingdom of God, Christ's resurrection and his miracles form a part of a single coherent system which defines the historical Jesus in his constant personality but also in his originality. A chapter apart in this sense – which, however, I cannot address within this very simplified and specific analysis – is that of the gospel accounts where he comes to deal with a possessed man through the liberation of his obsessions.

This is an explicit confrontation with the dark root of evil which has in itself a dimension that is also moral and transcendent and which, therefore, cannot be reduced to illness alone. It is certainly the case that in some cases we encounter 'satanic' coverings of what are pure and simple grave psycho-physical syndromes: we may think of the 'possessed' boy who was healed at the foot of the mountain of the Transfiguration and who manifested the typical symptoms of epilepsy ('Whenever the spirit attacks him, it throws him to the ground, and he foams at the mouth, grits his teeth and becomes stiff all over…he fell on the ground and rolled around, foaming at the mouth' (Mk 9:18-20). On other occasions, however, the mystery of Satan which overwhelms the person even when that person is at prayer in a synagogue is explicitly involved (Mk 1:21-26): the hand of Christ does not hesitate to place itself, becoming a source of liberation and salvation, on this moral evil as well, as it does on the whole of the dark horizon of sin.

In this light the miracles of Jesus, which occupy an ample space on his public ministry (about 45% of the account of Mark of the official activity of Christ – excluding his passion and his resurrection -

is made up of descriptions of miracles), are a fundamental element of the portrait we have of him, and to such a point that it is not only Jesus who 'touches' the sick in order to heal them but it is they who seek him out to be healed: 'all those who were ill kept pushing their way to him in order to touch him…people would…beg him to let them at least touch the edge of his cloak; and all who touched him were made well' (Mk 3:10; 6:56; one may also remember the episode of the woman with an issue of blood in Mk 5:27-31). It is because of this realism – as an Italian writer, Luigi Santucci, observed in 'life of Jesus' entitled *Volete andarvene anche voi?* (1969) – that we 'narrate the miracles of Christ as though they were things that befallen us, because each one of us, if one thinks only of history, has been to Cafarnaum, on the lake of Galilee, has experienced paralysis, fever, madness, storms, and death. A thousand times it has been said to us: 'Be healed!' and our being has been reborn, 'Be cleansed!' and our wounds have disappeared, 'Come out!' and he stone of the tomb has rolled away in our darkness'.

The Hands of the Disciples

There is, however, at this point a decisive element that should be added, that of the *imitatio Christi* of his disciples. And this takes place on the basis of a precise mission that goes back to the historical Jesus himself. Indeed, as is well known, during his public ministry he assigned to his group of disciples a precise mandate which has its lapidary formulation inside the second of the five discourses to be found in the structure of the Gospel of Matthew, the so-termed 'missionary discourse'. In this sense the same intertwining between words and acts, between lips and hands, that had outlined the portrait of the Teacher and Lord, is formulated in a clear way: 'Go and preach, 'The Kingdom of heaven is near! Heal the sick, bring the dead back to life, heal those who suffer from dreaded skin diseases, and drive out demons' (10:7-8).

On the one hand, therefore, there is the *kérygma*, the 'preaching' (*kerýssete*, 'preach') which has – like the preaching itself of Christ (Mt 4:17) – its programme in the proclamation of the Kingdom, that is to say the project of salvation of God. On the other hand, there are the signs of the Kingdom in action, expressed in the four imperatives that define the same number of categories of people to be freed from evil, following the model of the behaviour of Christ in his public action: the sick (*asthenountes*) to be healed (*therapéuete*); the dead (*nekroús*) to be risen (*eghéirete*); lepers (*leproús*) to be purified both physically and socially, as has been mentioned above (*katharízete*); and lastly the victory over the *daimónia*. Well, this programme is implemented immediately afterwards through the first apostolic mission since Jesus 'sent them out two by two. He gave them power over impure spirits' (Mk 6:7).

Their missionary activity is explicitly modulated both upon preaching, and thus upon words: they 'preached that people should turn away from their sins', and upon their healing works because their hands 'drove out many demons, and rubbed oil on many sick people and healed them' (Mk 6:13). This is what was emphasised in the post-paschal mission of the disciples since the risen Christ declared of his disciples: 'they will drive out demons in my name…they will place their hands on sick people, who will get well' (Mk 16:17-18). In practice we have in these synoptic passages the prefiguring of the promise in John of the discourses of the last supper: 'those who believe in me will do what I do – yes, they will do even greater things, because I am going to the Father' (Jn 14:12). The ministry of revelation and of salvation, of which the miracles are signs, will continue on from Christ in the disciples, that is to say in the Church, his glorious body at work in history.

If we wanted to create an exemplary model of this action of liberation and of love performed by a disciple, we could refer to the parable figure of the Good Samaritan who not only is moved 'viscerally' (*splanchnísthe*), taking part in the suffering of the unfortunate man, but who also cares for him with concern and with active charity: 'He went over to him, poured oil and wine on his wounds and bandaged them; then he put the man on his own animal and took him to an inn, where he took care of him (Lk 10:33-34). This is what is performed by the apostles in their public ministry. Here what is of significance of the testimony of the two columns of Christianity at its origins – Peter and Paul – within the account of the Acts.

To the paralytic Aeneas of Lydda – as had already happened in the case of the lame man of the Beautiful Gate in Jerusalem, healed by Peter and John (Acts 3:1-10) – Peter proclaims: "Aeneas, Jesus makes you well . Get up…!" (Acts 9:32-35). The work of the disciples is based, therefore, on the salvation offered by Christ. In a similar way, at Jaffa, it is Peter who once again repeats the same acts of Jesus towards the daughter of Jairus (Mk 5:41: 'He took her by the hand and said to her , "*Talitha, koum*," which means, "Little girl, I tell you to get up"'). Indeed, to Tabitha who is lying in a funeral bed he says: '"Tabitha, get up!". She opened her eyes, and when she saw Peter, she sat up. Peter reached over and helped her get up' (Acts 9:40-41).

A scene which from certain points of view is analogous even though pertains much more to 'daily life' has as its protagonist the apostle Paul. At his shoulders is the dramatic event of the shipwreck which had thrown him onto the coasts of the island of Malta. There the local Roman governor

(*prótos*), known as Publius, helps him and hosts the apostle in a kind way, and Paul reciprocates his gesture in an unexpected way: 'Publius' father was in bed, sick with fever and dysentery. Paul went into his room, prayed, placed his hands on him, and healed him. When this happened all the other sick people on the island came and were healed' (Acts 28:8-9).

Prayer and Illness

It is significant that the Apostle also implements the appeal of Christ to lay on hands and to heal. But there is always care to avoid conceiving these acts as pure and simple acts of healing. Indeed, either there is an explicit invocation of the name of Christ or the gesture is intertwined with prayer. It is in relation to this dual element that we can introduce a further consideration that unites lips and hands in a special way, that of prayer and healing. Let us read first of all the text of reference we have chosen and which is taken from the Letter of James, a passage that deserves to be reflected upon both by sick people and by pastoral workers in the field of suffering. 'Are any of you in trouble? You should pray. Are any of you happy? You should sing praises. 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. This prayer made in the faith will heal the sick; the Lord will restore them to health, and the sins they have committed will be forgiven. So then confess your sins to one another and pray for one another, so that you will be healed. The prayer of a good person has a powerful effect' (Jm 5:13-16).

As is well known, it is specifically on the basis of this passage that Christian tradition has celebrated the sacrament of the anointing of the sick which unfortunately in the past often degenerated into 'last anointing' as though it was only a sacred act reserved to the dying. The Council of Trent solemnly established that it is a 'sacrament instituted by Christ our Lord and promulgated by the blessed apostle James'. As has already been observed in this paper, in the Gospel of Mark we read that the disciples who were sent out by Jesus on their first mission 'rubbed oil on many sick people and healed them' (6:13). Now, in the ancient Near East oil was considered to be a tonic for the tissues of the organism and this to such an extent that it was rubbed onto athletes as well. However, holy oil was also the material used for the consecration of kings and priests because it had the function of irradiating in the chosen one the power and energy themselves of God. The phrase that the prophet Isaiah used for himself and for his prophetic vocation, but which Christ applied to his messianic consecration, is famous: 'The Sovereign Lord has filled me with his Spirit. He has chosen me…' (Is 61:1; Lk 4:18-19).[1]

So let us now return to the text of the Letter of James where we encounter various elements that allow us to be able to intuit the reality of the sacrament: suffering, prayer, the sick person, his or her appeal, the elders of the church, that is to say the heads of the community, anointment with oil, the invocation of the name of the Lord, healing and the forgiveness of sins. We will now try to define the physiognomy of this sacrament, that is to say of that gift of divine grace offered in the Church to those who believe in the Lord Jesus which is often administered in our hospitals and not rarely is celebrated in a communal way, as is specifically appropriate to a true sacrament and as is suggested by the Letter of James itself. There are first of all the ministers of the sacrament – these are the presbyters. Reference is then made to the recipients – these are the sick (the Greek word '*asthenein*' means 'being infirm, weak') and not the dying. Indeed, it is observed that they themselves must be able to call the church elders, that is to say they must be conscious and be characterised by freedom and participation, as is required – at least implicitly – by every sacrament so that it is not transformed into an act that is almost magical.

This has been the approach of recent pastoral care in relation to suffering which bestows the anointing of the sick on those who are conscious, without excluding, certainly, those people who, in a critical situation or when dying, have, through their lives or at least through their general approach, demonstrated an openness to the grace of faith. Unfortunately, as has already been pointed out, for some Christians anointing of the sick is still only a 'last anointing' of the terminally ill, if, indeed, not for those who have just died: once, indeed this sacrament was administered *sub conditione*, that is to say conditional upon a person's real capacity to go on living which could not be verified externally. Let us now pass, after the ministry and the subject of this sacrament, to what used to be called the 'material' of the sacrament.

Two elements should be considered in this rite. On the one hand the anointing with holy oil in line with that symbolism to which reference has been made above; on the other hand, there is prayer which includes an authentic formula for the anointing, and to such an extent that reference is made to the 'name of the Lord' in line with a liturgical dimension that is well known and connected with this phrase. Lastly, one comes to the effects of this sacrament which are of two kinds. There is physical salvation, the health offered by the God of life to the sick person who can thus rise from his or her bed or from where he or she was lying. But there is also spiritual salvation which is liberation from sin where the sick person is still involved in interior evil or recognises that he or she needs the mercy of God because of his or her frailty as a weak

and unfaithful creature. In this union between illness and sin one can perceive the Biblical tradition which has already been cited in this paper known as 'retribution', which tried to identify a sin at the root of every illness (see for example Psalm 38).

Jesus very much reduced this idea. One need only read the beginning of the account of the blind man in the Gospel of John: 'As Jesus was walking along, he saw a man who had been born blind. His disciples asked him, "Teacher, whose sin caused him to be born blind? Was it his own or his parents' sin?" Jesus answered, "His blindness has nothing to do with his sins or his parents' sins. He is blind so that God's power may be seen at work in him' (9:1-3). However, one can see in this mention of the forgiveness of sins a more general statement about the function of salvation of every sacrament, that function, that is to say, of freeing man from evil and making him belong to the life itself of God. I mentioned above that a response is required from man to the gift of God: this response is expressed in the faith of the sick person who welcomes the grace offered by Christ. In the passage quoted above of James reference is made in an explicit way to faith: 'This prayer made in the faith will heal the sick'. In this way the two dimensions of this sacrament intersect: on the one hand we have the efficacious action of God who saves, and on the other hand, we have the free choice of the man who entrusts himself to the Lord in faith and prayer and takes part in the life and the worship of the ecclesial community, a setting of salvation. We can, therefore, refer this sacrament to its ecclesial context, to its solemn celebration and to its function as an efficacious sign of salvation and of hope for those who live in the shadow of pain.

His Eminence Cardinal
GIANFRANCO RAVASI
President of the Pontifical Council for Culture, the Holy See

Note

[1] Translator's note: some translations of Holy Scripture choose to employ a reference to oil in translating these passages.

ANGELO AMATO

The *Salus Animarum* in Pastoral Care for the Sick

1. A person who suffers does not leave us indifferent – he or she calls upon us. A sick person, in his or her weakness and powerlessness, is the bearer of a call for help, for assistance, for nearness, and for sharing. His or her painful situation stresses the frailty and the weakness of our humanity and its impelling need for physical healing and spirtual redemption.

His or her 'voice' makes sound out in us a truth that is often concealed, that is to say the reality of our finitude, our being limited and the conseqeunces of that original sin that brings with it suffering, illness and death.

In his or her frailty as well, however, a sick person always remains a person created in the most resembling image of God and redeemed by the precious blood of His son, Jesus Christ.

In the Gospel, Jesus paid particular attention to the poor, to the marginalised and to the sick. In addition to being a physician of souls, he also presented himself as a physician of bodies, healing the deaf and dumb, those suffering from leprosy and paralystics, and raising people from the dead. For him, man was wounded both by sin and by infirmity. To both these limits of man Christ provided a remedy, forgiving sins and restoring physical health. For him, healing was like a holy door through which to place in the heart of a sick person the abundance of divine grace. A sick person was thus restored to physical and spiritual health. Physical healing constituted the visible image of invisible spiritual healing. This relationship between the healing of illness and the healing of the soul is an important indicator for the pastoral pathways of Christian health-care workers.

Medical treatment can be accompanied, in the freedom of, and sacred respect for, the consciences of other people, by healing other invisible but nonetheless real infirmities, such as ignorance about being Christian, neglecting one's own way of behaving in life, and the obscuring of one's own existence of faith. The invocation of physical healing can be united to care for spiritual health.

2. Hence the urgent need for a service that those who work in the field of pastoral care in health, whether they be parish priests, hospital chaplains, make religious, sisters, extraordinary ministers of communion or volunteers of various kinds, can, and must, provide. One is dealing here with spiritual accompanying which can, with prudence, supplement catechesis, the administration of the sacraments, and, where this is appropriate, the first preaching of the Gospel of Jesus Christ. In our multireligious and multiracial society, one can but propose the good news of salvation in Jesus Christ, without any kind of constriction and with the most rigorous attention being paid to respect for the consciences of other people.

For Christians who are often dazed by a society that is distracted and shallow, who forget about caring for their own souls, agents of pastoral care can but give value to the sacraments, above all the sacraments of reconciliation and of the Eucharist. By the first one frees the soul of sick people from those worries and fears that always, consciously or unconsciously, accompany a sinful situation, restoring serenity and joy in living. By the Eucharist one places in the heart of a sick person that divine grace that impregnates his or her person, his or her feelings, and his or her thoughts, with charity and holiness, giving him or her the courage and the strength that are needed to rest his or head on the breast of the Crucified Christ, so as to share with him the sufferings and the humiliations that illness often brings with it.

3. Especial attention must be paid by agents of pastoral care to the use of the sacrament of the sick. Indeed, the Church, having received from the Lord the command to heal the sick, is commited to putting this commandment into practice through care for the sick and prayers of intercession: 'Above all the Church possesses a sacrament specifically intended for the benefit of the sick. This sacrament was instituted by Christ and is attested by Saint James "Is any among you sick? Let him call in the presbyters of the Church and let them pray over him and anoint him with oil in the name of the Lord" (Jas 5:14-15)'.[1]

This sacrament, as is known, can be repeated many times, indeed each time that a worsening of the illness takes place. Perhaps it is advisable to remember that this sacrament can be administered only by priests, whether they are bishops or presbyters.[2]

The effects of this sacrament are particularly important. First of all, it bestows a special grace which unites the sick person more intimately to the passion of Christ, for his or her good and for the good of the whole Church. It also gives him or her comfort, peace, courage and also the forgiveness of sins if the sick person has not been able to go to confession. This sacrament at times allows, if God so wishes this, also the recovery of physical health. Lastly, anointing prepares the sick person for the move to the House of the Father.[3]

4. Divine grace gives to illness and suffering a particular value of purification and of redeption. The *Compendium of the Catechism of the Catholic Church* teaches that: 'The compassion of Jesus toward the sick and his many healings of the infirm were a clear sign that with him had come the Kingdom of God and therefore victory over sin, over suffering and over death. By his own passion and death he gave new

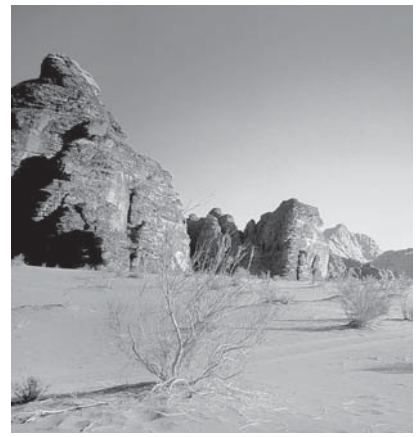
meaning to our suffering which, when united with his own, can become a means of purification and of salvation for us and for others' (n. 314).

The infirmity itself, with its burden of physical weakness, can also become an opportunity for religious maturation and at times a vocation to Christian perfection and to holiness itself. This is a common experience not only of consecrated people and ministers of God but also of men and women members of the lay faithful who, afflicted by illness, have become heroic witnesses to faith, hope and charity.

I will cite only two examples of such members of the lay faithful, who were solemnly beatified in this year of grace 2010. They were sick people who turned their beds of suffering into altars to offer up to the Lord their physical tribulations and into teaching chairs to educate the healthy to give thanks to God for their physical health. I am referring to Blessed Manuel Lozano Garrido, known as 'Lolo', a journalist and writer, who was beatified in Linares, Spain, on 12 June of this year, and the young member of the focolare movement, Chiara Badano, who was beatified here in Rome on 25 September 2010.

After being raised to the cross of suffering at the side of Jesus, divine grace strengthened their souls and transformed their Calvary into the Tabor of the transfiguration. Afflicted by grave illnesses which made them invalids, both of them, nourished by divine grace through the sacraments of reconciliation and of the Eucharist, were teachers of serenity, of Christian fortitude, and they converted their illnesses into a mission of evangelisation and conversion.

Lolo, with the eyes of his body eclipsed, refined his eyes of faith so that he could perceive the Holy Spirit in himself and in his neighbour. For this reason, he was wont to say that you see the stars at night. Despite his stiffened limbs, he moved wih agility with his heart and his mind, travelling in the skies of truth and beauty. His physicial maladies made him more sensitive to spiritual harmonies, differently from ourselves who, stunned by a sea of futile daily images and deafened by the din of their sounds, no longer manage to perceive the song of the creation, ending up by becoming, we ourselves, deaf and dumb. Lolo saw and understood the thousand beneficial presences of divine Providnce in his personal life and in the history of humanity. For this reason, his existence was not marked by sadness but, instead, by joy; not by regrets but by apostolic enterprise; not by loneliness but by communication and friendship with everyone, great and small, healthy and sick, poor and rich. His was an existence of authentic gospal holiness.



A second example is provided by the eighteen-year old member of the hearth movement Chiara Badano. Love for Abandoned Jesus infused in her that spiritual energy, that grace capable of bearing every misfortune. Struck by osteosarcoma at the age of sixteen, she accepted the cross with pain but with serene fortitude: 'I no longer have my legs and I very much liked riding my bicycle but the Lord has given me wings'.[4] She suffered, but her soul sang. She rejected morphine because, she said, 'It takes away my lucidity and I can offer to Jesus only my pain'. At the end of December 1989, when her illness was divouring her, she received a Message of life from Chiara Lubich: 'Those who remain in me, and I in them, will bear much fruit' (Jn 15:5). On 26 July 1990 Lubich gave her a new name, 'Light'. A very well chosen name because Chiara became an explosion of divine light which surprised everyone, both young and old. She often said: 'Jesus should be loved, and that's that'. Those people who visited her thought they were bringing her affection and comfort but in reality it was they who were receiving comfort and encouragement. Her apostolate was to unite this valley of tears and heavenly Jerusalem in a harmonious way. A meeting with Chiara – one witness even came to say – gave a 'sensation of meeting God'.

5. In his encyclical letter *Spe salvi* the Holy Father Pope Benedict XVI observes that 'The true measure of humanity is esseentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society' (n. 38). In this sense the Church continues to offer a contribution of incalculable value to promote a world that is more able to welcome and care for sick people as persons. I will end with a reference to the Venerable Pope John Paul II who, at the height of his personal physical suffering, which was not concealed from, but instead shown to, the world with humility and fortitude, in his Message for the Thirrteen World Day of the Sick invited people to appreciate pastoral care in health more: 'In our time, marked by a culture imbued with secularism, some have at times been tempted not to recognize the full value of this pastoral context. They think that human destiny is played out in other fields. Instead, it is precisely in times of sickness that the need to find adequate responses to the ultimate questions about human life is the most pressing: questions on the meaning of pain, suffering and death itself, considered not only as an enigma that is hard to face, but a mystery in which Christ incorporates our lives in himself, opening them to a new and definitive birth for the life that will never end. In Christ lies the hope of true, full health; the salvation that he brings is the true response to the ultimate questions about man'.

His Eminence Cardinal
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Notes

[1] *The Catechism of the Catholic Church. Compendium* (Paulines, Paulines Publications for Africa, Nairobi, Kenya), n. 315.

[2] *The Catechism of the Catholic Church. Compendium* n. 317.

[3] *The Catechism of the Catholic Church. Compendium* n. 319.

[4] *Informatio Relatoris*, p. 2.

LUIS GOMES SAMBO

Access to Primary Health Care: Thirty-Two Years after Alma Ata what Advances have been Achieved in the Continent of Africa?

It is a great honour and privilege for me to be here at the Vatican, addressing this august gathering of eminent personalities. I would like to express my deepest appreciation and gratitude to His Holiness, Pope Benedict XVI, for the latest encyclical, *Caritas in Veritate*, in which he provides us with his profound reflections on social and economic issues connected with inequalities and underdevelopment in the world today. By advancing concepts such as *integral human development* and *development as a vocation*, and by promoting *respect for human dignity* and *the equality of all men*, His Holiness reminds the world community and its leaders of their duty and responsibility to address the plight of billions of people living in poverty today.

One of the key features of public health is its underlying philosophy of social justice. Significant factors within society such as distinctions of social class, racism, ethnicity, culture and differences in norms and values, hamper the fair distribution of societal benefits and burdens. These differences often create tensions and conflicts between people and institutions that have competing views and interests. Health, as a state of complete physical, mental and social well-being, is affected by such tensions.

Primary health care, as a social movement, is both public and political in nature, but it is grounded on the broad basis of the biological, physical, social and behavioural sciences. The primary health care approach has provided new public health thinking that embraces knowledge of, and responses to, new public health threats and their determinants. Its practice involves a wide range of actors and initiatives within health systems.

The subject on which I was requested to give a speech at this gathering, 'Access to Primary Health Care: Thirty-Two Years after Alma Ata what Advances have been Achieved in the Continent of Africa?', is timely and pertinent especially when placed within the context of the Millennium Development Goals and their attainment by 2015. This international conference is therefore an opportune moment for reflection and stock-taking.

In my paper, I will first briefly review the concept of primary health care and what has been achieved since the Alma Ata Conference of 1978. Based on the latest statistics available, I will then give an overview of primary health care implementation and the factors hampering progress towards achieving universal access to health care. In the final section of my paper I will focus on the role of the Church.

The Concept of Primary Health Care

Permit me to recall the historical developments that led to the emergence of the concept of *primary health care*. In my view, three main events laid the foundations for primary health care. First, in 1973, a WHO global study on 'Methods of Promoting the Development of Basic Health Services', which revealed the inability of health services to meet the expectations of the majority of the population due to increasing costs and inequities in access to health care. Second, the Thirtieth World Health Assembly of 1977 which agreed that the main social target by the year 2000 would be the attainment by all peoples of the world of a level of health that would permit them to lead socially and economically productive lives. Third, the 1978 International Conference on Primary Health Care (PHC), held at Alma Ata in the then USSR, which reaffirmed the goal of 'Health for All' and adopted primary health care as the strategy for attaining this goal by the year 2000.

On the one hand, because of its primary focus on health promotion and disease prevention, *primary health care* was put forward and accepted as a cost-effective strategy for achieving *health for all*. On the other hand, the principles underpinning primary health care, such as social justice, equity, human rights, universal access to services, community involvement, and priority for the most vulnerable, were upheld. These principles attracted interest and gained wide currency within the international community and with people of good will.

The need for universal coverage of health services is as paramount today as it was in Alma Ata thirty-two years ago. The current social, economic, political and environmental climate, the impact of globalization, and the advances in health science and technology, all call for health sector reforms to

achieve its continuous adaptation to complexity and change. These reforms should be guided by evidence-based health policies that also take into account fundamental values such as equity, human rights and social justice.

Today, a number of health systems and public health challenges persist in sub-Saharan Africa. These challenges compromise the health status of people and their ability to lead socially and economically productive lives.

The current weaknesses in health care systems can be grouped into five categories:

First, there is an apparently paradoxical situation whereby people who are better off in society and relatively less likely to need health care services consume more of health services than those who have the least means and are in greatest need of such services. This reflects an *inequitable access to health care*.

Second, the vast majority of people in the region lack social protection, and a large proportion of payments for health services are inevitably made out-of-pocket. Most of these people subsist on meagre resources and live under precarious conditions, almost on the brink of poverty. Millions of them, confronted with major illnesses and catastrophic health expenditures, easily and quickly slide into poverty. These reflect *impoverishing systems of health care* that need to be addressed.

Third, having gained wide acceptance, the holistic approach to health care for individuals and families is taught in medical and public health schools everywhere. However, in practice, in healthcare settings almost everywhere excessive specialization and a narrow focus on vertical illness control programmes creates situations of *fragmented health care* where illnesses are managed irrespective of the social and mental dimensions.

Fourth, health systems in the African region are under-resourced. Thus, ensuring optimal safety, hygiene standards, and protection of people from counterfeit drugs in such a situation is indeed a herculean task. Such *unsafe care,* as it is called, leads to high rates of avoidable hospital infections, and many other complications.

Fifth, it is common epidemiological knowledge that the burden of illness is better addressed through health promotion and illness prevention and control. However, funding priorities usually put more resources on hospitals and other curative services. Such distortions in the allocation of resources within the health system leads to what has become known as *misdirected care*.

The implementation of the primary health care approach to strengthen health systems has the potential to expand the gains from health investments to cover more people in the world. The essential features of primary health care include:

People-centeredness – meaning a focus on the needs of individuals, families and communities at the local level.

The full *involvement of individuals, families and communities* in decision-making about their own health and health care.

Comprehensiveness – in addition to offering curative services, PHC offers opportunities for health promotion, preventive care and rehabilitation.

Integration – because PHC involves teamwork by health professionals from various disciplines and at various levels, it provides an excellent approach to improve multidisciplinary and intersectorial responses to health and health-related needs.

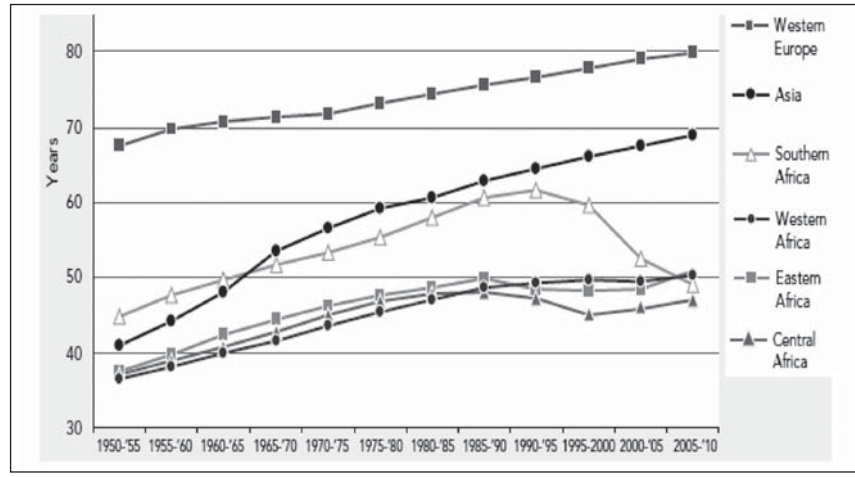
Primary health care is therefore a useful strategy for addressing current health system issues related to leadership and governance; human resources for health; health financing; access to health technologies; quality of health care; the social determinants of health; research promotion; and the management of information and knowledge.

Access to Primary Health Care

Since the Alma-Ata Conference on primary health care, some progress has been made by countries in the African region. The eradication of smallpox is a major achievement shared with all countries of the world. More recent examples include the control of measles, the progress in poliomyelitis eradication, the elimination of guinea-worm disease and leprosy, and the control of river blindness in most areas of the continent.

There have also been reductions in child mortality and maternal mortality, even though these indicators are the worst in the world and a source of great concern (Figure 1).

Figure 1 – Trends in life expectancy at birth, in selected regions, 1950-2010



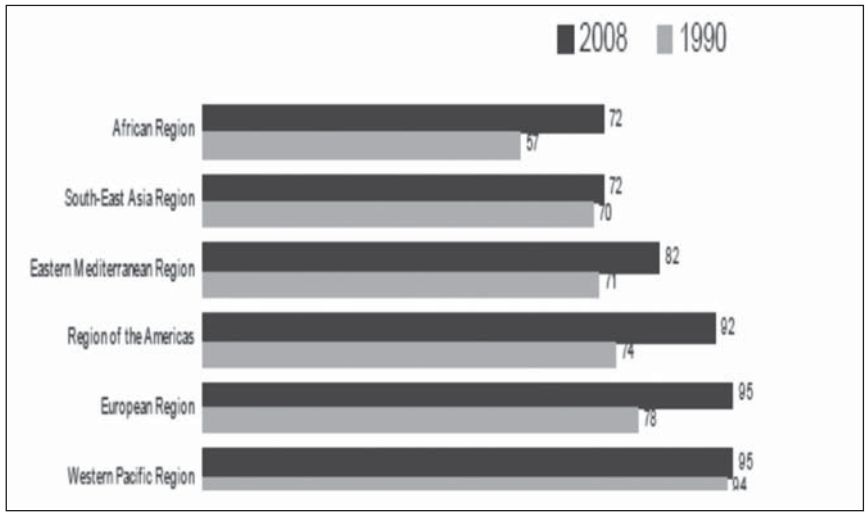
The trend of increasing life expectancy in the African region in the 1970s and 1980s was reversed in the 1990s with the advent of the HIV/AIDS pandemic which devastated several countries in Africa.

Because of a lack of progress in human development and in health in particular, and mindful of existing knowledge and wealth in the world, global leaders, in the year 2000, agreed on the Millennium Declaration and the Millennium Development Goals (MDGs) to address income poverty, hunger, ignorance, squalor and disease. This brought renewed hope for millions of people. As you know, three of these goals (MDGs 4, 5 and 6) concern the health of children and women and major diseases such as AIDS, tuberculosis and malaria. As I will show in subsequent slides, progress towards the MDG targets has been variable.

The under-five mortality rate dropped from 182 per thousand live births in 1990 to 142 in 2008. However, it is decreasing at an average rate of 1.4% per year, much slower than the 8% per year needed to achieve MDG4 by 2015.

The key to progress towards attaining this goal by 2015 is to reach every newborn baby and child with a set of priority interventions. These interventions include: appropriate breastfeeding and infant and young child feeding practices; the prevention of vaccine-preventable diseases through effective immunization; and the prevention and management of common childhood illnesses such as pneumonia, diarrhoea, malaria, malnutrition and HIV (Figure 2).

Figure 2 – Percentage of DPT3 immunization coverage among 1-year-olds, 2008 e 1990



For example, if we consider immunization coverage among one-year-old children for the third dose of Diptheria/Pertusis/Tetanus (DPT3), we note that this coverage increased in the African region from 57% in 1990 to 72% in 2008.

The maternal mortality ratio also decreased from 910 per 100,000 live births in 1990 to 620 in 2008. The rate of decline in maternal mortality ratio is such that reaching the MDG5 target by 2015 is unlikely in most of the countries in the African Region (Figure 3).

We have the knowledge and the technologies to deliver proven and cost-effective interventions to avert the vast majority of maternal deaths if every woman has access to quality reproductive-health services. These include skilled attendance during pregnancy, childbirth and the postnatal period, emergency obstetric care and family planning. In addition, there is a need to promote the social and

Figure 3 –Percentage of births attended by skilled health personnel, 2000-2008

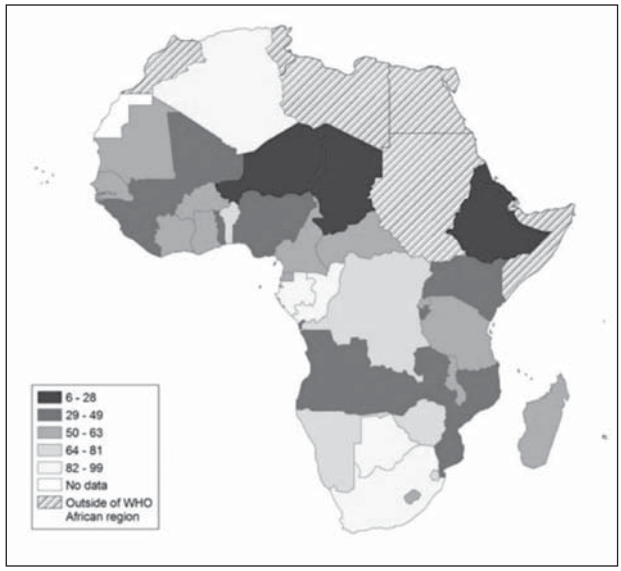
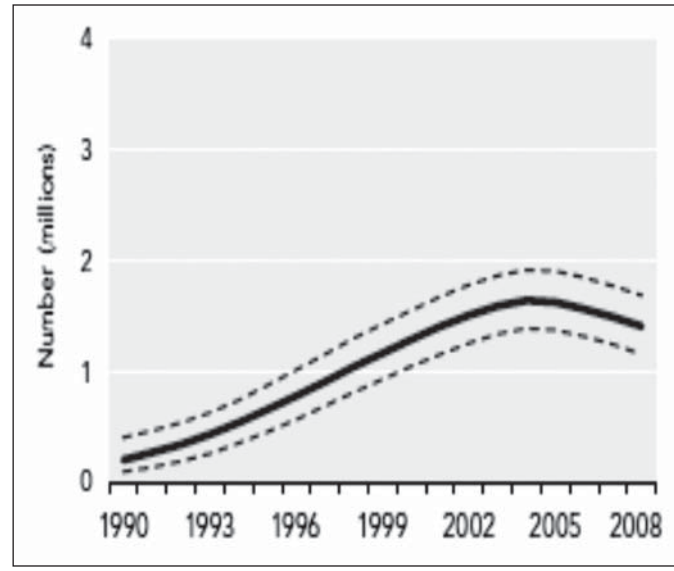


Figure 4 – Number of adult and child deaths due to AIDS (in millions) in sub-Saharan Africa



economic status of women and strengthen the capacity and involvement of families and communities.

Coverage of skilled birth attendance in the African region remains low at 47%, with a wide variation in the rates among countries. Only a small fraction of pregnant women requiring emergency obstetric care or adequate antenatal care actually receive it.

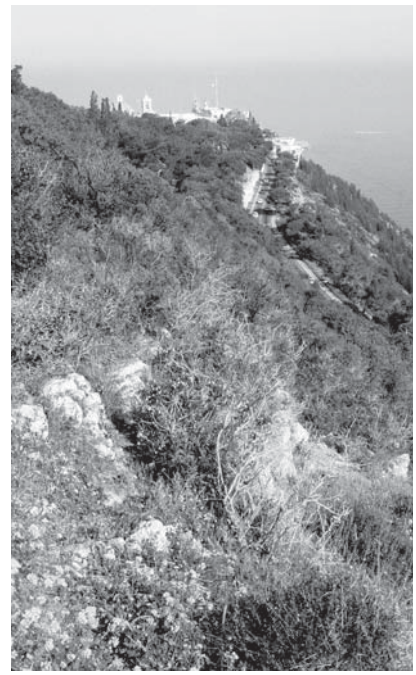
The global community has resolved to halt and reverse the incidence of HIV/AIDS, malaria and TB by 2015 as part of efforts to achieve MDG6. Yet whereas the African region is home to just over 10% of the world population, it accounts for a staggering two-thirds (67%) of people living with HIV/AIDS worldwide; two-thirds (68%) of all new adult HIV infections; over 90% of new HIV infections in children; and over 70% of AIDS-related deaths (Figure 4).

Although the fight to contain HIV/AIDS is far from over, there are indications that the epidemic is declining in magnitude. There has been a decline in the number of deaths due to AIDS in the last couple of years. The number of new HIV infections per year is on the decline on average, but in general the incidence rate is still very high and requires the strengthening of preventive measures among the population.

Primary prevention methods are not yet widely applied among the population. Access to prevention services is also limited, although coverage of services for the prevention of mother-to-child transmission has improved in the last few years. Although Africa has made significant progress in increasing access to antiretroviral treatment, over half of the people who need anti-retroviral treatment still lack access.

The African region also accounts for more than a third (31%) of all TB cases; the situation is aggravated by the lethal combination of HIV with TB and poses new challenges to the control of both diseases.

Malaria in Africa constitutes 85% of all malaria cases and 89% of all malaria-related deaths worldwide. While there is not much progress in tuberculosis control, the fight against malaria is progressing significantly in some countries providing good coverage of essential anti-malaria interventions such as artimisinin-based combination therapy, vector control including the use of insecticide-treated nets (ITN) *and* indoor residual spraying (IRS), and intermittent preventive treatment of malaria in pregnancy.



Strengthening Health Systems and Tackling the Social Determinants of Health

It is now clear to governments and partners that progress in achieving the MDGs will be slow as long as access to essential interventions remains limited. There is also increasing awareness that cost-effective and equitable delivery of these interventions requires the strengthening of health systems, using the primary health care approach. It is no wonder, therefore, that the need to renew primary health care is gaining increasing recognition three long decades after it was first formulated.

As part of this global drive to renew primary health care, the WHO Regional Office for Africa organized an 'International Conference on Primary Health Care and Health Systems in Africa' in Burkina Faso in 2008. The conference reviewed past experiences in PHC and adopted the 'Ouagadougou Declaration redefining the African strategy for scaling up essential interventions to achieve the health MDGs'.

The Ouagadougou Declaration focused on nine major priority areas, namely Leadership and Governance for Health; Health Services Delivery; Human Resources for Health; Health Financing; Health Information Systems; Health Technologies; Community Ownership and Participation; Partnerships for Health Development; and Research for Health.

The social determinants of health are being addressed through a framework of interventions developed by the WHO Commission on Social Determinants of Health. The interventions aim at action on the circumstances of everyday life and the structural drivers of inequity. On the *improvement of daily living conditions* the commission calls on countries and their partners to improve the well-being of girls and women and the circumstances in which their children are born, and to create the conditions for a flourishing older life. In order to *tackle the inequitable distribution of power, money and resources,* the commission recommends countries and their partners to place responsibility for action on 'health and health equity' at the highest level of governments, and ensure its coherent consideration across all policies.

At its inception sixty-year years ago, the World Health Organization (WHO) made human rights central to health and social justice, putting them at the core of its values. The Constitution of the World Health Organization states that: 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. These values were reiterated 32 years ago at Alma Ata and also underpin the current *WHO 11th General Programme of Work* covering the period 2006–2015.

Before ending my paper I want to refer to the important role that the Catholic Church has played in medicine and public health

throughout its long history. In early medieval times, Church institutions such as monastery hospitals were established to provide charity and care to ease the suffering of the sick and the dying. In the Age of the Enlightenment ideals such as human autonomy, reasoning, equality and progress also started influencing the governance of humankind and gradually permeated new developments in health and health systems.

Actually, through its vocation, the Church has remained a major stakeholder in health-care provision. This is demonstrated by the work of mission hospitals, faith-based organizations, and social and health workers who provide health care through charity, with particular emphasis on people in greatest need and usually living in poor-resource settings.

Caritas in Veritate focuses on the current global issues of underdevelopment, inequity, hunger and the environment. These issues are central to health and health systems and are major social determinants of health, influencing the understanding and implementation of the primary health care approach.

Therefore, thirty-two years after Alma-Ata, I should say that the African region has made some progress in reforming health systems and improving the health status of people. Nevertheless, African communities, governments and partners still have a long way to go before achieving the highest possible level of health.

It is my strong hope that the Twenty-Fifth International Conference entitled 'Toward an Equitable and Human Health Care in the Light of the Encyclical *Caritas in Veritate*' will shed more light on, and bring renewed impetus to, the application of its values for the better health and dignity of every human being.

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World Health Organization.

MARIO BENOTTI

The Mass Media and the Health of Citizens

I would like to thank the President and the Superiors of the Pontifical Council for Health Care Workers for the attention that they have wanted in this conference – which is rich in important points for reflection for the governing classes and for politics – to pay to the role of information and communication. We live in a globalised world and it is evident that *globalisation is a phenomenon that should be governed*, in the same way as it is increasingly evident that the economic factor in the thought of Benedict XVI and the whole of the social doctrine of the Church should be analysed, thought about anew, and made available to everyone. Very often, indeed increasingly often, the issues of health care are linked to the economy in a mechanism that does not always take into account an important factor, indeed the most important factor of globalisation: that of the globalisation of rights. But in what sphere does information move, in what sphere does the cultural instruments that govern this mechanism move, to which the Pope also refers in *Caritas in veritate* when he says that 'connected with technological development is the increased pervasiveness of the mass media'? We are speaking here about subjects that closely concern health care and health: at times *the mass media replace medical doctors for citizens*; the new media and social networks mean that at times word of mouth acquires credibility, that people by now construct on their own – and this is especially true of young people – their information palimpsests through internet and TV webs. But what do the media say, or rather what should they say, in the field that we are analysing here today?

It is the duty of all organised societies to take responsibility for their *weak internal sections*; and a sick person is a particularly frail subject by definition and condition. It is not conceivable that *access to health* should be regulated by income and that there should be discrimination within societies or outside them. Within societies, between the *rich and the poor*; outside them between developed nations with ease of access to treatment and nations with retarded development where it is a difficult undertaking to have basic care and medical products which in the rest of the world are available in clinics or across the counter.

Equally inconceivable is the approach to health-care policy of the most developed countries with hospital structures rewarded by additional funds on the basis of what they save in an indiscriminate way at the level of expenditure. But how often do the *media become pressing with governments as regards these needs*? Almost never. Perhaps we journalists should begin to say in a clear way – because this is something the press can do and should do – that it would be advisable *to reward hospital institutions on the basis of* how many lives they save. On the basis of the results of the research that is engaged in. On the basis of services of care. Not on the basis of savings *tout court*. Thus it happens that treatment is prescribed that is less expensive but devastating, for example, for the liver, to the applause of the politic al world and public opinion.

The point where action should be taken is not at summit levels but at the level of basic standards. And this is something that we do not manage to communicate. We need to raise basic standards to an adequate level as regards respect for the individual, taking care of his or her needs, and the requirements, of a psychological character as well, of welcoming and care. Once these basic standards reach a satisfactory level of excellence, the question of standards at the apex becomes secondary, on the condition, however, that in life-saving situations there is no discrimination in relation to care because of the wealth of individuals. I would like never to have hear my colleagues tell me the story of a middle-class Afro-American who was obliged to kidnap, by gunpoint, a medical doctor of a hospital because his credit card was not enough to pay for the urgent operation that was needed to save the life of his five-year-old son. He was arrested but his son had the operation. Do we have to come to this? This is something that should not take place.

In the same way it should not happen that grave but curable and controllable diseases such as malaria, TB or AIDS, which are weakened or under control in the developed world, continue to cause *massacres in the third world because of a lack* of nursing, hospital and pharmaceutical assistance. Although it is fashionable to speak about *AIDS* – even though this is much less the case than in the past – and the subject is spoken about in major economic newspapers such as *The Financial Times*, we forget to talk about important subjects and diseases about which almost nobody speaks any more in the developed world but which exist even though we do not want to see them. Some observations on *malaria* to which unfortunately or fortunately only the Holy See and the United Nations refer: there are 247 million cases of malaria in the world, of which 212 million are in Africa, 21 million are in Asia, 8.1 million in the Middle East, and 2.7 million in the Americas. There are 881,000 deaths because of this disease every year: 801,000 are in Africa, 38,000 in the Middle East, 36,000 in Asia, but also 3,000 in the developed Americas. And 85% of these deaths involve African children under the

age of 5. But in the media little is said about this or nothing at all, just as we do not in the least say that a half of the world's population, that is to say 3.3 billion people, continue to be at risk to malaria according to the World Health Organisation. And there is more.

In Europe *we take it for granted* that every birth is accompanied by qualified medical or paramedical staff. Such is not the case everywhere in the world. In Ethiopia or Laos, this is an exception. Ninety women out of every hundred, roughly speaking, give birth on their own or with the help of neighbours or of family relatives.

This is an area where national and multilateral institutions should act. If somebody who has the possibility to waste money and decides to treat himself by buying a monastery in Tibet, that is his problem. If he thinks this is an intelligent move, let him go ahead and do it. The real point is *to assure reasonably easy access of everyone to the treatment that is needed and in adequate structures*. This is the challenge. And it is no accident that this idea forms the basis of the Millennium Development Goals of the United Nations.

But although health should not become a market, health-care policy lives in the market. And I would not be serious if I addressed the question only from the point of view of theorizations, without in the least bearing upon the point that saying 'Yes' is entirely to be subscribed to and is beautiful, but who provides the money and how is research to be financed? I believe that this, too, is a duty of *journalists*, who are men of culture and who must *narrate, but who must also study and make proposals to those who have to decide*. And I also take the liberty of trying, starting from the fact that I am speaking at an international conference organised by the Holy See which through the local Churches, missions, religious Congregations, the Good Samaritan Foundation and the apostolic nunciatures makes its contribution every day, making available *117 thousand Catholic health-care institutions in the world which, however, cannot replace the responsibilities of states*.

In my view the problem should be addressed on two fronts: the domestic policies of developed countries and the aid policies for countries whose development is delayed.

On the first front I do not see any alternative to the use of the lever of *general taxation* within a clear and rational framework of health-care policy that impedes duplications and waste. And with a reasonable and progressive contribution of citizens to expenditure. But this policy must be clear and the controls must be clear as well. This is because *waste and abuses are not problems of personal civil responsibility – they are deliberate actions against the common good and as such should be prosecuted*. And with extreme harshness they should be brought to the attention of the mass media.

The policy of financial rewards for virtuous situations must, in addition, be modulated not according to narrow parameters of accounting worthy of Mr. Scrooge. It must be based upon a transparent mix of parameters whose priority *is care for, the welcoming and the treatment of the patient, efficiency in saving lives, and excellence in research*. And, as takes place in the *United States of America* – where, for that matter, a major debate is underway about the reform of the health-care system of President Obama and where, furthermore, the average citizen increasingly places health care third amongst the six most important questions for the country – one could think of tax rebates on large incomes when portions of these are given to projects that aim at promoting the common good. *Private forces and volunteers are welcome*. They help to improve the service and to complete it. *But a serious state cannot think of seeing its duties replaced by external interventions, of the Church or some other party*. We journalists must have the courage to say and to write that a serious state subsidises the action of private forces and supplements the action of volunteers. It is not they who are entrusted with building up a health-care policy; the state should not cede to them what is its duty to offer. If a state does not assure basic services, why should citizens pay taxes? And I do not say this because at times it may appear easy to engage in populism. I say this because people tell me this in writing; people say it to be when I travel around the world.

The problem for the *third world* is more difficult. In the third world central structures do not exist that are able to have an overall policy. We should, therefore, refer again to the logic of aid. The new *political approach of the European Union* is convincing. No longer aid for projects but subventions for budgets, with the African Union taking re-

sponsibility for performing the role of being a guarantor and for those controls that are needed to prevent development aid being used to finance the development of a few potentates and the purchase of weapons. To summarise: it is no longer a matter of financing a specific hospital or specific research. The accounts are supported so that the state pays the salaries of nurses or invests in the purchase of equipment. Side by side with this there is an impressive amount of aid from *non-governmental institutions, religious associations and private initiatives*. A great deal of money which, however, has produced almost nothing that has taken root. Perhaps because in the end it is not known whether something really happens because newspapers and TV do not speak about this things, with the exception of means of communication that are connected with missions or the environment. And since journalists at times need to have fresh news, it is increasingly necessary for the *Church to make an important effort to be present within the world of big communication*, that communication which reaches the homes of millions of citizens and hundreds of thousands of decision-makers with an authentic supra-structural emergency intervention designed to create agreement not about a caprice or complaint of the Church but to create agreement about Man. This is a little like when everyone invokes 'growth', forgetting about Man and then producing the dramatic crisis into which the developed world has fallen. This was observed this morning by *Prof. Gotti Tedeschi* who is a living example of what a committed layman should do without appearing to be complaining: *writing every day or almost every day in the Osservatore Romano, certainly, but also for Il Foglio, Sole 24 Ore, going on television, speaking with the clarity of an economist who talks* not about a fantasy but something that is concrete, perhaps one of the most concrete of things, and of common sense, the social doctrine of the Church.

And to continue with my paper, we need a centralisation of healthcare policies at a supra-national level and certainty at the level of funds. A commitment of this kind can only be made by *multilateral institutions: the United Nations with the help of the World Bank*. And one could think of a kind of Tobin tax for the health-care emergency, to be calculated as a minimal percentage contribution on the basis of special rights of imposition on the part of the International Monetary Fund. Naturally enough on the condition that this money is used for a purpose that is agreed upon, and not for the villa of a director or the large car of the head of a project.

For all of this, the role of the *media* and communication is of fundamental importance, both in terms of *contributing to the shaping of public opinion* and in *sensitising* and informing people. But let us be clear about what we mean by the media and what the responsibilities of a journalist are, as well as what our responsibilities are. The *media* are *generalist* and speak to everyone. The *scientific* and sectorial *press* is an information and communications structure within those who work in this field, who at times love to use it to quarrel with each other. The role of this specialised information is important and crucial but sensitisation does not pass by way of this instrument.

The generalist media, in specialist pages as well, are obliged to engage in *simplification and the use of language that can be generally understood*. They are not perfect, there are errors and omissions; at times there is not a sufficient amount of cross checking, and often sensationalism is looked for. But in general terms one thing is certain: a journalist tells about what is told to him or her. The more scrupulous he or she is in checking things, the better he or she is as a journalist. But if at times one can see splashed across newspapers dramatic news about the discovery of a molecule that is a panacea for all maladies, before criticising the journalist one should go and see what a researcher or a research institute, which are interested in fame or obtaining new funds, said to him or her. One should also assess what the source said if we want to understand what is disseminated. And if tongues were connected to brains, things would be better.

Once this has been clarified, we can agree that it is the duty of journalists to be responsible for correct and explored information and a suitable work of sensitisation. And in my role as the director of the television channels of the largest European public service and one of the largest in the world, I before you make that commitment.

However, sensitisation does not mean a prior partisan alignment with one thesis against another. Apart from the fact that this does not form a part of the ethics of the profession, it is also dangerous and counter-productive. It is a good thing to have journalists as friends who support you, whatever the case, in your battles. But, and here we should be careful, in the *perverse logic of the journalist who is a friend of yours, there is the equally perverse logic of the journalist who is your enemy*. And when the wind changes it is not a good thing to see yourself attacked *a priori* because general thinking has changed and what is right or wrong, good or bad, does not count – what counts is only the dichotomy friend/enemy. And I can well imagine that those present here today understand what I am referring to at an international and national level.

A journalist is a witness. He or she is the eyes of public opinion. And he or she must maintain, according to what is possible in human capacities, an impartial position in telling the news and a balanced and responsible position in his or her comments. The system then works. Otherwise we are dealing with the delirium of an aligned press, a press that is on one side, a press of disinformation.

To end this paper of mine, the sources should play their part with transparency, seriousness and determination. Journalists will play their part if it is possible to draw near to them, to speak to them, to offer news or a point of view in a clear way. That clarity that marks out the message of the Church and also the capacity to listen to a journalist that you wanted to invite here to engage in a discussion with you.

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ENRICO GARACI

Towards Anthropocentric Health Care: a Health Service with a Human Face

What is the contemporary state of medicine: is it a medicine of illness or a medicine of the person in his or her totality? Has progress conserved the fundamental task of medicine (which was applied from the Council of Nicaea of 325 onwards when it was established that episcopal curias had to provide welcome and accommodation to pilgrims) which is at times to treat, often to provide relief and always to comfort? How many critical points, unfortunately, are present today! There is something that has not worked in medicine! The great medical-scientific advances, although, on the one hand, they have solved problems of very great importance connected with pathologies that would otherwise be fatal, they have also introduced critical elements by placing in medical doctors an approach of clinical and human disengagement. The same happens with new scientific equipment. The patient is cut up, photographed and examined to the most intimate details and then left alone in the poverty of loneliness that is typical of those who lack a vision of human existence and become lost in an ocean of expectations – the gravest of which is that health is always within reach of a medical product and wellbeing is something to do with medical doctors.

How should we act to correct this situation? The fundamental cause behind the critical character of the process of humanisation is the loss of a holistic vision of the person as a consequence of a scientific reductionism which it is difficult to reconcile with the emergent complexity of medicine. Scientism is a philosophical position that exalts the methods of the natural sciences beyond other methods of human investigation and embraces materialistic-mechanistic thought with the claim that it has the instrument by which to explain all physical, social, cultural and psycho-sociological phenomena. This is equivalent to the claim of dogmatic positivism which transforms the philosophy of science from being rational to being irrational. This vision precludes a real understanding of human thought, of suffering and of death, of the beauty of the visual arts, of music, of literature, of philosophy, of religion and spirituality, and of the emotions (Andrew Miles).

We must, therefore, make a distinction between scientism which does not admit that it has limits and science which, inasmuch as it recognises its own limits, becomes a real instrument of advance.

When we apply these concepts to medicine we see that the scientistic position is a position that separates care and improvement from care to patients, thereby constituting a radically incomplete model of clinical practice that does not being benefits to the patient or to the medical doctor. In this vision the patient becomes a clinical case, a diagnostic code, an anonymous individual to whom medical products are administered and to whom the results of biomedical knowledge are applied.

A more correct scientific position is one based upon a holistic model of care based upon the person and upon his or her interpersonal relationships.

A sick person requires clinical readiness to help, a presence, attention, understanding, benevolence, patience, dialogue and dignity. Scientific experience is necessary but on its own it is not enough. In addition, care for the sick must never lose from sight the profound corporeal, affective, intellectual, spiritual, social and environmental unity of human beings. Illness and suffering are not experiences that afflict only the corporeal part of human beings – they also afflict them in the totality of their somatic-spiritual unities.

In addition a sick person has a family and friends. These people, as well, can have need of treatment, consultation and support.

In the final analysis, a medical doctor should make his or her own the questions and the worries of the sick person and his or her family.

Thus it is that this incomplete model of medicine based upon illnesses must be transformed into a medicine of the person in his or her totality, a medicine centred around the person (Andrew Miles).

The Holy Father Benedict XVI in his encyclical *Caritas in veritate* declares that authentic development must be centred around the person and must promote the advance of every man, of every group of men and of the whole of mankind.

A health-care service with a human face must promote this new culture, which does not necessarily address patients alone – it also addresses healthy people in order to prevent pathologies. Our national health service is the second in the world as regards life expectancy (81 years in women and 78 years in men) but health expectancy, that is to say an absence of disability, is very low.

Research over recent years has demonstrated that correct lifestyles (diet, physical activity) can combat obesity (an epidemic on a vast scale) in an effective way, reduce the risk of many (cardiovascular, neurodegenerative) pathologies, increase life expectancy with health and without disability and thus save on resources that could be directed towards other pathologies that cannot be prevented. This medicine is medicine that is centred around the person. This is also a demonstration

that science and research, when correctly applied, can be a formidable instrument in the promotion of health. In order to promote the culture of person-centred medicine it is necessary to create training courses and university master's degrees that take into consideration: narrative medicine, spiritual and religious assistance, psycho-social assistance, personalised medicine, social and rehabilitation assistance, the importance for medicine of the humanities, art, music, literature, complexity and reductionism in medical care, and the sharing of decisions.

As a consequence of a low-level of attention and imperfect conceptualisation (a shared framework is absent), we have witnessed a total absence in health care of indicators that are able to assess (that is to say

to measure the presence and intensity of a phenomenon and judge its dimensions and quality) the level of humanity (humanisation). The development of indicators of structures (what is available), of processes (what is done) and of outcomes (what is obtained), in order to test their quality and adequacy and increase the possibility of comparing medical doctors, centres and care settings, is indispensable.

It is of fundamental importance that we define the human impact factor, an instrument for assessing the quality of the humanisation of health-care workers which could constitute the discriminating element in the choice of personnel and workers.

Patients and their family relatives must be privileged interlocutors in the qualitative assessment of the humanisation of institutions and workers, both in the definition of pathways and settings and in the assessment of quality, through standardised instruments (based upon reports and ratings).

The 'hospital system' changes radically if the patient returns to its centre, and it becomes easy to understand the revolutionary importance of humanisation both for the purposes of the structural organisation of a hospital and as regards the professional conduct of the workers. Humanisation is not something extra to be done, something that is added. Instead, it is something natural to the organisation itself of a hospital. Relationships, powers and communication are directed towards the patient.

Patients who at the centre of a humanised hospital must receive answers that are not only scientific and technical in character but also human.

Here are some of the characteristics of a humanised hospital: it must have its doors open, be open, and be ready to engage in specific and constructive changes.

A transparent hospital calls relatives, nurses, medical doctors, the local church and assessors to surround the patient so that a constant flow of humanity is created without too many filters and precautions.

A humanised hospital has a map of power that is very precise and transparent and it is characterised by a constant assessment of the work group.

In a humanised hospital one must engage in ongoing training. The risk of technical and managerial incompetence is high. One needs, therefore, more method and a more widespread professionalism.

The definition that Pope John Paul II gave at a famous conference entitled 'The Humanisation of Medicine' which was held in Rome in 1987 is much more detailed and stimulating: a) 'Within the context of individual relationships, where humanisation means openness to everything that can help to understand man, his interiority, his world and his culture. To humanise such relationships involves both giving and receiving, creating, that is to say, that communion which is total participation'. b. 'At a social level the need for humanisation is translated into the direct commitment of all health-care workers – each in his or own field and according to his or her competence – to improving conditions that are suitable for health, to improving inadequate structures, to fostering a just distribution of health-care resources, and to ensuring that health-care policy in the world has as its goal only the good of the human person'.

In this way the intelligence and the rationality of the people of God are called to actuate humanisation as a way of relating to sick people.

The best way of humanising medicine lies, to sum up, in treating patients as persons, respecting their dignity and making them participants in the decisions that affect their lives and their health.

I have outlined a general picture of the prospects for the humanisation of medicine in the West. In the South of the world as well, and perhaps to an even greater extent, there is a need for strongly humanised relationships with patients, but there also exist strong inequalities as regards access to care and treatment.

The so-called poverty-related diseases (AIDS, malaria, tuberculosis) provoke millions of deaths every year and require, as the President of the Pontifical Council for Health Care Workers, Zygmunt Zimowski, has pointed out, courageous action and urgent intervention.

Prof. ENRICO GARACI
President of the Higher Institute of Health Care, Italy

SILVANO M. TOMASI

Pontifical Diplomacy and the Promotion of Health for All

Globalization and Cooperation

1. Only 53 States in a world of some 2 billion people attended the foundation stone ceremony of the Palais des Nations in Geneva in 1929. But they shared with the 192 Member States of today's United Nations, now representing over 6.5 billion global citizens, a clear understanding of our interdependence. We are living in a time of multiple crises, including those related to economics, finance, food, maintenance of peace, and health. None of these challenges can be confronted successfully by any one nation acting alone. These threats require collective strategies. Thus U.N. multilateralism addresses disarmament, climate change, economic and social development, global public health and food security. It works at building consensus as the indispensable basis of effective multilateral action. Across national borders and institutional boundaries, the search for the global common good is pursued through consolidation of partnerships, negotiations, and operational engagement in the field. Realistically, the international system often is paralyzed while pursuing its noble ideals. Strains in multilateralism are seen in the lack of success in the Doha Round of world trade negotiations and in the climate change talks. The effort to share mutual benefits and responsibilities between developed and developing countries *vis-à-vis* the looming challenges, such as water, diseases, migration, demographics, post-conflict states, often appears to be a difficult task. But the call for an effective global architecture and a healthy 'new multilateralism' is repeated again and again.[1] Multilateral institutions need to be inclusive, fast, flexible and accountable, serving as an interconnecting tissue for the benefit of all in our multi-polar system.

2. During his visit to United Nations Headquarters in 2008, His Holiness Pope Benedict XVI offered an equally compelling view of the challenges to be faced by the international community.[2] He reminded those assembled on that occasion that the peoples represented there "look to this institution to carry forward the founding inspiration to establish a 'centre for harmonizing the actions of nations in the attainment of these common ends of peace and development.'"[3] He recalled the call by his predecessor, Pope John Paul II, for the Organization to serve as a "a moral centre where all the nations of the world feel at home and develop a shared awareness of being, as it were, a 'family of nations'."[4] He urged "…all international leaders to act jointly and to show a readiness to work in good faith, respecting the law, and promoting solidarity with the weakest regions of the planet." He insisted that, "[in] the context of international relations, it is necessary to recognize the higher role played by rules and structures that are intrinsically ordered to promote the common good, and therefore to safeguard human freedom" and called for "renewed emphasis in the principle of the responsibility to protect". He rejected efforts "to reinterpret the foundations of the *[Universal] Declaration [of Human Rights]* and thus to compromise its inner unity so as to facilitate a move away from the protection of human dignity towards the satisfaction of simple interests, often particular interests." He warned against attempts to facilely link "new situations" to "new rights", and counseled that "since important situations and profound realities are involved, discernment is both an indispensable and a fruitful virtue." In his closing remarks to the U.N. General Assembly, the Holy Father identified the United Nations as "a privileged setting in which the Church is committed to contributing her experience 'of humanity', developed over the centuries among peoples of every race and culture, and placing it at the disposal of all members of the international community."

The Trend to Universalizing the Right to Health

3. Papal diplomacy responds to the Church's efforts to embody her message and witness her good works in today's historical context and it adds an original and necessary contribution, the subsidiarity approach, which gives the right place to States, NGOs, corporations and the civil society in general in the construction of a global system. The area of health is part of the concern for the global common good. Several U.N. agencies in Geneva are mandated to work on health issues and papal diplomacy is engaged with them as well as with Catholic NGOs that engage in advocacy for all people with health problems.

The health-related policies of the World Health Organization (WHO), the World Trade Organization (WTO), and the International Labor Organization (ILO), represent an increasing attempt to universalize health protection through the strengthening of health care infrastructures, the affirmation of right-to-health standards, the prevention of pandemics, etc. The strengthening of intellectual property rights and the subsequent problem of access to medicines have led States, international organizations,

non-governmental organizations and academia to express their concerns in an increasing number of forums within the international community. Intellectual property issues are currently high on the agenda of international organizations, such as the World Health Organization (WHO) and the Food and Agriculture Organization (FAO), and they are discussed by such bodies as the Conference of the Parties to the Convention on Biological Diversity of 1992 and the United Nations Council on Human Rights. States and other political actors in the international community are advancing negotiations within areas other than those related to intellectual property, including areas related to fundamental rights or biodiversity. These issues and objectives are much closer to the interests of developing countries and call into question regulations and obligations already established in international conventions, while successfully creating new approaches and standards to facilitate the process of access to medicine. Today's progress is rooted in history and it carries on a long tradition.

The Church's Care for the Sick: an Integral Approach

4. Solicitude for the sick and suffering is certainly not a recent development in the Church's ministry. From their experience and witness of Jesus' constant concern for, and response to, those suffering from physical, mental, and spiritual challenges, Saint Peter, our first Pope, accompanied by Saint John, responded to the beggar's plea for alms, "I have neither silver nor gold, but what I have I give you!" Immediately thereafter, according to the Acts of the Apostles, "the beggar's feet and ankles became strong; he jumped up, [and] then began to walk around."[5] The Church's tradition of caring for the sick has been maintained faithfully and lovingly throughout the ages. Today, the same pastoral response is carefully promoted by this Pontifical Council, which was established by the Servant of God, Pope John Paul II, twenty-five years ago, to "serve as the coordinating organism for all the Catholic institutions, religious and lay, committed to the apostolate of the sick,[6]" and by the daily witness of tenderness and care offered, by a variety of apostolates.

At the level of pontifical diplomacy, the Holy See has been represented, as an Observer State, at the World Health Assemblies since 1952, and was invited, even earlier, to the Second World Health Assembly held in Rome in 1949. The participants in the latter event were received in audience by Pope Pius XII, who declared, "[Health] is that which encompasses the positive spiritual and social well-being of humanity and, on this ground, is one of the conditions required for universal peace and common security."[7]

In the field of health, especially with regard to some areas of human behavior, ethical differences between the Holy See and the international community have become strident, and, in high-handed fashion, the media focuses on these differences. The roots of these differences include the underlying anthropology of extreme individualism, as well as the lack of respect and understanding for natural law. In particular, the ethical shortcomings of such an approach are evident in a definition of freedom without any reference to the common good, the mistaken criteria for understanding the family or the right to life, and the attempts to formulate policies on research and on access to medicines from the sole perspective of profit.

Within a cultural context of this type, the representation of the Holy See finds itself, in some ways, in convergence, as in the case of efforts to achieve universal access to health care and medicines, and, in other ways, countercultural, as in the case of its defense of life and family ethics. In particular, our diplomatic activity pursues informal dialogue and makes public interventions to orient the development of a public health culture to meet the needs of all persons, poor and rich, through its advocacy for universal care on the basis of a justice-oriented Christian anthropology: the person at the center of concern, but also in relation to others. This type of dialogue with concrete aspects of post-modern culture and with the "producers" of this culture (agencies, research groups, international officials, etc.) is not easy, since it requires competent preparation, up-to-date information, sufficient understanding of scientific research, of its consequences for the common good, as well as of the application of its findings. But the task indicated by the Second Vatican Council and the Holy Father is clear: the charity of the Church – her love for people – does not allow her to retreat from presence in, and service to, modern society, especially to its more vulnerable segments like the sick.

5. In this vast area of human concern, there exists significant potential for cooperation between the Holy See and the international community on many issues that affect the health of people, from poverty-related and chronic, non-communicable diseases, to pandemics such as HIV/AIDS, malaria, tuberculosis, and various forms of influenza.

Through its representatives in the multilateral system and their activities in field of health concerns, the Holy See assumes a particular role by insisting that the dignity of the human person and respect for life from conception to natural death must be promoted and maintained at the centre of such activities and that all persons should gain equal access to decent care, medications, and life-saving and life-enhancing technology.

Specific Issues

6. Now let us review some of these specific issues as well as the response of the Holy See in the light of Caritas in Veritate.

a) *"Morally responsible openness to life represents a rich social and economic resource" – Caritas in Veritate, (n. 44)*

Affirmation of the sacredness and dignity of human life, from the first moment of conception until natural death, constitutes the essential foundation of the Holy See's engagement in diplomacy at the United Nations and other inter-governmental and global forums. Pope Benedict XVI explained this in uncompromising fashion when he wrote "*Openness to life is at the centre of true development*. When a society moves towards the denial or suppression of life, it ends up no longer finding the necessary motivation and energy to strive for man's true good. If personal and social sensitivity towards the acceptance of a new life is lost, then other forms of acceptance that are valuable for society also wither away."[8] The Holy Father details additional disturbing trends in this regard: "To the tragic and widespread scourge of abortion we may well have to add in the future — indeed it is already surreptitiously present — the systematic eugenic programming of births."[9]

Thus the pontifical representations to the United Nations pursue every relevant occasion to insist on respect for the sacredness of human life at every stage, from conception to natural death, and to resist any attempts to insert ideology linked to the "culture of death" as "official" components of international policies or practice. We confront constant attempts to insert language into United Nations documents that later could be interpreted as recognition of so-called "sexual and reproductive health *and rights"* or a so-called "rights to 'legal and safe' abortions", or to "comprehensive sexual and reproductive services" (presumably including abortion).

For example, very late in the preparatory process for the 2009 World Health Assembly, one State introduced a Resolution on Birth Defects; this motion was postponed for consideration by the WHO Executive Board meeting to be held in January 2010. At that time, the WHO Secretariat listed "selective termination of pregnancy" as one means, *inter alia,* of preventing birth defects. The Holy See delegation to this meeting reacted decisively[10] by stressing that "… human life begins at the moment of conception and that life must be defended and protected. Abortion and policies which favor abortion should not be accepted. The Holy See can never condone abortion or policies which favour abortion… The Holy See further affirms that the right of conscience of health service providers is assured by, inter alia, Article 18 of the Universal Declaration of Human Rights[11]." The Delegation called attention, moreover, to Article X of the United Nations Convention on the Rights of Persons with Disabilities, which declares that "States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.[12]" In its report to the 2010 World Health Assembly, the WHO Secretariat maintained the reference to "selective termination of pregnancy" as a means of preventing birth defects, but the resolution passed by the Assembly made no such reference.

These concerns go beyond those inherent to the beginning of human life. Thus Pope Benedict XVI noted in *Caritas in Veritate*: "At the other end of the spectrum, a pro-euthanasia mindset is making inroads as an equally damaging assertion of control over life that under certain circumstances is deemed no longer worth living. Underlying these scenarios are cultural viewpoints that deny human dignity."[13]

In relation to this issue, the Holy See is attentively following discussions on a proposal to prepare a "Convention" or other form of international binding agreement on aged or elderly people. In a similar manner, we have urged careful consideration of the ethical issues inherent in consideration of "Expanded Guidelines on Human Organ and Tissue Transplantation" by raising the caution, at the WHO Executive Board Meetings in May 2008 and January 2009, about the use of "non-heart-beating" organ donors: "Particular care should be encouraged and taken in order to assure that, in all cases, the cessation of vital functions is truly irreversible and that it is certified by valid criteria."

b) *"The question of development is closely bound up with our understanding of the human soul"- Caritas in Veritate*, (n. 76)

In this landmark encyclical, the Holy Father cautions against "oversimplifications" that "stem from a profound failure to understand the spiritual life", and warns that these mistaken notions "obscure the fact that the development of individuals and peoples depends partly on the resolution of problems of a spiritual nature." He further maintains that "*Development must include not just material growth but also spiritual growth*, since the human person is a 'unity of body and soul'."[14] This point is particularly relevant with regard to the World Health Organization's definition of "health". In January 1998 a special working group of the WHO Executive Board on the Review of the Organization's Constitution, and the Executive Board itself, recommended to the 51st World Health Assembly that the preamble of the WHO Constitution be amended to include the following definition of "health" as "a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity."[15] However, to this very day, the definition lacks any reference to the spiritual dimension of health and very little discussion on this matter can be heard during WHO proceedings. Clearly, our efforts at pontifical diplomacy in the field of health must be strengthened in order to assist experts, as well as the general public, to understand the statement of Pope Benedict XVI that "… between faith and science there is no opposition, notwithstanding some episodes of misunderstanding recorded in history," since "[a] man of faith and prayer … can cultivate serenely the study of the natural sciences and progress in the knowledge of the micro and macro cosmos, discovering the laws proper of

matter, because all this concurs to feed the thirst for and love of God."[16]

The Holy See and Access to Medicines in the WTO Framework

7. Another important area of activity concerns access to medicines. A fundamental distinction in human rights law is between civil and political rights ("first generation" rights) and socio-economic rights ("second generation" rights). The former are "negative" rights that curb state power by imposing a duty on it not to act in certain ways; the latter are "positive rights" that impose obligations on the state to secure for its citizens a basic set of social goods – education, health care, food, water.

The most important international instrument related to socio-economic rights is the International Covenant on Economic, Social and Cultural Rights (ICESCR)[17] of 1966, which has been ratified by some 130 States. One of the substantive rights recognized by the Covenant is "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[18] Parties are obliged, in particular, to take the steps necessary for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases",[19] and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness"[20].

The AIDS crisis, together with the worrying and continuous spread of longer-known infectious diseases, such as malaria and tuberculosis, constitutes a global disaster of dramatic magnitude. Most poor people suffering from these diseases receive only very inadequate health care. In so many of the poorest countries, lack of basic medicines together with poor health infrastructure, prevents an appropriate response to urgent public health care needs. The legal protection of intellectual property, especially through patents, gives to the patentees monopoly rights over the product or process, during the patent life-span. "Such a right may indeed allow a patentee to produce and supply the product only when and where it is possible to recover, through pricing policies, the costs of the investments contained in its development, as well as the expected revenues, while disregarding those who cannot afford the product's prices. Within an open free trade system, intellectual property rights constitute an exceptional monopoly regime."[21]

We are reminded by Pope Benedict's latest encyclical letter: *"…in the context of immaterial or cultural causes of development and underdevelopment, we find these same patterns of responsibility reproduced. On the part of rich countries there is excessive zeal for protecting knowledge through an unduly rigid assertion of the right to intellectual property, especially in the field of health care. At the same time, in some poor countries, cultural models and social norms of behaviour persist which hinder the process of development."*[22]

The current system interferes with the right to health in two ways, at least from the general and theoretical point of view. First of all, people from the Least Developed Countries (LDCs) cannot afford the very high cost of patented drugs, which can be traced to the patent owner's rights claimed for the production of such medications. However, even in developing countries, the high cost of patented drugs undermines the budget earmarked for public expenditure for health care. The second obstacle relates to research and development (R&D): patent protection, in fact, does not operate as an incentive to research on so-called "no market" treatments, including those for HIV, tuberculosis, or malaria. In other words, the market to be addressed by such drugs, even if it is a large one, is found primarily among poor people and thus is unable to ensure a return on the R&D investments made by the pharmaceutical companies. One group particularly deprived of access to medicines is that of children. "Many essential medicines have not been developed in appropriate formulations or dosages specific to paediatric use. Thus families and health care workers often are forced to engage in a "guessing game" on how best to divide adult-size pills for use with children. This situation can result in the tragic loss of life or continued chronic illness among such needy children."[23] It is because of an excessive focus on profit, therefore, that we witness an orientation of pharmaceutical research toward strategic areas of less importance, such as for weight-loss treatments or remedies for impotence, which have greater market potential in wealthier industrialized countries. In relation to this issue the Holy See is carefully following the debate on intellectual property and public health in the Trade Related Intellectual Property Rights (TRIPs) Council in the World Trade Organization. As Observer Member, the Holy See emphasizes the very creative and innovative impetus offered by the system of intellectual property

rights – especially in the health sector – as well as its primary function, which is to serve the common good of the human community.

8. In conclusion, the examples given should indicate that the Church's perspective transcends borders and categories of people and reaches out to the whole human family. In the area of health, her perspective is kept alive so as to serve as a voice of conscience. The diplomacy of the Holy See patiently promotes life and the common good in response to the "ups and downs" of today's circumstances. The Holy See's diplomatic activity has been, and remains, a real part of the international community, a presence at the multilateral level that bears witness that its work is a service of love to the entire human family.

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Notes

[1] U.N. Secretary General, Princeton Colloquium, 17 April 2009. "The Imperative for a New Multilateralism."

[2] Pope Benedict XVI, *Address to the General Assembly of the United Nations, New York*, 18 April 2008, *http://www.vatican.va/holy_father/benedict_xvi/speeches/2008/april/documents/hf_ben-xvi_spe_20080418_un-visit_en.html*

[3] *Charter of the United Nations*, article 1.2-1.4.

[4] Pope John Paul II, *Address to the General Assembly of the United Nations on the Occasion of the Fiftieth Anniversary of its Founding*, 5 October 1995, *http://www.vatican.va/holy_father/john_paul_ii/speeches/1995/october/documents/hf_jp-ii_spe_05101995_address-to-uno_en.html*

[5] Acts 3:6-8.

[6] Pope John Paul II, *Dolentium Hominum,* 11 February 1985, Vatican City, *http://www.vatican.va/holy_father/john_paul_ii/motu_proprio/documents/hf_jp-ii_motu-proprio_11021985_dolentium-hominum_en.html*

[7] Pope Pius XII, *Address to the World Health Assembly*, 1949.

[8] Pope Benedict XVI, encyclical letter *Caritas in Veritate,* Vatican City, 29 June 2009, #28, *http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate_en.html*

[9] *Ibid.,* n. 75.

[10] Holy See Intervention at the 126th Executive Board Meeting of the World Health Organization on Secretariat Report on "Birth Defects" - EB126/10, 18-23 January 2010

[11] Statement of the Holy See at the Concluding Session of the 21st Special Session of the General Assembly for the Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development New York, 2 July 1999, *http://www.un.org/popin/unpopcom/32ndsess/gass/state/holysee.pdf*

[12] *http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf*

[13] *Caritas in Veritate*, n. 75.

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

[15] World Health Organization (1998) Executive Board 101st Session, Resolutions and Decisions, EB101.1998/REC/l, pp. 52-53.

[16] Pope Benedict XVI, General Audience Address, 24 March 2010, Vatican City, *http://www.vatican.va/holy_father/benedict_xvi/audiences/2010/documents/hf_ben-xvi_aud_20100324_en.html*

[17] GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 49, UN Doc. A/6316 (1966); 993 U.N.T.S. 3; 6 I.L.M. 368 (1967) [hereinafter "ICESCR"]. It entered into force on 3 January 1976, in accordance with Article 27.

[18] ICESCR, Art. 12(1).

[19] ICESCR, Art. 12(2)(c).

[20] ICESCR, Art. 12(2)(d).

[21] Intervention by the Holy See Observer to the December 2002 plenary Council of the World Trade Organization on Trade-related aspects of Intellectual Property Rights, Geneva. *http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20010620_wto_en.html*

[22] Pope Benedict XVI, encyclical letter *Caritas in veritate*, n. 22.

[23] Intervention by His Excellency Mons. Silvano M. Tomasi to the 14th Session of the Human Rights Council.

REINALDO A. GARCIA

Ethics and Access to Health-Care Technologies

Introduction

Thank you. I very much appreciate this opportunity to share with you some thoughts about "Ethics and Access to Healthcare Technology" ...though with a small but significant addition to the title:

In recognition of how the field of medical and other technology has rapidly advanced, and because the healthcare challenges faced by countries around the world differ, I believe it is more relevant for us to consider: "Ethics and Access to Appropriate Healthcare Technology".

In my view, when discussing Ethics and Access to Healthcare Technology it is essential to fully understand the local or regional healthcare issues you are trying to address, together with local cultural, economic and social conditions.

The 'access to healthcare technology' challenges that face the businessman in Rome, the mother of five in Botswana, and the rural worker in Brazil are quite different. And so, it should come as no surprise that the technology solutions to these challenges will also be different. Therefore, the key questions on 'access to technology' should be:

"Access *to* what?" and *"for* what?"

Too often in the past, debates regarding 'access to technology' have been generalized with discussions conducted without taking into account local needs. Technologies were developed that neglected areas that pose the greatest challenge such as rural communities, socially disadvantaged populations and, of course, developing nations.

I am happy to report that this is no longer the case and that, certainly in the case of GE Healthcare, "location, location, location" is the mantra for how we develop medical technologies today. We call this approach "in-country for country" and it is already improving access to technology throughout the world.

The pace of change

As a medical technology provider we are very proud of the advances the medical community has achieved through the use of high-tech diagnostic imaging such as MRI, CT and PET. These platforms have provided ever increasing diagnostic specificity, and sensitivity, to the benefit of millions of patients in Europe and throughout the world.

The research community has also used diagnostics coupled with IT to better understand the causes of cancer, heart disease, stoke and many more chronic diseases that we will need to address in the coming years as our societies age and the numbers of medical professionals and carers decrease – a major issue on access in itself but one that I shall not address today.

Yet, however remarkable these achievements are, their effects have been unevenly distributed throughout the world's population. Today 10% of the world's population receives 80% of healthcare expenditure. We must address this. We must develop innovative technologies that not only match the different needs, but also and the different budgets.

I hope to show you that we have the technical ability and are making greater advances – particularly in increasing access for more people to affordable quality healthcare that addresses their needs in all parts of the world and circumstances.

Digital revolution

Over the last few decades we have all witnessed the changing landscape of communication technology… digitization, miniaturization and broadband have resulted in the ubiquitous mobile phone.

These same influences are driving the development of healthcare technologies, where the power of medical imaging, information technology and biology are fusing together, resulting in a new wave of products that are transforming healthcare delivery.

It's an exciting time when you can hold in your hand an Ultrasound device, no bigger than an ipod, which uses nothing more complex than sound waves to render highly specific and sensitive images of the body. Products like this have the potential to become the most widely used imaging technologies in the world.

We all have a role to play in harnessing the power of this digital

revolution to improve access to healthcare. Right now across the world, governments, companies, NGOs and academics are working together to reduce health inequalities and make healthcare more sustainable.

GE is working with them and so too is the Catholic Church and other faith based delivery organizations which have a long and proud history in bringing better health to some of the world's most challenged regions and populations. The type of technologies we are developing will be of little use unless they can be put into practice in the areas of most need. Hence, we need to work closely with the delivery organizations to ensure that we meet their needs. Let me explain how we go about this.

HEALTHYMAGINATION – improving access, quality and cost

As a global, technology based, diagnostics and healthcare solutions business, GE Healthcare sees its critical role as making cost-effective life-saving technology more accessible in the semi-urban, rural and developing areas which often bear the brunt of the disease burden.

This is epitomised by GE's healthymagination programme which aims to deliver technologies and solutions that improve the quality, access and cost of health in all parts of the world, with a commitment to metrics that are validated by a third party.

Our healthymagination commitment applies to the poorest and richest countries alike: to those places with underserved healthcare systems where technology can improve access and patient outcomes; and to places where technology is regarded as a driver of healthcare costs and where, instead, it needs be used to drive efficiencies and improvements in delivery.

So, how does healthymagination apply to, say, rural Africa, Latin America or South East Asia?

When healthymagination was launched in May 2009, GE CEO Jeff Immelt highlighted two products that looked to the future. The MAC 400 Electrocardiogram device and the Venue 40 tablet sized portable ultrasound scanner.

These devices are battery powered, portable, self contained and simple to use. They are examples of using the consumer electronics boom to miniaturize and adapt technology that was once the sole preserve of the hospital, and take it into clinics and rural locations remote from mainstream medical facilities.

Both these technologies take healthcare to the patient rather than the patient to the healthcare provider, and both were developed and manufactured in the markets for which they are designed.

Even in poor emerging markets, chronic disease remains the largest cause of health morbidity and mortality. The MAC 400 enables the district nurse or health assistant to run ECG in remote locations, but still using the best and most up to date algorithms, to screen and treat patients with heart disease. Just because someone is poor, and lives remotely, should not condemn them to an inferior diagnostic service. The MAC 400 allows modern technology to be brought to the bedside, remotely.

VENUE 40 delivers point of care ultrasound in a wide variety of applications such as anaesthesia, rapid abdominal and cardiac examination, or trauma, and allows safer needle guided procedures. To drain a pleural effusion, the patient no longer has to travel to the remote hospital, instead the health assistant, nurse or local physician, can do this procedure at the patients' home or local rural clinic.

These examples of new generation products help save lives improve health care productivity, and importantly increase access to health care.

New mindset – in country for country

In order to develop these technologies GE had to change its mindset.

GE's traditional "glocalization" business model, where products were developed in home markets like the USA and Europe, then adapted for sale elsewhere – often by reducing specifications and manufacturing locally – worked to some extent, but frequently the products were not suitable for local circumstances – too big, too complicated, susceptible to power fluctuations and difficult to use and maintain in physical environments quite different from those they were originally designed for. And, despite lowering the capital cost of equipment, financial models for its use and upkeep based

upon home market experience did not work and were not sustainable.

The company now increasingly researches, develops and manufactures the right technology for local needs in the country or region of use as part of our "in country for country" approach to new technology development.

In short, GE teams with deep local knowledge and unprecedented autonomy in Latin America, India, and South East Asia and a dozen other countries now manage the development and production of new products to meet local needs.

In an interesting twist, because these new products do not compromise on quality, some are finding a use "back home" in the developed markets. This has become known as "reverse innovation."

Reverse innovation

Technologies designed to meet the specific medical needs and circumstances of developing nations are proving popular in more developed markets, particularly where there are large rural, underserved populations.

The MAC series of electrocardiograms (ECG) is a good example of this. Originally developed in India, their ease of use and portability make them equally attractive for primary care physicians and nurses in clinics and on home visits in other countries including the USA.

These machines are even used by "flying doctors" serving the Inuit populations in Northern Canada, and data from examinations can be viewed on the spot or transmitted to specialists in urban centres for analysis or second opinion.

In today's financially restrained times, technology that enables more diagnostic tests to be conducted outside of the hospital environment or at the patient's bedside, rather than referral and physical transport, are likely to be attractive in helping to improve access and drive healthcare system efficiencies.

Marketing these technologies in developed as well as emerging markets allows the development costs to be spread wider and hence the price point to the developing market can be set at an affordable level. This enables the country to purchase and maintain the technology – meeting GE's healthymagination commitments relating to quality, access and cost – and helps to create sustainable healthcare systems that work within local economic conditions and do not have to rely on long term international aid or charitable contributions.

"Appropriate" technology solutions

Innovative medical technologies are now being developed for almost all the diseases and conditions found across developing nations. Until relatively recently the predominant focus was on medicines, vaccines and prevention and awareness campaigns. This work has been critical to address the acute challenge of communicable disease such as Malaria, TB, HIV/AIDs and other tropical diseases.

However, throughout the developing nations it is now clear that their populations are suffering from massive increases in the same chronic conditions affecting all countries- cancer, cardiovascular and respiratory disease and the many medical consequences of obesity and diabetes.

To help address these challenges, there is an emerging shift towards new and better technologies for screening, earlier diagnosis, treatment assessment and monitoring of chronic disease and equipping the healthcare system to provide this. There is also a renewed focus on working to resolve the global burden of mortality and illness in maternal and newborn health.

Maternal and newborn health

In September, the United Nations met in New York to consider progress to date in implementing the Millennium Development Goals set in 2000 with targets for attainment by 2015. Prominent amongst these were the challenges of Maternal and Newborn Health

MDG 4 aims to reduce by two-thirds the mortality rate among children under five – and deliver this by 2015. Of the 139 million babies born worldwide every year, over 3 million die in the neonatal period, the main direct causes being preterm birth, severe infections and asphyxia.

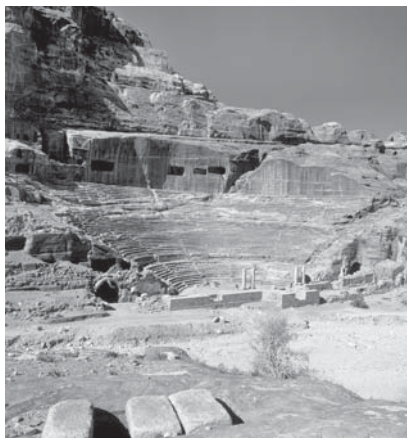
The real tragedy is that most of these deaths are preventable. With just five years to go, reaching the MDG will require new levels of cooperation amongst everyone concerned, from doctors to midwives, Governments to NGOs and researchers to businesses. It will also require a reappraisal of the ways in which healthcare technologies are developed and deployed, especially in areas where neonatal mortality rates are the highest.

As part of GE's global healthymagination commitment, we shall expand our Maternal-Infant Care portfolio to offer more, targeted technologies to over 80 lower income countries and increase local access to care. Included already are safety tested, affordable and easy-to-use infant care products that provide warmth for newborns, phototherapy to treat jaundiced infants and incubators for premature babies.

Many of these products are designed and manufactured in India and Turkey. GE is now working on developing very simple warmers and phototherapy devices for developing nations at dramatically reduced cost. A novel method for providing oxygen to mothers in childbirth and to new born babies is also under consideration.

Another very exciting new product, I showed you earlier, is the VScan – our hand held portable ultrasound scanner, developed in emerging markets. Its clinical applications are currently being assessed in both emerging and developed markets for a wide range of diseases and conditions. These include assessing its capabilities and clinical protocols for its use in maternal and neonatal care applications in emerging markets.

Imagine you're a doctor or health worker in one of the most underdeveloped regions of Africa. 40 miles from your clinic, a woman in her second trimester of pregnancy is in pain. You travel to her village. When you get there, you open your hand-held ultrasound. It only weighs 390 grammes, but it's just as powerful as the large machine found in the most advanced hospitals. It quickly allows you to see that the baby has turned and is in some distress with a slow heart beat – the mother needs to get to the clinic for treatment. Alternatively, the scan shows the baby is fine and the pain is caused by a distended gall bladder: the mother can be treated with antibiotics at home and avoid the arduous trip. Is this just a vision? Right now yes, but also right now we are working with several global NGOs to pilot training porgrammes for health workers in several African nations to use VScan for this very purpose. So the vision may soon be reality.



Ultimately, our vision is for VScan to be as ubiquitous as a stethoscope and to achieve that it must have a truly global reach. As in consumer electronics, unit costs will be reduced as more clinical applications are approved, production increased and other design innovations are deployed.

The goal is to reach a point where the purchase, training and upkeep costs can be recovered by a sustainable pricing model in even the lowest income countries of the world. This is a goal that was simply unimaginable only a few years ago and now promises to bring to anywhere powerful diagnostic technologies previously the exclusive domain of the hospital.

Working with NGOS and delivery organisations

Having designed new technologies the next challenge to ensure better access, is to test, refine and deploy them in the field. Lessons have been learned from the GE Foundation's keystone philanthropy programme "Developing Health Globally".

This programme is improving the healthcare capacity in Africa, South East Asia and Latin America by equipping hospitals and clinics with the technology they need and ensuring staff are properly trained in its use. In this programme we draw on resources from across the different GE businesses, like GE Energy for power generation and GE Water for purification plants.

Using volunteers from GE and GE Healthcare the programme has shown that what is actually required on the ground is often not what is perceived from afar and that what works in Rome may not in Rwanda. In short, the learning is that there is no substitute for having people in situ on the ground.

It is here that we actively seek partnership with governments, professional organisations and increasingly NGOs with a presence in developing markets. While we may have design teams and sales and marketing and business expertise in many countries, we sometimes lack the infrastructure on the ground to take the new technologies out to the patients.

Another example of our partnership approach is a project we've just completed in Namibia. This project was conducted for Namibia's Minister of Health with a 13M€ special credit loan from the Finland government. Together we renovated 46 main hospitals focusing on Maternal and Infant Care. The program was about providing 'a healthcare solutions' package which included the supply of the appropriate technologies, the logistics, the installation, the maintenance provision, and a large education and training program.

This is just one example of projects that GE Healthcare is promoting that leverage funding sources from the developed countries toward the poorest ones.

There are also many global and local NGOs experienced in this type of work and we are keen to join with them to provide the training programmes and capacity building in country for testing new technologies. I would be interested to hear from you in discussion afterwards whether there may also be opportunities to work through similar networks in developing countries operated by the Church.

Through this type of partnership we can better reach the end users to determine if access to a new technology really will be of use on the ground. If yes, working in a partnership could also allow us to develop clinical protocols and appropriate uses for the technologies, speed up delivery, provide the right training and support needs and minimize costs.

Only the beginning

Much remains to be done. GE is not claiming to have all the answers to ensure that all parts of the world have access to innovative technologies that improve health. We do however understand the problems and can see many of the obstacles in the way.

Hopefully I've convinced you that "yes it's important to increase people's access to healthcare technology"… but that healthcare benefits will only follow if that technology is relevant to solving local issues, and that this cannot be a one-size-fits-all technology approach. We need to tailor our technology solutions to the local circumstances and use them in a way that they become significant drivers of change.

Having spent the majority of my time talking about the health issues, and technology enablers to improve access to healthcare in the developing nations, we should not forget that closer to home European healthcare systems are al-

so under intense pressures. In light of the financial crisis policy makers are already attempting to balance health expenditure while improving quality and efficiency of healthcare delivery.

Here again GE has mobilised its expertise to help our customers here in Europe, and across the developed world, to redesign their businesses and address these demands for higher quality and more efficient health care. Our teams in Hospital and Healthcare Solutions (HHS) provide services that help our customers in three major areas:

Increase the quality and safety of their patient care with treatment pathway protocols and clinical decision support systems.

Better understand how their operating performance affects the delivery of efficient, high-quality health care through the continuum of care.

Develop integrated health organizations that run more efficiently through improved business operations.

It's the powerful unique combination of our clinical expertise and technologies, coupled with GE's process excellence and change leadership tools, which help our global customers find new ways of organizing, measuring and managing health care delivery over the full-cycle of care to drive better cost, quality and access.

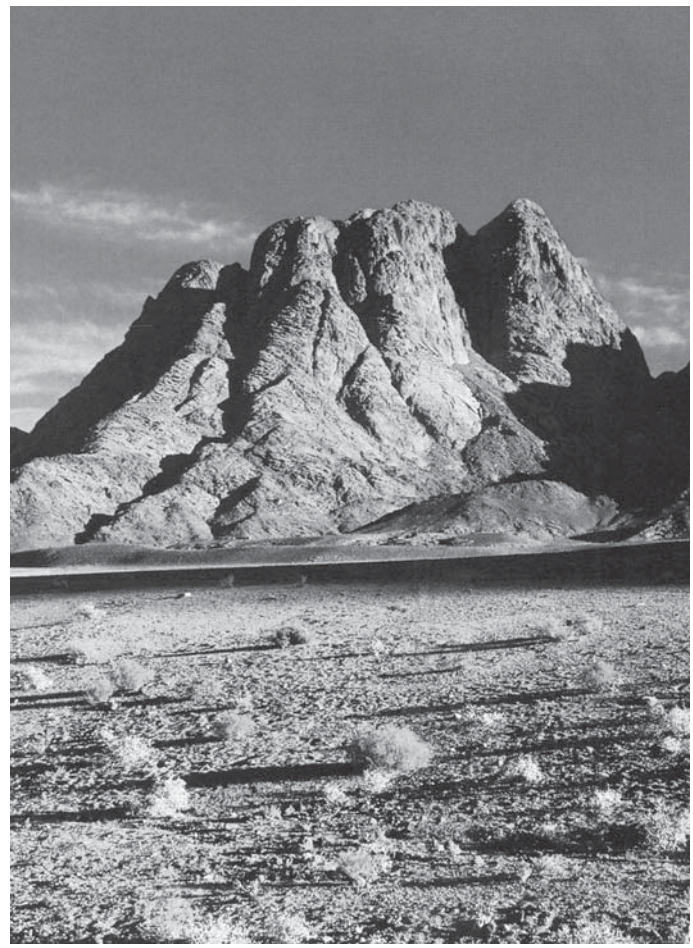
In summary

Wherever we are in the world we must all be smarter. We must use technology to transform healthcare. We cannot afford not to. We all know the problems that exist with healthcare today: soaring costs, declining access, ineffective treatment, inefficient administration, rampant medical errors, and so on. And these aren't limited to one country or one continent.

Through healthymagination and the development of new technologies we are committed to working to help overcome the challenges. It will require more collaboration, partnerships, clear thinking and the courage to do things differently.

The transformation of healthcare is no doubt one of the toughest challenges we will face this century. But I'm optimistic that by using innovative technology it's a challenge we'll overcome. And when we do, history will record our achievement as one of the great triumphs of this century.

Dr. REINALDO A. GARCIA
President & CEO,
General Electric Health Care



RENATO SALVATORE

The Contribution of Catholic Health-Care Institutions to Improving the Conditions of Health of Peoples

The subject that has been entrusted to me, in order to be addressed in a complete way, requires a discussion that goes beyond the time limits that have been wisely established. I will not dwell upon the admirable things that Catholic health-care institutions (CHCIs) have been doing for decades in all the continents of the world but, rather, upon their specific goals as works of the Church.

In my view, the crucial point is the concept of health that these institutions should promote. Everyone knows that there are multiple definitions of health and as a consequent different strategies by which it is in turn achieved. The Christian concept of health is different from the others because it derives from a specific vision that Revelation has given to man: man created in the image and likeness of God, redeemed by Christ, and open to transcendence.

A second aspect to be stressed is that CHCIs have the task of 'analysing the structural causes that cause pain, poverty and malaise and of being able to plan adequate interventions that seek to remove them, promoting synergies and cooperation with all those who are sincerely interested in the good of man'.[1]

1. Suffering Man: the Special Way of the Church

The pages of the gospels demonstrate to us the tender mercy of Jesus towards people who were 'sick' in body, in spirit, in social relationships…For them he had words and approaches that expressed compassion, understanding, forgiveness, welcome, and they were frequently transformed into powerful 'signs'. Christ, the visible manifestation of the infinite love of the Father, did not come only to save 'souls' but also to offer 'full life' to every person in all his or her (spiritual, psychological, physical and relational) dimensions.[2] Thus he linked in an indissoluble way not only the concepts, but also the true and definitive achievement itself, of health and salvation: in him we are given a 'health-inducing salvation' and a 'salvific health'.

The Catholic Church, in order not to betray the mandate of Jesus Christ, must care for everyone without any form of discrimination; the sole particularity is special attention being paid to the poorest. In addition, inasmuch as it is the mystical body of Christ and a community healed by him, it becomes in its turn healing, that is to say an instrument of health and salvation.

The practical and constant charitable activity of the Church down the centuries should not be interpreted primarily as a response to social needs[3] but, rather, as faithfulness to the example of Christ and to the mandate of the Risen Christ: 'Go and preach, the Kingdom of heaven is near! Heal the sick, bring the dead back to life, heal those who suffer from dreaded skin diseases, and drive out demons' (Mt 10:8). Very many documents of the Church emphasise this basic belief: 'In this meeting man 'becomes the way for the Church', and this is one of the most important ways. At this moment *the suffering individual is the way of the Church* because that person is, first of all, the way of Christ Himself, who is the Good Samaritan who "does not pass by", but "has compassion on him, went to him... bound up his wounds... took care of him" *(Lk* 10:32-34)'.[4] The Church brings into play initiatives consonant with its own vision of man. In truth, those who know man are in a condition to provide the best 'recommendations' by which to achieve the deepest human finalities. Jesus Christ, in revealing to us the Father and himself, revealed to men their identities, their true needs and the way by which these could be met.

The involvement of the Church in the social/health-care field is very significant from a quantitative and qualitative point of view and it is also universally very much appreciated. The Church cares for a large number of people with the contribution of thousands of pastoral and voluntary social/health-care workers and by drawing upon various kinds of institutions.

In order to understand how relevant the role performed by the Church is, it is sufficient to look at its innumerable activities: for example, in the sub-Saharan region the Church is the first partner of governments, even providing 60% of health-care services.

The *Annuario Statistico della Chiesa* provides the following data on the year 2008 as regards the social/health-care activity of the Church in the world: hospitals: 5.428 (of which 1,137 were in Africa, 1,717 in America, 1,130 in Asia, 1,288 in Europe, and 156 in Oceania); clinics: 18,025; old people's homes for the chronically ill or invalids: 15,985; centres for social education or re-education: 34.250. When we add leper hospitals, orphanages, nurseries, family counselling centres and other charitable institutions one reaches a total of

120,826 structures that are owned or administered by the clergy or religious.

The characteristics, challenges and responses of these structures are obviously different according to the continent involved and within each individual nation. It is not the aim of this paper to provide a description of this. Those who are interested can find a rich analysis in the proceedings of the Third World Congress of the AISAC (3-5 October 2007 published in *Dolentium Hominum*, n. 66, 207/3.[5]

The activity of Catholic health-care institutions are principally characterised not by 'what' they do but by 'how' they do it, that is to say because they care for people in line with the Christian anthropology, respecting the special dignity of the person in a holistic vision of the person and his or her needs, within the framework of the social doctrine of the Church, with the promotion and defence of rights…

In addition, there is a *proprium* (a 'motivation') that must define each member of the Church in his or her relationship with each person and which should never be forgotten: love. The imperative for every Christian is to love others as Christ has loved him or her. This belief offers all Christian health-care workers in the world of health and health care a motivation and strength for a truly unique approach, pushing him or her not only to give something but to 'give himself or herself'! And love to be such must be conjoined with truth: 'Truth needs to be sought, found and expressed within the "economy" of charity, but charity in its turn needs to be understood, confirmed and practised in the light of truth'.[6] At this point I would like to draw attention to some of the specific features of the CHCIs to which I have just referred.

2. The Christian Vision of Man

History has taught us, at times dramatically, the relevance and the consequences of the idea (ideology) that people have of man.[7] The Church cannot escape the question 'who is man' when it decides to begin, continue or transform activities in the social/health-care field.

For its understanding of the identity, the vocation and the ultimate destiny of man and mankind the Church draws upon Revelation.[8] Each person finds the foundation of his or her dignity in being generated in the image of God and his or her destiny of eternal communion with God. We are made aware of this dignity by Christ himself who in being incarnated joined himself in a certain way to every man and as perfect man (the new Adam) 'fully reveals man to man himself and makes his supreme calling clear' (*GS*, n. 22).

To take on board these facts means for a Catholic health-care institution, for example, to uphold and defend the transcendent value of every human being from conception until natural death and in every condition of life and health. It also involves the welcoming of the magisterium of the Church: for example the appeal of the Supreme Pontiff John Paul II 'in the name of God:

respect, protect, love and serve life. Only in this direction will you find justice, development, true freedom, peace and happiness!'.[9]

For our subject this means working in a way that is consistent with the Christian concept of health. The specific contribution to the health of the peoples of the world by the Church, through CHCIs, depends on its faithfulness to the gospel and in particular to the health/salvation that Christ wishes to give to all men. The Church has the duty and the right to be the promoter of this health through the Word of God, the sacraments and charity.

Within this vision of man one understands that health cannot be isolated from a scale of values in which the first place must be held by God, He alone who gives live and can dispose of it to the utmost. From this point of view, life with God comes before earthly life; just as the person in his or her totality comes before his or her parts. Suffering and illness, as well, at times can confer on a person's existence depth and fullness of meaning because health is a good that should be spent/used within an approach to life lived in giving to other people: health is not a supreme good but an instrumental good; that is say a useful but not indispensable good, to obtain other goods of a higher value.[10] '*The health of a person* is dynamically inserted into a life project in which all experiences, joys as well as wounds, are integrated and are a part of a person's own personal history. It can, therefore, also be present in sick or disabled people who, physically, remain such, but who are able to perform (with the help of grace and the support of a com-*forting* community) the mission that God has entrusted to them, according to the moment of their lives in which they find themselves'.[11]

The gestures of Jesus – addressed to the least, the excluded, the poor and the sick – are emblematic of an integral health and of salvation: he is not only a healer, he is the Saviour. His 'health' is offered to the sick and to the healthy! Christ is health: he is both physician and medicine, healer and saviour; the new man and the model of the new man.[12] He heals us and enables us to heal other people who are prisoners of evil because the promotion of health belongs to the work of the building of the Kingdom.

The large number of ways of conceiving of human health reveal those human needs that are held to be fundamental and thus mark the consequent initiatives that are implemented in order to try to preserve health, recover it or promote it. As witnesses to the merciful love of Christ, physician and medicine of souls and bodies, Christians are called to understand and then

achieve the health that he offered to the sick and the healthy. Catholic health-care institutions are required to promote this kind of health.[13]

3. The Deaconate of Charity and Evangelisation: Charity in Truth

'As the years went by and the Church spread further afield, the exercise of charity became established as one of her essential activities, along with the administration of the sacraments and the proclamation of the word: love for widows and orphans, prisoners, and the sick and needy of every kind, is as essential to her as the ministry of the sacraments and the preaching of the Gospel. The Church cannot neglect the service of charity any more than she can neglect the Sacraments and the Word' (*DCE*, n. 22).[14]

The Church is requested to move swiftly in the face of emergency, an urgent need, a need that requires a rapid response,[15] but it also true that this response is not the ultimate response nor the most important one. CHCIs aim at health in an integral sense; they see the person in the totality of his or her needs, with a special consideration of those that are most foundational – spiritual needs.

The development of a suitable social/health-care system is not only a question of technological improvement – it is also a question of greater and better attention being paid to the person, the bearer of non-material needs that are essential for his or her wellbeing. The achievement of this goal involves, amongst other things, man being able to benefit from love and truth that liberate: there cannot be development without freedom and truth, without fraternity and solidarity.[16]

The proclaiming of Christ is the first and principal factor of development (*CiV*, n. 8) that is truly human and in the construction of a social/health-care system that is really on a human scale. Here the following observations of Pope Benedict XVI are illuminating: 'the Church, being at God's service, is at the service of the world in terms of love and truth… *authentic human development concerns the whole of the person in every single dimension…* In the course of history, it was often maintained that the creation of institutions was sufficient to guarantee the fulfilment of humanity's right to development... institutions by themselves are not enough, because integral human development is primarily a vocation, and therefore it involves a free assumption of responsibility in solidarity on the part of everyone. Moreover, such development requires a transcendent vision of the person, it needs God: without him, development is either denied, or entrusted exclusively to man, who falls into the trap of thinking he can bring about his own salvation, and ends up promoting a dehumanized form of development. Only through an encounter with God are we able to see in the other something more than just another creature, to recognize the divine image in the other, thus truly coming to discover him or her and to mature in a love that "becomes concern and care for the other"' (*CiV*, n. 11).

Evangelisation is first of all witness in our lives[17] which raises questions and as a consequence produces adequate answers to them through the service of the Word and the Sacraments: 'Charity makes us more witnesses than teachers. The 'prophecy of speech' is not sufficient: burning and humble, silent and provocative witness is necessary… Through this wordless witness these Christians stir up irresistible questions in the hearts of those who see how they live: Why are they like this? Why do they live in this way? What or who is it that inspires them? Why are they in our midst?'.[18]

Charity, as the Pope reminds us, is 'always more than activity alone' (*DCE*, n. 34), 'Practical activity will always be insufficient, unless it visibly expresses a love for man… My deep personal sharing in the needs and sufferings of others becomes a sharing of my very self with them: if my gift is not to prove a source of humiliation, I must give to others not only something that is my own, but my very self; I must be personally present in my gift' (*DCE*, n. 34).

'This love does not simply offer people material help, but refreshment and care for their souls, something which often is even more necessary than material support. In the end, the claim that just social structures would make works of charity superfluous masks a materialist conception of man: the mistaken notion that man can live "by bread alone" (Mt 4:4; cf. Dt 8:3) – a conviction that demeans man and ultimately disregards all that is specifically human' (*DCE*, n. 28).

Thus it is all that all Catholic health-care institutions become oases in which one can also receive that look of love which every person really needs, beyond his or her social status, race, religious, social difficulty or kind of illness. 'Fidelity to man requires *fidelity to the truth*, which alone is the *guarantee of freedom* (cf. Jn 8:32) and of *the possibility of integral human development*. For this reason the Church searches for truth, proclaims it tire-

lessly and recognizes it wherever it is manifested. This mission of truth is something that the Church can never renounce. Her social doctrine is a particular dimension of this proclamation: it is a service to the truth which sets us free'(*CiV*, n. 9). Thus CHCIs are first and foremost 'instruments to bear witness to and preach Jesus Christ the only saviour. They are not instruments of proselytism but of – often silent – fitness to that Charity in Truth that the Church has received from her Lord and which alone can construct a just and solidarity-based society' (*CiV*, n. 6).

4. Healing Communities: the Pieces of a Single Mosaic

If Catholic health-care institutions see themselves as an expression of the care of Christ for the suffering, the least and those in need, then they should engage in their activity in the name of the Church and thus by fully belonging to the action of their local Churches and the universal Church. This is what I would like to stress in this last part of my paper by briefly listing the fields – within the promotion of the health of the peoples of the world – to which especial attention should be paid.[19]

A Catholic health-care institution is a 'piece' of the great mosaic of charity-evangelisation: it constitutes an eloquent sign and valid means of the Church in its task of transmitting the salvation/health given to us by Christ.[20] The gospel message is the ultimate answer to the often unexpressed yearning of humanity for a full and definitive health and thus concerns every person in his or her dimensions.

a. Human life and the person

These are the first and fundamental values that CHCIs are required to respect, defend, serve and promote in line with their own status as works of the Church.[21] This role is today 'especially pressing because of the extraordinary increase and gravity of threats to the life of individuals and peoples, especially where life is weak and defenceless' (*EV*, n. 3).

Everything that goes against life, violates the integrity of the person or offends human dignity 'is both a disturbing symptom and a significant cause of grave moral decline…The end result of this is tragic: not only is the fact that of the destruction of so many human lives still to be born or in their final stage extremely grave and disturbing, but no less grave and disturbing is the fact that conscience itself, darkened as it were by such widespread conditioning, is finding it increasingly difficult to distinguish between good and evil in what concerns the basic value of human life' (*EV*, n. 4). Not only this but increasingly what is a crime against life is perceived as a right that the state should recognise and whose exercise it should protect.

In many ways Catholic health-care institutions, in communion with the whole Christian community and people of good will, can involve themselves in a productive way in the fight against what 'can be described as a veritable *structure of sin*. This reality is characterized by the emergence of a culture which denies solidarity and in many cases takes the form of a veritable 'culture of death'. This culture is actively fostered by powerful cultural. economic and political currents which encourage an idea of society excessively concerned with efficiency' (*EV*, n. 12).[22] It is necessary to proclaim and bear witness to the gospel of life, knowing that the ultimate root of this culture is to be found in the *eclipse of the sense of God and of man*: '*when the sense of God is lost, there is also a tendency to lose the sense of man*, of his dignity and his life' (*EV*, n. 21). Without God, life can no longer be seen as His gift and thus a sacred, inviolable and non-disposable reality; 'Life itself becomes a mere "thing", which man claims as his exclusive property, completely subject to his control and manipulation' (*EV*, n. 22).[23] To promote the health of peoples and their healthy development CHCIs must, in every society, make their own the urgent need to 'rediscover those essential and innate human and moral values which flow from the very truth of the human being and express and safeguard the dignity of the person' (*EV*, n. 71). [24]

Support for, and the promotion of, human life is a fundamental task of every CHCI and 'finds expression in personal witness, various forms of volunteer work, social activity and political commitment' (*EV*, n. 87) and in the awareness that it is a work of the Church: 'Everyone has an obligation to be at the service of life. This is a properly "ecclesial" responsibility, which requires concerted and generous action by all the members and by all the sectors of the Christian community' (*EV*, n. 79)

b. Education in health

Every health-care system is based upon certain values which form its basis as a foundation. Thus those who work in the world of health and health care are called to understand what the values are to which the state refers when it legislates so that in this way they are able to engage in an effective and prophetic evangelisation. Indeed, the state tries to provide to citizens those services that it believes to be suited to achieving the kind of health that it wants. In the same way, for that matter, as citizens want from the state all those instruments that are required to achieve those results that are in line with the standard of health that is expected (and at times requested).[25] One can offer and ask a little or a great deal, just or unjust things, licit or illicit things, moving from a lack of minimal means to the waste of public and private money! And, above all, ethical choices on the part of the state but also on the part of citizens come into play.[26]

Catholic health-care institutions are required to be involved in promoting, at all levels, a concept of health that respects the dignity of every person, the needs of the neediest sick people and health-care expenditure that manages with the least cost to reach the greatest number of people. 'Educating in health means, therefore, promoting the value of health in parallel with the value of life, sensitising people to subjects such as the right and the duty to health, the avoidance of styles of behaviour that threaten life itself and promoting a moral education that helps the person to locate health in a critical way within a broader hierarchy of values'.[27]

Education in health should be di-

rected both to the subject and to the community to which he or she belongs (the family, parishes, schools, social and health-care institutions, institutions of the local area), involving that community as a group and ordinary daily life with a view to behavioural changes in the individual but also with a view to institutional and organisational change. This assumes both knowledge of the specific cultural heritage as regards health of the person/community and their participation in the search for, and implementation of, a methodology of intervention. And it involves a real involvement – in a circular communication – of experts and users in a shared search for the meaning of health and for how, therefore, to best promote it through the acquisition of greater knowledge and of responsible attitudes and forms of behaviour.

Being educated in health requires an existential re-orientation and a re-orientation at the level of values, a welcoming of suffering as a part of life, and a use of the personal values and the context in which one lives.

Promoting health means 'affecting and as it were upsetting, through the power of the Gospel, mankind's criteria of judgment, determining values, points of interest, lines of thought, sources of inspiration and models of life, which are in contrast with the Word of God and the plan of salvation,[28] observing, through prophetic and alternative modes, non-respect for the completeness of the request for health of people to whom one is committed to treating'.[29]

Amongst the tasks of the Church in this field there is that of 'emphasising the therapeutic and health-inducing value of preaching. Down the centuries the 'medicinal' dimension of the gospel has weakened, the figure of *Christus medicus* has practically disappeared, and the Church has developed models of assistance (the protagonist for a great deal of time of a kind of 'Christian management of health') but has not developed its model of health based upon the Gospel' [30].

At the same time 'we must recover the evangelising force inherent in our care because as an ecclesial community (and Catholic health-care institutions must be a specific and 'accredited' expression of this) we have been sent to 'evangelise through healing', following the example of he who of this was not only a *messenger* but also the great *message*'.[31]

The variegated and growing search for health expresses a latent wish for fullness, for more, for going beyond what is frailty and precariousness. All of this can be interpreted as a request for 'salvation': this unconscious search should be grasped by the Church in order to propose its gospel 'therapy' which acts directly on lifestyles that are not healthy.

c. The promotion of justice and solidarity

There are many factors which can foster the emergence and the spread of conditions of malaise and make a healthy life arduous. Amongst these, the social, economic and political contexts deserve to be carefully considered. An effective promotion of health must reach these levels because it is here that it is possible to see the origins of a series of problems that afflict many populations (poverty, illiteracy, unemployment, civil wars, marginalisation, discrimination).[32]

There is an intimate connection between access to 'goods' (instruction, work, food, water, housing, peace, freedom to profess one's own religious faith or to express one's own opinions…) and health. But even more determining is another link: 'the denial or the limitation of human rights… do these not impoverish the human person as much as, if not more than, the deprivation of material goods? And is development which does not take into account the full affirmation of these rights really development on the human level?'.[33]

A careful and prior reading of reality is required in order to understand the causes that are at the origin of very many injustices and also the 'economic, financial and social mechanisms which. although they are manipulated by people, often function almost automatically, thus accentuating the situation of wealth for some and poverty for the rest' (*SRS*, n. 16).

The Church does not forget the duties of the state and does not intend to ignore the cries of the poor because it will never feel exonerated from struggling for justice:[34] to its ministry belongs 'the condemnation of evils and injustices… But it should be made clear that proclamation is always more important than condemnation, and the latter cannot ignore the former, which gives it true solidity and the force of higher motivation' (*SRS*, n. 41).

The state has the duty to create conditions for a just social order and the Church has the duty to offer 'contents' to the category of 'justice': 'Faith enables reason to do its work more effectively and to see its proper object more clearly. This is where Catholic social doctrine has its place: it has not intention of giving the Church power over the State. Even less it is an attempt to impose on those who do not share the faith ways of thinking and modes of conduct proper to faith. Its aim is simply to help purify reason and to contribute, here and now, to the acknowledgement and attainment of what is just' (*DCE*, n. 28).[35]

In this way, the Church by its presence and action in the social/health-care world 'strives to build the *earthly city* according to law and justice. On the other hand, charity transcends justice and completes it in the logic of giving and forgiving. The *earthly city* is promoted not merely by relationships of rights and duties, but to an even greater and more fundamental extent by relationships of gratuitousness, mercy and communion' (*CIV*, n. 6). 'On its own justice is not sufficient. It can even come to deny itself if it does not open to that deeper force which is love';[36] 'the Church's social doctrine places alongside the value of justice that of solidarity',[37] a value connected with the principle of subsidiarity and which should be conjoined with that of the centrality of the human person and respect for local and traditional values.[38]

Without any doubt, a Catholic health-care institution has as a part of its mission 'condemning all the surrogates of life and health, attacks on the dignity and the integrity of the weakest, the unjust distribution of health-care resources, mechanisms and structures that impede the poorest from reaching the table of life and health. This role, howev-

er, requires an equally important effort to promote a new culture of health, on a human scale, able to heal the pathogenic, personal and structural elements of society… Lastly, no less important is the challenge to demonstrate, through one's own life and in dedication to others, that the lived Gospel is the best source of health willed by Christ and given to the Church as a gift and a mission. *This is the prophecy of new health for a world thirsting and hungry for fullness*'.[39]

'Through the gospel message the Church offers a force for liberation which promotes development precisely because it leads to conversion of heart and of ways of thinking, fosters the recognition of each person's dignity, encourages solidarity, commitment and service of one's neighbour, and gives everyone a place in God's plan'.[40]

d. Being an example

The works of the Church must have the characteristic of setting an example: as regards the quality of services, the qualification of personnel, the human promotion of users, the absence of any discrimination between rich and poor and the elimination of financial reward and profit (cf. *DCE*, n. 34).

In a pastoral Note on health the Italian Bishops' Conference listed certain features that define the identity and the service of Catholic health-care institutions; obviously enough, this list could be much longer and adapted to notable local realities: – 'integral assistance to the sick, with attention being paid to all the dimensions of the person: the physical, the social, the spiritual and the transcendent…; – the defence and promotion of unborn life, commitment to the rehabilitation of the disabled, qualified assistance for sick people who are dying; – the training of personnel at a human, Christian and professional level; – a prophetic presence in the most difficult and newest areas of medicine; quality and efficiency of the ministry of spiritual and religious accompanying of the sick and their family relatives; the safeguarding of the humanity of care and services, humanising technology and assuring a climate in which sick people feel accepted and their rights defended; – the promotion in the areas in which they work of a health-care culture based on authentic human and Christian values; – a healthy administrative transparency'.[41]

In addition to achieving excellence in assistance, in teaching and in research, in the efficient use of resources, Catholic health-care institutions should be exemplary as regards professional expertise, humanity and love for all people, which should be at a practical level at the centre of such institutions: 'while professional competence is a primary, fundamental requirement, it is not of itself sufficient…Those who work for the Church's charitable organisations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of their humanity. Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart"' (*DCE*, n. 31).

Equally requested is an equidistance from political parties in order to conserve the freedom to proclaim always and to everyone the requirements of the gospel and in particular to carry out with rigour and credibility prophetic action in favour of the less defended: 'Christian charitable activity must be independent of parties and ideologies. It is not a means of changing the world ideologically, and it is not at the service of worldly stratagems, but it is a way of making present here and now the love which man always needs' (*DCE*, n. 31).

e. Preferential love for the poor

The poor, the privileged subjects of the work of salvation, must be the first recipients of the care and apostolic commitments of a Catholic health-care institution: the works of the Church must take concrete form in moving towards the human spaces of the poorest and the most marginalised, choosing the needs that are discovered, there where the presence of Christians clearly takes on the character of prophecy (cf. *DCE*, n. 34).

Just as God has always raised His voice in defence of the poor, so the Church does this through its teaching and through a special proximity to the poor both inside and outside her own communities.[42] 'You hear rising up, more pressing than ever, from their personal distress and collective misery, "the cry of the poor." (cf. Psalm 9:13; Gb 34:28; Prov 21:13) Was it not in order to respond to their appeal as God's privileged ones that Christ came,(cf. Lk 4:18; 6:20) even going as far as to identify Himself with them(cf. Mt 25:35-40)? In a world experiencing the full flood of development this persistence of poverty-stricken masses and individuals constitutes a pressing call for "a conversion of minds and attitudes,"(*GD*, n. 63).[43]

Taking the side of the poor con-

stitutes a criterion of the pastoral discernment of the practice of the Church, it is a 'proof of her fidelity to Christ, so that she can truly be the "Church of the poor"'.[44]

Catholic health-care institutions must engage in initiatives of solidarity towards the poorest, both on their own and by provoking the solidarity of others. 'Without this concrete solidarity, without persevering

attention paid to the spiritual and material needs of our neighbour, there is no true and full faith in Christ. Indeed, as the apostle James warns us, without sharing with the poor religion can be transformed into an alibi or be reduced to mere membership (cf. Jm 1: 27-2, 13)'.[45]

In order to be consistent with this option, it is necessary to have the courage to close those CHCIs that no longer meet urgent needs so as 'to be open to charitable, educational and social works in the direction of the poorest geographical areas and social strata' (*ETC*, n. 48).

Paul VI (*ET*, n. 18), in inviting religious to answer the 'cries of the poor', suggested certain paths valid for everyone: to avoid compromise with any form of social injustice; to provoke consciences in the face of the drama of acute poverty and the requirements of social justice; to reconvert certain works for the benefit of the poor; and a limited use of possessions.

'To privilege the poor means, at an anthropological and social level, to privilege 'non-subjects', offering them the concrete possibility of raising themselves to the awareness and reality of social subjects able to manage in a responsible way their own existences and to contribute to the common good. This is a charity that implies justice and promotes the construction of an authentically democratic society'.[46] Justice must be obtained for everyone within the framework of the fundamental rights of the every human being and every society. It thus becomes a duty of everyone to engage in the defence and the promotion of rights belonging to the field of health and health care, in a special way of the poorest, through resort to all those pathways that can be ethically followed.

At a local, national and international level, it is very important to work for respect for all the rights inherent in health and health care that have already been affirmed, just as it is very important that those that have not yet been recognised but which derive from the dignity of every human being should be adopted. And here Catholic health-care institutions can play a role of great importance.

f. Health-inducing alliances

The great challenges of the world of health and health care[47] cannot be addressed through the involvement of few people or in a haphazard way: 'so that the values of life and health are respected and directed towards salvation, and the moments 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',[48] 'a unitary project of pastoral care in health should be outlined, directing the entire Christian community towards this type of apostolate'[49] with a view to choral action of a broad spectrum which also bears upon the roots of the matter, Here, more than elsewhere, one should avoid acting separately.[50]

The people who are present and work with Catholic health-care institutions make up a 'community' that is open to an appreciated relationship with the local Church[51] and the other realities that are present in the local area with a view to synergies as regards shared objectives directed towards the defence, promotion and recovery of health.

Catholic health-care institutions not only engage in activity involving care for their guests, they also attend to health-care workers as regards their human, professional and Christian formation and involve them so that the institution itself is humanised and they are humanised. A Catholic health-care institution is a place that is open to the local area and to the Christian community in particular (the state, the regional government, other agencies) for a series of activities: health-care information, prevention, the protection of health, health-care education, and education in health.

The subject of pastoral care in health is the whole Christian community which is called to be faithful to the example of Christ, the physician of souls and bodies, and to his mandate *to preach the gospel and heal the sick*. 'So that the presence of Catholic health-care institutions can exercise a positive influence on the ecclesial community and society, certain steps should be taken. The first leads these institutions to overcome isolation, making them increasingly visible within the ecclesial community. The population of the local area must be able to recognise in them a point of reference, an instrument of sensitisation as regards questions and issues connected with health and health care, with death, with old age and disability'.[52]

'Obviously when charitable activity is carried out by the Church as a communitarian initiative, the

spontaneity of individuals must be combined with planning, foresight and cooperation with other similar institutions' (*DCE*, n. 31).[53]

Amongst all CHCIs of the world at a planetary level cooperation, sharing and communion must be fostered. In an increasingly globalised world networks should be created which allow the sharing of human, financial, technological and intellectual resources which, without impoverishing those who give them certainly enrich those who receive them. 'It seems more necessary than ever before to think, search and work together… in order to build together a therapeutic mosaic, a fabric and a network of care for health, able to meet the requests for health of people in situations, to educate them, to engage in prevention, to treat always and everyone with competence and humanity'.[54]

Amongst the many fields of cooperation there emerges that of formation where what should be privileged is an 'integrated local-area educational (or training) system and a network of intervention where schools, families, services, groups and associations which in various ways work in the local area should not be closed monads, 'orchards to be cultivated', but, rather, educational realities in continuous interaction with each other and with the problems and resources of the community'.[55]

In these alliances – directed towards the construction of the civilisation of love, justice and solidarity and with a view to the universal promotion of health – there must be involved all people and agencies of good will, beginning with Christians. 'To work for the health of people, to treat illnesses and alleviate pain means to construct the kingdom of God, even though in still partial ways, *already* in this world. In their commitment to health the various Christian Churches and confessions can more easily encounter each other'.[56]

Conclusion

Catholic health-care institutions, when they are fully placed in the work of evangelisation of the Church (preaching, sacraments, charity), offer an important contribution to the promotion of the health of peoples. This contribution can become of an unthinkable importance and range both in the North and the South of the world when Catholic health-care institutions adopt the mission to achieve the Christological model of health, preaching and bearing witness to the Gospel of full and definitive health. Indeed, this 'good news' is not only a message containing *information* it is also a message that is *performed*, that is to say that 'the Gospel is not merely a communication of things that can be known – it is one that makes things happen and is life changing'.[57]

Rev. RENATO SALVATORE, M.I.
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Notes

[1] CEI, Ufficio Nazionale per la pastorale della Sanità, *La Chiesa a servizio dell'amore per i sofferenti,* 11 February 2010, Edizioni Camilliane, p. 6.

[2] 'Indeed, when the Word of God speaks about healing, about salvation, about the health of the sick, it means these concepts in an integral sense, never separating body and soul': homily of Pope Benedict XVI of 11 February 2010.

[3] 'For the Church, charity is not a kind of welfare activity which could equally well be left to others, but is a part of her nature, an indispensable expression of her very being' (Benedict XVI, *Deus caritas est* (hereafter *DCE*) , 25.XII.2005, n. 25.

[4] John Paul II, *Christifideles laici*, 30.XII.1988, n. 53.

[5] Cf. A. Brusco 'Hospital Católico', in J. C. Bermejo-F. Álvarez (ed), *Diccionario de Pastoral de la Salud y Bioética* (S. Pablo, Madrid, 2009), pp. 812-823; M. Petrini, 'Ospedale cattolico', in G. Cinà, E. Locci, C. Rocchetta, and L. Sandrin, *Dizionario di Teologia Pastorale Sanitaria* (Edizioni Camilliane, Turin, 1997), pp. 800-804. See also the proceedings of the twenty-seventh International conference organised by the Pontifical Council for Health Care Workers on 'The Identity of Catholic Health-Care Institutions', 7-9 November 2002, published in *Dolentium Hominum*, n. 52, 2003/1.

[6] Benedict XVI, *Caritas in Veritate* (hereafter *CiV*), 29.VI.2009, n. 2. 'Without truth, charity degenerates into sentimentality. Love becomes an empty shell, to be filled in an arbitrary way. In a culture without truth, this is the fatal risk facing love. It falls prey to contingent subjective emotions and opinions, the word "love" is abused and distorted, to the point where it comes to mean the opposite. Truth frees charity from the constraints of an emotionalism that deprives it of relational and social content, and of a fideism that deprives it of human and universal breathing-space' (*CiV*, n. 3).

[7] 'Deeds without knowledge are blind, and knowledge without love is sterile… Charity is not an added extra, like an appendix to work already concluded in each of the various disciplines: it engages them in dialogue from the very beginning. The demands of love do not contradict those of reason. Human knowledge is insufficient and the conclusions of science cannot indicate by themselves the path towards integral human development. There is always a need to push further ahead: this is what is required by charity in truth. Going beyond, however, never means prescinding from the conclusions of reason, nor contradicting its results. Intelligence and love are not in separate compartments: *love is rich in intelligence and intelligence is full of love*' (*CiV*, n. 30).

[8] 'The current condition of being creatures is marked by original sin. With it 'the harmony in which they had found themselves, thanks to original justice, is now destroyed: the control of the soul's spiritual faculties over the body is shattered; the union of man and woman becomes subject to tension…Harmony with creation is broken: visible creation has become alien and hostile to man…*Death makes its entrance into human history*' (*Catechism of the Catholic Church*, n. 400).

Humanity was redeemed by Christ and is called to a 'fullness of life which far exceeds the dimensions of his earthly existence' (*EV*, n. 2).

The human person is a profound unity of soul and body.

And needs relational life, needs society.

'the ultimate source of human rights is not found in the mere will of human beings, in the reality of the State, in public powers, but in man himself and in God his Creator' Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Editrice Vaticana, 2004, n. 153). For this reason, these rights are to be seen as universal, inviolable and inalienable.

[9] John Paul II, *Evangelium vitae* (hereafter *EV*]), 25.III.1995, n. 5.

[10] 'To live healthily means to modulate one's existence in line with an accurate hierarchy of values and for the believer to wed the design of God. To follow His will, to adopt His life project, to find a meaning to the journey through this world': F. Álvarez, 'Teologia della salute', in L. Sandrin (ed.), *Salute/salvezza perno della teologia pastorale sanitaria* (Edizioni Camilliane, Turin, 2009), p. 160.

[11] L. Sandrin, 'Comunità sanante: modello di Chiesa', in L. Sandrin (ed.), *op. cit.*, p. 194.

[12] 'In Jesus salvation is offered as health and health is offered as salvation and his good news is the proclaiming of a saved-health and a health-inducing salvation for man, for the whole of man and for all men': CEI, Ufficio Nazionale per la pastorale della Sanità, *Domanda di salute, nostalgia di salvezza,* 11 February 1999, n. 3.

[13] Cf. L. Sandrin, *Chiesa, comunità sanante. Una prospettiva teologico-pastorale* (Paoline, Milan, 2000); AA. VV., 'Salute, guarigione e salvezza', *Credere Oggi*, n. 145, 1/2005; D. Casera, *Chiesa e salute. L'azione della Chiesa in favore della salute* (Editrice Ancora, Milan, 1991).

[14] 'For the Church, charity is not a kind of welfare activity which could equally well be left to others, but is a part of her nature, an indispensable expression of her very being' (*DCE*, n. 25).

[15] 'Christian charity is first of all the simple response to immediate needs and specific situations: feeding the hungry, clothing the naked, caring for and healing the sick, visiting those in prison, etc.' (*DCE*, n. 31).

[16] 'The Apostolic Exhortation *Evangelii Nuntiandi*, for its part, is very closely linked with development, given that, in Paul VI's

words, "evangelization would not be complete if it did not take account of the unceasing interplay of the Gospel and of man's concrete life, both personal and social." "Between evangelization and human advancement — development and liberation — there are in fact profound links": on the basis of this insight, Paul VI clearly presented the relationship between the proclamation of Christ and the advancement of the individual in society. Testimony to Christ's charity, through works of justice, peace and development, is part and parcel of evangelization, because Jesus Christ, who loves us, is concerned with the whole person' (*CiV*, n. 15).

[17] 'Charity, furthermore, cannot be used as a means of engaging in what is nowadays considered proselytism. Love is free; it is not practised as a way of achieving other ends. But this does not mean that charitable activity must somehow leave God and Christ aside. For it is always concerned with the whole man. Often the deepest cause of suffering is the very absence of God. Those who practise charity in the Church's name will never seek to impose the Church's faith upon others. They realize that a pure and generous love is the best witness to the God in whom we believe and by whom we are driven to love. A Christian knows when it is time to speak of God and when it is better to say nothing and to let love alone speak. He knows that God is love (cf. *1 Jn* 4:8) and that God's presence is felt at the very time when the only thing we do is to love. He knows—to return to the questions raised earlier—that disdain for love is disdain for God and man alike; it is an attempt to do without God. Consequently, the best defence of God and man consists precisely in love. It is the responsibility of the Church's charitable organizations to reinforce this awareness in their members, so that by their activity—as well as their words, their silence, their example—they may be credible witnesses to Christ' (*DCE*, n. 31).

[18] PAUL VI, *Evangelii nuntiandi,* 8.XII.1975, n. 21.

[19] 'The struggle against the exclusion of a major part of humanity from health-care services and thus guaranteed access of everyone to the medical products required for treatment; the spread of compassion as a model for co-existence based upon Christian charity; the defence of life through the protection of the dignity and the rights of the person at all points and conditions of his or her life; and creativity in the planning of local interventions open to local-area and multicultural support. These are the defining points of the 'decalogue' recommended by the Pontifical Council for Health Care Workers to Catholic health-care institutions in the world' (Mario Ponzi).

[20] 'Every culture has burdens from which it must be freed and shadows from which it must emerge. The Christian faith, by becoming incarnate in cultures and at the same time transcending them, can help them grow in universal brotherhood and solidarity, for the advancement of global and community development' (*CiV*, n. 59).

[21] '*The Gospel of God's love for man, the Gospel of the dignity of the person and the Gospel of life are a single and indivisible Gospel*' (*EV*, n. 2).

[22] 'All this is aggravated by a cultural climate which fails to perceive any meaning or value in suffering, but rather considers suffering the epitome of evil, to e eliminated at all costs. This is especially the case in the absence of a religious outlook which could help to provide a positive understanding of the mystery of suffering' (*EV*, n. 15).

[23] 'A particularly crucial battleground in today's cultural struggle between the supremacy of technology and human moral responsibility is the field of *bioethics*, where the very possibility of integral human development is radically called into question. In this most delicate and critical area, the fundamental question asserts itself force-fully: is man the product of his own labours or does he depend on God?... We are presented with a clear *either/ or*…Faced with these dramatic questions, reason and faith can come to each other's assistance. 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 reason risks being cut off from everyday life*' (*CiV*, n. 74).

[24] 'These should not merely be institutions where care is provided for the sick or the dying. Above all they should be places where suffering, pain and death are acknowledged and understood in their human and specifically Christian meaning' (*EV*, n. 88).

[25] 'It is for that matter true that the difficulties experienced by legislators in responding in an adequate way the needs for care and health of citizens are more easily understood if one considers that such efforts are often opposed by cultural and social visions that are incompatible with the pursuit of the common good' (CEI, COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *«Predicate il Vangelo e curate i malati». La comunità cristiana e la pastorale della salute,* pastoral Note, 4 June 2006, n. 7).

[26] 'Health care is only one of the 'inputs' into the production of 'health', even not the most important…The most important determining factors as regards the status of health would seem to be (1) the genetic inheritance of an individual; (2) his or her socio-economic condition; (3) the physical environment in which he or she lives; and (4) the individual ability and will to manage well his or her own health which in turn is broadened by the formation of the person (UWE E. REINHARDT and MAY T. M. CHENG, 'In economia', *Dolenitum Hominum*, 52/2003, p. 63).

[27] M. T. CAIRO, *Persona e salute. Itinerari educativi* (Editrice La Scuola, Brescia, 1994), pp. 78-79. An integrated (interdisciplinary) approach to the subject of health leads to us 'seeing the promotion of health as a unique sector of activities and interventions that includes within it different areas: health-care information; prevention; health-care education; education in health; and the protection of health' (*Ibidem*, p. 137). Cf. CEI, *Educare alla salute, educare alla vita* (Edizioni Camilliane, Turin, 2009*).*

[28] PAUL VI, *op. cit.*, n. 19.

[29] L. SANDRIN, *Chiesa, comunità sanante*, p. 69.

[30] F. ÁLVAREZ, *op. cit.,* p. 146. Cf. F. ÁLVAREZ, 'El evangelio de la salud en una sociedad plural'*, Labor Hospitalaria*, 293-294/2010, pp. 60-80.

[31] L. SANDRIN, *Chiesa, comunità sanante* , p. 70.

[32] 'Today the picture of development has *many overlapping layers*. The actors and the causes in both underdevelopment and development are manifold, the faults and the merits are differentiated' (*CiV*, n. 22).

[33] JOHN PAUL II, *Sollicitudo rei socialis* (hereafter *SRS*), 30.XII.1987, n. 15.

[34] 'The just ordering of society and the State is a central responsibility of politics. As Augustine once said, a State which is not governed according to justice would be just a bunch of thieves' (*DCE*, n. 28). 'The Church cannot and must not take upon herself the political battle to bring about the most just society possible. She cannot and must not replace the State. Yet at the same time she cannot and must not remain on the sidelines in the fight for justice' (*DCE*, n. 28). 'The direct duty to work for a just ordering of society, on the other hand, is proper to the lay faithful. As citizens of the State, they are called to take part in public life in a personal capacity…The mission of the lay faithful is therefore to configure social life correctly, respecting its legitimate autonomy and cooperating with other citizens according to their respective competences and fulfilling their own responsibility' (*DCE*, n. 29).

[35] 'the formation of just structures is not directly the duty of the Church, but belongs to the world of politics, the sphere of the autonomous use of reason. The Church has an indirect duty here, in that she is called to contribute to the purification of reason and to the reawakening of those moral forces without which just structures are neither established nor prove effective in the long run' *(DCE*, n. 29). 'It is not a means of changing the world ideologically, and it is not at the service of worldly stratagems, but it is a way of making present here and now the love which man always needs' (*DCE*, n. 31).

[36] JOHN PAUL II, *Message for the World Day of Peace*, , n. 10

[37] PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, *op. cit.* , n. 203

[38] 'Development programmes, if they are to be adapted to individual situations, need to be flexible; and the people who benefit from them ought to be directly involved in their planning and implementation. The criteria to be applied should aspire towards incremental development in a context of solidarity — with careful monitoring of results — inasmuch as there are no universally valid solutions' (*CiV*, n. 47). Aid 'must be distributed with the involvement not only of the governments of receiving countries, but also local economic agents and the bearers of culture within civil society, including local Churches…the most valuable resources in countries receiving development aid are human resources: herein lies the real capital that needs to accumulate in order to guarantee a truly autonomous future for the poorest countries' (*CiV*, n. 58). '*Cooperation for development* must not be concerned exclusively with the economic dimension: it offers a wonderful *opportunity for encounter between cultures and peoples*…Technologically advanced societies must not confuse their own technological development with a presumed cultural superiority' (*CiV*, n. 59).

[39] RELIGIOSI CAMILLIANI, Documento Capitolare, *Uniti per la giustizia e la solidarietà nel mondo della salute. Religiosi camilliani e missione profetica*, Rome, 2007, n. 67

[40] JOHN PAUL II, *Redemptoris missio*, 12.VII.1990, n. 59.

[41] CEI, Consulta nazionale per la pastorale della sanità, *La pastorale della salute nella chiesa italiana* (1989), n. 56. The Note of 2006 (nn. 36-46) is also concerned with these, posing questions and pointing out certain steps that should be taken: 'The answers to these questions requires Catholic health-care institutions to be defined by their medical and managerial services; to be committed to responding with concrete initiatives to the challenges raised by bioethics; to give primacy to the sick person, integral care for the person and witness to charity as suitable criteria of intervention; they should be schools of communion and places where the sick person can open himself to herself to hope; and they should know how to 'obtain spaces for solidarity-inspired activity in favour of categories of sick people who are neglected by the public sector' (CEI, COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *op. cit.*, n . 41).

[42] 'the *option* or *love of preference* for the poor. This is an option, or a *special form* of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness' (*SRS*, n. 42). 'Thus part of the *teaching* and most ancient *practice* of the Church is her conviction that she is obliged by her vocation –

she herself, her ministry and each of her members – to relieve the misery of the suffering, both fare and near, not only out of her "abundance" but also out of her "necessities"' (*SRS*, n. 31).

[43] PAUL VI, *Evangelica testificatio,* 29.VI. 1971, n. 17.

[44] JOHN PAUL II, *Laborem exercens,* 14.IX.1981, n. 8.

[45] CEI, *Evangelizzazione e testimonianza della carità. Orientamenti pastorali dell'Episcopato italiano per gli anni '90* (hereafter *ETC*), 8.XII.1990, n. 39.

[46] CEI, *Evangelizzare il sociale,* 22. XI. 1992, n. 64.

[47] 'The present organisation of the world of health should also be understood in the light of certain tendencies of contemporary culture and scientific and technical progress which have influenced our way of conceiving of health and illness, life and death': (CEI, COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *op. cit.*, n. 8).

[48] CEI*, La pastorale della salute nella chiesa italiana* (1989)*,* n. 2.

[49] JOHN PAUL II, *L'Osservatore Romano*, n. 277, 29.11.1981, p. 2.

[50] 'Love of neighbour, grounded in the love of God, is first and foremost a responsibility for each individual member of the faithful, but it is also a responsibility for the entire ecclesial community at every level: from the local community to the particular Church and to the Church universal in its entirety. As a community, the Church must practise love. Love thus needs to be organised if it is to be an ordered service to the community' (*DCE*, n. 20). 'Socio-economic problems can be resolved only with the help of all the forms of solidarity: solidarity of the poor among themselves, between rich and poor, of workers among themselves, between employers and employees in a business, solidarity among nations and peoples, International solidarity is a requirement of the moral order; world peace depends in part upon this (*Catechism of the Catholic Church*, n., 1941).

[51] 'the true subject of the various Catholic organizations that carry out a ministry of charity is the Church herself—at all levels, from the parishes, through the particular Churches, to the universal Church' (*DCE*, n. 32).

[52] CEI, COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *op. cit.*, n. 42.

[53] This is the approach of the Italian Church 'which intends:

– to foster the discernment of the challenges raised in the world of health and health care to the presence and action of the Church, holding up lines of cooperation with all men of good will;

– to support the integration of pastoral care in health within the pastoral care as a whole of Christian communities;

– to promote greater integration between the spiritual assistance that is provided in health-care institutions and ordinary pastoral care in parishes, developing forms of cooperation between hospital chaplaincies and the ecclesial communities of the local are;

– to provide recommendations for the involvement of all the components of the people of God in pastoral care in health, strengthening bodies of communion and joint responsibility;

– to promote a greater overall approach and the making of projects as regards pastoral care in health, through specific training itineraries as well': (CEI, COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *op. cit.*, n. 4).

[54] CEI, UFFICIO NAZIONALE PER LA PASTORALE DELLA SANITÀ, *Le istituzioni sanitarie cattoliche in Italia. Identità e ruolo* (EDB, 2000), p. 6.

[55] M. T. CAIRO, *op. cit.*, p. 174.

[56] L. SANDRIN, *Comunità sanante: modello di Chiesa,* p. 200.

[57] BENEDICT XVI, *Spe salvi,* 30.XI.2007, n. 2.

JOHN F. GALBRAITH

The Vatican-CMMB initiative: Touching Lives, Bringing Health and Hope

Good Afternoon. It is always a pleasure to visit the Vatican and your beautiful city of Rome, but I am especially happy to be with you today. I welcome the opportunity to both tell you a little about my organization, the Catholic Medical Mission Board – or CMMB, as we call it – and to announce an exciting new initiative that we are embarking upon with the Pontifical Council for Health Care Workers.

First, let me introduce you to Catholic Medical Mission Board. CMMB will be 100 years old in 2012, but for many who learn of our work, we are regarded as the best-kept secret in the world of global health care. That is largely due to the fact that nearly 98 percent of our resources are devoted to the programs and services we deliver throughout the world.

We are so busy *doing* our work that we traditionally have not taken much time to promote our efforts.

The notion of a Catholic Medical Mission Board had its inception in 1912, and it was the result of one man's grief over the death of his wife. That man was Dr. Paluel J. Flagg, a young anesthesiologist working on the staff of a Catholic hospital in New York City.

From his sorrow was born the dream of assisting missionaries delivering health care in underserved areas of the world.

Dr. Flagg's mission then is our mission now: Rooting in the healing ministry of Jesus, CMMB works collaboratively to provide quality healthcare programs and services, without discrimination, to people in need around the world.

His vision then is also our vision now: A world in which every human life is valued and quality healthcare is available to all.

Throughout our history, we have been guided by values that we think Dr. Flagg would embrace. Certainly they are ones that form the foundation of caring Catholics throughout the world. They are:

– *Building Individual and Community Capacity* – In all the work we do, we always ask ourselves the question: "Will this activity be sustainable after we are gone."

– *Accountability* – CMMB values greatly the trust given to us by our more than 40,000 donors. That trust is built on the diligence with which we apply their generous and loving gifts.

– *Social Justice* – Everyone should have access to health care, without discrimination.

– *Integrity* – Respect for the individual is required in all that we do. As we see the plight of those we serve, many in the most wretched of circumstances, we are always mindful that "there but for the grace of God go me".

– *Leadership* – CMMB is a very strong advocate of the effectiveness of Catholic and other faith-based organizations, many of them delivering services in areas where a country's national government is unable to reach.

– *Quality Collaboration* – Catholic healthcare networks throughout the world are most often our partners in our work.

– *Courage and Risk-Taking* – CMMB, like many of you in your health care outreach, often go where others will not or cannot go. And, we often start programs that become best practices to be adopted by others.

– *Compassion* – It was Dr. Flagg's compassion and good heart that saw the dream of CMMB. We never forget that.

By now, you must be wondering: What exactly does CMMB do? The short answer is that we send medicines and medical volunteers around the world, and we run programs that address major healthcare problems. Let me begin with the volunteers and medical donations programs.

We call these our "legacy" programs because they have been in operation almost since CMMB's inception.

Dr. Flagg was CMMB's first volunteer, traveling to Latin America to minister to lepers.

From that beginning, the volunteer program has grown to one that, this year, has seen 68 volunteers serving terms of six months to two years, and an additional 1,595 on shorter missions, to 24 countries around the world. Over the last ten years, that number for long-term volunteers has totaled 773respectively. And, do you know what each and every one of them tells us when they return? They tell us that, in their volunteer work, they receive so much more than they give. It is a life-changing experience for all of them. *www. cmmb.org/healthcare-programs*

Never were our volunteers needed so much as in January this year, following Haiti's devastating earthquake. We worked with our partners to send hundreds there in the weeks following that disaster. For more information, please click on our *Haiti Fact Sheet.*

Our second "legacy" program is called Healing Help, and that is a great name for it. It refers to our program of soliciting and placing donated medicines and medical supplies to serve those in need throughout the world. And, it is the centerpiece in our initiative with the Pontifical Council for the Pastoral Care of Health Care Workers and the Good Samaritan Foundation, which I will tell you more about shortly.

Over the last decade, Healing Help has delivered medicines and medical supplies valued at more than $1 billion U. S. dollars. They have gone to more than 600 partners

in 100 countries around the globe. Those medicines and medical supplies have been donated to us by major pharmaceutical and medical supply companies. *www.cmmb.org /healing-help-program*

Those two legacy programs – our volunteer and donated medicines programs – were of immense value to us when, around 2000, we made the decision to move into a new realm of operations. It was then that we strategically branched out to tackle some of the world's major health problems, namely HIV/AIDS and child survival. In doing so, we collaborated with many of the healthcare facilities that we had been serving for decades by sending them medical volunteers and donated medicines.

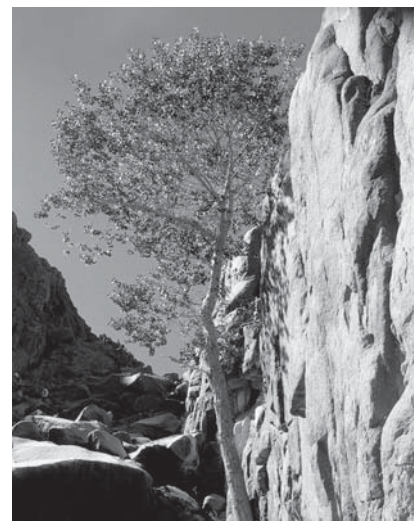
Today, we continue to conduct major programs in HIV/AIDS and child survival, but have recently also added as areas of focus neglected tropical diseases and the capacity building and strengthening of health systems in the countries where we operate.

CMMB helps more than 500,000 of the underserved through these programs annually. In addition, our medicines and volunteers touch the lives of hundreds of thousands more.

For more than a decade, we have been doing everything we can to improve these numbers, particularly with innovative programs in Africa. This includes helping to prevent the transmission of HIV from HIV positive pregnant mothers to their unborn children. We also, last year, provided life-saving antiretroviral treatment to nearly 47,000 Kenyans through a program called AIDSRelief, as part of a consortium that includes Catholic Relief Services.

In Kenya, South Sudan and Haiti we operate a very creative program that we call Mentor Mothers. This puts HIV-positive "mentors", who have been helped often via our mother-to-child prevention program, to work in hospitals and clinics to counsel, provide education, and work with pregnant women and their partners to overcome stigma and learn that they can take steps to improve their health and that of their children.

A few years ago, in Zambia, we took a look at male heads of households and determined that – since they are the dominant decision makers for their partners and family – education on HIV and AIDS was needed. This program, Men Taking Action, addresses male attitudes and behaviors that prevent women from attending antenatal clinics and accessing prevention of mother-to-child transmission services for HIV. The program empowers men to serve as positive change agents for family health, encouraging them to educate their families about HIV/AIDS and participate in voluntary counseling and testing for HIV. The program has now also moved into South Africa and, in total, 27,122 men and 50,275 of their partners have been tested for HIV. In addition, 4,460 HIV positive pregnant women have been linked to treatment services. *www.cmmb.org/ men-taking-action*



What began as a child survival initiative, we now often refer to as CMMB's maternal and child health outreach. There is much research that demonstrates that women are the key to sustaining healthy families.

In Latin America, more than half a million children die annually and one-third of their deaths are attributable to five preventable illnesses: respiratory infection, diarrheal diseases, malnutrition, measles and malaria. Peru displays one of the highest mother and child mortality rates in the region, so CMMB established Unidos Contra la Mortalidad Infantil (United Against Infant Mortality) there. We work in three key cities: Trujillo, Huancayo and Chimbote. We are very pleased that our partners in this important work are Bon Secours Health System, CHRISTUS Health and Caritas-Peru. *www.cmmb.org/unidos-contra-la-mortalidad-infantil*

Our work with mothers and children is present in virtually all our initiatives: in our HIV/AIDS programs, in food and nutrition programs for orphans in South Africa, and in our malaria programs, where the provision of insecticide-treated nets reduce morbidity and mortality in pregnant women and young children.

A tropical disease, leprosy, was the first illness we faced, for working with lepers was the first endeavor that our founder, Dr. Paluel Flagg, engaged in almost one hundred years ago. Today, we continue to battle this disease in such high-incidence locations as India and Zambia. We have trained nearly 500 community health worked and healthcare professionals, strengthening the capacity of local health facilities to diagnose, treat and care for leprosy patients. In the past decade, we have had a highly successful program, in Ghana, that provided healing education about and treatment of lymphatic filariasis, or elephantitis, another tropical disease. The program became a national model, reading 444,957 people over five years. CMMB has also provided de-worming medicines to countless children in Latin America. *www.cmmb.org/zambia-leprosy*

CMMB has reached out in other areas also, for instance we are a founding member of the Haiti Amputee Coalition, which was established following the earthquake to treat and rehabilitate those who lost limbs as a result of this devastating natural disaster. We have helped more than 700 people who have suffered in this way and we will continue to make this a priority of our work in Haiti.

In addition to our disease-specific, in-country programs, we have recently adopted a programmatic area of focus that we call Capacity Building and Health System Strengthening. Our objective is to develop sustainable local capacity to address major healthcare needs and build strong systems. We accomplish this through the design and implementation of high-quality, evidence-based

programs, directed by the following goals:

1. Increase access to health services that improve quality of life and reduce preventable deaths

In 2010, CMMB counseled and tested 119,087 individuals for HIV, reached 146,915 with HIV prevention messages, provided preventative antiretroviral treatment to 3,725 expectant mothers, and cared for 110,362 people living with HIV. CMMB's maternal and child health programs provided 16,273 young children and 79,959 pregnant women with primary healthcare.

2. Strengthen human resources for health

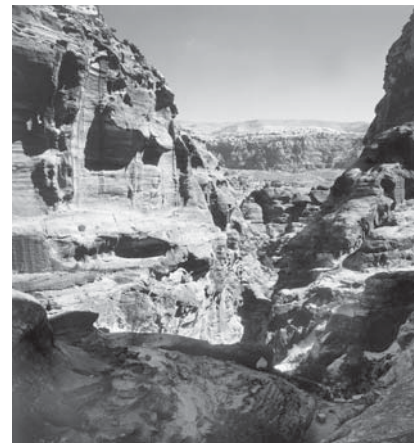
CMMB is working to bolster the global health workforce by filling gaps for medical professionals. In 2010, CMMB helped send 1,663 medical volunteers to 24 countries, where they provided over $10 million in donated services. Through local partnerships, CMMB promoted the training of trainers and motivated health workers to serve in their home countries.

3. Build supply chain capacity that will increase global access to lifesaving medications and technologies

CMMB collaborates closely with its partners to develop efficient and effective supply chains for medicines and medical supplies. Over the last decade, CMMB has provided over $1 billion of donated medicines and medical supplies to 600 local partners in 100 countries. Because of its reputation for strong leadership in supply chain management and close relationship with its consignees, drug manufacturers consider CMMB a trusted partner.

4. Develop strong financial systems in healthcare facilities

CMMB is helping many hospitals and clinics in Kenya go paperless with integrated and computerized Health Management Information Systems (HMIS). These systems help the facilities bill patients, track revenue, and build programs that aim to report to the U.S. government and other donors by public health outcomes. This is known as performance-based financing, and CMMB is assisting in its expansion to several countries, including Kenya.



5. Support program monitoring systems and key research that ensure quality programming and adoption of best practices in global healthcare.

CMMB's Monitoring & Evaluation team works with implementing partners to develop reporting procedures that ensure appropriate use of resources and create lasting change. Quarterly reviews of programmatic data by technical staff identify challenges, successes, and points for further research. CMMB is accountable to its beneficiaries to provide quality healthcare services; therefore CMMB engages local community-based organizations, associations of people living with HIV, and mothers clubs in the review of program progress-to-date and future planning.

6. Increase the ability of local leadership to effectively design and manage programs

CMMB's Country Directors and key staff members serve on technical advisory boards and work closely with local Ministries of Health to promote the needs of those we serve around the world.

Now, I come to the part of my presentation where I have the pleasure of announcing a major new collaboration: CMMB is joining the Pontifical Council for the Health Care Workers and the Good Samaritan Foundation to bring even more health and hope to those in need around the world.

We are honored to be able to donate, annually, medicines and medical supplies valued at $10 million dollars to the Council to support His Holiness' and the Vatican's health care efforts. These medicines will be sent to designated healthcare facilities in targeted countries that are chosen based on priorities of the Vatican, national laws pertaining to importing of medicines and CMMB's expertise. Because CMMB has developed nearly a century of expertise in shipping and delivering medicines to the developing world, we will manage the supply chain for this project.

I am deeply grateful to Archbishop Zygmunt Zimowski for his willingness to undertake this new initiative and it will be a milestone in CMMB's history as we move into our second century of work.

In the course of our meetings to plan and finalize this initiative, Archbishop Zimowski and I often were gratified to see that the Council's goals and CMMB's were shared. When Archbishop Zimowski speaks of access to health care being a question of justice and that it is a basic human right, he could be quoting from our vision and core values.

I am joined here in Rome and at this Conference by Adrian Kerrigan, CMMB's Senior Vice President for Advancement. We welcome the opportunity to meet with you, answer any questions you might have about our work and our exciting new collaboration with the Vatican. In addition, we have brought literature that provides more specific information about our "best kept secret", one that has been bringing health and hope to those in need for almost one hundred years. It is available as you leave the meeting.

Thank you for your attention. You can always learn more about our work by visiting our website at *www.cmmb.org*. To see videos of our work in action, please visit *www.CMMBHEALS.org*

Dr. JOHN F. GALBRAITH
President & Chief Executive Officer, Catholic Medical Mission Board (CMMB), USA

MAREK JUREK

The Cooperation of Various Government Ministries in Health Care

Public health is one of the components of the common good of every nation. According to the European Convention on Human Rights and a large number of subsequent national Constitutions, the protection of health is a right of all men and at the same time a foundation of the duties of the state. The same Convention recognises that actions connected with public health – because they serve everyone – even prevail over individual political rights.

Health-care policy, therefore, does not belong to the prerogatives of a concrete specialised institution. The necessary model for the functioning of the state lies in the fact that it concerns the entire activity of the state and the government. A Ministry of Health should be the privileged initiator of their work and the spokesman of tasks that should be performed through government and the legislative power at the level of health-care policy.

At the outset, budgetary questions had to be addressed, those involving the obtaining of the funds necessary to assure resources for public health, which should be accessible to everyone. This requires especial help from the Prime Minister for the Ministry of Health when there is conflict between the Ministry of Health and the Ministry of Finance, which is charged with watching over budgetary matters.

The subsidiary role of the state means that its duties increase with the importance of the good that people are not able to obtain with their own funds or through social organisations. From this point of view, the protection of health belongs to the primary tasks of the state which here should express itself through an allocation of funds for its achievement.

Solidarity means, and this should be well understood, not entrusting the state with matters which both families and individuals should assure through their own efforts, just as the subsidiary role of the state requires that there should be concentration on the social contexts and situations that most need help. One is dealing first and foremost here with the most serious illness (which absorb the greatest costs at the level of treatment) and categories that particularly need help (such as numerous families).

The field of the financing of public health is therefore for the state an essential choice. Indeed, the Ministry of Health always works within the frameworks indicated by decisions of a general nature which determine the action of the entire state apparatus and which go beyond the responsibilities of a single specialised institution.

Determining and recommending the right level of help to the poorest of society as regards health is the responsibility of the Ministry for Social Policies. This is a crucial question that concerns both those people who for no fault of their own find themselves in a situation that is especially difficult, and numerous families, namely people who, because of their own wishes, have accepted greater duties than those of other citizens and which concern the good of the whole of society. This also concerns in a particular way families who have responsibility for disabled children.

When one speaks about health-care policy one cannot ignore ethical questions. For example, the question of artificial *in vitro* fertilisation is seen by its proponents as a method by which to treat sterility, although no woman who has used this technique can become pregnant in a totally natural way as well. In this case, the whole of the responsibility falls on the Ministry of Health. The Minister of Health (as the spokesman for public health) can present the question of

in vitro fertilisation as something that is purely technical in character and also morally neutral, and can also recommend this method – as unfortunately takes place in the majority of cases in contemporary liberal countries. In adopting this approach, the Ministry of Health becomes not an executor of the common good but a representative of interests that are against the common good, that is to say the illegitimate interests of certain individuals. This Ministry should, instead, cooperate with the Ministry of Science, which should recom-

mend research into sterility and real methods by which this can be treated, such as naprotechnology.

Where one is dealing with fighting against social pathologies, public health policy should be supported by the action of the Ministry of Justice and the Ministry for Internal Affairs. The complex initiatives which have been undertaken recently by the Polish government in the fight against the distribution of what are called synthetic drugs, which are artificial substitutes for classic drugs, are an important example of such cooperation. The Ministry of Justice has drawn up a law which makes their producers responsible as regards the injurious effects on human health of these substances (even though, nominally, they are for industry and not for consumption). For a period of a year and a half, this law compels the Ministry of Health to examine such products in a laboratory before they are placed on the market. The Ministry for Internal Affairs is entrusted with preventing the distribution of substances which are recognised as being drugs.

The protection of the environment is also a question of primary importance which needs cooperation between the Ministry of the Environment and the Ministry of Agriculture. In the first case, one is dealing with analysing possible dangers for the safety of people in the field of health. In the second case, of assuring healthy alimentation and impeding the injurious effects of the industrial production of food, including genetic modifications.

With respect to the new technologies of procreation, like those of food production, all governments must demonstrate the courage to resist groups that try to exercise all kinds of pressure on them. This capacity to resist constitutes the real test of their political sovereignty, their authority and arbitration, which depend solely on the criteria of the common good.

The interests of the contraceptives industry form a pressure group which is particularly active and destructive. In all countries this pressure group tends to conquer access to public funds, both directly through subventions and indirectly through the reduction of taxes. The term 'contraception' is frequently abused in order to conceal the reality of abortion-inducing substances. These substances aim at the destruction of the life of the child but ruin the health of the mother as well and not rarely aso causes sterility. Abortion-inducing substances should simply be prohibited. As regards the Ministry of Health, it should inform people about the secondary effects of contraception, in line with the obligation to alert people about the effects of tobacco.

Unfortunately, Ministries of Health are habitually obliged not only to spread contraception but, and this is even worse, to propose what is called VIP (the 'voluntary interruption of pregnancy').

National education plays a primary role in the formation of the pro-life approach. 'Reparative' medicine (to employ the term) is nothing else but one of the factors that contributes to the level of social health. Preventive medicine, the promotion of health and the prevention of the illnesses of 'civilisation', such as hypertension, obesity or diabetes, and as a consequence their grave consequences such as vasco-cerebral accidents or heart crises, constitute a field in which it is constantly necessary to sensitise the conscience of citizens. The earlier this education is undertaken, the more effective will it be.

Schools have an opportunity to impede the propagation of the scourges that ruin health such as tobacco smoking, alcohol abuse or drug addiction. Given its preventive character, health-care policy also concerns the Ministry for Sport which has the prerogative of influencing – through practical encouragement and positive motivation – the healthy physical development of young people.

The question of sexual education is an especially delicate question, and not only in Europe. Unfortunately, Ministries of Health are often the spokesmen for so-called sexual rights and not those moral values which constitute the best protection against the scourges of prenatal murders or the AIDS epidemic.

Health-care questions also concern foreign policy. The period when I was the president of the Polish parliament was also the period when the Republic of China of Taiwan tried to join the World Health Organisation. Taiwanese politicians justified such membership by explaining that it would be an effective element in steps taken against epidemics in East Asia, above all as regards the grave acute respiratory syndrome. We should be well aware of the fact: the government of the People's Republic of China wanted to isolate Taiwan in the international arena and was opposed to this development. However, a pragmatic approach in the real sense of the term made such cooperation opportune. Nonetheless it was necessary to give way in the face of the pressure exercised by this great power.

With respect to health, there are many points which should be the subject of international cooperation, and therefore of the efforts of national governments and of national diplomacy. One may think here, for example, of the fight against paedophilia.

In some countries the minimal age accepted for sexual relations has been strongly reduced. What is Denmark is seen as the freedom of young people (sex between young people aged thirteen), is seen in Poland as paedophilia. Without any doubt, what has also had grave effects has been the propaganda of so-called sexual rights without reference to ethical rules. This propaganda certainly contributes to early sexual initiation amongst young people. How can all of this be reconciled with the official condemnation of paedophilia?

The question of the fight against paedophilia should also be the subject of international cooperation, addressed within the context of opposition to the pornographisation of mass culture. Before the Second World War two conventions were ratified on the fight against pornography. In documents since the Second Wold War as well, in particular in the European Convention on Cross Border Television of 1989, emphasis is laid upon the safeguarding of decency and public morality. Today this is noth-

ing else but a forgotten law which as a result of the efforts of countries which take into account the common good should be retrieved.

To conclude: the specific role of the Ministry of Health is to remember, within the context of the framework of duties of each government, the subsidiary function of the state which must intervene when people themselves do not have the means to act. In performing this function of subsidiarity, the state implements the principle of solidarity. The Ministry of Health should be the spokesman for an approach that is right and based upon natural law, as regards man who is the subject of moral rules because of his purpose, upon the rights of other people and upon the common good. The Minister of Health should equally be the spokesman for the ethics of the medical profession which are specific to our culture and go back to the Hippocratic oath.

On the other hand, the team work of a government should impede the Minister for Health from forgetting that the protection of health is linked to the good of man in his entirety and that this is not a simple technical question, and even less a field for the interests of the technological lobbies. These last should be subjected to the control of man which is expressed in the sovereign power of a free state and a state that is aware of its moral responsibility before God.

Health policy demonstrates how topically relevant is the classic idea of politics whose spokesman in the contemporary world is the Catholic Church. Pope Pius XII was already warning people about a technocratic utopia which sought to implement the common good without concerning itself about moral decisions and thus without taking into account moral responsibility.

Good health policy requires a correct vision of man which allows us to recognise the real needs of man. It equally requires authentic human solidarity with a view to impeding a formal or real exclusion of those who need support from society. Responsibility is required on the part of the state. It follows that this is not a technical problem of medical doctors or of medical managers. Technical skills must help in this because they are an indispensable element of political realism, but they cannot replace it.

Public health policy cannot be limited to the local frameworks of countries, but require, instead, international cooperation. However, it is the national state and the sense of responsibility of its citizens that constitute the essential factor in initiating and controlling, at a moral and democratic level, this cooperation.

Hon. MAREK JUREK
Former President of the Lower House of the Polish Parliament, Poland

friday 19 november

WILLEM EIJK

The Good Samaritan is the Greatest Justice

Obviously enough, one sees in the Good Samaritan of the parable told by Jesus in the Gospel of Luke (10:25-37) a model that can inspire every health-care worker. He felt pity and washed the wounds of a man 'who was going down from Jerusalem to Jericho when robbers attacked him, stripped him and beat him up, leaving him half dead' (Lk 10:30). Jesus does not say explicitly to which people or nation the victim belonged but it is gradually shown that he was a Jew.[1] Two other Jews, one a priest and one a Levite, who were travelling down the same road saw him and passed by. Perhaps they thought that he was dead and thus not wanting to be contaminated they were unable to perform their ritual duties on the basis of a precept[2] and so did not take care of him. The cardinal point, however, is that not his fellow countryman but a person who belonged to a people that was an enemy of the Jews,[3] a Samaritan, when he was passing by saw him and had compassion for him. 'He went over to him, poured oil and wine on his wounds and bandaged them; then he put the man on his own animal and took him to an inn, where he took care of him' (Lk 10:34).

The washing of the wounds of a man who had been subject to a bloody beating makes us immediately think of the activities of health-care workers. Thus it should not surprise us if Paul VI, during an address that he gave in 1966 to a group of medical doctors of the ENPAS (National Institute for the Social Security of Government Employees), when referring to the high human values that their noble mission involves, spoke the following words: 'These values are not only human values they are also clearly Christian values; they make us think of the gospel parable of the Good Samaritan, who bent down in front of his suffering and martyred neighbour and was personally prepared to pay for him; they make us reflect on the incomparable dignity of the art of medicine which is not only formidable technology, which requires constant updating and passion that never goes out, but also self-giving, mission, interior flame, and this acquires unique merit before men and inestimable merit before God'.[4] This parable acts to demonstrate the universality of 'love towards the needy whom we encounter "by chance" (Lk 10:31), whoever they may be' (Deus Caritas est, n. 25). This universality implies that we must also love an enemy, according to the words of Jesus in the Gospel of Luke: 'love your enemies, do good to those who hate you' (Lk 6:27).

A health-care worker has pity for a sick person, despite whether liking him or her or disliking him or her. On a battle field, military health-care personnel also attend to the victims of the enemy army. This conclusion is also shared by the contemporary secular world.

However, in confining ourselves to this conclusion alone, however right it may be in itself, we run the risk of failing to see the deeper meaning which for Christian health-care workers is specifically the most fascinating aspect of the Good Samaritan as a model for the greatest justice or better the greatest love, 'charity in Truth' towards the sick. On the one hand, a parable may appear to be a simple account, and one that can be understood at first sight, of an event that may have really occurred. On the other hand, a parable ha something that is enigmatic. It has to be examined and reflected upon so that its deepest meanings can be discovered.

1. The Christological Interpretation of the Parable of the Good Samaritan

The most fascinating interpretation of the parable which brings out in a very special way that the Good Samaritan is a model or icon for health-care workers is the Christological interpretation[5] which is to be found in the writings of a number of the Fathers of the Church, amongst whom Origen,[6] St. Ambrose[7] and St. Augistine.[8] Putting to one side the variations between these authors, the Christological interpretation says as follows. The man who was coming down from Jerusalem to Jericho is Adam (Origen)[9] or mankind (Augustine).[10] Jerusalem stands for heaven,[11] Jericho is this world (or our condition of mortality – Augustine). The robbers are devils[12] (or enemy powers, the thieves and brigands of John 10:8, who came before Jesus, the Good Shepherd, according to Origen).[13] The priest and the Levite refer to the Old Testament, the law according to the Prophets. The Samaritan who washed the wounds, the consequences of the sin of disobedience, is none other than Christ, the Redeemer. The animal of the Samaritan on which he places the wounded man in order to go to the inn refers to the body of Christ by which Christ, suffering on the cross, took our sins upon himself. The inn is the Church and the innkeeper is the leader of the Church (Origen) or the apostles (Ambrose[14] and Augustine[15]), to whom the Samaritan or Christ entrusts care for the wounded man. The declaration of the Samaritan that he will return refers to the return of Christ at the end of the world. Although contemporary exegetes no longer apply the allegorical exegesis of the Fathers of the Church in general, some theologians, such as Barth[16] and

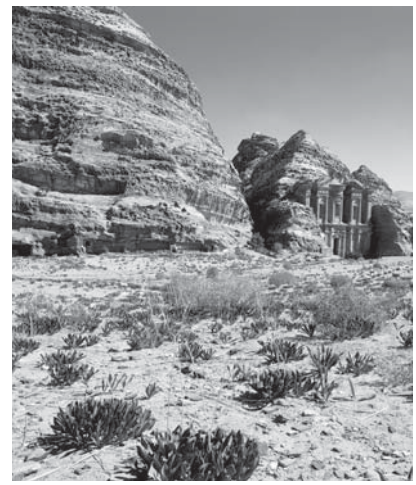
Daniélou,[17] attribute great value to the Christological interpretation. One of the arguments employed by Daniélou to accept the Christological interpretation is the analogy with the other parables of the New Testament which all reveal the mysteries of the Kingdom of God, and above all the parable of the Good Shepherd where Jesus also speaks about robbers and brigands (Jn 10:1-18).[18] This is a sign that the parable of the Good Samaritan must also involve, in the final analysis, the Kingdom of God.

The identification of the Samaritan, who acts as a physician, with Christ, further strengthens the analogy between the mission of Christ and the activities of a physician. By an obvious analogy between healing and redemption, the Fathers of the Church gave Jesus the epithet '*Christus Medicus*'.[19] A further reason was that Jesus healed many illnesses in a miraculous way as a sign that he was the Son of God but also as an external sign of that redemption from evil for which he was made man. Origen (+185-254) speaks in his *Contra Celsum* of healing 'the whole of rational nature and of leading it to familiarity with God the Creator of the universe through the remedy of the Logos (that is to say Christ indicated as the Incarnated Word of God)'.[20] Ambrose (339-397) refers to a physician who imitated the physician who came from heaven.[21] Augustine (354-430) uses the term 'physician' more frequently to describe what Christ did for fallen humanity.[22] Christ, 'the 'true physician',[23] humiliating himself through his suffering and his death, became 'the whole physician for our wounds'.[24]

The title '*Christus Medicus*' to explain Christ's mission as a ministry of healing was used above all until the sixteenth century, but it was also employed afterwards by both Catholics and Protestants.[25] This image also acted as a stimulus for medical doctors and Christians in general to treat the somatic illnesses and wounds of sick people with love of neighbour and compassion. Love, the core of Christian ethics, has its roots in the essence of God Himself, who is love (cf. Jn 4:8). This love was revealed in the incarnation of Christ as being unlimited, given freely, and sacrificial.

Love, expressed in this way, was expressed in caring for sick people not only through providing medical treatment to patients, that is to say the medical/technical aspect, but also in caring for them in a broad sense, in treating sick people who are poor for free and in looking after sick people during epidemics of the plague in the form of a self-sacrifice, at the risk of one's own life.

In the view of Sigerist, Christianity, inspired by Christus Medicus as a model, led to a radical change in the position of sick people and in the organisation of health care, of which the foundation of hospitals, which were unknown in antiquity, beginning in the fourth century, was a clear sign.[26]



2. The Samaritan as an Inspiring Icon of Christ the Physician for Christian Health-Care Workers

The parable of the Samaritan, who is identified with Christ, is a source of inspiration for Christian workers who want in their professional activity to follow Christ the Physician as a model. The figure of the Samaritan is in a certain sense an icon of Christ the Physician. An icon according to the eastern Orthodox tradition is an image which makes present, after a certain fashion, the person who is portrayed. Thus the saints who followed Christ the Physician are in a certain sense icons of him, representing in their behaviour and through the formation of virtues in their being, as well, something of Christ.

Such icons are, for example, the twins and physicians Cosma and Damian, who were born during the seond half of the second century and beheaded because of their courageous witness to the Christian faith. They treated their patients free of charge. Such an icon is also St. Alois of Gonzaga (1568-1591) who treated the victims of the plague in a heroic way, as a result of which he himself caught the plague and died at a young age. A more contemporary example is Giuseppe Moscati, an internist and lecturer in physiology at the University of Naples who lived from 1880 to 1927 and was beatified in 1987 by John Paul II.[27] This medical doctor, who was famous for his talents at the level of diagnosis, deliberately remained unmarried and practised medicine with great love and devotion towards his patients without asking fees from them. He lived in a very modest way. The Christian virtue of voluntary poverty out of imitation of Christ was something very dear to him. He often pointed out to his patients that the deepest healing was in the ultimate analysis the restoration of their relationship with God, above all through the sacrament of confession. On the basis of his deep faith, he established a relationship between redemption and healing, between his faith and his profession. He often did this with good results thanks to the great confidence he inspired in his patients through his sincere interest and his personal care for each one of them. In his patients he perceived the suffering figure of Christ (Mt 25:31-46) and viceversa they encountered in him something of Christ the Physician.

Giuseppe Moscati, the other above-mentioned medical doctors and those who cared for sick people in a heroic and self-sacrificing way were like the Good Samaritan, the icon of Christ the Physician and represented something of his care for everyone which was full of love. It is clear that not every health-care worker is called to such an intensive imitation of Jesus. In addition, the organisation of health care has changed drastically. The arsenal of diagnostic and therapeutic instruments that is now available to it has grown, and this occurred above all starting in the 1930s. In today's

Western Europe there is no need to treat patients without asking for a fee and this is the result of the system of health insurance (although, for example, a refugee who is in a country illegally is often not able to pay the costs of medical care). However, a person who acts as an icon must not be copied literally but, instead, can be a source of inspiration.

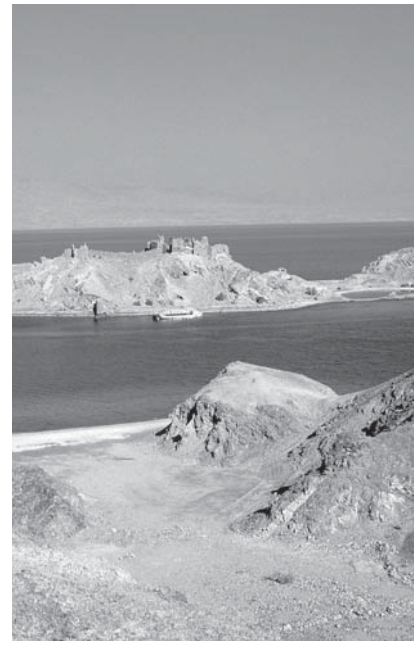
How can one sum up the most fascinating aspects of the figure of the Good Samaritan as an icon of Christ the Physician, or even someone who is identical with him, for health-care workers? I would like to point to three noteworthy aspects: 1. the inversion of the roles of the person who receives care and the person who provides care; 2. authentic compassion; 3. being a custodian/protector of the person without any form of paternalism.

1. The Inversion of Roles

When replying to a question of a teacher of the Law about what he should do to achieve eternal life (Lk 10:25), Jesus referred him in the first instance to the famous dual commandment of love for God and love for neighbour (Lk 10:28). However, the doctor of the law, wanting to justify himself, said "Who is my neighbour?" (Lk 10:29). The answer of Jesus to this question is more surprising than perhaps one might think at first sight. Jesus did not give a direct answer to this question, namely 'everyone, without any exceptions' but instead tells the parable of the Good Samaritan, where he inverts the roles of the wounded person and the person who provides care.

Superficially, we would have expected the conclusion to be that the wounded Jew was the neighbour of the Samaritan, that is to say of the person who helps him. In this case the only conclusion would be that one should also consider the member of an enemy people as one's neighbour for whom one should have equal pity. However, Jesus did not end in this way but inverted the roles. After telling the parable he asked the teacher of the Law: "In your opinion, which of these three acted like a neighbour towards the man attacked by the robbers" (Lk 10:36).

Jesus really inverts the roles. Contrary to what we would have expected at first sight, the neighbour is not the person who is in danger and needs help but the person who brings help. It is noteworthy that the parable, seen from the point of view of how Jesus ends it, is not a precise answer to the question of the teacher of the Law about who his neighbour is. The answer of Jesus is based upon a very different approach. The initial question of the teacher of the Law reveals that he sees himself as the person who brings help and sees the person who needs help as his neighbour. Instead, Jesus defines as the neighbour the person who brings help and makes himself a neighbour of the person who needs help.[28]



This Jesus himself did. Just as the wounded man went down from Jerusalem to Jericho, Christ came down from heaven to the world and in making himself man made himself a neighbour to men who needed to be healed in soul and body. Jesus placed the wounded man at the centre of this descent.

The question of the teacher of the Law about who his neighbour is reveals his individualistic and egocentric character. He places himself at the centre of concentric circles: he is at the centre of a circle of people, each one of whom is his neighbour. Outside this circle there is another larger circle of people who are not defined as neighbours, as the subjects of love.[29] The teacher of the Law thus does two things. He seeks to limit the number of people for whom he should feel pity; the question 'who is my neighbour?', indeed, implies that there is also a 'non-neighbour'. In addition, he places himself as a helper at the centre of everything.

The parable, however, rather than being told from the point of view of the helper is narrated from the point of view of the man who became a victim of robbers. For this reason, the parable implicitly invites its listeners, including the teacher of the Law, to place themselves in the position of the victim. The wounded man is presented as the centre of the movements of the priest, the Levite and the Samaritan: whereas the first two in refusing to become his neighbour not only continue on the their journeys but also pass by, the Samaritan draws near to the wounded man in order to wash his wounds, on which he pours oil and wine.

The change in the perspective of the question 'who is my neighbour' has a special purpose. Whereas the teacher of the Law, placing his own own ego at the centre of things, asks who should be the object of love for neighbour, Jesus, placing the person who needs help at the centre of things, emphasises that one can only find a true answer to that question by becoming the bearer of love for neighbour, that is to say by making oneself a neighbour to anybody who is in danger. The conclusion of this parable is to be found in a single sentence: 'wherever and whenever I am faced with the need of my fellow, I am challenged to act as a neighbour to that person'.[30] This is an intrinsic element of the imitation of Jesus. We learn this from the Samaritan who is identified with Christ and who, in seeing the wounded man, 'feels compassion, draws near to him and becomes his neighbour'.[31]

A person who helps another person has almost automatically the tendency to place himself at the centre of the circle, seeing the sick man as a neighbour who needs his or her help. The parable of the Good Samaritan invites all health-care workers to invert the roles – to see not themselves but the sick person as a subject who is at the centre of

the health-care world. The parable exhorts us not to see the sick person as an object but as a subject of medical care who is made a neighbour by the health-care worker who is a bearer of love for him or her.

2. Authentic Compassion

The reason why the Samaritan makes himself a neighbour of the wounded man is that when seeing him he feels compassion for him. This is expressed by the Greek word 'ἐσπλαγνίσθη'. This verb comes from the noun 'σπλάνχνα', that is to say 'innards'. One is dealing, therefore, not with a superficial compassion but a profound compassion that touches the interiority of the Samaritan and leads him to act, that is to say to clean the wounds of the victim and to take him to an inn where he can recover until the time when he can return to his journey. Here it is interesting to point out that in Dutch and German reference is made to the 'compassionate Samaritan', in the sense of being charitable ('*barmhartige*' and '*barmherzig*').

The compassion that is required should not be confused with superficial pity. It implies that we feel sympathy for the person and where possible put ourselves in his or her shoes. Compassion could not be anything else given that it is a form of imitating Christ the Physician who was made man and thus shared our existence: 'Let us, then, hold firmly to the faith we profess. For we have a great High Priest who has gone into the very presence of God – Jesus, the Son of God. Our High Priest is not one who cannot feel sympathy for our weaknesses. One the contrary we have a High Priest who was tempted in every way that we are, but did not sin…In his life on earth Jesus made his prayers and requests with loud cries and tears to God, who could save him from death. Because he was humble and devoted, God heard him. But even though he was God's Son, he learnt through his sufferings to be obedient. When he was made perfect, he became the source of eternal salvation for all those who obey him' (Heb 4:14-15; 5:7-9).

The Fathers of the Church cited above saw in the animal of the Good Samaritan that this latter used to carry the wounded man to the inn a reference to the body of Christ by which Christ took on the burdens of our sins. Whatever the case, the figure of the physician, himself wounded, is seen in Christ most intensely when he gave his life for our redemption on the cross. Jesus, although he was the Son of God, also made himself man, subjected himself to our human existence (Phil 2:6-11), and came to identify himself with suffering man. Christ, in allowing the righteous to enter his Kingdom, gives as a reason, amongst others, that they visited him when he was sick. To their question as to when they did this, he will reply: "I tell you, whenever you did this to one for one of the least important of these members of my family, you did it for me! (Mt 25:40).

The Good Samaritan as an icon of Christ emphasises that the true compassion that is needed to make oneself a neighbour to a sick person implies that one is able to put oneself in his or her shoes. We also encounter this idea in a precise quotation from Hippocratic writings: 'with the pain of the other a physician receives his own pain'.[32]

It is clear that for us it is often not possible to place ourselves totally in the shoes of another person. This requires both the experience and maturity by which a health-care worker is able to look at his or her suffering and impefections in the face and to integrate them into his or her own life. However, Christian care in a broad sense requires a certain solidarity on the part of the health-care worker towards the suffering person that is analagous to the solidarity of the Samaritan towards the wounded man and, in the ultimate analysis, the solidarity of Jesus towards all of us.

3. Being a Custodian/Protector without any Paternalism

A notable element is that the Samaritan, who is identified with Christ, is called in Latin a 'custos', which in English can be translated by 'custodian' or 'protector', of the wounded man. Origen saw in the Hebrew word for Samaritan ('šômrôn') a link with the participle 'šômêr' which means 'custodian' or 'guardian' in psalm 121, 4: 'The protector of Israel never dozes or sleeps'.[33] In this context Ambrose, in calling the Samaritan, who is identified with Christ, a custodian, bases himself on psalm 116,6: 'The Lord protects the helpless'.[34]

The meaning of the term 'custodian' is expressed in a negative way by Cain who, after killing Abel, answers God's question as to the whereabouts of his brother in the following way: "I don't know. Am I supposed to take care of my brother?" (Gen 4:9).

We health-care workers, who are called to follow Jesus in line with the model of the Samaritan, are also called to become custodians of our brothers and sisters who are sick. Being such custodians excludes any form of paternalism and implies full respect for the justified freedom of sick people, just as Christ gives us all freedom to be healed by him or otherwise.

3. Epilogue

In this context it has to be observed that unfortunately the present bureaucratic health-care system does not make it very easy for the health-care worker to follow the Good Samaritan as his or her model. Under the pressure of the ideology of the free market of the Western world, health-care institutions see themselves forced to reduce costs, thereby reducing personnel to the utmost and employing them according to criteria that are unilaterally economic in character. Through protocols it is laid down how much time, calculated to the last minute, a contract with a medical doctor or a nurse for certain activities can last so as to be able to control costs.[35] It is clear that in such a system interpersonal relationships between health-care workers are under pressure. Because of this development a notable number of health-care workers, and above all nurses, given that they no longer see the possibility of living their professional work as a vocation, experience feelings of malaise.

On the one hand, we should not underestimate the financial problems that health care is fighting against at the present time. On the other hand, we should not, however, become resigned to this situation

and thus abandon the Good Samaritan as a model for health-care workers. A health-care system that does not sufficiently allow health-care workers to realise their fundamental vocation to become neighbours to the people who are entrusted to their care in their professional activity implies in the final analysis a social injustice. According to the principle of subsidiarity (cf. *Quadragesimo Anno,* nn. 79-80; applied more to the international level in *Caritas in Veritate* nn. 47; 57), state and health-care authorities have the task of creating a health-care system where health-care institutions and health-care workers can fulfil their call to follow Christ the Physician *par excellence* in line with the icon of the Good Samaritan.

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Notes

[1] The quotations from the Bible come from the *Good News Bible. Today's English Version*, published by the American Bible Society, 4th. edn., New York, 1976.

[2] J.J. KILGALLEN, *Twenty Parables of Jesus in the Gospel of Luke* (Pontificio Istituto Biblico, Rome, 2008, Subsidia Biblica 32), pp. 33-34.

[3] *Ibid.*, pp. 29-31.

[4] PAOLO VI, 'Discorso ai medici dell'E.N.P.A.S' (6 October 1966).

[5] Cf. R. ROUKEMA, 'The Good Samaritan in Ancient Christianity', *Vigiliae Christianae* 58 (2004), n. 1, pp. 56-74.

[6] ORIGEN, *In Lucam Homiliae* XXXIV (*Fontes Christiani* 4/2, pp. 336/337-344/345). The homilies of Origen on Luke were conserved only in a Latin translation by St. Jerome.Girolamo.

[7] AMBROSE, *Expositio Evangelii Secundum Lucam*, VII, 69-84 (*CCSL* XIV, pp. 236-241).

[8] AUGUSTINE, *Quaestiones Evangeliorum* II, XIX (*CCSL* XLIV B, pp. 62-63).

[9] ORIGEN, *In Lucam Homiliae* XXXIV, 3; Origen here cites an unknown presbyter Origen denies that the man who waas going down from Jerusalem to Jericho is everyman (*ibid.*, 4). Roukema concludes that Origen as a Platonist, without saying so explicitly, supposes that the coming down from heaven to the world refers to the fall of pre-existing creatures from heaven because of sin; this would imply that Origen understands heaven to be the sky (R. Roukema, 'The Good Samaritan in Ancient Christianity', p. 63).

[10] AUGUSTINE, *Quaestiones Evangeliorum* II, XIX, 2.

[11] In the view of Origen probably the skyo (see the footnote on p. 10), in the view of Ambrose and Augustine earthly paradise.

[12] AMBROSE, Expositio Evangelii Secundum Lucam, VII, 73; Augostine, Quaestiones Evangeliorum II, XIX, 6-7.

[13] ORIGEN, *In Lucam Homiliae* XXXIV, 4.

[14] AMBROSE, Expositio Evangelii Secundum Lucam, VII, 81-82.

[15] AUGUSTINE, *Quaestiones Evangeliorum*, II, XIX, 26-27.

[16] K. BARTH, *Die Kirchliche Dogmatik*, Bd. III, 2 (Zurich, A.G. Zollikon, 1948), p. 250; Bd. IV, 1 (Zurich, A.G. Zollikon, 1953, p. 115.

[17] J. DANIÉLOU, 'Le Bon Samaritain', in *Mélanges Bibliques rédigés en l'honneur de André Robert* (Paris, Bloud & Gay, 1956), pp. 457-465.

[18] *Ibid.*, pp. 460-461.

[19] In addition they also promoted this epithet in order to combat the cult of Asklepios, the Greco-Roman god of medicine who was also venerated as a saviour and physician, according to K.H. Rengstorf, *Die Anfänge der Auseinandersetzung zwischen Christusglaube und Asklepiosfrömmigkeit* (Münster, Aschendorff, 1953).

[20] ORIGEN, *Contra Celsum* 3,54 (*SC* 136, p. 128; cf. 4,15).

[21] AMBROSE, *De Helia e ieiunio* 20,75 (*CSEL* 32[II], p. 458).

[22] R. ARBESMANN, 'The Concept of 'Christus Medicus' in St.Augustine', *Traditio* 10 (1954), pp. 1-28.

[23] AUGUSTINE, De Civitate Dei 4,16 (CCSL 47, p. 112): 'Ad quam (quietam) vacat verus medicus dicens: Discite a me, quoniam mitis sum et humilis corde, et invenietis requiem animabus vestris (Mat. 11,29)'.

[24] AUGUSTINE, *In Joannis Evangelium* 3,3 (PL 35, col. 1397): '*... totus medicus vulnerum nostrorum*', cf. *Ibid.*, 25,16.

[25] H. SCHIPPERGES, 'Zur Tradition des 'Christus Medicus' im frühen Christentum und in der älteren Heilkunde', *Arzt und Christ* 11 (1965), pp. 16-19.

[26] H. SIGERIST, *Civilization and Disease*, (Chicago, University of Chicago Press, 1943), pp. 69-70.

[27] G. INFUSINO, *Un santo in corsia. Giuseppe Moscati* (Cinisello Balsamo, Milan, Edizioni Paoline, 1987); G. Papàsogli, *Giuseppe Moscati. Das Leben eines heiligen Arztes* (Stein am Rhein, Christiana-Verlag, 1982).

[28] Cf. BENEDICT XVI, "Angelus" (11 July 2010): 'This time Jesus answers with famous parable of the 'good Samaritan '(cf. Lk 10:30-37) to point out that it is our task to make ourselves a 'neighbour' to anybody who is in need of help'.

[29] Cf. H. HENDRICKX, *The Parables of Jesus*, p. 84.

[30] *Ibid.*, p. 89.

[31] ORIGEN, In *Lucam Homiliae* XXXIV, 6: '...misertus accessit ad eum, ut fieret eius proximus'.

[32] *De Flatibus*, I, 7-8, in: *Hippocrates*, translated by W.H.S. Jones (London, William Heinemann, 1923), vol. II, pp. 226/227.

[33] ORIGEN, *In Lucam Homiliae* XXXIV, 5; cf. R. Roukema, 'The Good Samaritan in Ancient Christianity', p. 64.

[34] AMBROSE, *Expositio Evangelii Secundum Lucam,* VII, 74.

[35] Cf. W.J. EIJK, 'Modelli etici per la gestione della salute' (paper given to the Twelfth International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers 'Church and Health in the World: Hopes and Expectations on the Threshold of the Year 2000'), *Dolentium Hominum* 13 (1998), n. 37, pp. 58-63.

MASSIMO PETRINI

The World of the Future: Demographic Prospects and Heath Needs

In the encyclical letter of Pope Benedict *Caritas in Veritate* there is a statement which should be seen as a preliminary warning about a reading of the demographic data on the world's population and in particular of the data that refer to the health needs of the world of the future. This statement is as follows: 'The risk for our time is that the *de facto* interdependence of people and nations is not matched by ethical interaction of consciences and minds that would give rise to truly human development. Only in *charity, illumined by the light of reason and faith*, is it possible to pursue development goals that possess a more humane and humanizing value' (n. 9), and one could add that only in this way is it possible to use the information that demographic and health-care data can provide. These data describe demographic, economic, political, social and health-care situations, but behind these data there are 'people'.

This statement means that it is not possible to engage in a reading that operates only at the level of knowledge. As this encyclical goes on to say: 'The urgency is inscribed not only in things, it is not derived solely from the rapid succession of events and problems, but also from the very matter that is at stake: the establishment of authentic fraternity. The importance of this goal is such as to demand our openness to understand it in depth and to mobilize ourselves at the level of the "heart", so as to ensure that current economic and social processes evolve towards fully human outcomes' (*Caritas in veritate*, n. 20).

The scenario of the world is characterised by notable mutations. For the first time in history we are faced with extraordinary demographic changes as regards the world's population, with the consequences that this fact involves. This is a scenario that began during the course of the twentieth century and which can be described in the following way:[1] a) a world population that is still growing in terms of numbers; b) a numerical decline in the populations of many developed countries (which is mitigated in some cases by sizeable immigration flows); c) a decrease in birth rates which in many countries has been going on for a long time and where birth rates are 'excessively low'; d) a decrease in death rates, in the elderly age bands as well, with a consequent increase and spread of long life expectancy; e) a very major increase in those parts of the population of working age in the less economically advanced countries of the world; f) an increase in the elderly age band in particular, but not only, in developed countries, with a drastic increase in the number of elderly people and a drastic reduction in the numbers belonging to the age bands made up of children and adolescents; g) a more frequent and prolonged co-existence of three to four generations within the same populations; h) a notably more urbanised population concentrated in vast megalopolises, above all in the South of the world, and sprawling urban areas of a notably large range above all in the North of the world; and i) an increase in international migrations and a rather strong increase in ethnic diversity within immigrant populations.

The complexity of these major and difficult challenges can be summed up in two facts that relate to the demography of the world in the year 2050: it is calculated that there will be a population increase of more than 22 million people in the North of the world (including the immigration of 2-3 million people every year) and of more than 2,498 million people in the South of the world (including the emigration of 2-3 million people every year).

In particular, for the fifty poorest countries of the world it is calculated that for the period between the year 2008 and the year 2050 there will be an increase of 918 million people (from 824 million to 1,742 million), equal to an increase of 114%; as regards countries that are at the present time developing countries, the intermediate countries, which include those with the highest economic growth rates, such as Brazil, China and India, it is calculated that there will be an increase of 1.5 milliard people (from 4,770 million to 6,200 million), equal to an increase of 32%; and with respect to the most developed countries it is calculated – albeit taking into account an immigration from less developed countries of about 2 million people a year – that there will be a growth of only 19 million people (from 1,226 million to1,245 million), that is to say substantially a zero growth rate, or roundabout 2%.

This an increase in the population of the world that should be read correctly, quite beyond the concerned concerns about a greater sharing of existing resources. Indeed, Pope Benedict XVI observes that: 'To consider population increase as the primary cause of underdevelopment is mistaken, even from an economic point of view. Suffice it to consider, on the one hand, the significant reduction in infant mortality and the rise in average life expectancy found in economically developed countries, and on the other hand, the signs of crisis observable in societies that are registering an alarming decline in their birth rate' (*Caritas in veritate*, n. 44).

Although the decline in death rates and the decline in birth rates marked the demographic scenario of almost all countries and brought about what has been defined as the first demographic transition, for some decades now we have been witnessing a second demographic transition due to, and characterised by, lasting and very low birth rates accompanied by a further decline in death rates which has been especially concentrated in the elderly age bands. This phenomenon has led to the 'ageing of populations', in particular in the developed countries of the world.

This situation is described in the table 1 which describes the *population of the world* in the year 2005 and the envisaged population of the world in the year 2050, by major age bands (in millions).

A clarification should be made: to speak about the year 2050 means referring to people who are presently already alive: a person born in 2000 will be 50 years old in the year 2050, although a person born in 2010 will be only 40. Taking into account that it is expected that average life expectancy will increase to 85, this means that a little more than 60% of the population that will be alive in the year 2050 will, with all probability, have been already alive in the year 2008. To speak about the year 2005 does not mean therefore to refer to abstract figures which appear in graphs or table. It means, rather, to refer to a great extent to real people who are already alive on the planet earth.[2]

The relevant fact is the notable deformation of the structure of the world's population in age terms and, in parallel with this, the very great ageing of the population. At a detailed level, the developed countries will have to face up to an ageing of very great intensity and reduced velocity, given that the proportion of people over sixty years of age in their populations as a whole should, in the year 2050, be over 32%; countries of intermediate de-

Table 1

	2005	2050	Increase	Increase %	% of total 2005	% of total 2050
Part of the Population Aged Less that 15						
World	**1.844**	**1.829**	**-15**	**- 0.8**	**28.3**	**19.9**
Developed countries	207	189	-18	- 8.6	17.0	15.2
Developing countries	1.637	1.637	0	0	30.9	20.6
Part of the Population of Working Age of 15- 65 Years of Age						
World	**4.196**	**5.873**	**1.677**	**40.0**	**64.4**	**63.9**
Developed countries	823	731	- 92	- 11.2	67.7	58.7
Developing countries	3.374	5.141	1.767	52.4	63.6	64.7
Part of the Population Aged 65 or More						
World	**476**	**1.489**	**1.013**	**212.8**	**7.3**	**16.2**
Developed countries	186	325	139	74.7	15.3	26.1
Developing countries	291	1.168	877	301.4	5.5	14.7

Source: Golini's calculations based on data of the United Nations, 2007

Table 2

Area or Country	2000-2005	2005-2050	Increase	Increase %
World	**65**	**75**	**10**	**15**
Developed countries	78	84	6	8
Europe	78	83	5	6
Japan	82	88	6	7
United States	77	82	5	6
Canada, Australia, New Zealand	80	85	5	6
Economies in transition	65	74	9	14
Union of Independent States	65	74	9	14
South-east Europe	74	80	6	8
Developing countries	63	74	11	17
Latin America and Caribbean	72	79	7	10
East Asia and the Pacific	70	78	8	11
South Asia	63	75	12	19
West Asia	68	78	10	15
Africa	49	65	16	33

Source: Golini's calculations based on data of the United Nations, 2007

velopment will have to face up to an ageing of very great intensity and very great velocity, with the number of people over the age of sixty being a little over a milliard in number (from 391 million people to 1,398 million people), with a percentage increase of 239%; and countries with a minimal development will have to face up to an ageing of lower intensity but very great velocity, with an increase of 320%.

Table 2 describes *average life expectancy* in some regions of the world, taking life expectancy for the years 2000-2005 and envisaged life expectancy for the years 2045-2050.

To express a simple demographic fact: by 2050 there will have been an increase of 1,300 million people of over sixty years of age whereas, and this is another relevant phenomenon, in countries of intermediate development and in poorer countries with a minimal development there will be one and a half milliard people of working age, a development that will challenge the possibilities of creating, and the ability to create, jobs, and jobs with dignity.

Another element that should be considered is the development of sustained urbanisation, although we have to take into account that in the year 2008 the urban population was already larger than the rural population. In the year 2007 the rural population was calculated to be made up of 3,377 million people and the urban population to be made up of 3,294 people; it is expected that the increase between the years 2007 and 2005 will be only 49 million as regards the rural population and 1,290 million as regards the urban population – 1,106 million of these will be in developing countries. It is calculated that after the year 2025 the urban population will increase more but that the rural population will decrease with greater intensity.

The experts believe that this trend should be adjudged positively given the importance of urbanisation for economic growth and the wellbeing of people, and indeed to such an extent that they state that the growth of cities will the principal factor influencing the economic-social development of the twenty-first century, and this despite the fact that a milliard people will live in shanty towns in overcrowded conditions without access to essential services such as drinking water and sewerage. However, it is observed, all the evidence demonstrates that the rural population has less access to the key services of contemporary life compared to the inhabitants of small cities, who in their turn have less services than their counterparts in the large cities. As a consequence, levels of nutrition, of health and of instruction are worse in rural areas than in small cities, where, however, they are lower than in large cities where, with notable differences existing from one continent to another, the costs *per capita* of instruction, of housing, of health care, and of hygiene systems are lower than in the countryside.[3] The experience of China, however, demonstrates that a rapid and immense development of large cities can involve an increase in poverty, pollution and social turbulence.

An important role in demographic transformations has been performed, and will be performed, by international migration, even though as regards this phenomenon one cannot refer to specific demographic regimes. There is uncertainty in assessing the role of this factor in the future because there are many factors which can influence its evolution: from the most relevant factor, which is connected with the equilibrium of the international economy, to the migration policies of the host and departure countries, and on to economic opportunities, not to speak of refugees who often constitute flows from politically unstable countries to countries which are equally poor but politically stable.[4]

Here it is important to describe the *decline in birth rates* which is still a worldwide phenomenon, as is demonstrated by the table 3 which provides a comparison between the average number of children for each woman in some regions of the world (for the years 2000-2005) and the corresponding number envisaged for the years 2045-2050.

Table 3

Area or Country	2000-2005	2005-2050	Increase	Increase %
World	**2.6**	**2.0**	**-0.6**	**-23**
Developed countries	1.6	1.8	+0.2	+13
Europe	1.4	1.8	+0.4	+29
Japan	1.3	1.9	+0.6	+46
United States	2.0	1.9	-0.1	-1
Canada, Australia, New Zealand	1.6	1.9	+0.3	+19
Economies in transition	1.6	1.8	+0.2	+13
Union of Independent States	1.6	1.8	+0.2	+13
South-east Europe	1.6	1.8	+0.2	+13
Developing countries	2.9	2.1	-0.8	-28
Latin America and Caribbean	2.5	1.9	-0.6	-24
East Asia and the Pacific	1.9	1.9	0	0
South Asia	3.2	1.9	-1.3	-41
West Asia	3.5	2.0	-1.5	-43
Africa	5.0	2.5	-2.5	-50

Source: Golini's calculations based on data of the United Nations, 2007

But here we should remember the reading of this phenomenon which is engaged in by Pope Benedict XVI in his *Caritas in Veritate* when he observes that: 'some parts of the world still experience practices of demographic control, on the part of governments that often promote contraception and even go so far as to impose abortion. In economically developed countries, legislation contrary to life is very widespread, and it has already shaped moral attitudes and praxis, contributing to the spread of an anti-birth mentality; frequent attempts are made to export this mentality to other States as if it were a form of cultural progress. Some non-governmental Organizations work actively to spread abortion, at times promoting the practice of sterilization in poor countries, in some cases not even informing the women concerned. Moreover, there is reason to suspect that development aid is sometimes linked to specific health-care policies which *de facto* involve the imposition of strong birth control measures' (n. 28).

From an economic point of view, these data indicate a shift of people who twenty years ago lived on less than one American dollar a day (1,482 million people, now 1,093 million people) to the category of those who live on less than two American dollars a day, who have gone from 2,450 people then to 2,735 million today[5]. But the problem of poverty is not to be confined to certain countries alone.

Pope Benedict XVI rightly observes in *Caritas in Veritate* that: *'The world's wealth is growing in absolute terms, but inequalities are on the increase*. In rich countries, new sectors of society are succumbing to poverty and new forms of poverty are emerging. In poorer areas some groups enjoy a sort of "superdevelopment" of a wasteful and consumerist kind which forms an unacceptable contrast with the ongoing situations of dehumanizing deprivation. "The scandal of glaring inequalities" continues. Corruption and illegality are unfortunately evident in the conduct of the economic and political class in rich countries, both old and new, as well as in poor ones' (n. 22).

As regards the health of the world's population, one should remember the process of 'health-care transition'[6] which has already been described in this paper and which has led life expectancy to reach general levels never imagined before in history and to which have contributed, above all in recent years, great scientific and technological advances, which, in their turn, have led medical science to exercise an increasing control over the causes and the consequences of the majority of pathological processes.[7]

Although this applies to developed countries, where there is even discussion about an excessive use of new medical technologies which may compromise the sustainability of existing health-care systems without bringing about improvements in the state of health of the population, the situation of countries in the South of the world is very different. In these countries, the majority of the population is excluded from the possibility of having access to health-care services and to medical products.

An indicative fact is the comparison in the world rankings of average life expectancy: over forty years of life separate men in those countries where men live longest (82-79 years in Australia, Iceland, Italy, Japan, Sweden, Switzerland) from those countries where men live the least (37-39 years in Sierra Leone, Swaziland and Angola). In the case of women, the gap is even greater, with almost fifty years of difference between the 86 years of Japan and the 37 years of Swaziland.[8] But on the other hand there is the high death rate of children under the age of five (the best documented in terms of statistics). In the Countdown report of 2008, an independent initiative sponsored by the United Nations and by other international organisations, attention is drawn to a dramatically grave situation in the mother/child sector both in terms of health and in terms of the organisation of health-care services for a significant part of humanity which produces a little less than ten million deaths a year of children under the age of five and over half a million deaths of mothers (about 50% of this death rate is concentrated in sub-Saharan Africa).[9]

In beginning her job at the beginning of 2007, the new Director General of the World Health Organisation, Margaret Chan, from China, once again placed stress upon primary health care (PHC) as a strategy for the strengthening of health-care systems as the best way by which to assure the sustainability of improvement in health and best guarantees for fair-

ness in access,[10] albeit in a context that is by now globalised which has new challenges that have to be addressed: urbanisation, the ageing of populations, the contamination of the environment, changes in lifestyles and the consequences of these changes for health, the increase in the incidence of chronic illnesses, obesity, the emergence of new infectious diseases and the re-emergence of already known diseases which are resistant to antibiotics, migrations, the globalisation of the labour market and the removal of health-care personnel from countries where they are most needed, the growing gap between North and South, between urban and rural areas, between the rich and the poor.

Primary health care is defined in the following way: 'basic care is essential health care based upon practical methods and technologies that are scientifically valid and socially acceptable, made universally accessible to the individuals and to the families of a community through their full participation at a cost that the community and countries can afford at every stage of their development in a spirit of self-confidence'. This principle assigns to states and their agencies tasks that go well beyond the simple management of health-care systems. They should take responsibility for identifying, and trying to change through suitable alliances, those factors that have a negative influence on collective health, promoting at the same time those factors that are favourable to such health.

Primary health care, that is to say basic health care, must be an integral part of the health-care system of each country but above all of the overall social and economic development of society, in a vision based upon fairness, on communitarian participation, on attention centred around prevention, on appropriate technology and on an inter-sectorial approach which is integrated with development.

This definition certainly has a 'utopian' character inasmuch as is describes a situation of complete satisfaction which is difficult to achieve, but it constitutes a point of reference for the direction of the efforts that are made. The World Health Organisation has tried to make operative two strategies and has done this since the beginning of the 1980s. These strategies go under the name, respectively, of 'health promotion' and 'health strategy for all', and seek to transform a principle into a practical plan at the level of individual governments.

The ten principal individual risk factors at a global level indicated by the World Health Organisation in its *World Health Report* are: low weight and malnutrition, unprotected sexual relations, arterial hypertension, tobacco smoke, alcohol, undrinkable water and hygiene deficiencies, excessive cholesterol, lack of iron, and obesity. Even though there are many possible definitions of 'risk', in this field it is defined as 'the likelihood of an adverse outcome or a factor that increases this possibility'.

Table 4 lists the number of deaths (in millions) and their respective causes, comparing countries with low individual incomes ($US 825 or less) with those where individual incomes are high ($US 10,066 or more).

Table 4 - Ranking of selected risk factors: 10 leading risk factor causes of death by income group, 2004

	Risk factor	Deaths (millions)	Percentage of total		Risk factor	Deaths (millions)	Percentage of total
	World				**Low-income countries***		
1	High blood pressure	7.5	12.8	1	Childhood underweight	2.0	7.8
2	Tobacco use	5.1	8.7	2	High blood pressure	2.0	7.5
3	High blood glucose	3.4	5.8	3	Unsafe sex	1.7	6.6
4	Physical inactivity	3.2	5.5	4	Unsafe water, sanitation, hygiene	1.6	6.1
5	Overweight and obesity	2.8	4.8	5	High blood glucose	1.3	4.9
6	High cholesterol	2.6	4.5	6	Indoor smoking from solid fuels	1.3	4.8
7	Unsafe sex	2.4	4.0	7	Tobacco use	1.0	3.9
8	Alcohol use	2.3	3.8	8	Physical inactivity	1.0	3.8
9	Childhood underweight	2.2	3.8	9	Suboptimal breastfeeding	1.0	3.7
10	Indoor smoking from solid fuels	2.0	3.3	10	High cholesterol	0.9	3.4
	Middle-income countries				**High-income countries***		
1	High blood pressure	4.2	17.2	1	Tobacco use	1.5	17.9
2	Tobacco use	2.6	10.8	2	High blood pressure	1.4	16.8
3	Overweight and obesity	1.6	6.7	3	Overweight and obesity	0.7	8.4
4	Physical inactivity	1.6	6.6	4	Physical inactivity	0.6	7.7
5	Alcohol use	1.6	6.4	5	High blood glucose	0.6	7.0
6	High blood glucose	1.5	6.3	6	High cholesterol	0.5	5.8
7	High cholesterol	1.3	5.2	7	Low fruit and vegetable intake	0.2	2.5
8	Low fruit and vegetable intake	0.9	3.9	8	Urban outdoor air pollution	0.2	2.5
9	Indoor smoking from solid fuels	0.7	2.8	9	Alcohol use	0.1	1.6
10	Urban outdoor air pollution	0.7	2.8	10	Occupational risks	0.1	1.6

* Countries grouped by gross national income per capita - low income (US$ 825 or less), high income (US$ 10 066 or more).

Experience with anti-retrovirals in the treatment of HIV/AIDS demonstrates that the obligatory liberalisation of patents adopted by certain governments has allowed the introduction of new general medical products in a number of poor countries. However, although all countries agree on the absolute need for an international agreement which, although not binding, would have an enormous political impact, the identification of concrete initiatives that go beyond declarations of principle in favour of the protection of the health of poorest populations is slow to emerge. Here we also have to take into account the resistance of the pharmaceutical industry which is motivated from the outset by the costs of research.[11] However, one should add that it would be ungenerous to attribute to the laws of the market, to pharmaceutical multinationals and to the governments of rich countries the whole of the responsibility for the lack of access to the most effective medical products. The following table demonstrates that none of the players involved can escape criticism and it also shows how the prices of medical products are also influenced by policies of governments which are not always understandable. Table 5 illustrates the impact of tariffs and taxes on the retail prices of medical products in certain countries:[12]

Table 5

Country	Tariffs and Taxes
India	55
Sierra Leone	40
Nigeria	34
Pakistan	33
Bolivia	32
Bangladesh	29
China	28
Jamaica	27
Morocco	25
Georgia	25
Mexico	24

In order to define the needs at the level of intervention in a more effective way, the World Health Organisation drew up a classification which identifies three major groups of diseases:[13]

– *Type I diseases*, which afflict both rich and poor countries, everywhere causing a high number of illnesses and deaths. Amongst non-transmissible diseases, to this category belong: diabetes, cardiovascular diseases, dementia, tumours and so forth; amongst transmissible diseases, to this category belong: measles, hepatitis B, etc. Many vaccines and many kinds of treatment have been created to combat some of these diseases but they encounter obstacles at the level of their diffusion in poor countries because of their high cost.

– *Type II diseases*, which are widespread in both rich and poor countries but with a clearly higher level of cases in poor countries. HIV/AIDS and tuberculosis are examples of these kinds of diseases: both are present in rich countries and in poor countries, but more than 90% of cases are to be found in the poor countries of the world.

– *Type III diseases*, which exclusively afflict the poor countries of the world. Here we encounter Chagas' disease, dengue and haemorrhage dengue, leishmaniosis, leprosy, lymphatic filaria, malaria, river blindness (onchocerciasis), sleeping sickness, and gangrenous stomatitis. Many of these pathologies are completely unknown in developed countries or belong, like leprosy or malaria, to a more or less remote past, but they constitute a grave risk at the level of illness for the poorest populations of the world.

These are the diseases that are often defined as being 'neglected diseases' by scientific research given that they do not produce a market of consumers (those people, that is to say, who in addition to expressing a need also have adequate purchasing power) that is sufficient to justify investment in research.

But the level of health of a population does not only depend on the level of health care – it is also the result of a number of factors: health-care factors, economic factors, social factors and more generally cultural factors. A reorganisation of health-care systems through vertical programmes (vaccinations, family planning – albeit with methods that are debatable at an ethical level – the control of individual diseases, etc.) has led in any countries to a disruption of the work of public health with a multiplication of costs and a waste of resources, without mentioning the total breakdown of development initiatives that should be carried out in other sectors (public instruction, agriculture, production, etc.). In the same way, divisions and programmes directed at specific diseases have taken on a disproportionate role within the World Health Organisation itself as regards the resources allocated to the development of health-care systems and integrated action for the promotion of health. Attention has moved away from health and become focused upon diseases. For example, the funds given by sponsors to health-care sectors are often directed towards combating individual diseases such as AIDS, tuberculosis, malaria, polio, etc. Between the year 2000 and the year 2004 funds for combating HIV/AIDS more than doubled and funds for primary care were halved.[14]

How much this policy helps to improve the state of health of whole populations, as many people think happens, is debatable. The contribution of health-care services to an improvement in the state of health of populations is marginal and limited. The health of entire populations depends more on the availability of food, water, instruction, work and decent housing than on the availability and quality of health services. Another misunderstanding that is frequently encountered, and which after a certain fashion contributes to exaggerated expectations, is that in poor countries people fall sick or die because of illnesses such as diarrhoea, measles, respiratory infections and others which could be easily cured or prevented. If these illnesses were easily preventable or curable it would be easy to prevent or cure them. This is not the case because even the simplest methods are difficult and expensive to apply in contexts of acute poverty where a few litres of water of dubious quality can cost a four, six or even eight hours' journey; food is rarely sufficient; people's

homes are unhealthy huts, hygiene is a luxury; and education is absent. When these (and other) factors come to be corrected in line with justice and decency, the illnesses that kill the poor people of the world will be easily preventable and curable. But not before.[15]

Pope Benedict XVI observes in *Caritas in Veritate* that 'In *development programmes*, the principle of the *centrality of the human person*, as the subject primarily responsible for development, must be preserved. The principal concern must be to improve the actual living conditions of the people in a given region, thus enabling them to carry out those duties which their poverty does not presently allow them to fulfil' (n. 47).

But, for example, the humanitarian ideology tends to see the victims of wars and natural disasters as the mere objects of help rather than as individuals who find themselves in a state of temporary difficulty but who are fully able to address the challenges raised by the environments, understood in a social and political sense, in which they live. Just as the loans of the last three decades have put many poor countries into a state of debt, making them dependent on rich countries and international financial organisations, so aid tends gradually to make the countries that depend on aid unable to deal with their own crises. Humanitarian aid is often focused on the right to survival, forgetting about the right to life with all its economic, social and political aspects. Humanitarian aid tends to come to the aid of populations without asking very many questions about the network of causes that lead to a humanitarian crisis.[16]

Caritas in Veritate observes: 'Knowledge… can certainly be reduced to calculation and experiment, but if it aspires to be wisdom capable of directing man in the light of his first beginnings and his final ends, it must be "seasoned" with the "salt" of charity…Indeed, "the individual who is animated by true charity labours skilfully to discover the causes of misery, to find the means to combat it, to overcome it resolutely"' (n. 30)

A committee of the United Nations (the Committee on Economic, Social and Cultural Rights) states that the right to health should not be seen as the right to be healthy, which is not possible, but as the right to have access to a variety of goods, services and conditions which are required for the achievement of the highest possible standard of health. This committee interprets the right to health as an inclusive right that concerns not only appropriate and speedy health care but also a series of determinants of health such as access to safe water and environmental hygiene, to adequate alimentation, to housing, to safe employment conditions, to instruction and to information.

In the absence of these conditions, all the major risks to the health of populations appear to be destined to continue in the immediate future. Armed conflicts and their inevitable consequences in terms of the destruction and weakening of health-care systems and the rise of infectious diseases, and large population movements and the concentration of great masses of people in refugee camps, are favourable terrains for the spread of epidemics. Climatic changes themselves, as the conference of the FAO of November 2007 observed, have a very strong impact on the availability and distribution of foodstuffs, with obvious consequences. And in addition regulated urbanisation, which is still underway in a major part of the South of the world, involves living conditions that are absolutely inadequate, without access to drinking water, to hygiene services, to safe food, to decent shelter and work, and which can only cause a deterioration in general living conditions and an increase in health-care risks as well. To all this is added specific health-car risks which today are obstacles in the way of a further improvement in health care. The development of a growing resistance on the part of microbes to antibiotics and the constant need to resort to the accelerating development of new strains meant that during the second session of the Inter-Governmental Work Group on intellectual property rights of the World Health Organisation the urgent need emerged to develop drugs of the second and third generation to deal with the increasing resistance of bacteria and viruses.[17]

These situations also threaten the developed countries of the world. The growing interconnection between countries and peoples has brought about the rapid spread of epidemics, perhaps ones provoked by systems of food production or animal rearing, and has destroyed the illusion of protection that the richest populations of the world seemed to enjoy until a few years ago. At the same time the rhythm with which new diseases have emerged is creating widespread concern (since 1970 on average one or two new diseases have been identified each year and today there are forty diseases

which were completely unknown until a generation ago) and encourages a push towards increasingly effective monitoring systems. The appearance of new infectious diseases, such as AIDS and SARS, and the threat of pandemics, such as that of bird flu (more or less justifiably feared), have helped to make many people, if not everybody, understand that health is a global possession. A strengthening of the health-care systems of the poorest countries of the world, in addition to being an act of justice, helps to protect the whole of mankind. It is possible that precisely because of these fears, which do not avoid the richest and most developed countries of the world, a determination will arise – something that hitherto has been rather lacking – to address the health-care problems which afflict the world, even though the pursuit of a better state of health for (all) populations must be engaged in because this is a value in itself, a fundamental human right.

But 'the earthly city', Pope Benedict XVI observes in *Caritas in Veritate*, 'is promoted not merely by relationships of rights and duties, but to an even greater and more fundamental extent by relationships of gratuitousness, mercy and communion. Charity always manifests God's love in human relationships as well, it gives theological and salvific value to all commitment for justice in the world' (n. 6).

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Notes

[1] Cf. A. GOLINI, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), pp. 16-17.

[2] Cf. A. GOLINI, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), p. 9; A. Golini, 'Demografia della popolazione anziana', *Dolentium Hominum* 67 (2008), pp. 17-30.

[3] Cf. A. GOLINI, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), p. 14.

[4] Cf. S. SALVINI, 'Popolazione, sviluppo economico, mercati del lavoro e migrazioni internazionali', in A. Golini., *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), pp. 69-94.

[5] A. ANGELI and S. SALVINI, *Popolazione e sviluppo nelle regioni del mondo* (Il Mulino, Bologna, 2007).

[6] A. R. OMRAN, 'The Epidemiologic Transition: A Theory of the Epidemiology of Population Change', *The Milbank Memorial Fund Quarterly* 8(1971), pp. 509-538; J. Frenk, J.L. Bobadilla, C. Stern, T. Frejka, and R. Lozano, 'Elements for a Theory of the Health Transition', *Health Transition Review* 1(1991), p. 21.

[7] V. EGIDI, 'Popolazione e tecnologia: opportunità e sfide per la salute', in A. Golini, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), p. 95.

[8] United Nations, *Common Data Base* (United Nations Statistic Division, New York, 2005; World Health Organization, *World Health Statistics* (Geneva, 2007).

[9] Countdown Working Group on Health Policy and Health Systems, 'Assessment of the Health System and Policy Environment as a Critical Complement to Tracking Intervention Coverage for Maternal Newborn, and Child Health', *Lancet* 371(2008), pp. 1284-93.

[10] M. CHAN, 'Keynote address at the International Seminary on Primary Health Care in Rural China', Beijing, 1 November 2007.

[11] V. EGIDI, 'Popolazione e tecnologia: opportunità e sfide per la salute', in A. Golini, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), p. 108.

[12] P. STEVENS, *Diseases of Poverty and the 10/90 Gap* (International Policy Network, London, 2004); V. Egidi, 'Popolazione e tecnologia: opportunità e sfide per la salute', in A. Golini, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), p. 108.

[13] V. EGIDI, 'Popolazione e tecnologia:opportunità e sfide per la salute', in A. Golini, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), pp.10-110.

[14] M. MURRU and F. TEDIOSI, 'L'aiuto pubblico allo sviluppo e la cooperazione sanitaria', in AA.VV., *Salute globale e aiuti allo sviluppo Diritti, ideologie, inganni 3° Rapporto dell'Osservatorio Italiano di Salute Globale* (Edizioni ETS, Pisa, 2008), p. 69.

[15] M. MURRU and F. TEDIOSI, 'L'aiuto pubblico allo sviluppo e la cooperazione sanitaria' in AA.VV., *Salute globale e aiuti allo sviluppo Diritti, ideologie, inganni 3° Rapporto dell'Osservatorio Italiano di Salute Globale* (Edizioni ETS, Pisa, 2008), pp. 65-66.

[16] A. CATTANEO, C. DENTICO and A. STEFANINI, 'Gli aiuti umanitari: tra carità, ideologia, inganno', in AA.VV., *Salute globale e aiuti allo sviluppo Diritti, ideologie, inganni 3° Rapporto dell'Osservatorio Italiano di Salute Globale* (Edizioni ETS, Pisa, 2008), pp. 113-127.

[17] Cf. V. EGIDI, 'Popolazione e tecnologia: opportunità e sfide per la salute', in A. Golini, *Il futuro della popolazione del mondo* (Il Mulino, Bologna, 2009), pp.115-116.

ANTONIO G. SPAGNOLO

Biomedical Technologies at the Service of Life

1. The Reference to Technology in *Caritas in veritate*

The reference to technology, and to its extraordinary applications in the biomedical field, constitutes one of the crucial points of the encyclical *Caritas in Veritate* (*CV*) to which is closely linked the question of the development of man. The entire development and the socio-cultural changes of man on earth are, in fact, strictly linked with that technological progress which has so extended itself with its extraordinary applications in the biological and biomedical field as well. Technology, as Benedict XVI observes, 'is a profoundly human reality, linked to the autonomy and freedom of man. In technology we express and confirm the hegemony of the spirit over matter… Technology enables us to exercise dominion over matter, to reduce risks, to save labour, to improve our conditions of life. It touches the heart of the vocation of human labour: in technology, seen as the product of his genius, man recognizes himself and forges his own humanity' (*CV,* n. 69).

More specifically, in technologies in the biomedical field, or biotechnologies as they are defined in summarising fashion, the reference to '*bios*' allows us to distinguish them, without separating them, from technology in a simple sense, because as Pessina observes,[1] they constitute a practice mediated by theories that interpret life itself according to a precise approach. We should therefore reflect on a further question: whether, that is to say, progress brought about by biomedical technologies also involves an automatic anthropological improvement or whether, instead, such technologies are not translated in some cases into an 'anthropological mutation', as Melina writes,[2] which ends up by becoming no longer governable by man himself. But this mutation is also located at the level of the 'technical' possibility of destroying humanity itself through a genetic-structural mutation of man (enhancement, manipulation of the mind, etc.) or of other living beings (biological weapons or alterations in the environment).

The growing power of technology as regards intervening upon man's body and mind – celebrated for its contribution to the wellbeing of humanity – also lends itself, indeed, to uses that could slide into dehumanisation, into what C.S. Lewis defined as the 'abolition of man', the title of his short but incisive volume.[3] But it is above all man in his very vulnerable embryonic state of life who is threatened by this biomedical technology when it is no longer governed, when unborn human life is seen as being raw material which confuses procreation with production.

Thus the ethical question today can be formulated in the following way: what must one do or not do for man to survive and remain man? The birth of bioethics after a certain fashion sought to provide an answer to this question. In introducing the term and in giving it a very precise task, V.R. Potter spoke, indeed, about bioethics as the 'science of survival',[4] fearing the negative impact of man were a control not established over the development of such technologies. And *Caritas in Veritate* (n. 74) speaks about bioethics as a 'particularly crucial battleground in today's cultural struggle between the supremacy of technology and human moral responsibility' in which is at stake the very possibility of integral human development. The fundamental question, indeed, is the choice between two rationalities: that of reason open to transcendence or that of reason closed in immanence. Reason and faith help each other in turn in this choice, given that reason without faith, attracted by pure technical action, is destined to lose itself to the illusion of its own omnipotence. And, on the other hand, faith without reason runs the risk of becoming estranged from the concrete lives of people.

The ethical character of technology, therefore, should not be seen simply in terms of the stage of application but also in terms of its radical insufficiency, in its teleological ambivalence and in its dynamic of knowledge/power which is increasingly growing and, therefore, in its explicative stage, its stage of meaning. In other words, technology needs to be completed and to refer to itself within an overall anthropology in which it can find its role at the side of the dimensions of man. This assumes a project for man which backs up technological development without man being dehumanised by this development and without this development being absolutised.[5]

Technology, to follow Jonas, contains in itself two basic elements: a formal dynamic which should be understood as an 'uninterrupted collective undertaking' which advances according to its own 'laws of movement' and a substantial content 'made up of things that it places at the service of man, by the opportunities and forces that it bestows on us, by the new goals that it holds up or imposes, and by the changed modalities of acting and human behaviour'.[6]

Both these factors are inherent to the ethical dimension, indeed they constitute a new and singular case for this dimension which should be analysed morally in the light of a 'strong' anthropology of reference, that is to say centred around the ontological dimension of man. One is dealing, in definitive terms, with distinguishing – as Leon R. Kass writes – between the perfection of means and the wisdom of ends.[7]

And referring to the essay of Lewis cited above, Kass emphasises that in the debate on biomedical technologies there is a tendency to neglect the anthropological implications that biotechnologies involve, but even before this we should have a deep understanding of the human values that we want to conserve and defend.

2. Unborn Life and the Applications of Biomedical Technologies

Starting in the 1970s, the biomedical technologies – which were initially derived from fertilisation with animals – developed in a notable fashion in particular in the field of human procreation, intervening upon life at the initial stages of existence and raising by no means few problems of a moral character.

The introduction of biomedical technologies applied to unborn life actually began with the prospect of providing an answer to the 'treatment' of sterility: faced by physiological alterations of the sexual or reproductive apparatus, biomedical technologies sought to overcome these obstacles and to meet – in some cases in an extraordinary way – the natural aspirations of married people to have a child. But after the initial enthusiasm linked to the possibility of removing certain pathological failings which had been hitherto insuperable, there soon followed an awareness that human procreation was losing its original and originating character of generation and that one was confusing the procreation level with the production level; conceiving with manufacturing. Reproductive technology allowed, indeed, the creation of techniques to replace the biological relationships of paternity and maternity.

The recovery in many cases of the functionality of physical apparatuses connected with the reproductive process was not enough for biomedical technology which went beyond those situations that were insoluble at a merely therapeutic level: where procreation could not take place through a conjugal act, techniques of insemination and homologous fertilisation were employed; where the germinal cells of the couple were not able to bring about fertilisation, steps were taken outside the couple to use the gametes or embryos of third parties; where the female genital apparatus was incapable of pregnancy there was a move to wombs for rent; and where the idea was to disassociate completely the beginning of life from the relationship of two people of a different sex, relegating it to the replication of one person alone, the prospect of cloning was held up![8]

Biomedical technology drew up all possible solutions to overcome all the difficulties that could be diagnosed, with the sole objective of giving a child to those who wanted it, without posing to itself the problem of the impact of these techniques on the meaning of generation but above all on that being itself called at all costs into existence through those techniques. Indeed, those who first of all and more than anybody else were subjected to the consequences of procreative technologies were specifically the embryos that were endangered by these techniques themselves, and to the point of being destroyed.

This evident consequence of reproductive technologies was soon manifested in all its dramatic character as the results were gradually presented of FIVET as a success. Robert G. Edwards himself, who recently received the Nobel Prize, when he was called upon to illustrate the biological mechanisms and results of FIVET to the Pontifical Academy of Sciences in faraway October 1982, four years after the birth of Louise Brown, the first child born as a result of the technique that he had helped to create, showed an explanatory table on the success rate in terms of the onset of pregnancies after the transfer into the womb of embryos that had been fertilised *in vitro*. In an explanatory table in the publication that published the proceedings of that week of study, Edwards showed[9] that after in vitro fertilisation the percentage rate for the onset of pregnancy in women who had received FIVET was at the most 25%, that is to say only one embryo out of four of those that had been transferred gave rise to the onset of pregnancy. As would become clearer subsequently, however, the onset of pregnancy was not always followed by the birth of a conceived foetus because of the 'spontaneous' interruptions of pregnancies that had begun, and thus success in terms of 'babies in arms', to use the phrase, was even lower.

Today, after thirty years, however much this technique may have been improved (pharmaceuticals, the incubation time of the spermatozoa and the ovocytes, the means of culture, the number of embryos transferred…), the results are not significantly different from those of Edwards. In a recent review published in the *NEJM*[10] one can see that in a cycle of FIVET with a percentage rate of about 33% of pregnancies that begin from the total of embryos

transferred, only 25% witness the birth of these children. These data indicate that this technique, today as at the outset, has an intrinsic limit which it appears cannot be overcome. Hence the worrying question: how many other children, in addition to those who are born because of reproductive technologies and have been taken up in their mothers arms, have not been born even though they received an ephemeral existence, because of reproductive technologies, involving a few hours or days, or an existence relegated for years to a freezer before being destroyed? Very many, too many to be able to justify – if one could ever justify – an international prize to the man who helped to introduce and apply those reproductive technologies. Perhaps during the first few years after the application of this technology to man one could be enthusiastic about the extraordinary photographs of *in vitro* embryos or the birth of children conceived *in vitro*, but the dramatic consequences of those techniques were immediately very clear and indeed Edwards himself, after reporting on the scientific data in the publication referred to above, in relation to the debate about the beginning and the end of life described without any shadow of a doubt in a very explanatory table that the techniques of *in vitro* fertilisation were to be placed with post-coital contraception and IUD as being amongst the causes of medically induced death! This is a fact that certainly contradicts the high value of 'service to life' which defines the activities of health-care workers.[11] Every honest biologist, indeed, should be struck by the fact that after fertilisation (including *in vitro* fertilisation) there is a continuity with the subsequent development even tough the location of the new living being changes following implantation or birth, and thus one cannot deny that human life begins with fertilisation. Kass observes that even Dr. Edwards – perhaps inadvertently – encountered this truth when he spoke about Louise Brown and observed: 'The last time that I saw her was when she was only eight cells in a test tube. She was very beautiful *then* and she still is *now*!'[12] Thus what most seemed to be lost in the development of reproductive technologies was the sense of continuity between the embryo and the born child.

In biomedical literature, in addition to technologies applied to unborn life, many other finalities can be identified which go well beyond the meaning of 'true good' for unborn life: the *in vitro* maturation and manipulation of gametes, procedures for the fertilisation and the transfer of embryos into the maternal womb, pre-implant and prenatal diagnosis, pregnancy and birth. Indeed, when using the above-mentioned terms in research through PubMed, articles emerge on experiments on embryo stem cells or even abortion-inducing procedures for eugenic purposes!

It is, therefore, to be excluded that any of these procedures, techniques, pharmaceuticals and methods can in any way or to any extent produce, even potentially, any benefit for embryos/foetuses. Indeed, they constitute with certainty or a great deal of probability a grave risk to their lives and health.

3. Biomedical Technologies at the Service of Unborn Life

Side by side with the very problematic use of biomedical technologies which have in various ways replaced the biological relationships of paternity and maternity and which have placed at risk, and continue to place at risk, the lives of embryos produced in laboratories, with their selection and their elimination in large numbers, these very biotechnologies, can, however, hold up the prospect of service to unborn life.

In many circles people are thinking about responsibility in the use of procreative techniques, human dignity and unborn life itself which is threatened by these techniques[13] and so in this field as well one must think about the strategies for the achievement of more equitable and human 'health care', as we are reminded by the title of this international conference organised by the Pontifical Council for Health Care Workers.

In this sense, one can identify biomedical technologies (pharmaceuticals, methods, surgical techniques, genetic tests…) used before (to eliminate the causes of in/hyperfertility in couples), during (to treat pathologies of the embryo/foetus and/or the mother), and after (perinatal therapies and forms of treatment) pregnancy and childbirth, in order to promote the life and health of conceived human beings and mothers. I will refer to these briefly below, inviting the reader to the existing literature in the field for a detailed analysis.

3.1 The treatment of sterility/infertility.

To return to the originality finality of biomedical technologies, one has to recognise that they can really contribute to an overcoming – where this is possible – in a fully therapeutic sense of the causes that lead to sterility/infertility. This means that the most up-to-date biomedical technologies as well can/must respect the three fundamental goods that the recent Instruction *Dignitatis Personae* refers us to: a) the right to life and to the physical integrity of a human being called to existence; b) the unity of marriage which involves reciprocal respect for the right of the conjugal partner to become a mother and a father only through each other; and c) the specifically human values of sexuality which 'require that the procreation of a human person must be pursued as the outcome of the specific conjugal act of love between the spouses' (*DP,* n. 12)

Thus those techniques that are presented as a help to procreation are not to be rejected 'inasmuch as they are artificial' but, in contrary fashion, they can constitute an instrument of real help to unborn life, just like all those therapies or forms of treatment which can be practised before or during pregnancy and are directed towards treating pathologies that cause a condition of hypo-/infertility in the couple or a risk or a pathology for the embryo/foetus itself (embryo-foetal therapies), of the placenta and areas connected with it, during the pregnancy or at birth.

An example of technologies at the service of unborn life is naprotechnologies which have as their peculiar feature the capacity to function in agreement with the menstrual cycles and the fertility of

the woman.[14] One is dealing here with a research project that was begun in the 1990s in the United States of America through Prof. Hilgers at the Paul VI Institute in Nebraska and which reached the top of its first stage with the publication in 2004 of a large textbook on the subject.

On the basis of a standardised and outlined method for the observation of the various biological parameters of the menstrual cycle and of fertility, the existence of biomarkers associated with women with reproductive disorders appeared to be evident. When studying the basic reasons for the abnormality of these biomarkers, through hormonal studies, scanning assessments and diagnostic laparoscopy, it was possible to draw up forms of intervention which allowed the identification of pathological conditions, such as endometriosis, which previously in many cases had produced negative results in the examinations that had been carried out and which allowed much greater success in treating infertility caused by endometriosis (56.7% of births) than was the case with centres that used FIVET to by-pass the problem of infertility caused by endometriosis (21.2% of births).

Similar successes have been achieved with technologies of micro-surgery in cases of tubal pathologies of notable frequency but which today have become, 'paradoxically', pointers for choosing FIVET techniques. This has led researchers to lose interest in the surgical approach to female infertility, with an increasing recommendation of replacement techniques rather reparatory ones. Couples, indeed, are more easily directed towards techniques involving artificial fertilisation, even when an etiological diagnosis has not yet been carried out and thus without attempting all those medical, psychological and surgical techniques that could lead to the problem being overcome in a natural way. Here a consultation, even an ethical consultation,[15] could be useful which provided all indications as regards the techniques available to overcome sterility, including the ethical implications connected with the various technologies. The field of surgical technology, in particular, is a field that needs to be strongly implemented and this is one of the objectives that the International Paul VI Scientific Institute of Research into Human Fertility and Infertility and the Department for the Protection of Maternal and Foetal Health of the Catholic University of the Sacred Heart of Rome have been have been pursing for many years with excellent results.[16]

3.2 *Knowledge about the state of health of the embryo for the purposes of treatment/prevention*

The technologies of prenatal diagnosis can help to improve knowledge about the state of health of a foetus with a view to implementing therapy and prevention. In this field as well one should assess well the goals and the risks connected with the use of these technologies.[17] Indeed, there are non-invasive technologies and more invasive technologies that can endanger the life of a foetus. In the Instruction *Donum Vitae* of the Congregation for the Doctrine of the Faith of 22 February 1987 it is stated that 'Such diagnosis is permissible, with the consent of the parents after they have been adequately informed, if the methods employed safeguard the life and integrity of the embryo and the mother, without subjecting them to disproportionate risks. But this diagnosis is gravely opposed to the moral law when it is done with the thought of possibly inducing an abortion depending upon the results: a diagnosis which shows the existence of a malformation or a hereditary illness must not be the equivalent of a death-sentence' (*DV*, p. I, n. 2). Subsequently, this approach was confirmed by the encyclical letter *Evangelium Vitae* of 25 March 1995 in which the Supreme Pontiff expressed the following warning: 'Special attention must be given to evaluating the morality of prenatal diagnostic techniques which enable the early detection of possible anomalies in the unborn child…. When they do not involve disproportionate risks for the child and the mother, and are meant to make possible early therapy or even to favour a serene and informed acceptance of the child not yet born, these techniques are morally licit. But since the possibilities of prenatal therapy are today still limited, it not infrequently happens that these techniques are used with a eugenic intention which accepts selective abortion in order to prevent the birth of children affected by various types of anomalies' (*EV*, n. 63).

In reality this approach has been implemented more often than one would have thought. In a study that we carried out a few days ago on the data in the literature in the field[xviii] it was clear that not all authors and health-care workers used in a consistent way the techniques of prenatal diagnosis for the purposes of preventing of illness, or treating, the foetus. Looking at works which between 1977 and 1990 had the key words of 'prenatal diagnosis' or 'prevention or foetal therapy', we realised that only in about 50% of the articles the use of prenatal diagnosis to prevent complications or to treat diagnoses illnesses was described. In the other about 50%, resort to prenatal diagnosis was employed to 'prevent' birth, that is to say to interrupt pregnancy through abortion. And this approach did not change over subsequent years when the use of prenatal diagnosis was much greater. Using the same key words, we found that between 1991 and 2010, 1949 publications met the criteria of our search. In 1337 the connection between prenatal diagnosis and prevention or foetal therapy was clearly evident, and – once again – in 48.5% prenatal diagnosis was used to prevent the consequences of the illness that had been identified whereas in 51.5% the diagnosis had been carried out in order to then proceed to the prevention of birth through the voluntary interruption of pregnancy.

Let us now refer, lastly, to biomedical technologies with a preimplantation diagnostic purpose that are carried out in a complementary way to the techniques of extracorporeal artificial fertilisation. At the present state of things they do not constitute a benefit for the unborn child but, instead, – in opposition to what is commonly believed – a grave risk for the life of the embryo because one is dealing with tests whose aim is to identify (with margins of uncertainty of varying degrees of importance) genetic

pathologies or anomalies which at the present time cannot be treated with therapies during pregnancy, as a result of which their use is often a prelude to the selection and destruction of the embryo itself![19]

3.3. *Intrauterine foetal therapies*

For some time, thanks to the opportunities offered by prenatal diagnostic techniques, methods have been experimented to treat the foetus in the uterus. Invasive and non-invasive techniques, and ones that are increasingly numerous, have been used with various methods and approaches.[20] There are various therapeutic approaches and they amply describe very many ways of treating the unborn child, with an absolutely proportionate and ethically acceptable risk. For example, using the help of screening, a 'foetus doctor' can reach the umbilical cord with a needle and carry out the same tests that are carried out in adults: azothemia, glycaemia, haemachrome coagulation, and hormonal and genetic tests.

If the foetus is anaemic, by the same pathway one can carry out a blood transfusion (the intravascular approach) to correct the anaemia or other pathological conditions. In this way, over the last fifteen years the survival rate of foetuses has passed from 60% to 92%. In other cases it is possible to inject into the circulating blood of the foetus medicinal products or albumin, when this is necessary. In the same way one can carry out a transplant of maternal stem cells to treat certain pathologies of the foetus.

In cases where there takes place for pathological reasons a breaking of the membrane and the whole of the amniotic liquid is lost at the fourth/fifth month of pregnancy, the current technological techniques allow the foetus to be treated in an invasive way through the introduction of a saline solution heated to 37° through amniocentesis. With this method the survival rate observed in these pregnancies has increased over the last fifteen years from 0% to 40-60%. This form of treatment has also been used in the treatment of the hypothyroid goitre of the foetus (the transamniotic approach) through the amnio-infusion of thyroxin and of foetal heart problems (integrated foetal therapy: non-invasive approach – maternal digitalisation and in uterus screening-guided invasive approach). In this way the survival of foetuses has increased from 10% to 60%.

Data accumulated over twenty years of experience of screening-guided foetal therapies at the Gemelli Polyclinic demonstrate that ethically guided foetal medicine obtains unthinkable results, ones of absolute clinical relevance, which restore dignity to prenatal diagnosis as a preparatory moment for treating and not for selecting and eliminating!

These therapeutic successes, of both a medical and surgical kind, have been made possible not only by technological progress in itself but also by awareness that the foetus is a real patient in the full sense of the term and this confirms the fact that technology, as well, should recognise the ontological and axiological meaning of reality, admitting that there are certain constitutive limits which can be seen as good only because they correspond to the specific being of the human.

4. Conclusions

Biomedical technologies can thus constitute a real service for unborn life when they are applied with moral responsibility as well as with professional skill.

Beginning with the fascination that technology has for human being, one must retrieve the real meaning of freedom which does not lie in the drunkenness of total autonomy but in the answer to the call of being, beginning with the being that we ourselves are (*CV*, n. 70). And human freedom is specifically itself only when it responds to the fascination of technology with decisions that are the outcome of moral responsibility.

Hence, as we are reminded by *Caritas in Veritate*, the urgent need for formation as regards ethical responsibility in the use of technology. In this direction, today, is moving that whole field which is called health technology assessment (HTA) which, within the framework of multidisciplinary research, welcomed from the outset, side by side with technical (clinical, economic and organisational) technical assessments, also the idea of an assessment of an ethical character which to the full can be placed in reports directed towards taking decisions.[21] In this context, which is without doubt a frontier context, ethical analyses could really perform the important task of discussing the ethical character of the employment of certain biotechnologies, verifying their conformity both with the integral goods of the person and with the culture of life. The development of biomedical technology as well, therefore, should be marked by a 'spiritual dimension' for it to be authentically human. And this development 'requires new eyes and a new heart,

capable of *rising above a materialistic vision of human events*, capable of glimpsing in development the "beyond" that technology cannot give. By following this path, it is possible to pursue the integral human development that takes its direction from the driving force of charity in truth' (*CV*, n. 77)

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Notes

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JOHN M. HAAS

Health, the Safeguarding of the Creation and Justice

Justice is, classically understood, "rendering to each his due", *reddere suum cuique*. In a strict sense, justice is what I owe to the other in accord with the other person's claim on me on the basis of his rights. Justice constitutes my obligation to the other but also his obligation to me. It implies community. As St. Thomas Aquinas puts it: Justice "consists in living one with another".[1]

Injustice, on the other hand, results from not rendering to the other what is his due, and injustice is actually more grievous than what might befall a person in the natural order. For example, unjustly to deny one access to health care is humanly more heinous than the illness itself from which one is suffering. Illness is a disorder of nature but injustice is a moral disorder.

As Immanuel Kant observed: "Man's greatest and most frequent troubles depend on man's injustice more than on adversity."[2] And the German philosopher Josef Pieper pointed out that "everything unjust implies that what belongs to a man is withheld or taken away from him – and . . . not by misfortune, failure of crops, fire or earthquake, but by man."[3]

Magisterial documents have consistently taught that there is a right to health care in the human community. Pope John XXIII in his encyclical *Pacem in terris* wrote: "Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services."[4]

However, rights are joined to obligations. Where there are rights, there must also be accompanying duties. In his encyclical *Caritas in veritate*, Pope Benedict lamented the fact that we have often lost sight of the obligations that must accompany rights. He wrote: "Hence it is important to call for a renewed reflection on how *rights presuppose duties, if they are not to become mere license."*[5]

In contemporary society there are many claims to rights but not much, if any, emphasis on duties. Benedict has provided the appropriate balance in this encyclical: "[I]ndividual rights, when detached from a framework of duties which grants them their full meaning, can run wild, leading to an escalation of demands which is effectively unlimited and indiscriminate. An overemphasis on rights leads to a disregard for duties. Duties set a limit on rights because they point to the anthropological and ethical framework of which rights are a part. . . . Duties thereby reinforce rights and call for their defense and promotion as a task to be undertaken in the service of the common good." In this brief passage Benedict points to the profound and necessary relationship between rights and duties which together ultimately serve the common good.

The complementarity of rights and duties is also true with respect to health care. For example, while each person has a right to medical care, he also has a weighty obligation to avoid what will place his health at risk. Indeed, positively speaking, he has an obligation to do what will foster and promote his own health. Otherwise, the person who does not care for himself could unjustly become a burden to the rest of society, to one's family and peers through his own negligence.

This basic principle of justice can be seen in some of the health insurance plans in the United States. If one smokes cigarettes, for example, one pays more for insurance since smoking is high risk and dangerous behavior. If one joins a fitness program at a health club, the cost of health insurance is lowered. These variable rates are based upon actuarial tables but they reflect an attempt to achieve justice among those in the insurance plan and indeed in broader society. And they show that rights and duties are not abstractions but are grounded in the human person and his actions.

But justice is not simply what individuals owe to one another, which is known as legal justice. As indicated, it has to be seen in a broader context. We also have duties to society at large and this is traditionally known as commutative justice. But we must look at the concept of justice in an even broader context still: the context of the created order within which we find ourselves.

As Pope Benedict said in his encyclical, "The environment is God's gift to everyone" and we must acknowledge, in his words, "the intrinsic balance of nature". A violation of this "intrinsic balance of nature" affects not only ourselves but also other human beings and even the environment. In fact, a violation of the created order has its adverse effects on the totality of God's creation. We can see this on the macro-level and the micro-level.

If we look at the interplay of the factors of health care, justice and guarding the creation on a macro-scale we encounter innumerable examples of their inter-relatedness: there are the illnesses and environmental degradation resulting from industrial pollution, the hazards from dangerously high levels of green house gases, health and environmental threats from the moun-

tains of trash produced by a consumerist society. Pollution endangers the environment and the health of those who live in it.

Some of the violations of the environment leading to the illness and death of our fellow human beings are so shocking we stand in horror of them. In 1965 an unspeakable tragedy occurred in Bhopal, India. Toxic gases leaked from a Union Carbide plant leading to the deaths of thousands. Men, women and children perished on the spot. There has never been a final official count but it is estimated that between 3,000 and 5,000 people died in that industrial accident. Governments have an obligation to regulate enterprises and to impose safety rules so as to protect the health of citizens and the environment which serves them.

Just this year, there was another industrial accident that destroyed lives and wrought havoc on the environment. In October a containment reservoir filled with caustic waste

from an alumna plant in Hungary burst and a toxic sludge flooded several villages and spilled into the Danube River. Since 2006 this plant had been on a watch list of dangerous industrial sites which was issued by the International Commission for the Protection of the Danube River. The red sludge covered 2.000 acres of farm land and killed off organisms that kept the soil healthy. Experts maintain that there will be a need for a complete soil change in order for agriculture to flourish again in the region. This plant was one of many others that had been inadequately built during the time of a radical and godless socialism that unjustly subordinated the good of the individual to the perceived good of the state. Such practices led to a degradation of the environment and significant risks to the health of the citizenry.

But the dangers to individual health and to the environment also exist on the micro-level. We can individually undermine our own health and endanger broader society and the environment by our actions. By not acting in accord with our duty to ourselves we in fact act unjustly toward the other, toward the social order and toward the environment.

For example, it has been conclusively shown that smoking leads to debilitating diseases and deaths. According to the American Cancer Society, almost 500,000 people in the United States die each year from smoking, and smokers constitute 30% of all cancer deaths.[6] In fact, smoking is the major single cause of cancer deaths in the United States. It is estimated that over 5 million die each year world-wide from the use of cigarettes. Smoking increases risks not only for lung cancer but also for cancer of the larynx, esophagus, stomach, pancreas, cervix, kidney, and bladder. Emphysema is also a common and deadly consequence of smoking.

And as is known, smoking endangers not only the one smoking but those around him because of the effects of so-called second-hand smoke. In the United States, an estimated 54,000 people die each year from having had exposure to second-hand smoke.[7] There is considerable dispute over what the actual social costs of smoking are, but there is no question that society must assume very significant financial and health care burdens because of the illnesses contracted by those who smoke.

Another modern health problem has become an increasingly grave problem and arises to a large extent from one's life style for which the individual is responsible. Diabetes has taken on epidemic proportions in some parts of the world. Diabetes can be triggered in part from obesity resulting from a lack of moderation and reasonableness in one's consumption of food and from a lack of exercise. India, for example, is experiencing an epidemic in Type 2 diabetes.[8] According to a report in Bloomberg Markets Magazine, which details the terrible economic costs of the diabetes epidemic, more than 50 million Indians suffer from the disease with one million a year dying from it. In October 2009 the International Diabetes Foundation listed India as the country with the most diabetes worldwide.

In India diabetes is leading to kidney failure, retina damage and the amputation of over 200,000 limbs a year. It is generally agreed that this epidemic has arisen because of changed eating habits and life styles resulting from India's rapidly growing economy and the fact that millions of Indians have subsequently risen from poverty to affluence. There is now greater consumption of sugar and trans-fats, a significant decrease in physical activity, and subsequent weight gain. These are characteristics of life-styles in the developed world as well which is also struggling with an alarming increase in Type 2 diabetes. While efforts must be made to make health care accessible to all, without regard to their wealth or social position, individuals also have a duty to one another and to society at large to care for their own health.

One can point to another indivi-

dual practice having deleterious health and environmental consequences. The attempt to regulate births through the use of oral contraceptives poses significant health risks to those who use them as well as to the environment.[9] According the Gutmacher Institute, oral contraception, or the Pill, is the most commonly used means of birth control in the United States with almost 30% of women of child-bearing age making use of it.[10] There are estimates that as many as 100 million women world-wide are on the Pill.[11]

As is well known, oral contraceptives are usually comprised of a combination of estrogen and the synthetic hormone progestin which, when ingested and assimilated by the woman's body, have the effect of suppressing the release of an egg each month from alternating ovaries. In the normal course of events, the natural hormone progesterone would be secreted by the egg follicle after its egg had been released. Progesterone sends chemical signals to the pituitary gland at the base of the brain to stop releasing the follicle stimulating hormone and the luteinizing hormone. When these hormones are not secreted no egg matures and is released. The synthetic hormone progestin, in a sense, tricks the body into thinking an egg has been released, thus stopping the process of egg maturation and release.

Regrettably there can be a number of severe risks to the woman who ingests these synthetic hormones, including the formation of blood clots that can settle in the brain or lungs with sometimes deadly effect, heart attacks, gall bladder disease, cervical and breast cancer, and benign liver tumors. The risks of taking the Pill are so great that women who are 35 or older, smoke, or suffer from hypertension, diabetes or high cholesterol are told not to take it at all. Since July 2005 the International Agency for Research on Cancer of the World Health Organization has listed the combined oral contraception Pill as a carcinogen.

However, oral contraceptives pose not only a health risk for the woman taking them but also constitute a danger for the environment. In 2005 scientists funded by the Environmental Protection Agency in the United States found that of the 123 fish they randomly caught in a river near Boulder, Colorado, 101 were female, only 12 were male, and ten had strange male and female characteristics. They found these changes were being caused by high levels of synthetic hormones associated with oral contraceptives in the water. Scientists in Washington State in the northwest of the United States also found that high levels of estrogen were being found in the water resulting in the reduced fertility of male trout.

In April 2007 the journal Scientific American ran an article reporting that fish caught in rivers and lakes had enough chemicals mimicking estrogen as to make breast cancer cells grow. The article said that the presence of the estrogen was also causing fish of undetermined sex to be born. Conrad Volz of the University of Pittsburgh's Cancer Institute's Center for Environmental Ecology reported that "estrogenic active substances" in the water were causing male fish to be born which looked like female fish. He stated that there are "eggs in male gonads and males secreting a yolk sac protein." The powerful chemicals in oral contraceptives are not being broken down in sewage plants and are making their way into the drinking water.

As is well known, the Catholic Church advocates a type of birth regulation known as Natural Family Planning that poses no health risk to the woman. There are certain physical signs in the female body which indicate when the woman is fertile. The couple abstains from marital relations during that period if there is a grave reason to avoid having a child. This approach of periodic abstinence poses no health risks to anyone or to the environment. It is a responsible, humane, healthy and just means of regulating births.

Through the promotion and marketing of contraceptives fertility has come to be viewed as the equivalent of a disease which requires medication to combat it. Prophylaxis refers to medical or health interventions to prevent disease. Increasingly contraception is being referred to a pregnancy prophylaxis as though the child were a disease. Drug companies reap huge profits through the sale of oral contraceptives which endanger the health and sometimes the lives of the woman who use them and which also pollute the environment. This constitutes a profound injustice against the woman who is being lured into taking these drugs as well as a violation of the environment.

God's creation is unspeakably complex and magnificently beautiful and harmonious in its interrelatedness. The word cosmos comes from the ancient Greek and referred to "good order" as well as to the jewels adorning a woman's dress. It is thought that Pythagoras was the first to use it to refer to the universe, perhaps because of the dazzling, starry firmament. But the word "cosmos" speaks to the beauty of a just order comprised of every facet of God's creation interacting with the other in accord with His divine plan. As Pope Benedict tells us in *Caritas in veritate*: "Nature expresses a design of love and truth."[12] Human flourishing and a just social order arise from acting in accord with that design of love and truth.

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Notes

[1] Commentary on the Nicomachean Ethics of Aristotle, 8, 9; No. 1658.

[2] IMMANUEL KANT, *Eine Vorlesung ueber Ethik,* Paul Menzer Berlin 1925, pg. 245.

[3] JOSEF PIEPER, *The Four Cardinal Virtues* (University of Notre Dame Press: Notre Dame), 1966, pg. 44

[4] JOHN XXIII, *Pacem in terris,* April 11, 1963, 11.

[5] BENEDICT XVI, *Caritas in veritate,* June 29, 2009, 43.

[6] *http://www.cancer.org/Cancer/CancerCauses/TobaccoCancer/CigaretteSmoking/cigarette-smoking-who-and-how-affects-health*

[7] *http://www.no-smoke.org/getthefacts.php?id=13*

[8] *http://www.bloomberg.com/news/2010-11-07/india-s-deadly-diabetes-scourge-cuts-down-millions-rising-to-middle-class.html*

[9] There is a website by Watson Pharm which manufactures oral contraceptives which explains how they work as well as the risks and benefits of using them: *http://www.oral contraceptives.com.*

[10] *http://www.guttmacher.org/pubs/fb_ contr_use.html*

[11] *http://contraception.about.com/od/contraceptionmyths/tp/pillmyths.htm*

[12] 48

PAOLA GERMANO

DREAM
Treating AIDS in Africa: a Possible Challenge

I am a part of the Community of Sant'Egidio and I have had the honour to participate from the outset in the DREAM programme (Drug Resource Enhancement against AIDS and Malnutrition), a programme to fight, together, hunger and illness in Africa.

In 2002 DREAM was born in Maputo, Mozambique, out of the intellectual honesty of not wanting to accept a reality that was widely shared but absurd and which implicitly decreed that Africa had to be left with thirty million AIDS sufferers without any treatment: within a few years one was dealing with something on the scale of a genocide. One had, therefore, to work to demonstrate that AIDS therapy, in Africa as well, was a possibility, with the same level of quality and with the same golden standard that had allowed major successes in the West. From the outset DREAM has sought to treat, free of charge, all those sick people who are in need, without any kind of distinction, above all the poorest people and children, in the belief that treatment and care, in addition to being a fundamental human right, also constitute an important step in the prevention of infection by HIV.

DREAM, therefore, was born to make available in Africa, as well, therapies and technologies which had already been tried in the rich world but at the same time it chose not to be only a programme for the distribution of medical products but also to care for AIDS sufferers in their totality. Thus: education in health, nutritional support, advanced diagnostics, the training of personnel, the combating of malaria, tuberculosis and opportunistic infections and above all else malnutrition. All of these are factors that make treatment and prevention themselves effective.

Indeed, the holistic approach enables AIDS sufferers to undergo the treatment in an effective way and this reduces the quantitative level of the virus present in the various biological liquids of the body. Indeed, even to such low levels as to make the transmission of the virus to other people rather low, but above all else as regards what is termed 'vertical transmission', that is to say from a mother to her child.

From the outset one of the objectives of DREAM has been to been to prevent the transmission of the virus from the mother to the future unborn child. The policy of DREAM has been not only to ensure that a HIV-positive mother gives birth to a healthy child but also to make sure that she keeps it and to assure the survival of the mother so that the newborn child and any other previous children do not become orphans.

The therapy given to mothers during pregnancy is continued with throughout the period of breastfeeding and this reduces, almost to the point of elimination, the transmission of the virus. The correctness of this approach is borne witness to by the high number – more than 120,000 – of children born healthy to HIV-positive mothers within the framework of the DREAM programme, that is to say nearly all of the pregnancies that have been monitored. To give birth to a child when one was condemned to death by this illness and to go on being well so as to be able to bring up one's own children, is for a mother the most important victory there is: it is a victory for the whole of the family, for the community and for health-care workers. This victory creates a positive contagion that leads fear and prejudice to be overcome, it creates hope, and brings AIDS sufferers to near to treatment.

A decisive key in the efficacy of DREAM lies in the fact that it is a programme that has a soul. If it had not had a soul, it would not even have come into existence. DREAM is rooted in spiritual and human values, The approach of DREAM was closely linked to the approach of the Community of Sant'Egidio: to work for a new world, feeling the responsibility to construct with audacity and patience new pathways of cooperation that constitute a concrete and practicable response to a great problem to which the large organisations and African countries themselves did not have any answers. It is this soul which has enabled DREAM to create synergies which were not always obvious and to become a model that can be reproduced and a model that is successful.

The first guiding idea, from which the others come, is the *centrality of the patient*. DREAM always begins from real men and women and not from institutions; the patient is always seen in his or her entirety, in the totality of his or her needs. A person suffering from AIDS has his or her complexity, he or she is not a photocopy of the patient who lives in rich countries, where he or she is known and studied, and one must respond to his or her specific needs in therapeutic terms, in terms of prevention, and in social terms. He or she is characterised by various opportunistic infections, amongst which one may cite tuberculosis and malaria. Each patient must be assessed from a nutritional point of view and he or she must be offered, when he or she needs it, this alimentary support as a therapeutic treatment in order not to nullify the

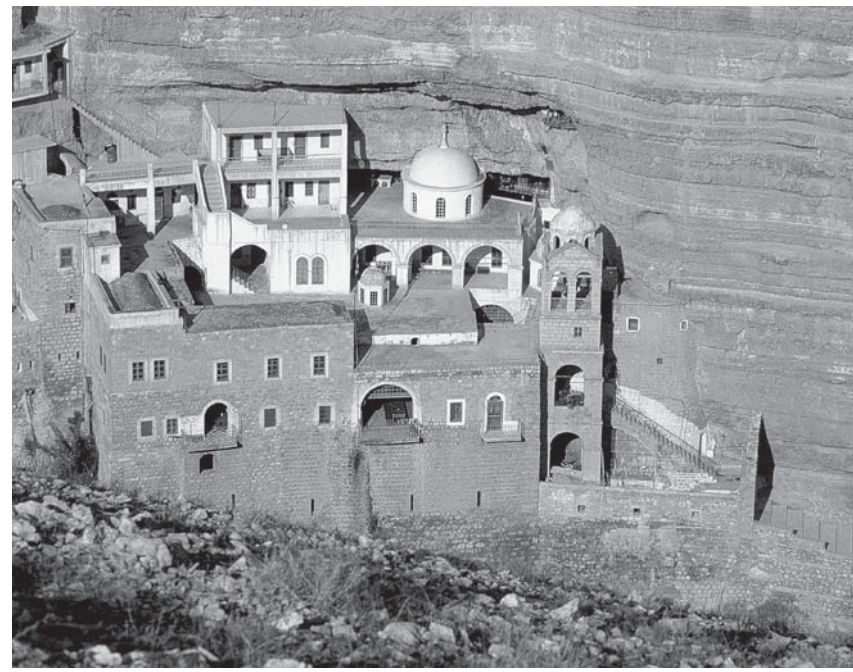
medical intervention. He or she is often an illiterate person who needs to be educated in health in order to increase his or her protection against pathogenic agents; he or she has to be motivated to continue adherence to the programme of care and treatment; and he or she must be reintegrated into his or her family and his or her social environment.

Anyone can have access to DREAM because all the forms of treatment, the procedures of care and diagnosis are *completely free*. In the continent of Africa, which is marked by the presence of hundreds of millions of people who live below the threshold of absolute poverty, this policy seemed an obligatory one. To the inability to meet expenditure of patients must be added another observation: the treatment involved is for life, at least for the moment, and the patient must remain loyal to that treatment. Now, the complexity of the procedures of care, which express themselves at a practical level in a high number of appointments so that the patient's condition of health can be followed, the handing over of medical products and the carrying out of analyses, have nonetheless a cost for the patient. Very many patients, indeed, have to walk for a long way on foot to reach the health centres and they have to allocate many hours of the week to this activity.

DREAM has chosen a system involving *excellence at the level of care*, and this fact, above all during the early years of the programme, has represented a strong element of contradiction as regards the policies of the international community, which have been characterised by a certain 'minimalism'. To us it seemed fair and human to adopt in Africa, as well, the same diagnostics and the same procedures of care which go to make up the standard level in the North of the world.

Conjoining Prevention and Therapy

DREAM began its first steps addressing a cultural and scientific climate opposed to the introduction of treatment in Africa. The only possible initiative possible seemed to be the prevention of the transmission of this disease. It was believed that this strategy on its own would have led to this epidemic being controlled. But to us working for DREAM it seemed immediately reasonable, as well as right, to associate action involving prevention with action involving therapy. We believed that treatment is a decisive element as regards prevention. Let us think here of the case of the transmission of the virus from mother to child: our programme, after successfully adopting the same protocols that were in use on Western countries, has almost eliminated the percentage of children born HIV-positive from mothers with the virus in our programmes. The adoption of the triple therapy, for that matter already widely used in Western countries, not only demonstrated its efficacy but became an authentic therapy for mothers, as well, and of great help in ensuring their full adherence to this therapy.



Partnership and Working Research

DREAM constitutes a model for intervention that aims at development and it is not a response of an emergency kind. To be near to Africa is a decisive fact: there is a need for long-term programmes because the transition will be neither brief nor easy. To install and maintain a programme for the control of HIV/AIDS is not a bridge that has to be built, which is achieved in the space of a few years, and the keys to which are then handed over. In the epoch of globalisation we can easily observe how interdependence is a fact of trade and the environment, energy sources and work. The same, it seems to me, applies to health and cooperation: the results of our efforts will depend to a large extent on our capacity to cooperate over the long term.

For this reason, we conceived of a programme of the long term, robustly placed within a framework of real partnership with the countries involved and with their technical and political personnel. One could say: 'we will work together and for a long time, at least until new and more decisive therapeutic answers to AIDS are available'. Another characteristic of this programmes is ongoing research in the field. The centrality of the sick person requires the constant identification not only of the best instruments but also of those instruments that are most suitable to the realities of Africa. This aspect of ongoing research in the field is one that has witnessed the greatest efforts at the level of cooperation of

DREAM: with universities, institutes of research, pharmaceutical companies and other kinds of companies.

A further valuable aspect of the quality instruments involved is certainly that aspect connected with software and in general with communications. Their application and their development in the programme has produced two principal results: a completeness at the level of information, which in Africa I do not hesitate to define as being unique, and the possibility of sharing it with other people immediately. Our workers in this sense are really never alone. As regards the first aspect you will see in the slide certain displays that allow medical professionals to accede immediately to all the important information on the patient. You should realise that an AIDS patient in general has an extremely complex clinical history and one that is rather difficult not only to remember but also to consult. You can see how the virus load, the CD4 cells and many other clinical parameters help to provide information to the medical personnel with great immediacy. All the information is shared and distributed equally within networks of various levels: that of the individual centre, that of the centre and the laboratory and so forth until the connections with European experts who are able to provide specialist consultations and second opinions on problematic situations.

DREAM is organised in line with a series of protocols and flow charts that are able to guide the medical and paramedical personnel in the vast majority of situations that exist.

Every challenge to health in Africa has for this reason to start from the observation that a large part of the continent is essentially rural in character and thus a health programme, to be effective, has to be accessible to the majority of the sick people aimed at; it has to reach patients where they actually live. DREAM chose health care that one could define as being 'light' and able to constitute a resource that is really widespread in local areas; health care that is elastic, flexible and able to discover needs even when these are without a voice or without the energy that is needed to become a health-care request. In the place of the building of large hospitals, architecture of a distributive kind was preferred, with centres of excellence and reference to which could come patients from second-level centres located in more peripheral and rural areas where health-care services of an intermediate level, such as the control and distribution of medical products, and the carrying out of certain kinds of analyses, are possible. In addition, mobile clinic and home care make access to care and treatment possible for everyone.

This approach, which has been chosen by the Community of Sant'Egidio to oppose AIDS in the land of Africa, has over nine years produced extraordinary results, which have by now been recognised at a scientific level, but above all else this approach has spread a new model for care and treatment in Africa.

At the present time DREAM is present in ten African countries: Mozambique, Malawi, Tanzania, Kenya, the Republic of Guinea, Guinea-Bissau, Nigeria, the Democratic Republic of the Congo, Cameroon and Angola. About a hundred thousand HIV-positive people are helped for no charge in thirty-two day hospitals distributed throughout various countries. There are eighteen molecular biology laboratories for the monitoring of treatment; about twelve thousand children have been born healthy and without AIDS to HIV-positive mothers; and there have been seven pan-African training courses for about 3,600 health professionals. Today all the health-care personnel working in our centres are African. More than a million people in recent years have taken advantage of the DREAM programme. These figures well demonstrate that AIDS is not invincible. It is possible to defeat AIDS. It is possible make life victorious.

From the extraordinary effort involving welcoming, care and the promotion of health, which has been described above in this paper, there springs a new prospect as regards the lives of patients. To arrive in a centre run by DREAM for many people is an experience where life is begun again, a life that is new and full. A life full of contacts and people but also of new ideas and words. Just think what it means for a sick person to come to a centre where everything is free of charge, where you are received with kindness and where there is great interest in the sick person! Through the approach of other people one comes finally to understand the value of one's own life, one discovers anew that dignity which has often been trodden on in the humiliation of illness and abandonment.

And then treatment improves quality of life: a very large number of symptoms and sufferings disap-

pear, weight is regained and energies are restored, one returns to looking after one's own home, one's own children, and one begins to work again. Lastly, one realises that one has entered a world of friendships with the members of the personnel and with other sick people. And then the patient himself or herself becomes again a person, often with another gear: the discovery of potentialities that were previously unknown to him or to her and the desire to take advantage of them for the benefit of people less fortunate than him or her, for other sick people who are still in a state of great suffering. It is from rediscovered energy and from this new impetus to solidarity that there has arisen the movement of the activists of DREAM which in recent years has undergone an extraordinary diffusion, always accompanying the opening of new centres and the growth in the number of sick people who are helped. Indeed, a very large number of patients, above all else women, have chosen to help other sick people and to no longer flee from this malady.

These activists are not so much voluntary workers on the Western model as authentic witnesses who are engaged in an irreplaceable function involving support and counselling. They bear witness, through their words and their lives, to the fact that AIDS is not a death sentence, that resurrection is possible, that there is a future for oneself and for one's family relatives. They carry in their bodies the sign of the effectiveness of antiretroviral therapy and they agree to share their experiences with other people, thereby achieving a kind of reverse contagion, the communication of hope as regards life; indeed joy in being alive.

These activists engage in an irreplaceable work of health-care education of the same kind which bears upon so many aspects of life. After recovering their strength, they become the mothers of other children and not only of their own children, of a very large number of children who are orphans, and in this way they expand their families. Thus women, who are the principal victims of AIDS, become the protagonists of liberation from this disease and their work is translated into a treasure for the countries they live in.

Over recent years the role of our activists has become increasingly public and many of them by now speak in television debates and on the radio. They are also interviewed by newspapers. The person testimony of healing has achieved an increasingly large range; it combats the stigma that marginalises the lives of a very large number of AIDS sufferers; and it has become a metaphor for a more general healing – the healing of society.

This is the 'care community': not only health-care professionals but also patients, women and men on the same level, brought back to life but also to work which they are passionate about and through which they can take part in saving a very large number of people.

This soul, this philosophy as regards AIDS, has led us to shoulder responsibilities that have often been shared with other men and women of faith, whom we have met in recent years during our journey down the roads of Africa. I am thinking here of the very large number of religious Congregations, missionaries and members of the local clergy with whom we share this soul and this project of love of God for the world. Even though we find ourselves in different places, we work together and with the same spirit for the dream of an Africa without AIDS. The rapid spread of DREAM over almost six years has been due, indeed, not only to the capillary presence of the Community of Sant'Egidio in a very large number of African countries, but also to the wish of a very large number of religious Congregations, non-governmental organisations, lay men and women, and people of good will to flank us in this strategy of the struggle against the virus. But with the sixteen religious Congregations with which we work we do not only have a kind of functional cooperation but also a friendship which, beginning with the poor and the sick, has touched the depths of Christian communion. This synergy allows us everyday to increase the number of Africans who suffer from this disease who can be reached. This is positive contagion between people who have an opportunity to increase the effectiveness of this battle which is decisive for the future of Africa.

The great Teilhad de Chardin wrote: 'Only love is able to unite living beings so as to complete them and bring about their fulfilment…because only love connects them through what is deepest in them'. We must only imagine our ability to love developed to the point of embracing all men and the whole earth'.

This is what DREAM tries to do: humanitarian work requires the creativity of love which becomes an ability to unite and to reduce great distances. The first victory is achieved in unity and the breaking down of isolation. It restores and returns human dignity, it creates life, and in a very large number of cases it sets in motion a healing that was thought to be impossible.

But today new challenges open themselves up for DREAM. In Africa there are still twenty-three million people infected with AIDS, and at the present time about eleven million people are receiving treatment. The vaccine or vaccines that are currently being studied are very far from producing relevant results. In the meantime, what should be done?

We believe that it is important to implement as many interventions involving prevention as possible in order to curb this epidemic. We should expand prevention of the transmission of the virus from mother to child in order to allow a healthy generation in the various countries of Africa to be born.

We should extend the therapy to as many people as possible. This strategy, which was recently recommended by the World Health Organisation to reduce contagion levels, is concentrated around more complete coverage at regional and national levels of the treatment, and this should allow the almost total eradication of this disease within more or less twenty years.

This is the new frontier of our dream and we are working on it, looking for allies and supporters who will share this human and spiritual adventure: the fight against AIDS in Africa.

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EMILIO LA ROSA RODRÍGUEZ

Traditional medicine

According to the World Health Organisation (WHO), by the term 'traditional medicine' we mean 'a complex of approaches, knowledge and beliefs that are based, rationally or otherwise, on the theories, beliefs and experiences of a culture, applied singularly or in association, in order to conserve wellbeing, and to treat, diagnose or prevent physical and mental illnesses'.[1] Others believe that traditional medicine is 'medicine based upon cultural beliefs and practices handed down from generation to generation. It includes mystical and magical rites, physiotherapy and other treatments that cannot be explained by modern medicine'.[2]

In reality, traditional medicine is a concept that greatly goes beyond the field of health and is located at a socio-cultural, religious, political and economic level. It can be seen as a 'system that is concentrated on (biological or not) malaise and which is based upon theories of the body, of health, of illness and of healing that are anchored in the histories of the cultures and of the religions that have built and build a country'.[3] Indeed, we can say that there are as many traditional medicines as there are cultures.

The multiplicity of traditional medicines, which differ according to the regions of the world, to countries, and even within countries, is at one and the same time both riches and a challenge. To give an example, whereas traditional medicine in Africa and Latin America is strongly characterised by oral tradition and a lack of training as recognised by medical doctors, traditional medicine in China has a more structured and documented character. In the same way, in some countries the appellations 'parallel medicine', 'alternative medicine' or 'soft medicine' are synonyms for traditional medicine, whereas in other nations the term 'parallel and alternative medicine' refers, instead, to a set of practices involving treatment which has no relationship with the traditions of those countries and are not integrated into their health-care services. For that matter, the term 'traditional medicine is employed at times to refer to practices which, in the final analysis, do not belong, in a strict sense, to medical practice.

Complementary, Parallel, Alternative and Soft Medicine

According to the World Health Organisation,[4] 'the terms parallel, alternative or soft medicine are synonymous with traditional medicine. They are related, therefore, to a vast set of health-care practices that do not belong to the tradition of a country and are not integrated into the dominant health system'.[5]

The term 'alternative' presupposes the choice of an approach to health and illness that is different from that of conventional medicine. The term 'complementary' or 'parallel' describes a form of therapy used in addition to medicine (acupuncture, osteopathy etc.). The World Health Organisation places these notions under the phrase 'complementary and parallel medicine' (CPM). This term includes various different approaches which at times are mutually incompatible. They are the contents of a particular set, inasmuch as they differ from the methods and treatments that are taught in medical schools.

The Situation Today

About 80% of the populations to be found in developing countries turn to traditional medicine for primary health care both because of traditional culture and because of other reasons (difficulties in having access to conventional treatment, the higher costs of conventional medical products, etc.). Resort to this kind of medicine is above all a result of its proximity, its ease of access, its availability, its cost and its philosophical conformity to native cultures.

In rich countries there are many people who make use of various remedies that are called 'natural' and which start from the principle that what is natural has no risk. For that matter, traditional and/or alternative medicines also constitute a path of action or a complementary path of action in the case of chronic, debilitating or incurable illnesses.

A large majority of the populations of Africa regularly use traditional medicine. In sub-Saharan Africa, for example, 85% of the population is said to turn to traditional healers. In Ghana, Mali, Nigeria and Zambia, primary treatment in 60% of children afflicted by strong fevers caused by malaria involves the use of medicinal plants that are given to these children at home.[6] In China, traditional plant-based products constitute between 30% and 50% of the total consumption of medicinal products. In industrialised countries alternative medicine is equivalent to traditional medicine and over 50% of the population uses, at least once, this kind of practice. In Canada 70% of the inhabitants of the country use parallel medicine at least once. In Germany 90% of the population, takes during the course of a lifetime, a natural remedy. In the United States of America 158 million adults have used the products of alternative medicine and according to the Commission for Alternative and Complementary Medicines, in 2000 the popu-

lation of America spent 17 billion dollars on traditional remedies. In the United Kingdom annual expenditure on parallel medicine amounts to 230 million American dollars.[7]

The world market for medicinal plants is expanding rapidly and at the present time it is worth more than 60 billion American dollars every year. This increase in demand deserves to be analysed and studied seriously in order to propose suitable measures whose goal should be to assure the efficacy and harmlessness of these medical practices. According to the World Health Organisation, in the year 2000 only sixty-four countries in the world had a system for the regulation of plant-based medicinal products.[8] The absence of regulations or a bad use of traditional procedures, practices and medicinal products can have effects that are injurious to, and dangerous for, health. For example, ephedra[9] is traditionally used to treat congestion of the respiratory tracts. This plant has been commercialised in the United States of America as an food complement and its excessive dosage has provoked, on the one hand, cardiovascular disturbances (arterial hypertension, tachycardia, arrhythmia, myocardial heart attack, heart attack and instant death) and, on the other, neurological disturbances (cerebral vascular injury and convulsions).[10] [11] In Belgium, about seventy people had to have a kidney transplant or dialysis because of interstitial renal fibrosis[12] [13] after taking, in order to lose weight, a manufactured product based on the wrong plant.

The development of the market in officinal plants has enormous effects at a commercial level as well, and this raises problems at the level of biodiversity because of the looting of those raw materials that are needed for the production of medicinal products or other natural health-care products. This situation, if it is not regulated and disciplined, runs the risk of leading to the extinction of species at risk as well as the destruction of natural resources and habitats. In addition, the international and national laws that exist are insufficient to protect the genetic resources of biodiversity and traditional knowledge.

Traditional Medicine and Health-Care Systems

According to the way it takes part in health-care systems, traditional medicine is integrated into, included by or tolerated in such systems.

Traditional medicine recognised by and integrated into health-care systems

In a certain number of countries, traditional and complementary medicine is recognised by and integrated into their health-care systems and forms a part of the forms of treatment that are offered to people. There are too few countries where we can say that this level has been reached: China, the Democratic People's Republic of Korea and Vietnam.

Traditional medicine recognised by but not integrated into health-care systems

Some countries recognise traditional and complementary medicines but these forms of medicine are not integrated into their health-care systems (treatment offered, education, formation, regulation). Amongst these countries we find Equatorial Guinea, Nigeria and Mali, but also Canada and the United Kingdom.

Tolerated traditional medicine

In a large number of countries, traditional medical practice is tolerated and the health-care system is based upon conventional medicine. But despite this tolerance, in some countries traditional medicine is completely ignored.

Countries should recognise the importance of the connections between the history and the medical practice of native communities inasmuch as traditional medicine, however much it varies as regards its technical expression, is always based upon native beliefs and experiences.

In order to integrate traditional medicine into health-care systems what is required first of all is that traditional knowledge and healers should be recognised. This assumes the application of regulations to control the sale of products and an alleviation of the lack of resources in the sector of research and training. The creation of research and study centres that deal with traditional medicine constitutes an important instrument by which to advance in the recognition of this practice in order to allow it to co-exist with conventional medicine within a single system.

In Africa, for example, because of the importance of traditional medicine, the African Union established the Decade of Traditional Medicine in Africa (2001–2010), seeing traditional medicine as 'the system of health care that is most accessible for the most of African rural communities'.[14] This criterion has the objective of associating all of the promoters of traditional medicine in order to 'make available, to the vast majority of the people of Africa, traditional medical practices and medicinal plants that are safe, effective, accessible and of high quality'.[15]

The integration of traditional medicine into the health-care systems of countries passes by way of the application of a series of recommendations proposed by the World Health Organisation. These recommendations relate to regulations, safety, efficacy, quality, access and rational use. The regulatory framework must take into account training, qualification, practice and research in relation to the traditional medicine. Research and practice require a suitable level of safety, efficacy and quality.

Lastly, a rational use of this form of medicine depends on the various factors mentioned above but in particular it depends on training, qualification, authorisation as regards practice, the correct use of products of quality, information, and the complementariness of allopathic medicine and traditional medicine.

Dr. EMILIO LA ROSA RODRÍGUEZ
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Notes

[1] OMS, 'Principi metodologici generali per la ricerca e la valutazione relative alla medicina tradizionale' WHO/EDM/TRM/2000.1, Organizzazione Mondiale della Sanità, (Ginevra, 2000).

[2] National Library of Medicine - Medical Subject Headings. MeSH Descriptor Data. *http://www.nlm.nih.gov/cgi/mesh/2010/MB_cgi*. Consulted 24 June 2010.

[3] A. EPELBOIN, 'Médecine traditionelle et coopération internationale', *Bulletin AMADES*, 50, 2002.

[4] OMS, 'Strategia dell'OMS per la medicina tradizionale per il 2002-2005' (Organizzazione Mondiale della Salute, Gineva, 2002).

[5] OMS, 'Medicina tradizionale. Definizioni', consulted 22 June 2010. *http://www.who.int/topics/traditional_medicine/definitions/fr/index.html*

[6] DANIELA BAGOZZI, 'Medicina Tradizionale', OMS. *http://www.who.int/mediacentre/factsheets/2003/fs134/fr/index.html.* Consulted 25 June 2010.

[7] DANIELA BAGOZZI, 'Medicina Tradizionale', OMS.

[8] Organizzazione Mondiale della Salute, 'Strategia dell'OMS per la Medicina tradizionale per 2002-2005', (OMS, Gineva, 2002).

[9] Ephedra or Ma Huang (Ephedra sinica Stapf, E equisetina Bge, E intermedia Shrenk et CA Mey) contains ephedrine which constitutes 40% to 90% of the total alkaloids of the plant and which has an indirect simpatomimetic effect which acts at a cardiovascular level (an increase in the heart beat), at a pulmonary level (bronco dilation), and at a central level.

[10] The French agency for the safety of health care products. A decision of 8 October 2003 which involved the banning of the importation, production, prescription and administration of teaching, laboratory and hospital products. *http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000794772&dateTexte=* . Consulted 21 March 2010.

[11] The French agency for the safety of health care products. A decision of 8 October 2003 which involved the banning of the importation, production, prescription and administration of teaching, officinal and hospital products. *http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000794772&dateTexte=* . Consulted 21 March 2010.

[12] This illness caused by Chinese herbs is a grave kidney condition that was described for the first time in 1993 in patients who had followed a diet based upon extracts of Chinese herbs (Aristolochia fangchi) containing aristolochia herbs.

[13] DEBELLE, FRÉDÉRIC, 'Modèle expérimental de fibrose rénale interstitielle induite par les acides aristolochiques («plantes chinoises»)', Thèse, Faculté de Médecine, 2005. *http://theses.ulb.ac.be/ETD-db/collection/available/ULBetd-10182004-224123/* . Consulted 21 March 2010.

[14] Decisions and declarations adopted by the 37th. Ordinary Session of the Conference of Heads of State and Government, 9-11 July 2001. *http://www.africa-union.org/Official_documents/Assemblee%20fr/ASS01.pdf* Consulted 21 March 2010.

[15] Decisions and declarations adopted by the 37th. Ordinary Session of the Conference of Heads of State and Government, 9-11 July 2001. *http://www.africa-union.org/Official_documents/Assemblee%20fr/ASS01.pdf* Consulted 21 March 2010.

ROUND TABLE: Equitable and Human Health Care

MARIO FALCONI

1. Equitable and Human Health Care at Home

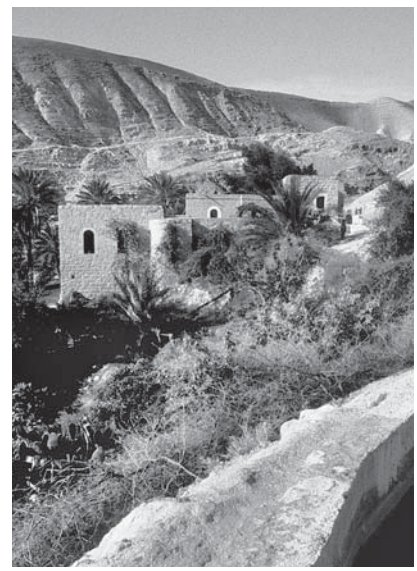
I personally, and also on behalf of the Council of the Provincial Order of Rome of Doctors, Surgeons and Dentists, keenly thank you, President of the Pontifical Council for Health Care Workers, not only for your greatly appreciated invitation but also for the subject which was entrusted to me, a subject that is very dear to us: 'Equitable and Human Health Care'.

We are an auxiliary organ of the state which defends citizens and above all the frailest amongst them. As Monsignor Zygmunt Zimowski said in his introduction to the twenty-fifth international conference on '*Caritas in Veritate*: Toward an Equitable and Human Health Care', we should, all of us together, address the burning and topical question of parity in access to health-care services if we want to act in conformity with human dignity. Unfortunately, profound inequalities exist between the health-care services of rich countries and the health-care services of poor or developing countries, but at the same time in rich countries themselves there is discrimination against very many citizens as regards access to care and treatment.

For have for years fought to ensure that in our country unforgivable geographical differences as regards health care in general, and health care provided at home in particular, are reduced and steadily eliminated.

The task of politics should be, in every field of collective life but in particular as regards the defence of health, to assure uniform and essential levels of care for everyone, but today we are witnessing a growing increase in the differences between the north and the south of the country.

In a country such as ours, where for years the average age has been increasing, and thus the number of elderly people has been increasing as well, the health-care supply should have been planned afresh in a broad and structural way in the face of a demand for health which had changed profoundly: more home, residential and semi-residential care and in particular the paying of more attention to elderly people living alone.



The ageing of the population brings with it an exponential increase in chronic-degenerative pathologies and this imposes the need, today more than yesterday, for effective and courageous policies. The real emergency in our country, as is the case with the other advanced countries of the world, is specifically the organisation of health care at a local level and above all at home, with a vision that cannot and must not correspond to a hospital-centric logic.

In the light of the encyclical *Caritas in Veritate* of Pope Benedict XVI as well, an encyclical that concentrates in the integral development of the person, it does not seem to us that our health service is going in he right direction.

A society that is really based on solidarity cannot exclude anyone from health care or continue to tolerate deep inequalities.

However, we are convinced that public economic resources will not be able, unfortunately, to grow in parallel with the exponential health-needs of citizens and thus, in order to achieve 'authentic fraternity', we should, all of us together, encourage that marvellous and rich reservoir made up of social voluntary work in all its expressions, starting, obviously enough, with Catholic social voluntary work.

Professor MARIO FALCONI
President of the Provincial Order of Rome of Doctors, Surgeons and Dentists, Italy.

W. HENRY CHIANG

2. Equitable and Human Health Care in Hospices: The Taiwanese Experience

Life is precious. Death is inevitable. And, as the late Supreme Pontiff John Paul II stated in the apostolic letter *Salvifici Doloris*, death causes suffering, including physical pain and moral suffering. Modern medical therapy, no doubt, can ease physical pain, but it seems less able to treat moral suffering.

In 2010, the Economist Intelligence Unit released a study of 'quality of death' by ranking end-of-life care around the world. The study identifies some crucial principles and difficulties in end-of-life care. It indicates that a high quality of death depends on four factors: the basic environment, quality of care, the availability of care and the cost of care. While some developed countries rank low due to problems connected with one or more factors, the BRIC (Brazil, Russia, India, China) and other developing countries rank lowest.[1] Notably, while more than 150 countries provide hospice care, the services are mostly localized and inaccessible to the general public; only thirty-five countries integrate hospice care into mainstream health care.[2]

Taiwan ranks fourteenth among the forty countries and first among the eight Asian countries surveyed in the quality of death comparison. We also offer hospice care as part of regular health services. The World Health Organization maintains that the integration of palliative care into the health care system requires appropriate policy, adequate medication, education and the implementation of service. Taiwan has relied on the cooperation of service providers, professional associations, non-governmental organizations and the government to construct a sophisticated network for hospice care centered on patients and their families. Regardless of where you are, what care you need or how much you are suffering, you will receive a uniform and decent standard of service. We are proud of this achievement. I would like to share our experience with everyone.

The hospice care movement in Taiwan began 27 years ago: in 1983, Prof. Chantal Chao of the Catholic Sanipax Foundation set up a home care program. In 1990 and 1994 respectively, the Mackay Memorial Hospital and the Cardinal Tien Hospital initiated inpatient services. Since then, hospice care has prospered in Taiwan: there are now 77 hospice care teams serving the country's 23 million people, providing inpatient share care and consultation, home visits and a total of 683 inpatient beds. This year, the government began funding a training program to equip caregivers in nursing homes with the skills to provide palliative care to residents in the last period of their lives.

Besides the vast and detailed network of service providers that has been established, there are two professional associations that conduct specialist training programs for doctors and nurses, as well as appraisal and accreditation of hospice care teams. These associations have advanced the hospice care movement in Taiwan by helping medical professionals to develop expertise in treating terminally-ill patients, and more broadly, by ensuring that service providers reach a standard of excellence.

There are also several local non-governmental organizations involved in advocacy, education and family support. These organizations provide education to the public on the concept of end-of-life care, as well as practical information and assistance to patients and their families. Their efforts have advanced the hospice care movement, as well, by bridging the distance between public awareness of proper end-of-life care and traditional Chinese culture which emphasizes a good ending for the dying and a good farewell from the family. Families must have the courage to face the reality that death is approaching their loved ones.

Lastly, the government has supported the hospice care movement in Taiwan in at least three ways. First, it has declared that palliative care is a "must have" service under the National Health Insurance plan. As a result, most hospitals not only provide some kind of palliative care services, but provide these services for free because the National Health Insurance plan reimburses their costs. This helps to ensure that all persons who need the services will receive them, and is a demonstration of equitable health care. Second, the government has partnered with, and provided funding to, private groups to educate both medical professionals and the public to establish a standard of care, as well as to expand services. This is evident in the new training program for workers in the nursing homes mentioned above. In addition, in 2000, the Legislative Yuan passed the "Hospice and Palliative Care Act," which enables patients to choose DNR (do not resuscitate). This represents a big step in protecting human rights and a demonstration of respect for life.

I have discussed how service providers, professional associations, non-governmental organiza-

tions and the government have each shaped the development of hospice care in Taiwan. To conclude, I would like to emphasize how Catholic institutions have responded, and could respond, to the hospice care movement.

As the leading Catholic hospital in Taiwan, guided by the core value of "Love God, Love People and Respect Life," the Cardinal Tien Hospital has put a lot of energy into our long-term care and end-of-life care services. The concept of "holistic care" is central to our services. It entails four aspects: whole person care (not only physical care but also mental and spiritual care); whole journey care (care from the beginning of illness to the end of life); whole family care (such as bereavement counselling); and whole team care (a multidisciplinary professional approach). This care model has become the standard of practice in Taiwan, but the unique characteristic of our model is the inclusion of a pastoral care person in our hospice care team. The inclusion of a pastoral care person is significant because human health care should involve not only acute medical care, but also spiritual care. Modern medicine no doubt has focused on the physical demands but often has seemed to neglect the emotional and spiritual needs of patients and their families. This neglect may double their suffering.

As was stated in the encyclical letter, "there cannot be holistic development and universal common good unless people's spiritual and moral welfare is taken into account." Guided by this, local Catholic churches can thus contribute by relieving pain and promoting well-being in the spiritual dimension of life. They can collaborate with medical authorities to provide holistic, human health care. They can also urge medical professionals to become more involved in end-of-life care, and advocate to the public and to the government the need for more equitable and human hospice care. Given such efforts, I believe that excellent hospice care with love could one day be provided in every corner of the world.

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Notes

[1] Economist Intelligence Unit. (2010). *The Quality of Death: Ranking End-of-life Care across the World.*

[2] International Observatory on End of Life Care. (2006). *Mapping Levels of Palliative Care Development: A Global View*. As cited in Economist Intelligence Unit (2010).

CHRISTOPH VON RITTER

3. Equitable and Human Health Care in Prisons

Equitable and human health care in prisons is associated with major challenges. More than other patients, prisoners suffer from both mental and somatic illnesses. In this context, the problem of guilt plays a central role. An effective therapy needs to address this problem and liberate the prisoner from his guilt. Forgiveness, therefore, must be an essential part of equitable and human health care in prisons.

The question of guilt plays a central role in any illness. Like almost all other patients, the sick prisoner asks himself whether he bears responsibility for his illness. To ask this question is reasonable since an analysis of the risk factors may, at least in part, clarify the cause of the illness, thereby preventing recurrence and supporting rehabilitation.

The prisoner is guilty because of the crime he has committed. The time in prison is meant to redeem his guilt and is also meant to induce the rehabilitation necessary to reintegrate the prisoner into society.

Exposed to this double form of guilt, the prisoner may end up in a situation in which he is locked up in his own prison of guilt. Unrelieved, guilt causes desperation and neurotic alterations. These mental problems may lead to an aggravation of the somatic symptoms of the prisoner, a deterioration of his illness and, finally, generate a vicious cycle which perpetuates psychosomatic illness.

Forgiveness is the appropriate means to interrupt this vicious cycle. Only complete forgiveness will create a resolution of guilt and lead to sustained health, i.e. health that aims to achieve complete recovery from mental and physical illness. Such a complete recovery is necessary to restore the balance of a prisoner and is the basis for the reintegration and rehabilitation of a prisoner.

Forgiveness has to involve all aspects of the guilt which affect the prisoner. How can such complete forgiveness be achieved?

First, the prisoner has to accept the guilt he has caused himself through the crime he committed and undertake whatever is possible to relieve that guilt. The prisoner may have suffered injustice himself and this injustice may possibly be part of the circumstances that led to the crime. So the second part of complete forgiveness is that the prisoner needs to forgive the injustice inflicted on him and abstain from any feeling of revenge. Recently, the value of forgiveness has been explored in the scientific literature of psychological research. The studies present evidence on the powerful healing capacity of a personal attitude that includes complete forgiveness.[1]

Finally, and most importantly, the prisoner, in general, and so much more the prisoner as a patient, needs treatment that is based on forgiveness and tender care. This is based on respect for the person and the dignity of the prisoner. This respect for the inherent dignity of the prisoner must be unconditional and not related to the past and present life of the prisoner. Such an unconditional respect for the prisoner is ideally rooted in the Christian faith which respects all men as being in the image of God. Secular society, on the other hand, runs the risk of modifying human dignity according to the aims of society. At worst, individual groups such as prisoners are thereby excluded from the full benefits of human dignity.

The Christian tradition of healing on the basis of forgiveness is ample. Through the sacrament of confession, God grants complete forgiveness of the sins committed by men. The forgiving God looks for a chance to forgive guilt. Therefore, the Christian gospel may constitute an important and very helpful part of the complex therapy needed to cure a sick prisoner. The certainty that God has never left him and will never let him down will help to free the prisoner from his self-generated prison of guilt. This will then provide the basis to return to society as a full and healthy member.

If complete forgiveness and respect for the dignity of the prisoner is missing, the prisoner becomes a helpless victim who can be exploited in numerous ways. A horrible and extreme example of such treatment of prisoners was the concentration camp in Dachau, Germany. Innocent people were kept with no respect for their human dignity. The prisoners were exploited and used for forced labour. Instead of health care, medical treatment was perverted in such a manner that prisoners were forced to participate in pseudo-scientific experiments. The protocols of the Nuremberg trials indicate that the medical staff did not recognize their victims as equal human beings and perceived them as *Untermenschen* who did not deserve respect and dignity.[2] Treatment of prisoners in Nazi concentration camps dramatically illustrates how absence of respect for human dignity generates an unrestrained exploitation of prisoners.

Completely different is the treatment of female prisoners in the prison of Repy in the Czech Republic. The prison, which is in a suburb of Prague, forms a part the convent of the Sisters of Mercy of St. Charles Borromeo. The monastery was originally founded in 1858. In 1865 the sisters started working with women prisoners. In 1948, under Communist rule, the monastery was closed, the sisters

were incarcerated, and the buildings were used for a Research Institute of Agricultural Technology. Forty years later, in 1989, the buildings were again taken over by the Sisters of Mercy of St. Charles Borromeo With the help of many sponsors, the convent was beautifully restored. It again serves a twofold purpose: as a nursing home and day care centre for chronically ill and disabled people and as a prison for female prisoners. The female prisoners work together with the sisters and the lay staff in different sectors of the nursing home. They are occupied in the kitchen, the laundry, in housekeeping and in the garden. In addition, they may also help in the wards and assist the nursing staff. For some of them this is the first time that they encounter illness and physical and mental disability. The possibility of helping the elderly patients offers a unique opportunity to practise kindness and understanding. This, in turn, promotes the process of forgiveness for themselves and others, restores self-esteem, and generates the certainty that they will again become useful members of society. The prisoners are offered training courses in nursing and are entitled to achieve a diploma as medical orderlies. This is additional valuable assistance to achieve their successful reintegration into society. Finally, for some the caring love and spiritual life they witness around them helps to lead them back to the Christian faith which may become the basis of their future lives.

The relapse rate of prisoners released from Repy prison is significantly lower then elsewhere in the country and some of the former prisoners stay in close contact with the convent after their release. So, after functioning for several years this unique project has proved to be highly successful and deserves wide application all over the world.

In conclusion, the treatment of prisoners in prison is a good example of the need for equity and humanity in health care. More than other patients, the prisoner suffers from somatic and mental illness in part caused by an overwhelming and unrelieved feeling of guilt. To restore physical and mental balance, complete forgiveness is an essential precondition for sustained cure. The prisoner has to seek forgiveness for his crime, forgive himself and has to be granted forgiveness. Forgiveness is based on unconditioned respect for the dignity of the prisoner. The firm basis for such respect is the Christian faith which sees the prisoner as being in the image of God.

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Notes

[1] F. LUSKIN, *Forgive for Good: A Proven Prescription for Health and Happiness* (Harper, 2002); 2. S. Sarinopoulos, 'Forgiveness and Physical Health: A Doctoral Dissertation Summary', *World of Forgiveness* n. 2 (2000), 16-18

[2] EBBINGHAUS/DÖRNER ,*Vernichten und Heilen, der Nürnberger Ärzteprozeß* (Aufbau Verlag, Berlin 2001).

STANISLAW SZCZEPAN GÓŹDŹ

4. Equitable and Human Health Care in Factories

One of the basic human rights is access to health care. However, the violation of these rights, including the right to basic medical services, is a worldwide practice. This paper will deal with the topical issues relating to access to health care in factories, the purpose being to determine to what extent the aforementioned right is respected. I will start by presenting this problem with the example of my home country, Poland, being used, then I will make reference to western Europe and emerging economies, and, subsequently, I will go on to touch on the situation in low-income and slowly developing countries. No statistical charts will be included in this paper, as the available data are fragmentary or approximate only. On the other hand, my paper is supposed to provide a global outline of the problem.

Poland boasts a long tradition of health-care services provided in factories. One of the originators of this system was a Catholic priest, Stanisław Staszic, the founder of the so-called Industrial District located in central Poland. It was as early as in 1809 that in the steel mills and foundries that he had established, a physician was employed in order to provide workers with the necessary health services. The health-care system introduced after World War II was based on the universal availability of medical services that were completely free of charge. In each major factory, there was a medical doctor, a dentist and nurses, and thus employees had unrestricted access to high quality medical services. The system of health care in workplaces organized in the 1960s was very effective indeed. Work medicine institutes were also being established, which placed our country among the world's leaders in this respect. The focus was on the protection of the employee's health. Many medical doctors were being specially trained to become work medicine consultants. Relevant legislation was being formed simultaneously, the aim being to regulate those processes in a highly logical and consistent manner. Thus, employees regularly received medical examinations, which not only determined their ability to continue work but also provided highly effective and comprehensive prevention measures. It is worth emphasizing that owing to the insignificant unemployment rate, the majority of the population was covered by this health care system. Twenty years ago Poland saw extensive transformations. Unfortunately, in some areas, including health care, these changes brought unanticipated and unacceptable outcomes. Transformations in the sphere of politics entailed large-scale economic changes. Most of the state-owned industrial plants were transformed into private enterprises while many of the remaining ones collapsed, with no new entities being established to take their place. A high rate of unemployment appeared and became a major issue. Those changes also had a significant impact on health care, which, while quite effective and well-functioning in the previous economic system, failed to meet the challenges of the free market economy.

Is a free market beneficial for health care, as advocated by liberals? I would like to draw your attention to the very term 'health *care*', which is in itself in contradiction with the mechanisms of a free market. The free market excellently regulates the operation of factories where some commodities (things!!!) are manufactured. However, when introduced into the health care system, these free market mechanisms can easily convert the patient into a product (a thing). A question arises here: is such a situation normal? Can such a system, which is still maintained in many highly developed countries, including those in Europe and America, be acceptable? The more so as these countries claim to be in the vanguard of civilization, with a deep sense of humanism being cherished there. Where in a free market is there the necessary space for compassion, selfless help, a moment of contemplation, and, first and foremost, the willingness to offer a helpful hand to those in need? Free market mechanisms are destructive of the essential relationship between the patient (man) and employees of the health care system (people) because 'time is money', because the number of patients (or, perhaps, dehumanized things) received and the revenues generated in the process constitute the superior goal. What has emerged is a heartless following of all stages of an impersonal, auto-

mated procedure, concluded with the phrase "Goodbye – the next, please". Hence, I would like to ask whether such a system brings any value to society, as this society, in order to function properly, has to be provided with healthcare services beginning with the place in which every man spends a third of his earthly life – the workplace.

A case in point is the situation in some European and North American countries which, notwithstanding their unquestionable affluence, have come to face major difficulties in the functioning of their health-care systems. Despite the official statements as to the high quality of medical services provided there, these systems are inefficient, with the poorer classes' access to adequate health services being hindered. In most cases, people are left unassisted as regards their health problems, because, being poor, they offer no opportunities for someone else's further profits. This is the way in which liberals try to push through the rules of free market in the health-care system. Isn't it, by any chance, a step-by-step journey towards the civilization of death? "This patient is worth receiving treatment and that one isn't, as he is severely ill. From the economic point of view, he is unprofitable, and he had better pass away on the quiet, or, if only possible, (which would be more rewarding in terms of finance) let someone generate some revenue on his death." And who is supposed to make this profit? It is, obviously, a commercial company, a liberal enterprise, which, at a low expense, will help you to organize a "human death" – modern and financially sound – euthanasia. The question that has just been asked should be answered by all of us. Are we all still human beings? Or do we tend to treat others as if they were mere commodities – things? Or, perhaps, have we already ceased to think and perceive life and death in the manner we used to?

The extensive transformations that the health-care system underwent instantaneously triggered major changes within the organization of work medicine services. Most of the clinics operating as part of industrial plants were simply closed. Nowadays, large companies do not employ even a limited number of medical doctors or nurses to meet their employees' needs. Instead, they outsource such services to external, often private, institutions – out-patient clinics or work medicine units. It should, however, be noted that employees are still covered by the national insurance system, with periodic medical examinations as well as other aspects of work medicine being effectively regulated by relevant laws.

Unfortunately, this *status quo* seems to be under threat. With the ongoing globalization processes, new tendencies, being awkwardly justified by the necessity to cut costs, have emerged with the aim of "optimizing" the health-care system. This simply means that the health-care system has to be poorer. For instance, efforts are being made to impose limits on the scope of preventive examinations, *with laboratory tests being eliminated*. This brings instability within relevant legislation, which is dangerous, as it results in an outflow of professional, highly qualified medical personnel. In fact, work medicine has ceased to be a field in which medical doctors want to specialize. What testifies to this situation is a large number of unused specialist training opportunities in this area, which, as compared with other specialties, applied for by many candidates, is a new phenomenon. If the pursuit of profits is supposed to be the only determinant here, the pressure on labour costs results in the unfortunate mothballing of the idea of comprehensive health-care services being widely available to employees.

Another topical issue in Poland is the illegal hiring of workers, without registering them, as well as forcing employees to continue work on a self-employment basis, whereby they carry on *de facto* the same services as they did on the basis of an employment contract. Such self-employed "employees" (employees and employers in one person) are not offered periodic examinations and other basic health services, which results in a wide range of illnesses developing in this group of people, in addition to a general deterioration of their health. At the end of the day, not only human suffering is a consequence here but also considerable costs incurred by society, as patients with chronic occupational illnesses are usually taken care of by the state-owned health-care system. Treatment in the case of an advanced health condition involves expenses which are dozens of times higher than the cost of procedures to be carried out at the onset of the illness, not to mention the insignificant amounts of money necessary for prevention efforts. Prevention is much better than cure, in terms of finance as well. This applies not only oncology but also illnesses associated with the progress of civilization.

The situation is much the same in other European countries, including the highly developed ones, with migrant workers from the so called "new Member States" or from beyond the European Union, who, being usually hired illegally, agreeing to be paid low rates, without any social insurance, are especially exposed to these problems. Such workers, in addition to earning much less money, do not have access to basic health-care services. A common reason for them returning to their home countries is their ruined health, with the ultimate result of such a situation being an even bigger burden on the inadequately financed health-care systems in these countries, which are economically weaker anyway.

Now, I would like to briefly address the situation in emerging economies, whose impact on the global economy, including European countries, is increasingly significant. According to the Amnesty International report of March 2007, the violation of fundamental human rights is a common occurrence there. Potential foreign investors, with huge profits being their superior goal, regard these countries as highly attractive places. In these countries rates of pay are very low. Hiring children is widespread. Work conditions are generally very bad, with no basic health-care services being provided. In most textile factories young women from rural areas are employed. Regarded as being more obedient, they accept the harder work and inadequate conditions, as the economic situation in the areas from which they come is even worse. In general,

these employees work 12-14 hours a day, having only one day off per month. They develop a vast array of occupational illnesses and related health conditions. According to this report, 90% of women employed in the textile industry do not have access to social welfare facilities, including basic health-care services. Thus, incomparably cheap goods are manufactured in this process, unrivalled in terms of price. The world is being flooded with such products which often causes serious disturbances in local (e.g. European) labour markets, which cannot fight a competition based on social injustice and human suffering.

Europe, the cradle of modern civilization, should use all its available economic instruments (e.g. embargo) or exercise political pressure with the aim of improving work conditions in factories and ensuring that health-care services are widely available in developing countries. There is no denying that awareness among the Europeans and citizens of the USA and Canada as to the blatant injustice regarding the availability of health-care services in emerging economies is accompanied by their unrestrained use of the "benefits" of a cheap labour force through the purchased of a wide range of goods manufactured there, beginning with designer shoes and finishing with high-tech electronic products.

Your Holiness, in your encyclical *Caritas in Veritate*, you emphasize the idea of replacing the narrowly-understood "logic of the market" with the logic of gift and global solidarity.

What we should call for today is a fundamental thing – *the logic of humanism*: respect for the man-employee as a person, who, having been given one life, is unique and invaluable in the eyes of God. Man cannot be reduced to the level of a manufacturing machine. That would mean the fall of the civilization of the twenty-first century.

At the same time, a voice should be raised – *less money spent on armaments and new killing technologies (defence industry) and more money spent on protecting health*, especially in those places where health is most often damaged and wasted – the workplace!

Politicians should invariably be reminded of their vocation to build the civilization of life, solidarity, and international co-operation rather than promoting fierce and heartless competition which ruins employees' health and dignity!

Press journalists and TV/radio reporters should be more involved in exposing these grave situations and human tragedies, as their scale and extent are often larger than in the time of the darkest capitalism (considering the higher level of knowledge and information flow nowadays)! Let them show solidarity with their brothers and sisters who are afflicted by these destructive processes! Without their reliable information, many politicians in many countries will not take decisive steps towards providing employees with the necessary health care.

Equally important is appealing to some representatives of the medical profession, who, realizing the potential of their expert knowledge and political strength, should not turn a blind eye to the tragedies of the "common people". What should be invoked is their accountability to the Creator, with docile and obedient collaboration with the merciless exploitation instruments being the evil here, as they realize what they sometimes fail to do even though they have the necessary knowledge and capacities to perform their duties to the full. The public should be shown these medical doctors and ministers whose minds are set on providing medical services to each person, poor and the rich alike, and who try to build a health-care system that will support people like them in doing do. The viable idea of health-care services being provided in workplaces should be given priority.

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Health-Care Workers Faced with Certain Questions of a Deontological, Ethical and Legislative Character

Why should health-care personnel have to face up to certain questions of a deontological, ethical and legislative character? Let us try to understand this question: it suggests that deontology, ethics and law can contradict each other. This disaccord can be at the origins of difficulties encountered by health-care personnel. One thus understands how these people feel the need for a clarification which is necessary for the practice of their profession, in the best conditions for their patients and for themselves.

In the first part of this paper, I have thought it useful to explore the causes of the contradiction between deontology, ethics and law. In the second part I will examine the consequences of this contradiction.

1. The Causes of the Contradiction between Deontology, Ethics and Law

The disaccord between deontology, ethics and law seems to be at the origins of difficulties encountered by health-care personnel. Indeed, when these three normative sources are in agreement, health-care personnel have no reason to subject themselves to such a coherent corpus unless they themselves want to be excluded from their own communities. The problem, therefore, comes from the fact that health-care personnel may have to deal with the prescriptions of deontology, ethics and law which go in the same direction. They can also be tempted to oppose these various prescriptions, exonerating themselves from respect for some of them. In this case, they are as blameworthy as they are victims. Whence comes the fact that between these three normative sources there is a contradiction which can prejudice sound practice in the service of patients? It seems to derive principally from two causes: the fracture of positivist law and the epistemological fracture of the status of science.

a. The fracture of positivist law

In order to understand fully the fracture of positivism, it is useful to remember the historical itinerary of ethical reflection in medicine. 'At the origins of medical ethics, in archaic societies and also in the more evolved societies of antiquity, three elements were always present: the requirements of an ethical character that a medical doctor had to respect, the moral meaning of help for sick people, and the decisions that the state had to take in relation to the problems that its citizens had to address in the field of public health. The Code of Hammurabi of 1750 BC, which itself was influenced by previous Sumerian rules, contains norms that govern medical activity and an early regulation of taxation as regards help for health. In addition, in the outlining of Western ethical thought in the medical field, one cannot ignore Hippocrates (460-370 BC) and his Oath', observes Cardinal Sgreccia.[1] Here he shows how this oath based the morality of medical action on the principle of doing good, that is to say the good of the patient, which was placed above law itself, and not upon the mere morality of a caste of physicians.

Thereafter, with Plato, Socrates and Aristotle, efforts were directed towards establishing the non-subjective criteria of morality, based upon objective truth and upon awareness of good in itself. In this way formulations similar to the Hippocratic Oath were present in a number of cultures.

Christianity, for its part, not only involved a strong acceptance of Hippocratic ethics but never ceased to innovate, basing the concept of the human person above the dualism of the soul and body, upon the concept of help for the sick ('you did it to me') and the medical profession (the Good Samaritan). Christianity always sought dialogue between faith and science through the mediation of reason, which is their common reference point.

In contrary fashion, the principle of autonomy, derived from the philosophy of the Enlightenment thinkers, bases moral action solely on the autonomous choice of the individual, independently of truth: his or her freedom is practically limitless, it stops only where the freedom of others began, but on the condition that other people have the means by which to take advantage of their freedom. For 'others', such as embryos, foetuses, handicapped children, the elderly or sick people at the end of their lives, who are no longer seen as persons, this freedom is not recognised. The scission of the tandem truth/freedom made difficult the defence of the notion of the common good. Subjective interest became of primary importance and provoked ethical relativism. Law in no way any longer depended on truth and no longer had justice as its purpose – it was reduced to an act of normative will by those who govern. This was juridical positivism which recognises as law only what is to be found in laws,

whether their contents are right or not.

The consequences of this positivist approach were extremely grave. Law became a simple mechanism for regulation, for arbitrating between individual interests, a way of searching for consensus, a formal procedure by which to defend the interests of a changing majority. A dual contrary phenomenon was the result: on the one hand, law was amoral in that it was no longer irrigated by morality, and, on the other, law and morality tended to be confused in the minds of citizens who no longer had normative reference points other than law. What was legal became moral. One needed only to change the rules to be in a sound position. In reality, the result was the same: law was the law of the strongest and was arbitrary. It became, above all, toxic, inasmuch as it by now appeared to be able to pollute morality and traditional deontology which were not the products of synthesis.

As *Evangelium Vitae* observes: 'But the value of democracy stands or falls with the values which it embodies and promotes. Of course, values such as the dignity of every human person, respect for inviolable and inalienable human rights, and the adoption of the "common good" as the end and criterion regulating political life are certainly fundamental and not to be ignored. The basis of these values cannot be provisional and changeable "majority" opinions, but only the acknowledgment of an objective moral law which, as the "natural law" written in the human heart, is the obligatory point of reference for civil law itself. If, as a result of a tragic obscuring of the collective conscience, an attitude of scepticism were to succeed in bringing into question even the fundamental principles of the moral law, the democratic system itself would be shaken in its foundations, and would be reduced to a mere mechanism for regulating different and opposing interests on a purely empirical basis'.[2]

The modern negative movement of law towards positivism has thus dug a deep ditch which increasingly separates it from medical deontology at the service of the sick and personalist ethics. 'In this way, and with tragic consequences, a long historical process is reaching a turning-point. The process which once led to discovering the idea of "human rights" – rights inherent in every person and prior to any Constitution and State legislation – is today marked by a *surprising contradiction*. Precisely in an age when the inviolable rights of the person are solemnly proclaimed and the value of life is publicly affirmed, the very right to life is being denied or trampled upon, especially at the more significant moments of existence: the moment of birth and the moment of death'.[3]

b. The Epistemological Fracture of the Status of Science

The recent advent of genetic and cellular discoveries, that is to say of the scientific laws that govern the formation of life, has provoked a kind of conceptual devolution that has strengthened the separation of morality and law. Indeed, with these discoveries man has believed that he can create and destroy himself, seeing life being born at the bottom of a test tube or under the lens of a microscope. Lastly, he has come to control his own destiny from the beginning to the end of life. His power has become that of a demigod. Dazzled by these undertakings, he no longer needs a transcendent reference point. What is requested is solely a utilitarian and economic reference point, and a justification based upon the search for an eternally unsatisfied happiness which has still to be defined. All of this carries us very far from deontology and morality. The feeling of dizziness, drunkenness and omnipotence felt by the whole of society acts as a powerful accelerator of transgression. Medical science, therefore, has entered a new phase under the impact of the accelerated developments of technology. Nothing is any longer predictable as regards the application of these technologies, inasmuch as the very finality of science, at the service of the common good, is no longer assured. As a consequence, the ethical boundaries invoked in a bewitching way in social debates, continue to move forwards, increasingly rapidly, according to legislative frameworks that follow one another. Governments and parliaments try clumsily 'to frame negative tendencies by the law' but in practice 'it is the law that becomes a negative tendency within the framework'.[4]

Law's function of regulating demonstrates its ineffectiveness, As the philosopher Michel Serres observes,[5] science does not aim simply at knowledge about reality – it has become the realisation of everything that is possible. By now it is borrowing its epistemological status from politics – the art of the possible.

This phenomenon is striking because of its newness. It comes from after the Second World War. Absolute evil was put aside, closed up, surrounded once and for all within the perimeter of Nazi crimes. The concert of sentences, of contestations, of indignations, exhausted its resources, dulled its competences, dried up its streams in order to avert the errors of genocide. Paradoxical-

ly, the Nuremberg trials, rather than intensifying our vigilance as regards the future, closed the dossier of the divorce between law and morality and sent it back to a finished past. Politics was seriously discredited by its tradition and incompetence. Morality signed a confession of weakness faced with the concrete taking place of the unthinkable. God appeared to be strangely absent during this period and the Church's opinion was no longer asked for. In this context of disillusion and cynicism, it appears to our contemporaries that only the myth of an objective science, a factor of renewal and of peace, a predictive magic, a progressive dream, is able to reopen the field of hope. In the name of what can one forbid this utopia to prosper if nothing else remains? 'Scientific research should be allowed to work freely', we can read everywhere. This is virginal, redemptive and almost deified science which will save us from everything and will make us happy because politics is corrupt, morality has disappeared, and God is silent. In brief, people believe in nothing anymore except in a science that calmly occupies the place left vacant by religion, by philosophy and by the art of governing the city.

2. The Consequences of the Contradiction between Deontology, Ethics and Law

Deprived of objective morality and drugged by technical performance, medical and scientific activity is like a drunken ship whose engine is increasingly competitive but which is no longer on course. The consequence of this are to be perceived in the action of health-care personnel. On the one hand, there arises great confusion as regards the decisions that are to be taken. On the other, the burden of these decisions falls upon health-care personnel who are increasingly out on their own.

a. Confusions as regards the decisions to be taken

The situation has become very confused because of an increasing technical complexity and at the same time because of the normative relativism that I have already described, but also because of the abandonment of positions which has already been allowed and which are not always perceived as such. The situation is often characterised by the fact that society has already accepted a transgression that we could define as 'primary', within which 'secondary' questions are posed. This takes place, for example, with the techniques of *in vitro* fertilisation with third part donors which constitute illegitimate acts in themselves. This is primary transgression. We then raise the question of knowing whether, within the framework of *in vitro* fertilisation with third party donors, it is necessary to accept some arrangement or other, such as the ending of the anonymity of the donor. It is worrying to pronounce on a secondary point that runs the risk of concealing the true problem, which is the very possibility of *in vitro* fertilisation with third party donors. It is disquieting to see health-care personnel or chiefs who belong to the Catholic Church align themselves in favour of anonymity or the removal of anonymity since their efforts – at least at the level of formation and arguments – should above all concern the elimination of *in vitro* fertilisation with donors.

In the same field, one can make an identical observation on the freezing of ovocytes for vetrification which is a technique of rapid freezing as opposed to the technique of slow freezing which has been used hitherto. The merits or dangers of vetrification are thus assessed within the framework of the collection of gametes, which in itself is already a morally contestable activity where we should go into reverse. This secondary technical debate, however seductive it may be from the point of view of an improvement of medically assisted procreation, in particular eliminates the fact that one should not experiment on the effects of the vetrification of ovocytes on human embryos which are not intended to be placed in the female womb.

In another field, that of prenatal screening, it is very common for us to see the emergence of debates on the development of these practices: for example the improvement in services thanks to the combination of scans and biological markers, the bringing forward of the test for trysome 21 from the second to the first three months of pregnancy, the analysis of the karotype beginning with the cells of the foetus circulating in the blood of the mother, greater information being provided to the expectant woman in order to help her in the choice she takes, etc.[6] The very purpose of screening has never been called into question or discussed anew, although it is constantly directed towards abortion. And there are a large number of people, among whom Catholic health-care personnel or health heads, who do not realise that in taking part in these discussions, or choosing *a fortiori* to align themselves in favour of an improvement in such techniques, they help to install in an easier way, and thus to strengthen, a perverse approach.

It is important to observe here that resort to article 73 of *Evangelium Vitae*, which is at times requested, is ineffective. This article allows support for a more restrictive law intended to replace a more permissive law but certainly not to improve the component parts of a bad system whose negative effects, at the level of respect for life, would not in the least be reduced.

This is why one should constantly remember the need to find criteria for judgement not only in scientific research and medical technology themselves, returning to an ontological, axiological and teleological vision of the reality involved: the human being at all the stages of his or her life, from conception to death.

'In order to take a decision beginning with these criteria, one should as a consequence answer in a clear way to the three following questions: what is man (ontology)? What is his value (axiology)? What is his destiny (teleology)?'[7]

b. The Isolation of health-care personnel

When confusion rules as regards the decisions to be taken, health-care personnel feels the responsibility weighing on their shoulders more heavily. If the direction provided by law contradicts deontology and morality, the task of recre-

ating a hierarchy of applicable norms falls, in the final analysis, on the actors themselves of the health-care world. For the health-care personnel, most of the time, one is dealing, therefore, with being able to engage in a judgement of conscience, that is to say assessing an action in relation to moral principles and norms. To engage in a judgement of conscience appears at the same time a right but also a duty. Here it is important to remember that in a judgement of conscience although the exercise of freedom is necessary it is not sufficient. Indeed, for us to be able to speak about a true conscience, there must be a correspondence between moral judgement and conformity with an act with a good end. For this reason there is an obligation for the person involved to receive a moral formation that is the more demanding the more goods are involved.

Unfortunately, in countries where law no longer pursues a good end and where a contradiction between deontology, ethics and law is pervasive, a real difficulty exists as regards finding moral formation worthy of the name. It is thus the task of ecclesial structures to mitigate this shortcoming by proposing moral formation for Catholic health-care personnel. This task would be greatly facilitated if in school institutions of the Catholic Church a formation in bioethics was already provided. It would also be facilitated if couples who asked for marriage were to receive a specifically bioethical formation – and not only formation of a conjugal character – in the field of the grounding provided to them by the Church.

Lastly, Catholics who are responsible for formation in bioethics are recommended not to hesitate to place themselves within a logic of fracture – and not of accompanying – with the legislative framework of countries which dissociate deontology, ethics and law. If this will to break with a system of deviant norms is not clearly established, it is impossible to dispense with a formation that is able to form consciences, to break the isolation of health-care personnel and to hope that the members of this personnel will place technological and scientific advances at the service of medical decisions which are in conformity with the common good.

Respect for the human being does not stop where the freedom of technology/science begins: the freedom of technology/science stops where respect for the human being begins.

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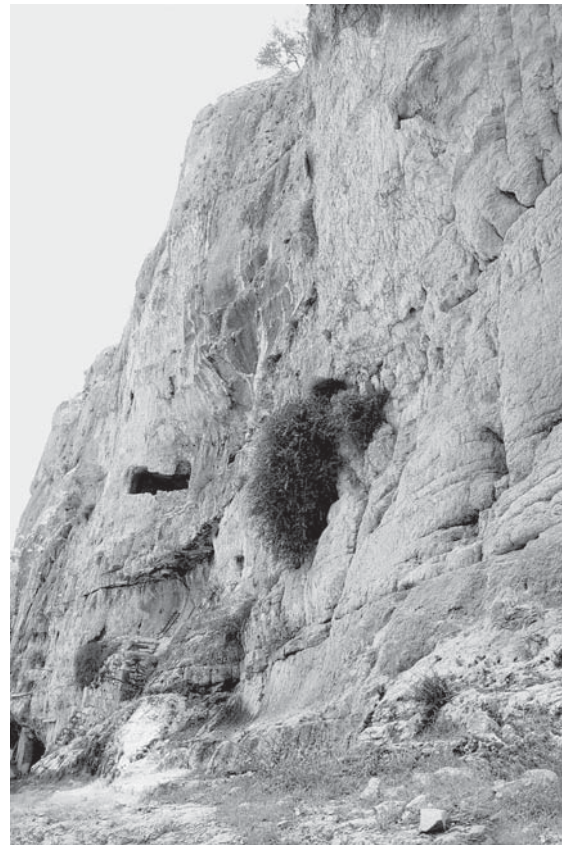
Notes

[1] E. Sgreccia, *Manuel de bioéthique* (Mame-Edifa, Paris, 2004), pp.13 ss.
[2] *Evangelium Vitae*, n. 70.
[3] *Evangelium Vitae*, n. 18.
[4] J.M. Le Méné, *Nascituri te salutant – La crise de conscience bioéthique* (Salvator, Paris, 2009).
[5] J. Testart, *L'œuf transparent*, preface by Michel Serres.
[6] J.M. Le Méné, *La trisomie est une tragédie grecque* (Salvator, Paris, 2009).
[7] E. Sgreccia, *Manuel de bioéthique*, p. 47.



BARRY L. DUNCAN

The Question of the Use of Psychiatric Pharmaceuticals in Paediatrics

A 2004 US review concluded that spending for medications for childhood behavior problems now eclipsed expenditure for any other drug category, including antibiotics (Medco Health Solutions, Inc.). While the US continues to lead the world in psychiatric prescriptions to youth, global use of ADHD drugs has increased by 274% (Scheffler et al., 2007) as prescriptions for antipsychotics doubled across Europe (e.g., the UK: Rani, Murray, Byrne, & Wong, 2008; and Germany: Schubert & Lehmkuhl, 2009). The number of youth taking 1 or more psychiatric medicines has hit nearly 9% in the US, 6% in the UK, and 3% in Australia – although not one clinical trial has examined polypharmaceutical intervention with children (dosReis et al., 2005).

Prescriptions for antidepressants for youth have increased at a rate of 11% per year from 1994 to 2000, and 5% per year since, totaling to over 11 million prescriptions written annually. The number taking antipsychotics soared 73% in the four years ending in 2005 – over 2.5 million youth per year are prescribed antipsychotics (dosReis et al., 2005). A study of 11,700 US children under age 18 covered by Medicaid (program for the poor) found that the number of children newly treated with antipsychotics increased from 1,482 in 2001 to 3,110 (or 26%) in 2005 (Mathak, West, Martin, Helm, & Henderson, 2010). Another study found that children covered by Medicaid were prescribed antipsychotics at a rate four times higher than children with private insurance, and were more likely to receive antipsychotics for unapproved uses (Crystal, Olfson, Huang, & Gerard, 2010). A study of foster care children (on Medicaid) found that 57% received three or more drugs (Zito et al., 2008), six times the national average. Finally, the use of antipsychotics with privately insured children, aged 2 through 5, has doubled between 1999 and 2007 (Ofson, Crystal, Huang, & Gerhard, 2010). About 1.5% of all privately insured children between the ages of 2 and 5, or one in 70, received some type of psychiatric drug in 2007 despite the fact that there is little to no evidence in this age group.

While psychotropic drug use has risen, community behavioral intervention has remained flat or declined (Case, Olfson, Marcus, & Seigel, 2007). Several questions arise: First, are the skyrocketing rates of prescription justified by clinical trial evidence? Are physicians who routinely prescribe psychotropic medications following the scientific mandates of evidence based medicine (EBM)—the integration of the best research evidence with clinical expertise, including patient values, to make informed decisions about individual cases (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996)? Next, are children, by virtue of their powerless position and dependence on adults, the victims of an industry motivated by greed rather than social consciousness? Finally, are the differential rates of prescription of psychiatric drugs to poor children a violation of equitable and human health care? This presentation addresses these questions via a risk/benefit analysis of the major drug classes and provides a template for health and pastoral professionals to evaluate the drug literature and facilitate medication decisions.

Children and Antidepressants

Two randomized controlled trials of fluoxetine (Prozac) (Emslie et al., 1997; Emslie et al., 2002) gained approval for young people aged 8-17 diagnosed with depression (FDA, 2003, January 3). However, both Emslie studies failed to find a statistical difference between Prozac and placebo on primary outcome measures. Additionally, in both trials, manic reactions and suicidality were notably higher in the drug group compared with placebo (Sparks & Duncan, 2008). An independent analysis by the FDA concluded that only 3 out of 15 published and unpublished trials of SSRIs showed them to be more effective than placebo on primary measures (Laughren, 2004). None of the 15 found differences on patient or parent rated measures.

The NIMH funded Treatment of Adolescent Depression Study (TADS) (TADS Team, 2004), again evaluated Prozac for the youth age group. TADS compared the efficacy of four treatment conditions: Prozac alone, cognitive behavioral therapy (CBT) alone, CBT plus Prozac, and placebo. Despite media claims, (*The New York Times* front page headline, "Antidepressant Seen as Effective in Treatment of Adolescents," Harris, 2004), the FDA did not count TADS as a positive study for SSRIs due to the negative findings on its primary outcome measure. Other end-point comparisons in TADS favored the combined medication/CBT arm. However, treatment was unblind, and only the combined group received all intervention components (drug, psychotherapy, psychoeducation and family therapy, and supportive pharmacotherapy monitoring), creating a significant disparity

in favor of the combination arm. The TADS recorded 6 suicide attempts by Prozac takers compared to 1 by non-Prozac takers, with more than double the incidence of harmful behavior in the Prozac conditions compared to placebo groups (despite the exclusion of youths deemed at high risk for suicidal behavior). Nevertheless, the authors recommended that "medical management of MDD with fluoxetine, including careful monitoring for adverse events, should be made widely available, not discouraged" (p. 819) – a challengeable conclusion given its inconsistency with the study's own harm data. In the 36-week follow up study (The TADS Team, 2007), all treatment conditions converged by 30 weeks with significantly more suicidal ideation in the Prozac alone group. The percentage of suicidal events for those on Prozac was nearly 12%, double the 6% in the CBT group.

The risks noted in published and unpublished data prompted the FDA to issue a black box warning on all antidepressants for youth for increased risk of suicidality and clinical worsening (FDA, October, 15, 2004). Further support of the warning emerged from an analysis of placebo-controlled trials of nine antidepressants, a total of 24 trials involving over 4,400 children and adolescents (Hammad, Laughren, & Racoosin, 2006). The investigation revealed an average risk of suicidality of 4% in drug treated youth, twice the 2% placebo risk.

Children and Stimulants

The American Psychological Association (APA) Report of the Working Group on Psychoactive Medications for Children and Adolescents (hereafter Working Group) (Working Group, 2006) noted the lack of data supporting long term efficacy or safety. Further highlighted was that stimulants, while reducing symptoms, show minimal efficacy in general life domains of the child, including social and academic success. Stimulant advocates, however, point to the Multimodal Treatment Study of Children with ADHD (MTA) (MTA Cooperative Group, 1999). Only 3 of 19 measures, all un-blinded, found differences favoring methylphenidate (Ritalin). Neither blinded classroom observers, the children themselves, nor their peers found medication better than behavioral interventions. Moreover, 14-month endpoint assessments compared those actively medicated and those who had ended therapy (4 to 6 months after the last, face-to-face, therapeutic contact) (Pelham, 1999). Given this unfair comparison, the fact only 3 un-blinded measures found an advantage for Ritalin is telling. At the same time, 64% of MTA children were reported to have adverse drug reactions: 11% rated as moderate and 3%, severe. At 36 months, treatment groups did not differ significantly on any measure (Jensen et al., 2007). Decreases in growth in medicated children averaged 2.0 cm and 2.7 kg less than not medicated groups, without evidence of growth rebound at 3 years (Swanson et al., 2007).

In March of 2006, a safety advisory committee of the FDA urged stronger warnings on ADHD drugs, citing reports of serious cardiac risks, psychosis or mania, and suicidality. The FDA elected to forgo a black box warning for most ADHD drugs, choosing instead to highlight risks on the label and include information with each prescription.

Children and Antipsychotics

The APA Working Group found that studies supporting the use of antipsychotics to treat children were plagued with methodological limitations. Consider the NIMH funded Treatment of Early Onset Schizophrenia Spectrum Disorders (TEOSS) (Sikich et al., 2008). TEOSS sought to examine the efficacy, tolerability, and safety of two second generation antipsychotics (SGA) (risperidone or Risperdal and olanzapine or Zyprexa) for youths diagnosed with early-onset schizophrenia spectrum disorder and to compare these to a first generation antipsychotic (FGA) (molindone or Moban). At the end of eight weeks, the response rate was 50% for those treated with Moban, 46% for Risperdal, and 34% for Zyprexa. Participants in the study were allowed concomitant use of antidepressants, anticonvulsants, and benzodiazepines, compromising even these disappointing findings. A 17-year old boy committed suicide and an unspecified number of participants were hospitalized due to suicidality or worsening psychosis. These events are particularly disturbing in light of the fact that youths considered at risk for suicide were excluded from the study. Weight gain was deemed serious enough to warrant suspension of the Zyprexa arm. Adverse events were "frequent" in all three groups. Only those youth who "responded" during the initial eight weeks – 54 of the 116 – were entered into the 44-week maintenance study (Findling et al., 2010). Forty of the 54 youth dropped out during this period because of "adverse effects" or "inadequate response." Thus, only 14 of the 116 youth who entered the study responded to the medication and stayed on it for as long as one year – only 12%.

A Critical Flaws Analysis

The former editor of the *New England Journal of Medicine* called attention to the problem of "ubiquitous and manifold . . . financial associations" authors of drug trials had to the companies whose drugs were being studied (Angell, 2000, p. 1516). Given the infiltration of industry influence, discerning good science from good marketing requires a willingness to en-

gage primary source material, and a critical flaws analysis.

Flaw # 1:
Compromises to the Blind

Fisher and Greenberg (1997) assert that the validity of studies, in which a placebo is compared to an active medication, depends upon the "blindness" of participants who rate the outcomes. They note that inert sugar pills, or inactive placebos, do not produce the standard side effect profile of actual drugs—dry mouth, weight loss or gain, dizziness, headache, nausea, insomnia and so on. Since study participants must be informed of the possibility and nature of side effects in giving consent, they are necessarily alert for these events, enabling them to correctly identify their study group. In addition, interviews that listen for or elicit side effect information easily reveal active versus inactive pill takers, effectively un-blinding the study for clinical raters and skewing results. Moreover, many trial participants in placebo groups have previously been on drug regimens, even some just prior to entering the trial, and are therefore familiar with medication effects. All of the studies described above used inactive placebos or none at all.

Flaw # 2:
Reliance on Clinician Measures

In the Emslie studies, the MTA, and TADS, client-rated measures found no difference between the placebo and SSRIs and among the conditions in the MTA. The lack of endorsement of efficacy by clients in clinical trials begs the question: If clients don't notice improvements, how significant can those rated by others be? In addition, clinician-rated scales are often categorical, allowing a subjective range of responses to participant interviews and potential bias due to compromised blind conditions. Moreover, continuous data are often converted into discrete categories (e.g., response and non-response), further magnifying differences (Kirsch et al., 2002). Finally, some clinician-rated measures tilt toward specific domains of discomfort that favor the investigative drug, potentially distorting findings. For example, measures in antipsychotic trials, like TEOSS, favor medications with sedative properties and many trials add sedatives or use drugs with sedative effects (Moncrieff, 2001).

Flaw # 3:
Time of Measurement

Psychiatric drugs are often prescribed for long periods of time. This suggests that most clinical trials, which last for 6 to 8 weeks, are not measuring how well the drugs do in actual settings or the long term side effects. Additionally, differences between medication and other treatments or placebo groups often dissolve over time (Fisher & Greenberg, 1997). Without longer term follow-ups, conclusions about effectiveness in real life cannot be determined. Authors of many short-term clinical trials fail to discuss time-frame limitations or to modify accordingly claims made in conclusions. For example, Emslie et al. (1997), an 8-week study, concluded that "fluoxetine in 20 mg/d is safe and effective in children and adolescents," (p. 1036) without mention of time. The MTA, TADS, and other studies show that differences with non-drug treatments tend to dissipate over time, and that initial effects of drug treatment must be weighed in terms of long term tolerability and impact beyond symptom remission. The TEOSS one year follow-up of only 12% showing benefit offers a dramatic example.

Flaw # 4:
Conflicts of Interest

Richard Smith, who resigned as editor-in-chief of the *British Medical Journal* because of rampant industry influence in academic research, explains that the number one aim of industry-sponsored trials is to find favorable results for the company drug (Smith, 2003). Most academic journals now recommend transparency regarding funding sources and author affiliations. With these as caveats, readers can approach the study with a warranted skepticism and a more careful analysis of trial methods and conclusions. The 1997 Emslie et al. study, published prior to disclosure requirements, did not identify author affiliations. Emslie et al.'s second fluoxetine trial for child and adolescent depression (Emslie et al., 2002) lists author affiliations on the first page. Here, readers learn that Emslie and Wagner are paid consultants for Eli Lilly, who funded the research and whose product was being investigated. The remaining six authors are listed as employees of Eli Lilly and "may own stock in that company" (p. 1205).

Flaw # 5:
Minimization of Risks

Many psychiatric drug studies downplay or fail to assess adverse drug reactions. As a result, rates of side effects may be substantially under-reported (Safer, 2002). Instead of detailed tables, adverse events may be described in a narrative rather than tabulated formats (e.g., Emslie et al., 1997). Authors of trials often confidently assert that the drug is safe when the data, in fact, show otherwise. In a study of Risperdal with youth diagnosed with disruptive behavior disorders (Reyes et al., 2006), the literature review asserts that "Risperidone has consistently demonstrated efficacy and safety in both controlled short-term and open-label long-term studies" (p. 402). Five studies are cited to back this claim—two short-term (Aman, De Smedt, Derivan, Lyons, & Findling, 2002; Snyder et al., 2002) and three, longer-term (Croonenberghs, Fegert, Findling, De Smedt, & Van Dongen, 2005; Findling, Aman, Eerdekens, Derivan, & Lyons, 2004; Turgay, Binder, Snyder, & Fisman, 2002).

The two short-term trials showed significant differences between the Risperdal and placebo groups for key adverse events: somnolence, elevated serum prolactin (for boys), and weight increase. The three longer-term studies were open-label extensions of the shorter term trials and examined the long-term efficacy and safety of Risperdal in children ages 5 to 12 with lower than average IQ scores. In all three trials, the top reported adverse event was somnolence, ranging

from 20.6% to 51.9%. Weight gain was another frequently reported problem (from 17.3% to 36.4%). The pattern of increased prolactin levels was observed across the three trials. Five participants in Croonenberghs et al.'s study required antiparkinsonan medications, six withdrew due to EPS, and two developed tardive dyskinesia, while 26% of participants in Turgay et al. experienced EPSs. *Overall, 76 of the 77 participants in Turgay et al. reported adverse events, close to 92% in Croonenberghs et al., and nearly 91% in Findling et al.*

Yet, the authors of all 5 studies report the drug's safety: "generally safe" and "well tolerated" are found in every abstract and conclusions section for all the studies. The claim that "risperidone has consistently demonstrated efficacy and safety" (p. 402), with the five studies reviewed here as evidence is, at best, misleading, and at worst a rhetorical construction revealed only via examination of the data. The problems of sedation, weight gain, increased serum prolactin, and movement disorders have been effectively swept under the rug, and the efficacy and safety case, over time, becomes undisputed (Sparks, Duncan, Cohen, & Antonuccio, 2010).

Conclusions and Recommendations

The clinical trial evidence does not justify current prescribing practices and is antithetical to evidence based medicine. While pharmacotherapy involves considerable risk for young people, psychosocial interventions have a strong track record with virtually no adverse associated medical events, leading the Working Group (2006) to conclude their massive review with the recommendation: "Thus, it is our recommendation that in most cases, psychosocial interventions be considered first." (p. 16.)

This conclusion, however, does not eliminate medication as one choice among many but rather frees health and pastoral professionals to put other options on the table and draw in the voices of those they serve: to engage in a risk/benefit discussion and help families choose treatments in concert with their values and cultural contexts, including Church and community – thereby enacting the call of EBM to integrate the best available research with patient preferences.

Where children are concerned, the stakes are higher. They are, essentially, mandated patients—most do not have a voice to say no to treatments or devise their own, and depend on adults to safeguard their wellbeing (Sparks & Duncan, 2008). Moreover, poor children often have fewer adults watching over them and are vulnerable to dangerous drugs used as interventions of control rather than therapy, and therefore require more care to ensure equitable treatment. The evidence demands that the trend of rising prescriptions and lower psychosocial intervention be stopped and a higher standard of care implemented: 1) psychosocial intervention should be considered first—families and youth should have a voice in decisions about their care, especially the disenfranchised; 2) no off label prescribing; 3) no polypharmacy; 4) immediate separation of the pharmaceutical company influence from science and practice; and 5) monitoring treatment response with patient rated measures.

The belief in the power of chemistry over Church, community, social and psychological process – fueled by unprecedented promotion from the drug industry that targets all players in health care – forms the basis of pharmacology's growing centrality in treatment, research, training, and practice. It promotes prescriptive treatments of questionable sustainability, fraught with potentially dangerous effects, often aimed at those most unable to refuse. This presentation called for a higher standard of care for our most vulnerable and precious commodity, our children, that invites unity among all concerned health and pastoral professionals. It is time to no longer accept prescriptive practices that do not follow the evidence and increasingly put clients at perilous risk for serious health consequences, dependence, and disability.

The Catholic Church, in addition to spiritual leadership, has a rich history of benefiting humanity, comforting and empowering the frail and disenfranchised, protecting the sanctity of human life, and strengthening families. The Church and her vessels hold great international influence and perhaps may be the only power on earth that can counter the forces of corporate greed that have no moral or ethical conscience. The Church, via FIAMC, Catholic Medical Associations and Catholic hospitals, Catholic schools, Catholic Church communities, the Catholic media, in conjunction with bishops, priests, and sisters in religious communities, can assist individuals and families in need of guidance/education in alternatives to medication as well as the appropriate risk/benefit discussions regarding the use of medication.

For there to be social justice and equitable care for youth, health professionals, pastoral workers, and families need access to accurate data – to the truth untainted by corporate influence. The risks presented here as well as the dangers

of psychotropics emerging with other vulnerable populations (e.g., birth defects and spontaneous abortions in pregnant women on antidepressants; increased heart attacks and strokes in the elderly with dementia on antipsychotics), offers a call to action to all of you attending this conference. Although a clinical trial will never address it, the use of psychiatric drugs in paediatrics begs yet another question: How much do these drugs interfere with spirituality, the voice of the soul, and one's ability to commune with the Divine?

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BONIFACIO HONINGS

The Blessed Don Carlo Gnocchi: a Heroic Figure of Charity of our Time

I have the very pleasant task of presenting, within the context of the subject of this international conference on '*Caritas in veritate*: Toward an Equitable and Human Health Care', one of the heroic figures of charity of our time – the Blessed Don Carlo Gnocchi. Ennio Apeciti characterises the figure of Don Gnocchi with the following words: 'he loved them to the very end'. These are the words of the solemn introduction to the Last Supper of Jesus with his apostles. 'It was now the day before the Passover Festival, Jesus knew that the hour had come for him to leave this world and go to the Father. He had always loved those in the world who were his own, and he loved them to the very end' (Jn 13:1). The commentators of this beginning of the Gospel of love according to John observe that from Chapter 13 until chapter 15 – that is to say until the end – the tandem 'light, darkness' disappears whereas the verb 'to love' and its derivatives are to be found thirty times. St. John thus seeks to emphasise that the Eucharist refers to love, presupposes it, and is its completion. By this change to the tandem 'love-life', the Evangelist makes clear that the gift of life that Jesus makes to his disciples, to men, because 'God loves them', is the crowning, the summit of the whole of a life, of the whole of his life'.[1]

The Saints: Witnesses and Ministers to Hope-Love

Ever since Jesus revealed this tandem of love and life, it has been incumbent for it to be repeated, to be shouted out aloud, in order to give human beings what they constantly need: the strength to hope which in its turn makes them able to love. To this need for a loving hope blessed and saints have known how to respond as witnesses and ministers. As witnesses, because Jesus did not come to offer a doctrine but to offer a life that 'speaks' of what one believes, hopes and loves. As ministers because they place themselves at the service of the dream of God, to bring it to every brother and sister of theirs, to every human being. Ministers and not so much teachers because not only do they bring the words of he who alone is the Teacher – they also bring him, he who is living and real, in the Bread that is broken and the Wine that is poured. Amongst these 'blessed witnesses and ministers' has been since 25 October 2009 also Don Carlo Gnocchi, an Ambrosian priest, who like his Lord and Teacher wanted 'to love to the very end'. And he managed to do this.[2] It is thus helpful to know him and to draw near to him in order to learn from him the path that heads to the Light, to that Dwelling where there are no longer any tears but only joy and peace, forever. To that Dwelling where the heroic figures of charity of all epochs live, including those of our time, such as Don Carlo Gnocchi. At the outset I would like to describe him as he was on the pathway of pain which led him to the priesthood.

A Convinced Priest at the School of Pain

Carlo was born on 25 October 1902. He was the third child of Enrico Gnocchi, a marble craftsman, and Clementina Pasta, who spent her time between working as a seamstress, looking after her children, and her intense and sober love for her husband. Theirs was a serene family solid in faith. At that time this was no small achievement: the society in which they lived or at least 'legal society', which lived in the corridors of power, of government and of parliament, had for some time and in various ways, sought to 'destroy' the family and its meaning, its way of being. Carlo was baptised in the Church of San Colombano in Lambro five days after his birth, on 30 October 1902, and was called 'Carlo, Fortunato, Domenico'. He received his confirmation

on 19 May 1911 in the parish of Santa Eufemina in Milan. This change of setting is not without significance because of the singular experience of pain of the little Carlo. Indeed, the life of Carlo was soon marked by pain. When he was still five years old he lost his father who died on 9 April 1907 of silicosis. The difficulties encountered in living in San Colombano for a widow with children led the family to move. His mother Clementina was helped by her sister who lived in Montesisto near Bressana Brianza and she began to

spend long periods in that place which seemed to strengthen the lungs of her first child, Andrea.

Carlo was a promising child in his life and at school, above all after attending the school year of 1914-1915 of his second '*ginnasio*' – today we would say upper secondary school – which was run by the Salesians in Milan. He never forgot their educational impact. In order to illustrate whom he based himself on in the development of his Work he explained many years later (on 7 January 1949): 'in the search for funds for the lives of my poor people (invalids with major disabilities, orphans, mutilated children, those with bad housing) I tried to base myself more on Don Bosco than on Cotolengo'. But his house companion, pain, had also moved to Montesisto, because on 3 August 1951 Andrea also died, He was twenty years old, given that he had been born on 25 March 1898.

However, it is was precisely this companion that had a determining reason to exist in his life. For some months Carlo had convinced his mother to allow him to enter the seminary so that he could fulfil a dream, a dream that he had had for some time, and to placate the wish that he had always felt in his heart. But how could he leave specifically at that moment? His mother would have been left alone. In those circumstances he was a teacher of Christian charity and supernatural prudence. When writing to Don Luigi Orione, to whom he was bound by sincere affection, it was no chance that Carlo observed: 'She was an exceptional mother' and to the Dames of St. Vincent of the Conzaga Institute he added: 'I feel every day more her strong love, her silent devotion to duty, her Christian holiness'.[3]

After these praises for his mother who was opposed to him entering the seminar, and above all after the dramatic events of the death of his father and of his brother Andrea, it is interesting to know why Carlo wanted to become a priest. He had the good fortune, or better the grace, to meet Andrea Carlo Ferrari, the holy bishop and future Cardinal of Milan. As soon as his appointment was made known, the newspaper *La Sera* declared on 14 February 1894: 'Msgr. Ferrari belongs to that most terrible category of priests, the category of *convinced priests*. He knows that with sweetness one can also tame tigers and thus he is sweet; he knows that with tenacity one can also perforate mountains, and thus he is tenacious. But he never gives himself away and never forgets his goal'. In a paper that he gave on 23 April 1895 Cardinal Ferrari said: 'the future is a Christian science, of gospel brotherhood, of religious light'. Now, Carlo Gnocchi wanted to be a priest of that category of convinced priests that never surrender to the powers of evil and always use sweetness, tenacity and charity. He always wanted to be an optimistic priest convinced that victory was on the side of good. This is why Carlo did not rebel against God but wanted to enter the seminary to become a convinced priest, for the Church in the world of his time.

A Priest in the Church of his Time

Don Carlo became a priest during the Holy Year of 1925 and more precisely on 3 January when everything pushed towards holiness as a 'norm' of the style of life of priests. This was a time of courage and of hope. It was no accident that Pius XI, immediately after his election as the Bishop of Rome (6 February 1922), wanted to appear for his first blessing *Urbi et Orbi* not within the Basilica of St. Peter's as had been done since 1877 but outside it, where the Pope always appeared (and appears). He wanted to give the Holy Year of 1925 a clearly missionary impress. Indeed, he wanted an exhibition on missions to be created for that Holy Year. It was so beautiful that it was never taken down and became the present 'Ethnological Missionary Museum' of the Vatican Museums. The year 1925 was to be a year of hope and a historic period for Christians. For this reason Pius XI marked it by an impressive and valuable series of canonisations from Teresa of the Baby Jesus to Pietro Canisio, and from Maria Jean Vianney, the curate of Ars, to Jean Eudes. He returned to this eight years later during the first Holy Year of Redemption of 1933 by canonising other figures: Bernadette Soubirous, Giovanna Antida Thouret, John Fischer, Thomas More, Alberto Mago, Giovanni Bosco, and Giuseppe Benedetto Cotolengo. There is a red line that they all share. They are all saints who lived through difficult times. But they did not become disheartened, indeed they were in granite fashion faithful to terrible daily life, transforming the hardship of the times into intense and hard-working charity that changed the societies in which they lived. Charity always wins. Indeed, this is the truth of charity or charity in truth.

For this reason, Pius XVI wanted to exhort people to hope, educating the faithful, priests and seminarians – like Don Gnocchi – to expand the horizon of their faith and their Christian experience. For this reason on 28 October 1926, the first anniversary of the Holy Year, he ordained the first six Chinese bishops and one Indian bishop. The next year, on 30 October 1927, he ordained the first Japanese bishop. The same hope led him to ordain four unnamed bishops for Russia. The epoch when the Church was barricaded in the peripheral peninsula of Europe (certainly glorious as regards its history but peripheral as regards its location) was over. The Church had, and had, as its horizon the whole world, and Pius XI did everything to open people's eyes as regards that great reality which allowed people to trust in the future and not to be resigned registrars of a sunset that could never take place and can never take place.[4] Don Carlo Gnocci was truly one of these people who trusted in the future and he was certainly not the resigned registrar of a sunset. He was a priest who loved God and men.

A Priest who Loved God and Men

Don Carlo answered '*Adsum*', 'here I am', to the call to the rite of priestly ordination because he loved the age that God had given him to live in. In his work entitled

'Education of the Heart' he wrote: 'We love with a jealous heart our time, which is so great and so discouraged, so rich and so desperate, so dynamic and so pained, but whatever the case always sincere and impassioned. If we had been able to choose the epoch of our lives and the field of our struggle, we would have chosen the twentieth century without hesitating for a second'. In the tragedy of the war on the Russian front he was led to think anew about the Letter to the

Hebrews on the 'High Priest' 'chosen from his fellow-men and appointed to serve God on their behalf, to offer sacrifices and offerings for sins. Since he himself is weak in many ways' (Heb:1-2). These words inspired his ministry. Indeed, he confessed 'when I manage to share my life fully with the alpine troops, then, moving out of the ranks for the Holy Mass held in the field I seem to taste and to love like never before the fullness and the rich truth of the definition 'the priest is chosen from amongst men and appointed to serve God on their behalf'. And if I am not wrong, I seem to see on the male faces of my people a tenuous smile of satisfaction and pride. As though one of them were chosen for everyone, to go up to the altar and offer the sacrifice of everyone to the Almighty God'. Don Carlo, who loved God and men, was always a great optimist and enthusiast as regards his epoch and his priestly vocation.

In his work 'Go and Teach' he regretted not being a poet 'because I would like to raise up on the powerful wings of poetry the humble figures of our assistant priests, these obscure and unknown infantrymen of the trenches of Christ who consume the burning torches of their youth in order to bring light in the world to so many young groping hearts who provide yeast through the greatness of their sacrifices to the generations of tomorrow, unknown and broken by the world, but great before God, *who animates their youth*'. To sum up: Don Carlo placed his hands in those of his archbishop, Cardinal Tosi, and bent his head under those hands that consecrated him because he was convinced that there is no greater form for a human being than to be a priest, a minister of love for his brothers out of love for God.[5]

A Priest who was Mature for Works of Charity

The choice of the lifestyle of a priest of charity was a wish in the heart of Don Carlo. It had grown slowly during his years of pastoral ministry amongst the young people of Cernusco and San Pietro in Sala, amongst the young members of the Balilla and the students of the GUF and at the side of the young people of the Gonzaga Institute. It was a wish that had been very strongly expressed during war when he had heard as though it was a 'divine voice' the need to leave as a military chaplain first for Albania and Greece and then for Russia. This was a 'voice' which had become even more precise and stronger when he returned from the first period of war at the Greek-Albanian front from which he had been recalled as a result of the pressures applied by his brothers of the Gonzagna College. After four months the 'voice' made itself heard with such intensity as to lead him to ask Cardinal Schuster to be able to return to the front because it seemed to him that that was the field of charity to which he was called in concrete terms at that moment. Then he added: 'I wish that the Lord after the end of this war would make me see things more clearly and assign to me a job in this chosen sector of the apostolate'. At this point it is important to make clear that his chosen apostolate was not military service but the field of charity. Of determining importance in his journey as a priest of charity was his experience at Gonzaga College, not only because of the educational aspects but also and above all else because of his so much wished-for vocation to charity.

In particular, it was his experience of the Dames of Charity of St. Vincent. He himself said: 'The 'Dames of Gonzaga' group was working with you when I felt irresistibly led to dedicate myself so much to a work of charity which I am happy about today, albeit serving it unworthily'. While he was marching towards Greece he repeated to the Dames of Charity of St. Vincent: 'How much good in life and how much security in death is given to us by doing something good for the poor of Jesus or better for Jesus in the poor'. Even more incisive is what he wrote to these Dames on the occasion of the feast of St. Vincent de Paul (19 July 1941): 'You should know how in recent days the Lord has made me understand – for me but also certainly for you – that it is not enough to work, to engage in charity, it is necessary first of all and above all else pray for charity. It is from him, from the Holy Spirit, that charity comes to our hearts, that charity of which the world and our souls have so much need to be saved'. And he ended as a priest who was mature enough for his

works of charity: 'It is therefore of the Holy Spirit that with insistence, I would say in a overbearing way, one should ask for the increasingly abundant diffusion in our minds of the luminous visions of charity and in our troubled hearts the sweetness of the love of God for our brethren'.

Don Carlo was by now a mature priest of charity. In the summer of 1942 he wrote to the Dames: 'Nothing is difficult for the Lord if we have faith and do our best'. 'The Lord will attend to the work of the Lord and initiatives will be gradually suggested and blessed by him directly'. 'Works of charity are of the Lord and he will take care of making sure they progress…One must have a steady faith in him who will complete a work that is born in his name and for his glory. We are certain of this and we will work'.[6] Don Carlo acted and worked above all else as a pedagogue of innocent pain.

The Pedagogies of Innocent Pain

He wanted his guests to experience not only charity that looks after and serves with love but also that charity that provokes and challenges and promotes. He wanted charity of the heart to be accompanied by charity of science. In order to understand at a deeper level this pedagogic wish of his we are helped by his meditation '*Suscipe, Sancte Pater hanc immacultam hostiam*'. Published after his death with the title 'Pedagogy of Innocent Pain', it became his public *testament*. 'After the explosion of a bomb, Marco, the only survivor of four children who in ignorance and without a care in the world were playing in the mine field, immediately underwent a surgical operation. Both his legs were amputated, his eyeball was removed, and the large and numerous wounds which racked his fragile palpitating body were dealt with…I saw him a little time after the operation when the daily medication made him suffer a great deal and I asked him: "When they take off your bandages and put their fingers in your wounds and make you cry whom do you think about?" "About nobody", he replied with an element of amazement in his voice. "But do you not think that there is Someone to whom you could perhaps offer up your pain, for love of whom you could repress your lamentation and swallow your tears and who could also help you to feel the pain less?" Marco stared with his devastated face into emptiness, looking with his only good eye, and then, slowly shaking his head, said "I do not understand" and went back to playing idly in a distracted way with the edge of his sheet. It was at that moment that I had the precise almost physical sensation of an immense irreparable misfortune of the loss of a very valuable treasure, which inwardly was much more painful than the burning of a painting by Raphael or the destruction of a diamond of inestimable value. It was the great innocent pain of a child who was falling into the void, which was useless and without meaning, lost in supernatural times for him and for mankind because not directed towards the only goal where the pain of an innocent person can lose value and find justification: the crucified Christ. And through all those hospital beds, in those suffering children, and through them all the suffering children of the world (what a Mass of pain was imposed on children during the war and in those tragic years of tormented peace!), I seemed to see expand inordinately this mad waste without Christian educators opposing it by perceiving the value of this pure treasure and the urgent need to recover it avariciously and make a gift of it to Christ and the Church'.[7]

The message of Blessed Don Carlo Chocchi is clear: pain finds its true meaning only in participation in the redemption of the crucified Christ. Here the question arises as to why Don Carlo chose mutilated children? The answer is simple: because he was answering the call of the Gospel. Indeed, our Saviour, although he was sent by the Father on a mission that was strictly supernatural, wanted to establish the incontestable signs of his messianic nature: 'the blind can see, the lame can walk, the deaf hear, those who suffer from dreaded skin diseases are made clean, the dead are brought back to life and the good news is preached to the poor' (Mt 11:5). And he wanted in a tireless way to journey down all the roads of Palestine to look for and to welcome all the different kinds of sick and suffering people in order to apply to them that 'force which went out from him and healed them all' (Lk 6:19). And this is why in the decalogue of the apostolate, outlined for those who were to actualise redemption down the ages, he clearly and imperiously commanded: "Go, *heal the sick* and proclaim to them that the Kingdom of God has arrived' (Lk 10:9). This need for charity and gospel love led Don Gnocchi to the discovery of the face of Christ, the beloved of God and men by definition. And with this I will end.

Discovering the Face of the Crucified Christ

The Blessed Don Carlo Gnocchi offers us a page in which he describes his discovery of the face of the Crucified Christ. 'Willingly or otherwise, we are all of us men on the earth, troubled, impassioned and never sated searchers for the face of God. At the bottom of every faith, even the steadiest and most compact, it is easy to find the audacious impatience and the feverish search for the Named One: "God, God, God! If I could see Him. If I could hear Him". The vast and solemn pages of the Bible implore 'Show us your face O lord'. They stubbornly propose: 'Always look for the Lord, always look for His face'. They longingly

sigh 'When will I come to see your face, O Lord'. I, too, have always looked for signs of Christ on the earth with an avid and insistent hope and I was resigned to seeing his look flash in the chaste and saved eyes of small children and in the pale and tired smiles of old people, already illuminated by the peace of remote and sweet regions. I had tried to hear the accent of his voice in the painful and equal speech of the poor and the afflicted and it seemed to me that on a number of occasions his light shadow had touched me during the twilight of the dying. Those eyes anxious for light, that face furrowed by pain, that troubled weight of breathing, were things that were so much 'his'…But these were only different and distant aspects of your face, O Jesus, and I was not able to make them into a form with permanent unity. Perhaps it was necessary for the great hour of war to strike. The hour of your most acute agony, O Lord. And yet the hour of your irresistible manifestation to the world. He was a gravely wounded men and was already near to dying. When I duly carefully took off his jacket, his shirt was atrocious and covered in blood, which like a liquid and living veil bound and made shining his vigorous limbs. Without speaking he looked at me. His eyes were full of pain and pity, of a strong will and childlike sweetness. The light of blessed and distant visions trembled, slowly decreasing, in the background. Like a child that was gradually falling asleep. Jesus could not have looked down in a different way from the cross. That clear and manly face of the alpine soldier. Under the dark frame of dishevelled hair and with the very convenient ornament of an uncut beard, he spoke such a virgin and strong pain, such a conscious and modest offering, such a humble and regal dignity, such a discreet request for compassion and help, that I suddenly experienced the joyous and intense trembling of Veronica when she saw the miraculous face of Christ emerge on her white and folded linen. From that day, my exact memorial of an irrevocable encounter, I was instinctively guided to discover the characteristic signs of Christ under the essential and deep mask of every man shaken and made naked by pain'.[8] Dear Blessed Don Carlo Gnocchi intercede for all of us so that everyone, in their own way, can actualise redemption through our epoch, and so that your precious mutilated children can give themselves as a gift to Christ and his Church!

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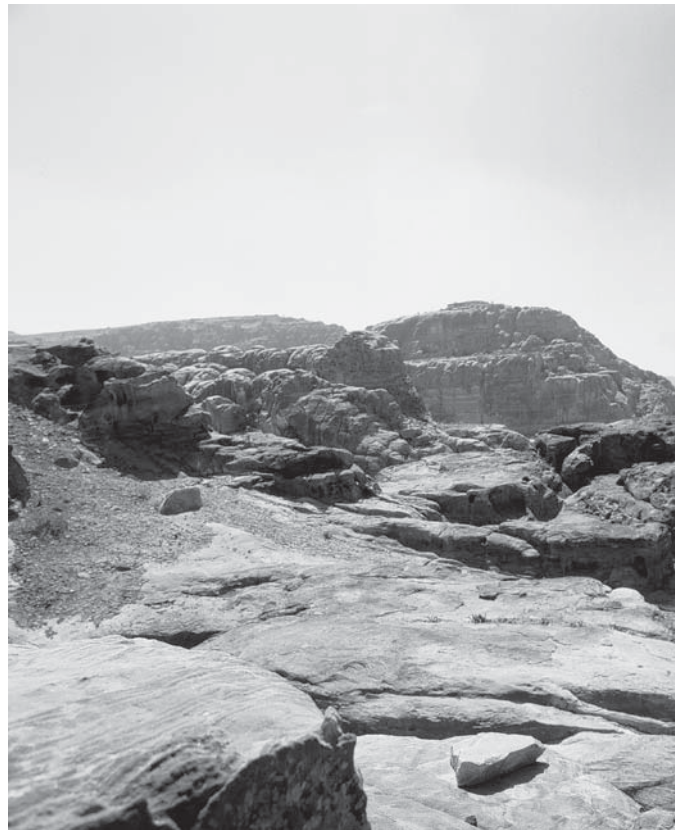
Notes

[1] ENNIO APECITI, *L'amò sino alla fine. Vita di Don Carlo Gnocchi* (Centro Ambrosiano 2009), p. 5. I have drawn much on this study to describe the figure of our Blessed.
[2] *Ibid.*, p. 13.
[3] *Ibid.*, pp. 19-20.
[4] Cf. *ibid.*, pp. 67-69.
[5] Cf. *ibid.*, pp. 69-70.
[6] *Ibid.*, pp. 114-115.
[7] *Ibid.*, pp.161-162. .
[8] *Ibid.*, pp. 138-139.



ANNA BRZEK

An Example of Heroic Charity of our Time: Sr. Marta Wiecka, a Daughter of Charity of St. Vincent de Paul

24 May 2008 was the day of the beatification of Sr. Marta Wiecka and this took place in Lvov, in the Ukraine. Cardinal Tarcisio Bertone, in his homily of beatification, addressed the following words to the Daughters of Charity and to the lay medical personnel that were there: 'The Blessed Sister Marta Wiecka generates in you solicitude, care, and dedication to those people who suffer in illness. Man is body and spirit: in caring for the pained physical do not forget that to achieve true and deep healing of the whole of man it is indispensable to bear in mind the spiritual needs of the human creature as well. How important, therefore, for the sick and suffering, is their encounter with God! How important it is for the culture of life and love always to be defended and promoted, effectively opposing the culture of death with its sad and worrying expressions, amongst which I will confine myself to citing the increase in abortions and in cases of euthanasia. This humble sister from Sniatyn, who today dwells in heaven amongst the Blessed, launches to all of us a hymn to Life, she exhorts us to love human life and to defend it at all its stages, from conception until its natural end'.

Who was this young Daughter of Charity who, in an act of heroic charity, gave her life for another person, at the age of just thirty, and twelve years after her vocation? She was born in 1874 in Poland, in Nowy Wiec in Pomerania. At the age of eighteen she entered the Company of the Daughters of Charity of St. Vincent de Paul, in Krakow. The hospital of Leopoli was her first destination. The sisters of her community taught her to care for sick people and to draw near to them, that is to say to see the suffering Christ in their persons. The founders of this Order, St. Vincent de Paul and St. Louise de Marillac, continuously laid stress on the fact that the vocation of the Daughters of Charity was to serve all sick people at a corporeal and spiritual level. In drawing near to sick people, these sisters were not to be hurried in their approach, but were, rather, to express a great deal of affection for them, to speak to them and to serve them with all their hearts. Sr. Marta had kept these recommendations in her heart and implemented them throughout her whole life. Subsequently, she was sent to the hospitals of Podhajce, of Bochnia and, lastly, of Sniatyn. After Christmas eve, which she spent amongst the sick of her hospital, she wrote: 'I have spent these days with my dear sick people in serenity and in a pleasant way, praying and singing with joy near to the crib'. St. Marta felt real joy in serving sick people. The director of the hospital of Sniatyn observed: 'She had the gift of influencing her entourage. She generated in others, in the sisters, in the personnel and in the medical doctors, the desire to care for the sick in the best way possible'. She served them all, without caring about their nationalities or religious confessions. She had the extraordinary charism of perceiving their spiritual needs. In her service, nobody died without first being reconciled with God.

The final event of her brief life was a heroic act of charity towards her neighbour. Like Fr. Maximillian Kolbe, she gave her own life for another person, a clerk in the hospital, a father with a family, when she took his place when the disinfection of a room had to take place. She contracted typhus and died on 30 May 1904. Public opinion saw her death as a sacrifice born out of heroic love for her neighbour. Her funeral was an expression of gratitude by people of different nationalities and confessions who perceived in her the *saint of Sniatyn*.

The message that Sr. Marta hands down to us is not that a message of words but a message of actions. The cult that continues to be alive after a hundred years talks to us about the prophetic power of her witness. It should be emphasised that the political events of her epoch were not at all propitious for the conservation of the memory of the heroic life and the death of Sr. Marta Wiecka. In 1920 the war between the Poles and the Bolsheviks forced the sisters and other people to leave Sniatyn. In 1945 the borders and the political forces in Europe underwent a series of changes. The territory of eastern Galicia was annexed by the USSR. The communist system forced people to deny their faith, and especially the Catholic faith. As a consequence, a very large number of people were put in prison and deported to Siberia. Churches and crosses were destroyed and hospitals were devastated.

In this context, it is admirable to record that despite the absence of the Daughters of Charity from that region and the complex political situation, the cult of St. Marta remained alive. People did not fear the threats or the possible consequences of what they did and went to pray at her tomb. In moving letters of the epoch, written by members of the lay faithful, we read:

'people pray and light candles. An hour after midnight they are already at the tomb of St. Marta. One can easily say that here could be built not only a chapel – this place could also be transformed into a church'. Let us now listen to an excerpt from another letter: 'I returned from the Soviet Union… at the cemetery of Sniatyn there is the tomb of a Daughter of Charity, Sister Marta Wiecka, who is famous for her miracles. The graces obtained through the intercession of Sister Marta are many in number'.

And such remains the case today. The tomb of Sr. Marta attracts a large number of people: Catholics, Orthodox, Jews…We can say that it has become a modest ecumenical temple. It is always decorated with flowers, with lit candles and with traditional Ukrainian drapes. Thanks to the power of attraction of the witness of life of Sr. Marta, many people today ask for graces through her intercession. Many requests and expressions of gratitude reach here not only from Poland but from other countries as well. And then many people follow her example and decide to live according to the Gospel and its values, through, for example, devotion, self-giving, and sensitivity towards other people, without looking at their beliefs, seeing not only their physical needs but also their spiritual needs as well. This wish is expressed in a variety of ways, for example through the decision to name the public hospital of Bochnia after the Blessed Sister Marta Wiecka. The ceremony for this took place this year. Or by naming the primary school of Skarszewy after her; or by the building of the 'Blessed Sister Marta Wiecka' Social Centre in Sniatyn; or by the creation of prayer groups.

A question arises, namely to know whence such a power and the very great constancy of her witness come. Perhaps people see in her the embodiment of charity, that is to say the essence of the Gospel. In reality, *love* is what most unites believers, and it is also what is important in the care that is provided to sick people. It is impossible to understand the charity of Sr. Marta towards her neighbour without believing that her life was entirely entrusted to the love of Christ the Spouse. How much, today, do we need to refer to Christ and to be aware of the fact that in Christ every man is our neighbour!

Today, the Blessed Sister Marta calls us to bear witness to unity amongst us in the Church and in the world and to participate actively in intercultural and inter-religious dialogue. She also invites us to see not only the corporeal needs of sick people but also the needs of their souls. She encourages us to love and to serve sick people following the example of Christ, to the utmost, to the point of giving our own lives.

Blessed Marta, pray for us!

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PASCUAL PILES FERRANDO

Welcoming: a New Paradigm of Humanisation

1. Introduction

The peoples of the world, with their various cultures, have always made welcoming one of the attitudes that has most characterised them and something that they have demonstrated is a value of their way of being and living.

When they have acted, the response that has spontaneously sprung from their hearts is that of marking themselves out by their hospitality.

When this has not taken place, there was something that justified this, such as, for example, the defence of their own identities or wars with other peoples in order to defend their own territories or because of ambitions involving power.

All religious traditions have been marked by this approach which is the outcome of consistency between one's own creed and one's own way of living.

Hospitality derives from the concept that one has of God as Mystery, as the Almighty, but also as the Father who has loved His children and asks love and respect from them.

This ennobles our being human, independently of the fact that on many occasions we have distanced ourselves from this concept. Wars, holocausts, exclusions, injustices, abuses, murders, differences in the distribution of wealth etc. are all expressions of a lack of hospitality, of a lack of conscience and a lack of fighting for the dignity of each person.

1. Hospitality in Biblical Language

It is impossible to make a list and engage in an analysis of what hospitality meant in times past and how it was received in a very precise way through the word of God.

There are any examples of action by the protagonists of the texts of the Bible in whose lives this value was present. On other occasions as well, through the description of anthropological categories in the figure of Jehovah, there appear in Him or in Biblical figures, attitudes of violence, of punishment and of war in which one clearly perceives the theologisation of historical realities as manifestations of the presence of God in the life of the People of Israel.

In the book Genesis we can already encounter a gesture of hospitality by Abraham towards three men who appear at his side at the oak tree of Mamre, Without knowing who they were, he invited them to draw near, to enter his home and to rest: he gave them fresh water so that they could be refreshed and he gave them food to eat and a place to sleep. Thanks to this gesture, Sara came to expect a child, even though on her part there was a response of incredulity and irony (Gen 18).

Moved by Jewish hospitality, Tobit welcomed the archangel Raphael and entrusted him with the mission of accompanying his son Tobias; with this, blessing descended on his house and he was cured of blindness (Tob 5 and ss).

The Book of Job, who is a symbol in Biblical theology of the reality of suffering and an expression of human frailty, abandoned the belief that suffering had to be linked to a moral cause, brought about by bad behaviour by a person, without condemning him, therefore, to a punishment by God, which puts the faith of believers to the test but with their trust makes them grow in humanity, in trust and justice. Chapter 31 is in praise of hospitality. The life of Job is founded upon law, upon justice and upon mercy for the less favoured: the weak, orphans, the homeless, foreigners, etc.

The Incarnation of Jesus Christ is an act of hospitality. Mary is the protagonist of this when she receives in her womb the Son of God who from the moment of her '*fiat*' was to be her son (Lk 1:38).

The figure of Jesus of Nazareth is the figure of a very welcoming person: he welcomes, he listens, he understands, he respects, he invites people to change their lives, he encourages mercy, he bases his life on love for other people, and all this with wonderful pages of the gospels. We may remember, for example, the parable of the Good Samaritan (Lk 10) and the parable of the last judgement (Mt 25).

Jesus himself, at the beginning of his public life and his mission, when reading the Book of Isaiah in the synagogue, identifies with this to the full and feels called to be Good News with his words and his actions (Lk 4).

The letters of St. Paul refer to the importance of hospitality in their exhortations to practise hospitality. In his letter to the Romans (12: 9 and 13), St. Paul clearly urges that hospitality be given much consideration: 'Love must be completely sincere. Hate what is evil, hold onto what is good. Love one another warmly as Christian brothers and sisters… open your homes to strangers'. In the first letter to Timothy, he sees hospitality as being required in the lives of widows: 'a woman who brought up her children well, received *strangers in her home*' (1 Tim 5:10). He exhorts Titus to encourage bishops who are 'hospitable, and love what is good' (Tit 1:8).

Lastly, in the letter to the Hebrews he speaks about hospitality and exhorts his readers to embody

it: 'Remember to welcome strangers in your homes. There were some who did that and welcomes angels without knowing it. Remember those who are in prison, as though you were in prison with them. Remember those who are suffering, as you were suffering as they are' (13:2-3).

2. What Hospitality Consists of

Hospitality is a *positive attitude* which denotes a *quality* of our being. It is a personal, ethical and religious value. It is a concrete way

of understanding and projecting life, even though, in cases such as those that I have just referred to, it seems to be not very much cultivated, if not even lacking.

This attitude is expressed through welcoming, the capacity to listen, respect, service, humility, simplicity, tenderness, responsibility, solidarity, love, sensitivity, nearness, rectitude, justice… Francesco Tollalba defines it as 'welcoming the other, who is a stranger and vulnerable, to one's own home'. In the case of professional assistance, we could find new values that it contains and embodies. This is an expression of its greatness.

3. Hospitality as Charism

Many of our religious *Orders and Congregations* feel that they are enriched within the Church by this gift. We are not the only ones to have this gift but we refer to it as our charism. Hospitality is a universal gift that all believers can receive and which each believer can live according to his or her own identity: bishops, priests, men and women religious, and members of the lay faithful.

We define hospitality as a *gift that the Spirit has granted* to us and which enables us to engage in that *mission* which we are called upon to exercise in the *Church and in society*.

According to the doctrine of St. Paul we feel theologically touched by the Spirit which enriches us and makes us able to engage in a rather anthropological engagement. It requires of us concrete training which we must follow for the development of our mission.

But many other people, as well, can be *anthropologically charismatic*, professionals of care with their own qualities, with a sense of humanisation as a paradigm, which includes both the ethics of responsibility and respect for religious values and beliefs, even though these people may not believers. They also feel that they are called to engage in a mission within society because of the fact that they are persons or because of their profession.

Professionals, like ourselves, must develop this gift in order to have a sufficient training to be able to perform the mission to which we are called: as regards the service that is offered to those people who suffer, these professionals must be professionals who are competent (Benedict XVI, *Deus caritas est*, n.31). Theirs will be a style, a different way of doing things, because they will have made *of welcoming the essence of their lives*, but we also see them as being humanly and professionally trained, some of them in a Christian sense as well, for the practice of hospitality. With them we share a mission; with them we live life. In this sense can we state that hospitality for the Church and for society is a paradigm of humanisation.

4. Our Society Needs to Promote the Approach of Hospitality

We have witnessed many phenomena during our lifetimes. A radical change has taken place and we are living through an epoch of *great transformations*. Globalisation has meant that in many of our countries we live with people who come from different realities, and to such an extent that a high level of *interculturality now exists*.

This fact facilitates the experience of the phenomenon of religion in a plural form. Different ethnic groups today live together in the same cities and have different religious expressions which they defend as an experience of their own identities, thereby creating *inter-religiosity*.

There has also been a growth in autonomy and secularity. Not all the results of this have been positive, and to such an extent that some people think that the negative results have outweighed the positive.

In this world, as a paradigm of humanisation we must embody *hospitality as an ethical category* that illuminates our way of behaving.

We are a part of this society and within it we have been called to live and to be witnesses to the profound experience of our commitment to the Church: from Christ, from ecclesial traditions based upon love for God our Father, we know how to be at the side of people who suffer, doing this starting from a project based on the person which comes from the Gospel. We know how to have the same feel-

ings that Christ had, with condemnations and appeals in certain contexts, to act in a worthy way, and in other contexts with all of the love and understanding for those people who, because of illness or exclusion, are suffering. 'Despite the advances made in science and technology…Our times call for a new readiness to assist our neighbours in need' (Benedict XVI, *Deus Caritas est*, n. 30).

5. Complicity between Hospitality and Humanisation

It often happens that in our language we speak about the *complicity* of individuals and also of ideas. I believe that we can state the same thing about the two terms that are at the centre of my brief paper.

We have seen that hospitality is a gesture and an attitude, an instrument of the presence of God in the texts of the Old Testament that I have referred to. We have observed hospitality in the way that Jesus Christ behaved. It is also present as an invitation in the letters of St. Paul and in his letter to the Hebrews.

To make hospitality germinate in our beings makes us grow as people, it makes us human, it humanises us. Our society, our service of care, need humanisation. A famous phrase of our Superior General, Fra. Pierluigi Marchesi, written in 1981 in his document entitled 'Humanisation', exhorts us to engage in this way of living: '*Humanising ourselves to humanise*'. He wanted to bring to us a humanising force for our lives and he wanted to lead us towards care that is performed by placing the person at the centre of things. His phrases were: 'the sick person is at the centre of our lives' and 'the sick person is our university'.

In health-care hospitality we need approaches that define it, we need to achieve a process that makes us become people who implement a form of care that is human, that places the sick person who is in front of us, and his or her family, at the centre of our attention, which attends to the instruments employed, professionalisation, but which also attends to the fulcrum of hospitality, that is to say humanisation. 'The suffering person – every person – needs… loving personal concern…[the] love [of the Church] does not simply offer people material help, but refreshment and care for their souls, something which often is even more necessary than material support' (Benedict XVI, *Deus Caritas est*, n. 28b).

6. The Challenges of our Society in Performing the Task of Care

We know about the world in which we live; the advances that have been achieved; the relationship between faith and science and its implications for the world of assistance; the actions which with various criteria those who work with suffering people can engage in; and the effects that all of this has on the bioethical field. To try *to look after, to care for and to accompany* when one cannot heal; to help people *to be born and live with* dignity; to help people *die* with dignity; today all of this is the subject of great concern for us as a Church and for those who surround us: scientists, politicians, professionals of the service of assistance, patients, and family relatives of patients.

We are a part of this world and we wish to bring our hospitality to this world within the context of the Tradition of the Church, its Magisterium, beginning with the word of God and our presence as hospitality, which must be humanised. Through what we do we seek to be signs of the merciful and healing Christ for those who are near to us, doing good, evangelising, although we always find ourselves in a world in which this evangelisation, starting with the care institutions of the Church, becomes '*Ad gentes*'.

To discern how our daily presence can and must be today is our task. We want to perform this task like Christ who denounced but drew near; we want to perform it like Christ who at times kept silent but invited people with a benevolent look; we want to perform it like Christ who drew near to people who were not socially correct according to the religious criteria of the time but who proclaimed that they would be the chosen of the Kingdom of Heaven and for whom he wanted to be the bearer of living water, with his salvation which provided the real meaning of existence.

Those of us who engage in hospitality in our centres of care and assistance often feel that we are in a *frontier zone*. We have accumulated a great deal of experience from our services of spiritual and religious assistance; we have the testimonies of people to whom we have done good and who have communicated this by written or spoken words. We always feel happy to be the Church but we feel this in a particular way in these situations.

Probably we will not convert them to the real meaning of our faith but we will have drawn them near to God, whom they often with difficulty manage to see as their Father, as Truth, as Good, and to whom we wish to be witnesses. The Church in its Magisterium, certain of its statements, in the evolution of its criteria. We feel that we are a part of the Church and we love the Church as it is. But in our usual practice we at times feel called to discern motivated by the love of God which was expressed in Jesus Christ and involved in a mission that comes from hospitality which in my paper I have defined as being a *paradigm of humanisation*. We want to live charity in truth, truth that is enriched by the power of charity.

7. Conclusion

We feel pride at having been called by God through the gift of hospitality. With a great deal of enthusiasm we experience the fact of being the Church of mercy and trying every day to do good to people whom we did not previously know and whom illness, exclusion or immigration have brought to us.

For them we want to be humanised, near, understanding and professional hospitality. For them we want to be the presence of the Church of people who are a part of the Church and specifically by the Church feel pushed towards this mission. If only we could transmit the value of the contribution of Jesus Christ and his Church to their lives and to history in general!

At every moment we want to reconcile *truth*, *good* and *love*, starting from hospitality, a paradigm of humanisation, which in our case always wants to be in its implementation evangelisation as well.

The words of Benedict XVI in his *Deus Caritas est* give us great strength in the performance of our mission: 'We contribute to a better world only by personally doing good now, with full commitment and wherever we have the possibility'(n. 31b). 'Charity, furthermore, cannot be used as a means of engaging in what is nowadays considered proselytism. Love is free; it is not practised as a way of achieving other ends'. Those who practise charity in the Church's name will never seek to impose the Church's faith on others'. 'A Christian knows when it is time to speak of God and when it is better to say nothing and to let love alone speak. He knows that God is love and that God's presence is felt at the very time when the only thing we do is to love (n. 31c).

Like Christ we want to bring salvation to the world so that everyone can achieve knowledge of truth. For this we pray and in this we trust. We try to do this with hospitality as a new paradigm of humanisation, conscious of the fact that we draw near to God and to people always and when God wants this and it is appropriate, and we do this with true evangelisation. With Benedict XVI we proclaim '*Caritas in Veritate*'.

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MANUEL DE LEMOS

The Contribution of Volunteers to the Humanization of Health: the Portuguese Reality

I would like to begin by expressing thanks, both I myself, and on behalf of all the Portuguese Santas Casas de Misericórdia (the 'Holy Houses of Mercy'), for the invitation of the Pontifical Council for Health Pastoral Care to come here and to reflect on the contribution of volunteer work to the humanization of health and, indeed, to its ethical dimension.

It seems relevant to mention that although founded in 1498 by a group of a hundred 'good men' under the auspices of the Portuguese monarchy, the mission of the Misericordias has always been to engage in 'works of mercy' – in line with their definition as associations of the faithful by canon law.

Moreover, it seems imperative to refer to the fact that since 1516, when the Portuguese king, Emmanuel II, bestowed upon the Misericordias of Lisbon the administration of the Hospital de Todos os Santos (the 'All-Saints Hospital'), the Portuguese Misericordias – without interruption – have actively engaged in the management of hospitals and other health services. They have thus fulfilled the 'work of mercy' that orders them to 'take care of the sick.'

The Misericordias possess an expertise as regards health care which, although on the one hand it extends beyond the horizon of memory, on the other, translates into a constant concern with quality. With regard to the latter, to cite one example, a study undertaken in 2010 by the Joint Commission International and Siemens, ranked the hospitals of the Portuguese Misericordias as being among the best in the country.

How can one explain the longevity as well as the recognition, of the Misericordias' commitment to health care? This, indeed, goes beyond the borders of continental Portugal, as the Portuguese took this movement across the globe, from Brazil to Angola, from S. Tome and Principe to Timor, and more recently to the Portuguese communities in France and Luxemburg.

First and foremost, I would like to stress their character as movements of volunteers dedicated (in accordance with carrying out 'works of mercy') to providing selfless care to those who suffer and those who are in need of help. It is thus appropriate to remember the words of St. Peter the Martyr, in the original statutes of the Misericordia of Florence: 'no brother can expect more for his contribution than a glass of water.'

In fact, we have every reason to believe that the ethical dimension of those who altruistically occupy their time and attention in caring for others makes a world of difference in the field of health; and whoever acts in this manner, places himself or herself in a dissimilar position to those who provide health care for institutional reasons, such as the state through National Health Services, or those who provide health care with the legitimate aim of obtaining profits, such as private hospital enterprises.

It is not by mere chance that the caregivers from the so-called third-sector or social sector are frequently cited among the best in the field of acute health care. It is also not pure coincidence that the aforementioned humanization dimension of care services has gained increasing prominence as a criterion for quality.

The concept of the 'volunteer' represents, first of all, a commitment to oneself, and to society in general, to helping others with no further interest, through specific, continued action and, as much as possible, within an adequate framework. From the ethical point of view, it indicates not only a growing consciousness of disparities and differences but also a search for the values and references that define an individual and his or her social environment.

For Catholics, the social doctrine of the Church provides the ethical framework within which volunteering takes place. Here the recent Encyclical Letter *Caritas in Veritate* captures the essence of volunteering for Catholics. In particular, it maintains that charity proclaims the truth of Christ in society and that development, social well-being and the overcoming of social-economic problems present a demand for 'caritas' – in other words, Love, understood here as Love for neighbour.

The same message permeates the statutes of the first Portuguese Misericordia – the Santa Casa de Misericordia of Lisbon – which states that 'God gave heart, reason, strength and charity to a few good and faithful Christians to create a brotherhood and a confraternity... so that by this brotherhood all works of Mercy, both corporal and spiritual, could be performed as much as possible.'

In the specific field of health, insofar as it corresponds to an activity that aims to help those who suffer and hence are unprotected, volunteering is the noblest of all answers to the deepest moral demands of individuals.

The five-century-old presence of Portuguese Misericordias in the

health sector represents, for Portuguese society in general and the Catholic community in particular, the embodiment of this ethical responsibility towards people. In practice, this responsibility translates into volunteering and the fulfillment of that 'Work of Mercy' which prescribes that we should 'take care of the sick'.

I would like to finish my paper by describing our role, over the last five years, in the creation of the National Network of Integrated Long Term Care in Portugal.

Ageing, and the subsequent explosion of chronic illnesses and mental disorders, along with the fragmentation of families, the ineptitude of existing hospital facilities and the limited financial resources of the state, has become an increasingly pressing issue in Portuguese society. Imbued in the Christian spirit that characterizes our activity, the Misericordias accepted the responsibility of establishing a highly qualified and efficient proximity network, providing care services at reasonable prices.

Today, the Portuguese Misericordias have in operation/construction close to 150 facilities, spread throughout the country, which correspond to more than 70% of the National Network of Integrated Long Term Care. In this decisive manner, they have assumed a central position in the National Health Service.

I called your attention to this circumstance not only as an illustration of our efficient answer to the problems that afflict modern societies, but also because we found here the clearest confirmation for the 'humanization' dimension of volunteering. The proximity to death, the implications of chronic illnesses, and the overall weakness of the individual at this stage of life, make human contact a particularly relevant part of providing care.

In contrast with acute care hospitals, where the plethora of technology reduces the human being to his or her most material dimension, in our services of continued care persistence, nurture, affection and understanding for the patient define our activity. The volunteer, in the ethical and practical position of a 'companion', adopts an approach that is certainly different from that of a more technical, and hence, colder, health-care provider. Clear evidence for this claim is that the volunteers in our services have more time at their disposal than professionals in other health-care services.

I believe that developments in medicine in the near future, and the introduction of high technology in acute care hospitals, will further contribute to strengthening the role of volunteers in continued health services. This will further corroborate Cecily Saunders' vision that palliative and terminal care compels us to 'do everything that can be done, when nothing else can be done.'

Humanization is precisely what can be done, when science and technology are no longer able to do anything. Hold a hand, listen to a story, draw a smile. This is the demand for humanization which, despite the good efforts of professionals, can only be met in a permanent, sustained and effective way by a volunteer.

Though it is true that many professionals today recognize and adopt this human dimension of care provision, it also evident that the efforts of volunteering teams have helped to impose this ethical approach in health-care services.

Ladies and Gentlemen: the Portuguese Misericordias have been providing services for 511 years. We adopt, as far as is possible, the notion of volunteering and thus we always place people above management. Indeed, if we start by helping people, taking care of people, managing the institutions that serve people will come naturally. Today, with more and more management efficiency, we return to people. It is thus my privilege to be the bearer of this example, an example for Catholic and Christian communities in the modern world.

Dr. MANUEL DE LEMOS
President of the Union of Misericordias of Portugal.

M. BENEDICTA

Health-Care Centers and Care for the Poor

The Missionaries of Charity were founded by Blessed Teresa of Calcutta with the special charism of quenching the infinite thirst of Jesus Christ on the Cross for love of souls by the profession of the evangelical counsels and a fourth vow of "Wholehearted and free service to the Poorest of the Poor."

In 137 countries we "partake of that special mission of the Church to shed on the whole world the radiance of the Gospel message; to 'unify under one Spirit all men of whatever nation, race or culture, standing forth as a sign of that brotherliness which allows honest dialogue and invigorates it'" (*GS*, n. 92) (*Const.*, n. 1).

We live our life in all different cultures, situations and agonies of our world – in the hospitals of London AND in the war zones of the Middle East and Africa; among the drug addicts of Frankfurt AND the street children of Rio de Janeiro; at the side of those given apparent mercy through euthanasia by depriving them of food and water in nursing homes in Melbourne AND those deprived of food and water in famine relief camps in Ethiopia; in prisons in Poland AND in night shelters in Cuba. Mother said: "Jesus is re-living His Passion in our poor people. It is Jesus in the poor that we feed, clothe and take in. We are to do it all with a great undivided love."

God did not create poverty. Man's selfishness and greed have allowed poverty to separate people. It is man's unwillingness to love and live as God wills. It is the accumulated result of sin. Yet God loved the world so much that He gave His only Son to conquer sin and turn the force of evil into Redemption precisely where it was at its worst – on the Cross. Man killed God's Son, who died yet rose from the dead. The work of Redemption continues. The Calvaries of our world are where also today Christ thirsts for the love of every man created to live in Him, with Him, through Him in the unity of the Holy Spirit to the glory of the Father – on earth and in heaven.

On the Cross, Jesus became THE Poorest of the Poor and THE Savior; the fountain of the mystery of God's love – to be received and to be allowed to flow also today from the Cross in each person's life: visible and crying out God's thirst at all the Calvaries of our world, invisible and resounding in each person's heart.

Ours must be a holy life, a mystical life which translates, if true, into love in action: "love received and given" (*CV*, n. 5) in our life of *prayer* and profound union with Christ – most expressed and impressed in the Eucharist AND "love received and given" (*CV*, n. 5) in our life of presence, compassion, *service* and profound union with Christ – most expressed and impressed in the suffering Poorest of the Poor. We live both dimensions, prayer and service (cf. *CV*, n. 79), to be Missionaries of Charity in truth.

Once a man came to Kalighat, the home for the dying "Nirmal Hriday" (= pure heart) in Calcutta. He was sincerely moved and in the generosity and goodness of his heart offered Mother Teresa to help her in this beautiful work. He would be able to provide the best available hospital beds and other useful medical equipment of the latest technology. Mother Teresa bowed and kindly refused.

Our conference is concerned with the issue of equity in health care. Equity is a term of justice: to give a person what is his due. In our world the inequity between the rich and the poor is increasing. Poverty becomes more and more the scandal Pope Paul VI described. Underlying this scandal are other more fundamental inequities that may have prompted Mother Teresa's refusal of an otherwise noble offer. Let us see three truths:

1. It is the fundamental right of each person to be given undivided attention and love, be received and treated as he is – coming from God and going to God, with a dignity demanding a reverence which is sacred and absolute. Health is a good that must be safeguarded to be sure, but it is not an absolute good (*EV*, n. 47). It is subordinated to the absolute good of each person's eternal vocation and destiny as a child of God.

Medical technology has greatly advanced in recent years. But must we not also admit that medical practice has often become more depersonalized? Must we not say that the respect for human dignity – the right to life being the first expression of this – has decreased for the greater part of humanity, even as technology has progressed? Do not technological advances, not only in medicine, sometimes come at the price of the poor, the unwanted, the unloved, the unborn? (cf. *CV*, nn. 70, 71) Abortion, euthanasia and organ trafficking constitute the biggest destroyers of society.

Not giving each person the love, attention and care due to him threatens the good of humanity in a way that is far more dangerous than illness or injury or even the lack of proper medical care. The most important response for all of us is to give our full love and attention in a Christ-like manner to every person we come in contact with, especially the poorest of the poor, first and foremost through our own human touch and of

course, where the concrete situation needs, with professional medical knowledge and skills.

Mother Teresa relates: "One evening we went out and picked up four people from the street. And one of them was in a most terrible condition. I told the Sisters: 'You take care of these three; I will take care of the one who looks worse.' So I did for her all that my love can do. I put her in bed, and there was such a beautiful smile on her face. She took hold of my hand, and she said one word only: "Thank you" and she died. I could not help but examine my conscience before her. And I asked: What would I say if I had been in her place? And my answer was very simple. I would have tried to draw a little attention to myself. I would have said: I am hungry, I am dying, I am cold, I am in pain, or something. But she gave me much more – she gave me her grateful love. And she died with a smile on her face. Then there was that man we picked up from the drain, half eaten by worms and, after we had brought him to the home, he only said: "I have lived like an animal in the street, but I am going to die like an angel, loved and cared for". Then after we had removed all the worms from his body, all he said with a big smile, was: "Sister, I am going home to God" and he died. It was so wonderful to see the greatness of that man who could speak like this without blaming anybody, without comparing anything. Like an angel…"

2. Another fundamental right of each person is the right to love as a member of the human family. We do not have regular hospitals, clinics or schools, etc. We cooperate with others who run them when our poor need access to them. Our houses must be simple and modest where the poor feel welcomed and at home. We have HOMES for: *abandoned, physically and mentally disabled children; *AIDS homes for children and adults; *sick and dying destitutes; *mentally ill; *leprosy and TB patients (including rehabilitation centers); *drug addicts and alcoholics; *girls in danger, unwanted mothers, women in distress; * malnutrition or food distribution centers and soup kitchens; * relief centers in times of famine or other disasters. Everyone contributes in his way to making the place a *home*. This is the new life in Christ, on earth already as one day fully in heaven. We learn from the poor by actions not measurable by technical data, but:

By the smile of that dying man and the woman Mother spoke of.

By a tear falling from the eyes of a prostitute.

By the turning of his face of a youngster, after an overdose of heroin, towards the Sister.

By one child in our home caressing the cheek of the smaller one crying beside him.

By the giving of a cup of water of one mentally ill woman to another one in our home .

By the giving away of his share of rice by a starving boy for his dying mother.

The poor are wonderful. Health, wealth, family, name, prospect in life and even life itself are taken from them. Stripped of all they have left only to be human. And this makes them so human – so much what God intended us all to be: able to be loved and to love in response, also in and through suffering, pain and death towards the new life in Christ.

That is why our houses must be homes where all rejected by everyone else can fit, no one shall be excluded; the great human family is growing from small seeds. In our homes, everyone is called out of himself to take part, to give in whatever way possible an expression of love and concern for all. Often there is much misery in our homes at first glance. Yet on the second look, there is much joy in the misery – fruit of the Spirit for all.

3. The most fundamental right of each person is to know God's love, that God is our Father on whom we depend, that we have come from Him and are sustained at each moment by Him, that we are redeemed by Him through His Son, and that we will be going home to Him for all eternity. This might have been Mother Teresa's main concern in refusing the offer of the gentleman in Kalighat. Technical means can narrow our vision of God, or cause us to forget Him entirely. Such means can make us forget that we are created and redeemed by love and can make us forget that God is at work in our concrete personal lives – here and now.

It can make us forget that we are only instruments of His love for each other; that God, not man, is the author of our own and others' life, that it is His gift and that He wants to make us 'an everlasting gift to Himself', through each

moment lived in love and also suffering, pain and death.

The Holy Father writes, "The fundamental question asserts itself forcefully: Is man the product of his own labors or does he depend on God?" (*CV*, n. 74). "When technology is allowed to take over, the result is confusion between ends and means." (*CV*, n. 71)

That is why we Missionaries of Charity choose deliberately simple and humble means in our service to the Poorest of the Poor. Though we meet crowds of poor; our dealing with them is always personal, that one person whole and entire. We live poor ourselves.

We want to imitate Christ who though He could have used all the means of His divinity to show us His love and to lift us up to Himself, emptied Himself, made himself our servant, *gave Himself* up for all – that all might live and give themselves to Him in love.

Technology promotes a spirit of usefulness. While this is good, the Gospel requests more from us: *self-donation* following the example of Jesus Christ.

God's providence includes many wondrous gifts, including advances in medicine and science. But all these gifts remain always at the service of the good of all and at the service of what remains everyone's greatest due: to be God's precious child.

We thank God for our vocation in the Church and all other vocations it gives life to in different expressions. When all is said and done, there is the certainty that in His wisdom God wants all to be together in His kingdom, where He will be all in all. Every inequity will be wiped away. We will be His beloved children in the Son. Our world needs our Christian message of sharing together the good of all our different gifts on the way to the Father's home.

Thank you.

God bless you.

Sr. M. BENEDICTA MC MD,
former Regional Superior in Ethiopia for Sr. M. Prema MC, Superior General of the Missionaries of Charity, Kolkata, India.

MARIO BONORA

A Challenge that has Just Begun

'The earthly city is promoted not merely by relationships of rights and duties, but to an even and more fundamental extent by relationships of gratuitousness, mercy and communion' (*Caritas in veritate,* n. 6). These words of Pope Benedict XVI say a great deal to all those people who, in various ways and with various functions, are involved as believers in activity involving clinical help, care and treatment, and rehabilitation that is carried out every day beginning with hundreds of thousands of health-care centres which in Italy and the world were created because of a strong impetus of Christian charity. They indicate, indeed, in a very clear and essential way, what should be the basic guideline, the approach at the level of ideals, the fact that connotes and defines the attitude of those who bend – this is the exact etymology of 'clinical' – at the side of a patient, of a brother who asks for our help and our solidarity.

1. The Riches of Dialogue

During these two days of intense work we have listened to analyses and recommendations made by eminent speakers – experts, scholars, workers and volunteers – who have taken us by the hand through the pages of the encyclical of Pope Benedict XVI. This has been an excursus that has been far from summarising and approximate. I believe that I can say that none of the multiple aspects of this document have been neglected: from those that are most evident to a rapid and shallow reading, and on to those that are most profound, I would say almost intimate, because in the most hidden folds of the thought of the Pope it is really possible to understand all the features that the exercise of charity must have in relation to the man of the third millennium.

In this sense, I cannot but point out with pleasure the 'experiential' background that has animated the itinerary of these days. Even in those papers that were intellectually most dense and demanding I seemed always to perceive an outlook projected 'beyond' mere theoretical analysis: an outlook focused on man, the image of God, and thus the focal point and reason for the existence of the role of every health-care worker. The riches of various papers, offered to us by skilled and competent speakers, were grafted onto this shared primary approach. These papers were scientific, pastoral, philosophical, economic and legal in character. If I can paraphrase the words used by Benedict XVI to describe the recent Synod of Bishops for the Middle East, I would say that this was a significant experience of 'polyphony in unity'. Various voices but a single dynamic of ideals towards the sources of charity that nourish our mission.

2. On the Course of Man

I feel that it is my duty to stress one thing in particular. Keeping the rudder of our reflection steady on the course of man, we enucleated what in my view remains the most authentic and faithful key to reading *Caritas in veritate*, which cannot be reduced to a simple, albeit authoritative, economic-social tract or a banal anti-crisis handbook. Professor Ettore Gotti Tedeschi, one of our most distinguished speakers, some time ago launched a provocation/proposal: to award the Nobel prize for economics to Benedict XVI. Behind this call I read above all an appeal to know how to look with new eyes at the 'economy', as the Pope explicitly suggests in his encyclical: beginning, that is to say, with its original etymological roots which are connected with the administration of the *ôikos*, the 'habitation'. And we well know that at the centre of every 'habitation', of every 'home', there is a person, a family, a human community.

Analysed from this perspective, *Caritas in veritate* appears to us as it really is: a textbook of humanity, a vademecum for that 'good life according to the Gospel' (Message to the Plenary Session of the Pontifical Council for Justice and Peace, 3 November 2010) which constitutes the concrete horizon of the social teaching of the Church. To outline the coordinates of this coexistence, the encyclical suggests a series of key words.

We recalled these at the beginning: gratuitousness, mercy, communion. And we could add: fraternity, giving, solidarity, reciprocity, subsidiarity. I would like to invite you to spell them mentally, one by one: gratuitousness, mercy, communion, fraternity, giving, solidarity, reciprocity, subsidiarity. And I am certain that you, too, as happened with me, will spontaneously ask yourselves: are these not exactly the modalities that our service at the side of those who suffer requires every day? I say this not to underestimate the work of Catholic health-care workers but rather to entrust them with a further responsibility.

Our witness as believers in the world of human health – and the papers of recent days have helped us to understand this – can truly constitute a prophecy and a paradigm for that 'good society' founded on 'true integral human development' (*Caritas in veritate*, n. 4) to which the encyclical addresses itself. On the condition that, naturally enough, we do not abandon being nourished by the gospel sources of love towards those who suffer – in particular that '*euntes docete et curate infirmos*' (Matthew 10:6-8) about which Archbishop Gianfranco Ravasi spoke admirably – and we do not forget that what is at stake is always and in all contexts man in his wholeness. We want to say this without boasting or presumption, with humility, almost submissively. When we take care of a sick person going beyond the logic of *do ut des*, refusing to measure ourselves solely with the yardstick of gain or profit, removing ourselves from the law – which is only apparently ineluctable – of the prevailing of the strong over the weak, we than demonstrate in concrete terms that ' economic activity cannot prescind from gratuitousness, which fosters and disseminates solidarity' (*Caritas in veritate*, n. 38).

When, with our style of a loving and disinterested presence, we break down the iron calculations of competitiveness without compassion, of exaggerated professing without professionalism, and of capacity without responsibility, we then demonstrate in concrete terms that 'The economic sphere…must be structured and governed in an ethical manner' (*Caritas in veritate*, n. 36).

When our eyes are not only fixed on numbers, statistics, and analyses of costs and benefits, but also remain fixed on the lode star of the inviolable and unrepeatable dignity of every creature, even the smallest and most insignificant creature, we then demonstrate in concrete terms that '*the primary capital to be safeguarded and valued is man, the human person in his or her integrity*' (*Caritas in veritate*, n. 25).

3. A Prophetic Task

In a technological and globalised society, like the one we live in – which is still paying the price for an economic and financial crisis which has been shown essentially to be an 'ethical crisis, as the papers of the authoritative economists who contributed to our deliberations confirmed – our task is to certify that caring for man is not a rearguard mission or a hobby for philanthropists. It is our task to demonstrate that what *Caritas in veritate* affirms more generally as regards the poor applies to sick people, that is to say they 'are not to be considered a "burden", but a resource, even from the purely economic point of view' (n. 35). In definitive terms, it is our responsibility to offer the world a model of health care that is able to conjoin competence and humanity, relief for the body and relief for the spirit, scientific innovation and gospel charity, and technical excellence and Christian witness. A model that should be plausible not only from a medical/health-care point of view but also – and here is the decisive wager and challenge – one which is fully sustainable from the economic and social point of view.

This is no small task. In this, as I have observed, the encyclical comes to our aid by suggesting to us a sort of 'vocabulary of humanity' made up of words that after a certain fashion are an integral part of our DNA. A vocabulary that we have leafed through together over recent days thanks to important and enlightening testimonies. I will recall here only that of Cardinal Peter Kodwo AppiahTurkson who in his dual capacity as African pastor and President of the Pontifical Council for Justice and Peace offered us a number of interesting approaches for the promotion of health that is truly on the human scale.

It seems to me that the greatest value of these papers was specifically that of explaining the economy to us in terms of humanity and at the same time telling us about humanity in terms of the economy. Thus we were able to understand, for example, that fraternity is not a residue of the sacristy or at the most an optional confined to noble souls, but an element that allows the market to function and to prosper: this was intuited eight centuries ago by St. Francis and was emphasised subsequently by those 'economists' based on his school (we should not forget that thanks to the minor friars during the fifteenth century the 'hills of piety' were created), as Professor Stefano Zamagni, who helped us with the summarises of the papers of the first day, loves to emphasise. In the same way we understood that what Pavel Florenski defined as 'the art of gratuitousness' (Letter from the Gulag, 11 May 1937) – on the basis of which we look at people and things as an end and never as a means for mere goals involving profit – remains a fundamental ingredient by which to humanise the economy and civilise social relationships. And we also realised that growing quotas of communion grafted onto a mercantile logic create sociality, develop fair-

ness, and construct solidarity. In other words, they assure that justice to which every society aspires but which, on the other hand, is constantly completed and surpassed by charity.

'Charity goes beyond justice' writes almost at the beginning of his encyclical Benedict XVI (*Caritas in veritate*, n. 6). This is an assertion which for us has a fundamental importance. It means that we have first and foremost the duty to have authentic and real professional competence, just as the right of a patient to take advantage of this competence is authentic and real, with full confidence. But the very professionalism of a clinic should be expressed in a humanly rich personal relationship, in a relationship of dialogue and sharing which 'goes beyond'. And we can thus draw near to illness not in the abstract but with a precise and concrete reference to the person of the sick individual, received in his or her irreducible singularity. There is, to sum up, an 'economy of charity' (*Caritas in veritate*, n. 2) which cannot but list amongst its most convinced and impassioned creators those people who, in the name of the Church, offer care and health. We all perceive the responsibility of this call. And in basic terms we know that the success of our works certainly depends on so many situations that constrain us and condition us externally but in the final analysis finds in faithfulness to its original charism its ineluctable, unassailable and thus truest source.

4. Towards a New Stage of Medicine

Medicine has by now entered a new stage in its history. I believe that everyone realises this. We are by now fully inside a season of a strong technological declination of the health-care act. We must, therefore, examine this aspect and ask ourselves how we can govern the thousand fronts that derive from it, being concerned to ensure, as believers, that the relational value of that 'therapeutic alliance' between a medical doctor and his or her patient which always constitutes the leading axis of caring for and taking care of people, never disappears.

However, a no less attentive stress must be placed on a second profile of our analysis. The strong technical/scientific approach which today drives medicine seems to be destined to ineluctably direct us towards political-financial conditions of such a character as to make it difficult to defend total coverage health systems. And as a direct consequence – and this is something we heard about in the paper given by Dr. Luis Gomes Sambo of the World Health Organisation – there is in objective terms the risk that we will go towards a situation where certain pharmacological and non-pharmacological centres, however essential they may be for the innovative and advanced treatment of certain pathologies, will have such a high price that they will not be accessible to everyone.

We are living, that is to say, in a historical stage of profound transformations, a time that is rich in challenges and authentic provocations, of authentic epochal changes. This is an age, for that matter, that is compelling and fascinating, and that will be decisive for the – who knows how long – centuries-old unfolding of human affairs.

Specifically for this reason, we are worried when we see around us the champions of a reductionist 'scientism' that blows on the fires of a purported and incurable conflict between science and religion and between reason and faith. There is a match underway which involves us and whatever the case commits us, even against our will. When every day, with the scruples that we always have, we carry out our work at the bedsides of our patients, we must be aware that this match is above all in our hands. This match is played out, that is to say, first and foremost, in the field of so-called 'new medicine', in the face of the enormous potentialities of a 'biotechnology' which only in an integral and profound respect for life and the person can find that yardstick and that rule that will safeguard it against itself, against an uncontrolled explosion of its unprecedented and immense power.

There is the risk that we will become the prisoners of that 'technocratic cultural perspective' according to which 'truth' coincides with 'the possible' (*Caritas in veritate*, n. 70). But we also heard from Professor Arduini about the dangers that can come from an exaggeration of technology that particularises sick people: the brain, the liver, the lungs and the heart. One runs the risk of losing sight of man in his entirety. Professor Arduini spoke about fairness in care, relating it to the level of its humanity which is that of humanisation, that aspect which should be looked for with greatest emphasis. It is no accident that he made the observation to us that to be fair care must be first and foremost human.

It is on the terrain of medicine and the connected biological sciences that today is manifested an 'anthropological' pressure that has an enormous impact in how we conceive of ourselves, of life and of the history of humanity which the 'post-modern' age is unceasingly re-elaborating. It is above all else genetics, so-called 'procreative' ethics, that is to say the set of techniques that intervene in the field of assisted fertilisation, the subjects connected with the terminal stages of life and the 'pro-euthanasia mindset' denounced vigorously in the encyclical (n. 75), that commands our attention. And it is here that, albeit in a diversity of roles and institutions, we feel pushed constantly to re-elaborate a shared and unitary perspective of 'Christian humanism' within which to decline health-care activity.

But even more compelling questions will continue to beset us on a number of fronts: for example, from 'predictive medicine', always within the framework of the so-termed 'genetic revolution'; from the new dimensions which it may be presumed will be taken on by conscientious objection; and by the most advanced applications of bio-engineering in many varied fields.

And perhaps the most intriguing and disturbing provocation that we must expect in the short terms (from certain points of view we have already arrived, even though not specifically in such an explosive way) relates to the 'ethics of health-care expenditure, within the general framework of public expenditure and welfare which is in difficulty to varying degrees in almost all developed countries and which encounters difficulty in redefining

itself in the new economic-financial context that is imposed by globalisation.

We are rapidly walking towards a technical-scientific development of medicine that could soon turn out to be incompatible – without certain suitable policies, but it is difficult to imagine which – with the maintenance of health systems offering universal coverage. But this is a problem that goes decisively beyond the traditional boundaries of medicine and its connected health-care policies and bears upon the dimension of democracy as such, and the values of freedom, of justice and of equality, whose guarantor it is called to be.

Our work in the health-care field is therefore to be the bearers of a great responsibility that goes beyond the boundaries of institutions. It also bears upon, for example and in the first instance, the need to draw up a richer concept of what 'health' means: not only the homeostatic and feeling equilibrium of our organisms, but, at an even deeper level, self-awareness. Not an exaggerated view of health or a general technical-formal acceptance of so-called 'lifestyles', but the active shouldering of responsibility for our personal existential journeys. This is a goal, our goal.

5. A Challenge that Begins Now

'When we come to the end of that story, we have not even begun'. Allow me to end my paper with the ancient – but always familiar to men of all ages and latitudes – wisdom of this sentence from the Book of Sirach (18:7). These are words that each one of us should bear in mind now that our conference is about to end.

When the time comes to make an assessment so as to approach again the story of such a broad, profound and detailed dialogue as that which we have witnessed in recent days, there is always the risk that the temptation of self-satisfaction, of intellectual reward for its own sake, will prevail. But none of us believe that we have completed our task here, however brilliantly. At the very moment when we agreed to 'give life' to this assembly, we agreed to go on 'giving it life' there where our technical, professional and spiritual capacities are called every day to deal with human suffering. Our real testing bench is what comes 'afterwards'. For us the challenge has just begun.

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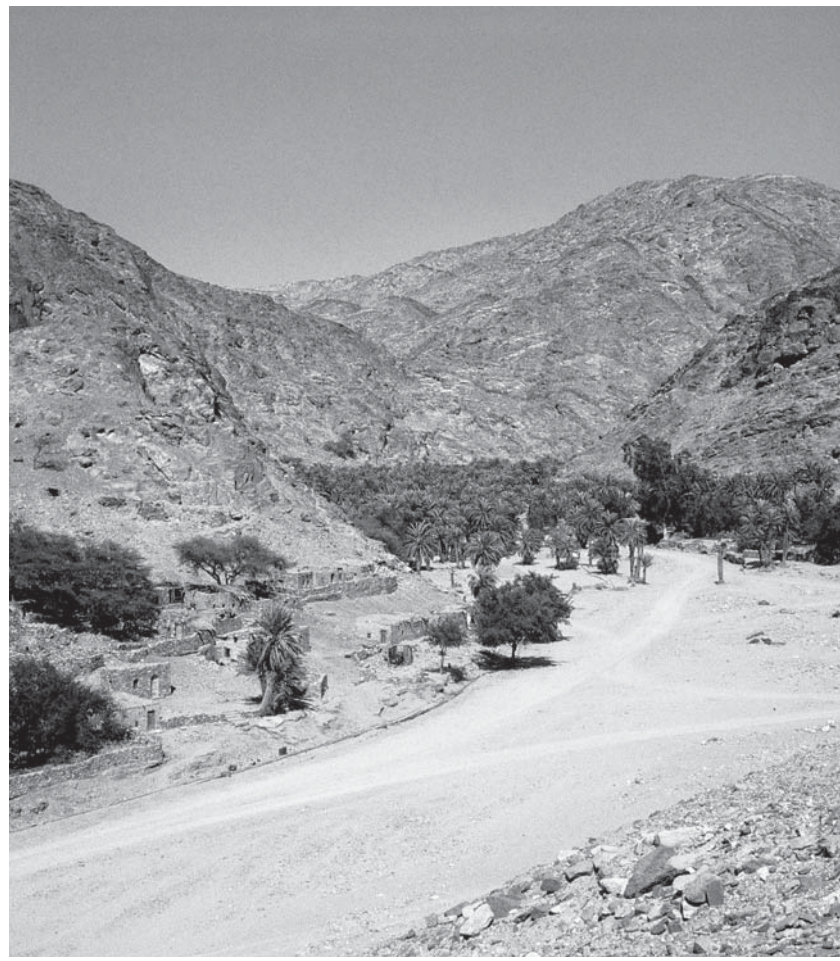


Concluding Paper by Prof. Filippo Boscia

The encyclical *Caritas in veritate* may be seen as an authentic Christian manifesto for the governance of global development; indeed, it is the only document on political economy of worldwide importance and proposes giving as an instrument for development, offered in the name of charity.

In this encyclical a new model for development is proposed in which the role of giving and gratuitousness are placed in an organic way, in a way that is different from that of those economic and social circles which, unfortunately, often defend the interests of the holders of power.

This encyclical invites us to a new responsibility, that is to say the construction of the earthly city; it leads us to generate fraternal relationships, social cohesion and political engagement in order to build the 'great human family'.

Caritas in veritate upholds a new need for social ethics at a global level based upon the rules of justice and solidarity, overcoming all temptations linked to financial speculation and the exploitation of men, women and children, with their related short-term advantages.

This encyclical lays emphasis upon the subjects of work, the fight against poverty and the various conditions of marginalisation and of social exclusion, drawing attention to certain new elements on which we believers, but also all people of good will, are called to reflect.

At the twenty-fifth international conference of the Pontifical Council for Health Care Workers reflection has focused on cogent questions and issues connected with the global economy, the authentic meaning of development, social justice, the rights and duties of citizens as regards the promotion of life in all countries, the role of states in assuring fair and solidarity-inspire care, hospitality, justice, charity in harmony with truth, development and progress, technology and finance, without, however, ever losing from sight the person and the environment or neglecting positive and virtuous actions as regards social and economic dynamics, and promoting suitable regulation of the laws of the market.

It seems to me that reflection on these subjects has characterised the deliberations of all the sessions of this twenty-fifth international conference entitled '*Caritas in Veritate*: Towards a Fair and Human Health Care'. When engaging in these deliberations, the person has always been at the 'centre' of things: the spirit of truth has sensitised those taking part to assuring in institutions fair an human care which could not be implemented without the emerging roles that are attributed to the family, to charity, to solidarity, to subsidiarity, to missionary work and to voluntary work.

There emerged a major effort to look for a renewed paradigm of humanisation to achieve increasingly forceful and audacious attention being paid to new forms of poverty and the very many situations of abandonment and denial of the most elementary rights.

The social question of equality in access to basic health-care services is not an optional – it is a categorical imperative that has its roots in the Gospel of charity. Man is the passion of the living God and for this reason our attention must be centred on man, striving to create a more welcoming and more just world. From our productive work has emerged the need to have credible witnesses and people dedicated to charity, missionaries of charity who are able to implement new forms of intervention amongst the poor, that is to say healthy nutrition, prevention, fair, human and solidarity-inspired care for everyone, welcoming through organisations of various kinds belonging to local areas or in the form of hospitals, and suitable health-care institutions and centres.

The introductory description of this international conference that was given by His Excellency Msg. Zimowski, the President of the Pontifical Council, stressed how the encyclical is the ideal instrument by which to assess economic and social systems from the perspective of charity and truth in order to achieve the integral development and the welfare of individuals and the whole of mankind as a social body.

During the preparations for this conference we were asked: 'who will remove the ongoing inequalities between the health systems of rich countries and of developing countries or those which in absolute terms are less developed?'

Who will remove the different levels of access to basic health-care services, to medical products and to lifesaving technologies?

Who will supplement the scarce health-care institutions that exist in the various 'poor or impoverished countries'?

This international conference has provided a precise answer: *the answer is charity in truth and truth in charity*, charity illuminated by the light of reason and of faith, open to achieving objectives of human development in a plurality of contexts.

During the various sessions of this international conference we have listened to important testimonies of people who are animated by charity and have worked to remove injustices, to establish more human and healthier relationships, as well as the testimonies of very many groups, movements and associations of Christian commitment who work in the field of health care in the world.

The moving papers and testimonies of the very many speakers whom we have listened to have had the function not only of being open denunciations of failings in the health-care world and of the strong imbalances that can be perceived in the world of needs, but also in a positive way of calling for resources to nourish the hope for an improvement in those criteria

that currently govern the choices that are made in the world of care but which also run the risk of marginalising the poorest and most needy sick people (for example mothers who are abandoned and not cared for, newly born children exposed to neonatal illness and death, malnourished children, abandoned children, the gravely physically and mentally handicapped, disabled adults and elderly people, men, women and children who are in pain and dying without the prospects of humanitarian and compassionate accompanying: men, women and children who are the orphans of medical products, perhaps of those medical products of which there is a surplus in opulent nations).

All the very valuable papers have been an invitation and a call to global charity, to place the person, the poor, at the centre of our attention, to be in communion with them, to promote missionary activities designed to create structures of voluntary work which by vocation serve man during his season of pain: men and women who bend before the wounds of this suffering humanity without ever failing to respect human dignity, so that the face of Christ may be seen increasingly in the poorest, the abandoned, the oppressed, and in all sick people.

All the papers have pressingly invited men of good will to make available their professional skills and their time, their resources, for service to health that is more coordinated and organised in depth. They have also called for responsibility, generosity and witness to charity towards men in pain who receive care and they have stated that pain and suffering can release love and strengthen the role of those who work in a good spirit to defend and support life in extreme situations, from birth to death, and in situations of malaise, poverty and illness.

Although, on the one hand, the problems of the health-care world are vast and complex, on the other the answers to them are often partial and not organised.

We should, therefore, work in synergy to outline a unitary project for pastoral care in health that involves, together with the Pontifical Council, the whole of the world of Catholic associations and all the Catholic health-care workers in the world so as to address with greater incisiveness the complex and numerous needs that exist.

This is a matter of building 'citadels of charity' in which authentic fraternity is achieved (*CV*, n. 20) as well as an improvement in the so much wished-for parity of access to basic health care that is respectful of the inalienable dignity of man.

The calling to repair in sick people the wounds of the Holy Face of Christ is the real, convincing and powerful impetus that is able to fulfil missions of truth and charity in the world, starting with perception of, and deep knowledge about, suffering.

This is a proposal, a recommendation, not to engage in a dispersal of those vital forces that promote commitment that is not only a matter of care but also cultural in character.

Because of their very great number, it is difficult to list the institutes of male and female religious that are all present in the most marginalised areas of the world and, animated by their specific charism, act in various fields: the health-care field, the agrarian field, the field of schooling, the cultural field and the field of training.

Many responses are awaited and amongst these are specifically those at a cultural level and the level of training, through the to-be-hoped-for creation of universities in critical countries as well – a further challenge and demonstration of the special role of culture in the field of that global charity connected with development, with progress, with the drawing up of the supply of training in all fields but especially in that special one of solidarity-inspired finance which works through microcredit.

What we are now going through is the first great post-globalisation crisis. The current world is already profoundly different from the one previous to it: the scenario is polycentric. It has already been invaded by risks and damage that were previously unknown, all of which are connected with planetary interdependence and the variation in geopolitical equilibriums.

Increasingly often there emerge new transversal phenomena that bear upon the economy and finance, the environment and the family, cultures and religions, migrations, the health and the defence of the rights of workers, child labour and the defence of the rights of children, with the need to prevent forms of exploitation, and the recruitment of minors for war or work or prostitution.

Many problems have to be addressed in this epoch of globalisation:

1. *The welcoming of life*. Contemporary development is closely connected with this subject: the greater importance that it has acquired compels us to expand the concepts of poverty and underdevelopment to questions connected with the welcoming of life.
2. *The reconstruction of social communities* (families, intermediate groups) that have been lost because of internal migrations or migrations towards richer countries.
3. *The loss of cultural and religious identities*.
4. *Hunger and inequalities*.
5. *The relocation of work and of the production of goods and services*.
6. *Violence in general*, civil wars and conflicts provoked by religious fundamentalism.
7. *The precariousness of employment*.
8. *The autonomy of 'economic arguments'*.
9. *Violence against people who are poor in resources* who are even driven to sell, or to have used, parts of their own bodies (for example the exploitation of the body through surrogate motherhood, prostitution, the supply of organs, etc.).
10. *Exploitation of people* in the field of work.
11. An unacceptable devaluation of life.
12. Varying levels of availability of goods and their distribution or, even worse, corruption and dominance by organised crime.
13. Mechanisms of development and economic democracy altered through the hypoactive destruction of goods and products in order to maintain a market economic logic.

Marginal welfare or emotional charity is no longer enough. There

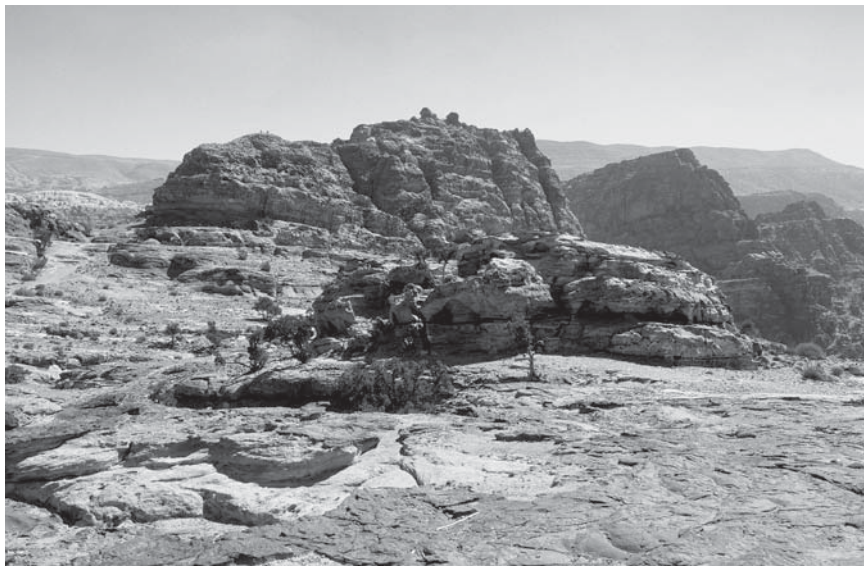
is a need for a full commitment at all levels to fighting against poverty and in favour of human promotion. We must go beyond individual areas of knowledge, work for acculturation, assure the right to communicate (through ICT instruments as well), and promote the need for an interdisciplinary approach ordered by knowledge and skills at the service of human development.

We need to denounce here the active trade in reproductive cells which is promoted by certain European countries in relation to women and men in less favoured countries (the Ukraine, Romania, Bulgaria, Poland, Russia, India and Pakistan).

Many Italian centres have agencies abroad and promote very grave reproductive tourism.

In Italy we can witness problems connected with the exaggeration of the self-determination of patients and as a part of this a reduced autonomy and responsibility on the part the part of medical doctors which makes the relationship between medical doctors and patients more fragile.

In this context are to be located the abuses or delays that take place as regards diagnosis, the abuses or delays that take place in relation to treatment, and the exaggerated resort to psychotropic drugs.



Men and women induced to sell their own gametes or even who have their gametes taken away, or even worse couples whose surplus embryos are expropriated and then frozen so as to be allocated to other women of advanced age, or in menopause, or in early menopause, or with pathologies involving an early absence of ovules, who uphold and wish to meet their need for motherhood at any price.

Surrogate mothers, wombs for rent, without any form of regulation, have emerged in the countries of Eastern Europe.

This trade adds poverty to poverty and today constitutes a grave emergency that is connected with globalisation and the breaking down of frontiers.

Any state law can be by-passed if fundamental rights are ignored or non-negotiable principles are overturned.

Very often there is an overdose of prevention, an overdose of the medicine of what people want, with a consequent waste of public resources to the detriment of those people who are most in need.

It is absolutely the case that we must propose anew the perspectives of an integral humanism to give importance to the value of fraternity: we should try to go beyond excessive individualism, selfishness, relativism, nihilism scepticism, and consumerist and excessive materialism, and give value to life as a gift.

At the origins of underdevelopment there is always a lack of fraternity and of charity, of hospitality.

International society will promote the authentic meaning of development if it brings to the fore social justice and the rights and duties of citizens and states for the promotion of life in every corner of the planet, the commitment of states to assuring fair and solidarity-inspired care, hospitality, justice, charity and truth, development and progress, technology and solidarity-inspired finance, never losing sight of attention being paid to the person and to the environment and never neglecting positive and virtuous actions as regards social and economic dynamics, and promoting suitable regulation of the laws of the market to achieve health and safety.

A final observation: in recent days I have perceived the Pontifical Council for Health Care Workers as a natural structure for the work of lay people, of all health-care workers (medical doctors, nurses, physiotherapists, obstetricians, x-ray diagnosis technicians, etc.).

I have experienced this Pontifical Council as a body of the universal Church of which lay people are an essential and participating component.

Lay people have not been passive spectators: they have felt themselves protagonists, an active part of the life of this dicastery!

Personally, I have lived, together with this Pontifical Council, in that great cathedral, the world of health and health care, in which there is God, the only begotten Son, the apostles, bishops, priests, religious, deacons and the lay faithful and where there come and go, calmly or in emergencies, all the creatures of the world, believers and non-believers, those that see the Father and those that do not see the Father.

This dicastery is for the world and deals with all the urgent problems of the world.

In this ideal church, in this cathedral, all the creatures of the world look for hospitality, compassion, nearness, religious consultation and comfort, but above all they look for listening, for care (even though one cannot always get better), and they find hope, mercy, a sense of sharing, a therapeutic alliance.

Within this great cathedral there are ‘workers of the Lord’ who engage in medicine with love and out of love.

If used with wisdom, technology for man is wisdom, a merciful heart, and hope.

Personally, I am profoundly convinced of this.

In the large structure of the

health-care world we increasingly need the work of active chaplains who dedicate their actions to the sick and their family relatives but also to medical doctors, to nurses and to the whole of the health-care staff.

All of this personnel must bear witness to charity, patience and humility and must call for updating and training so that their actions can be more effective.

Hospitals and health-care institutes near to the ecclesial world have a greater responsibility in assuring respect for the dignity of the person and in accompanying the experience of suffering and of pain.

Everywhere in the largest church in the world, in the world of suffering, of frailty, there is a demand for justice, love, assistance, for the joy of giving and those riches of comfort and light that spring from the mystery of Christ who died and rose again.

An incumbent expression of thanks goes to the President of the Pontifical Council, Msgr. Zimowski, for wanting and organising this international conference, to the Secretary of this Pontifical Council, Msgr. Redrado, and to the Under-Secretary, Msgr. Jean Marie Musivi Mupendawatu.

To them go my feelings of gratitude for the confidence that they have had in my person.

My gratitude also goes to all those speakers who with their analyses have borne witness to the need for, and also the fecundity of, conjoining theory and practice in the pathways of the humanisation of medicine and to all those who have constantly expressed the urgent need to always place the person at the centre of action in health care.

To give a voice to medicine, to the humanitarian undertaking, to thought about bioethics, to solidarity, to subsidiarity and to charity in truth means to care for relationships between men and to care for the hope that is in the world and in each one of us.

The words of the Holy Father which we have listened to through the voice of the Secretary of State, Msgr. Tarcisio Bertone, call us to respect for the human person, above all in extreme situations – birth, pathways of suffering, situations at the end of life and the natural decline of life.

We wish to keep in our hearts the words of the Holy Father which are deeply rooted in the Gospel of charity so that they may be giving, help, support and guidance in our daily conduct.

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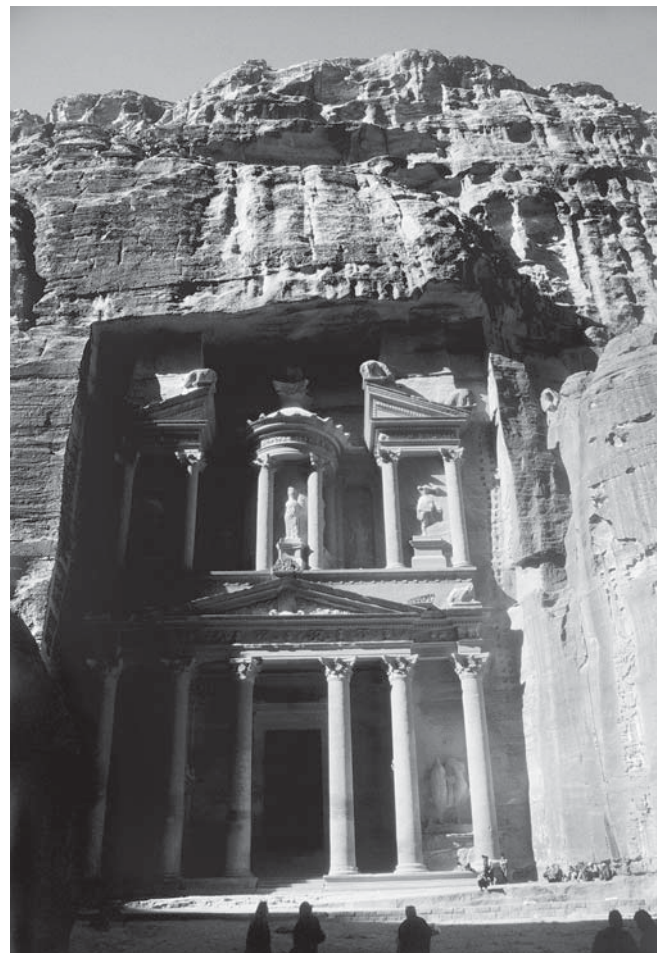

Concluding Observations by H.E. Msgr. Zygmunt Zimowski

We have come to the end of our twenty-fifth international conference on the subject '*Caritas in veritate*. Toward an equitable and human health care'. We give thanks to God for its successful outcome and above all for its conclusions and the recommendations.

First of all we thank the Holy Father Benedict XVI for the Message that he gave us and in which he emphasised how *justice in health care and the protection of life must be a priority in the action of governments*.

I would like to thank all those who gave papers and all the participants, beginning with His Eminence Cardinal Tarcisio Bertone, the other Cardinals, the Archbishops, the Bishops, priests, and men and women religious. In a special way I thank health-care workers who are ministers and 'servants of life', good Samaritans.

A heartfelt thanks goes to the Secretary, H.E. Msgr. José L. Redrado, the Under-Secretary, Rev. Msgr. Jean-Marie Mupendawatu, all those who work with me at the Pontifical Council for Health Care Workers, and the interpreters.

I would like to emphasise certain points that deserve the attention of everyone:

The mission of the Church in the health-care field is born from the command of the Lord '*Euntes docete e curate infirmos*' and finds its paradigm in the figure of the Good Samaritan. Without pastoral care in health the so-termed '*Salus animarum*' is absent from the primary mission of the Church.

The right to health, which is recognised by national and international legislation, must be matched by the duty of government, to ensure the fair access of citizens to health-care services; there is also the responsibility of each one of us to protect personal and collective health.

Solidarity and subsidiarity are cardinal principals in assuring the access of citizens to essential health-care services, ensuring that the resources or services available are managed not only with humanity but also with charity, and having as an objective the protection and the appreciation of human dignity.

The question of intellectual property rights in the field of biomedicine should be addressed by taking into account both the evident right of companies to enjoy the fruits of their innovative results and the right of populations to be treated so as to safeguard their lives and health.

Everything that has been said over the last few days can be summarised in the phrase '*nearness of hearts*'. On this point I would like to quote the words of Pope Benedict XVI pronounced on the occasion of the World Day of the Sick of 2007: 'And it is precisely to these our particularly tried brothers that today's World Day of the Sick is dedicated with special attention. We would like them to feel the material and spiritual closeness of the entire Christian community. It is important not to leave them abandoned and in solitude while they try to face a very delicate moment in their life. Praiseworthy are those who with patience and love place their professional skills and human warmth at their service. I think of doctors, nurses, health-care workers, volunteers, Religious and priests who without sparing themselves stoop down to them like the Good Samaritan, not considering their social condition, skin colour or religious affiliation, but only their needs. In the face of every human being, and still more if tried and disfigured by sickness, shines the Face of Christ, who said: "As you did it to one of the least of these my brethren, you did it to me" (Mt 25: 40).

I would like to finish with the words of the Holy Father Benedict XVI from his Message of yesterday to those taking part in this international conference: 'To suffering brothers and sisters I express my closeness and also the appeal to live illness as an occasion of grace to grow spiritually and participate in the sufferings of Christ for the good of the world, and to all of you, committed in the vast field of health, I give my encouragement for your precious service'

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

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

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