CAMILLIAN RELIGIOUS
The General Segretariat for Ministry

THE CAMILLIAN MINISTRY

Directions

GENERALATE HOUSE
ROME 2013

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THE GENERAL SECRETARIAT FOR MINISTRY

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Abbreviations

AA	*Apostolicam Actuositatem,* Decree of the Second Vatican Council on the Apostolate of the Laity
AG	*Ad Gentes,* Decree of the Second Vatican Council on the Missionary Activity of the Church
C	*Constitution* of the Ministers of the Sick
CL	*Christifideles Laici,* Post-Synodal Exhortation of John Paul II
EV	*Evangelium Vitae,* Encyclical of John Paul II
ECV	*Evangelizzazione e cultura della vita umana,* document of the Italian Bishops' Conference
ES	*Evangelizzazione e sacramenti della Penitenza e dell'Unzione degli Infermi,* document of the Italian Bishops' Conference
DH	*Dolentium Hominum,* Motu proprio of John Paul II
GS	*General Statutes* of the Ministers of the Sick
EN	*Evangelii Nuntiandi,* Post-Synodal Exhortation of Paul VI
GS	*Gaudium et Spes,* Constitution on the Church in the Modern World
LG	*Lumen Gentium,* Dogmatic Constitution on the Church
MR	*Mutuae Relationes,* Directives for the Mutual Relations between Bishops and Religious in the Church
PDV	*Pastores Dabo vobis,* Post-Synodal Exhortation of John Paul II

PSCI	*La pastorale Sanitaria nella Chiesa Italiana,* Guidelines on Pastoral Care in Health of the National Council of the Italian Bishops' Conference for Pastoral Care in Health
SC	*Sacrosanctum Concilium,* Constitution on the Sacred Liturgy
SpS	*Spe Salvi*, Encyclical of Benedict XVI
VC	*Vita Consecrata*, Post-Synodal Exhortation of John Paul II

Preface

Motion n. 22 of the fifty-fifth General Chapter (Ariccia 2007) reads as follows: 'The General Chapter should draw up guidelines for the Order in order to achieve more effective Camillian assistance'.

Following this mandate of the General Chapter, the General Councillor for Ministry created an *ad hoc* commission to draw up such 'guidelines for the Order'. The document that you are holding is the outcome of its work.

This document begins by describing the historical journey that the Camillian ministry has taken down the centuries (chap. I) from the epoch of St. Camillus to today. It then illuminates our roots (chap. II) and brings out the basic principles from which we cannot depart and to which we must constantly refer if we want to follow in a safe way – without any danger of distancing ourselves from them – those footsteps already taken in the exercise of mercy towards the sick.

The principal aspects of the health-care universe in which we live are emphasised (chap. III) in order to provide an accurate and effective framework for our ministerial activity in the contemporary scenario of the suffering world so that our action in this world is as effective as possible.

Most space in this document is dedicated to illustrating how the various aspects and moments in which our mission is organised are, and must be, offered (chap. IV), dwelling in particular on the importance of proclaiming, the offering of the sacraments and the deaconate, that is to say the way in which our ministry of service is expressed, through pathways that are innovative as regards the Camillian past, such as centres for formation, parishes and the Camillian Task Force.

The recipients of our ministry are then discussed (chap. V): they are above all sick people and their family relatives, and health-care workers, the valuable instruments of our ministerial action.

Suitable attention is paid to the need to act in union and cooperation with the Universal Church (chap. VI) and to the vital work of the lay faithful (chap. VII). An emphasis on the need for formation (chap. VIII) in its various aspects and in relation to the various categories of health workers – we religious must place ourselves in

the front line! – ends this document, which in this way has touches upon the central points of the Camillian ministry, offering necessary directions and useful suggestions for its actuation.

These *Directions* are, and must constitute, for each Camillian a valuable work instrument which we need to justify and update our ministerial activity of accompanying the suffering: a difficult and delicate activity which, however, is more possible the more it is flanked by the watchful help of our Founder and numerous brothers of ours – past and present – who point out to us, as milestones, the pathway to be followed.

Keenly-felt thanks go to the members of the *ad hoc* commission, made up of Fr. Francisco Alvarez, Fr. Eugenio Sapori, Fr. Krysztof Trebski, Fr. Paolo Guarise and Fr. Angelo Brusco, who was its chief author and to whom we express our deep gratitude.

Fr. Paolo Guarise
General Councillor for Ministry
Rome, 16 November 2012

Introduction

This document has amply gone beyond the request of the General Chapter of 2007. Indeed, we are not only simply presented with 'guidelines' that can help us to make our ministry more effective. I believe that one can assert that we have before us a short but at the same time complete tract on our ministry.

To an expression of our unanimous gratitude is joined a personal and community reflection on these *Directions* in order to identify always and everywhere: 'the best ways to preserve and adapt [the] charism and [the] spiritual patrimony to changing historical and cultural situations' (*VC*, n. 42).

Gradually, every community acquires awareness about the advisability of a shared project for spiritual life, fraternal life and ministerial activity. To enter into harmony with the *Directions* constitutes valuable help in fostering the sharing of 'the apostolic work of all towards the one mission' (*VC*, n. 45).

The Constitution reminds us that our charism 'is expressed and realized in the works of mercy towards the sick' (*C*, n. 10) in whom we see Christ himself: this is the ministry that every Camillian religious should exercise 'with all diligence and charity, with that affection that a loving mother has for her sick only child, according to what the Holy Spirit teaches him'.

A consistent and generous exercise of our ministry becomes the most credible way there is of bearing witness to, and proclaiming, the health and the salvation that Christ intends to offer to person. 'Often the very deepest cause of suffering is the very absence of God' (*Deus caritas est*, n. 31c). The acceptance of the gospel in one's own life, instead, generates a radical and progressive transformation of existence which allows us not only to pass through the tunnel of illness but also to transform it from within into a factor for human and spiritual growth.

The ministry should never be understood as a mere carrying out of certain activities. Its greatness requires, instead, our total involvement and – as we find written in this document (n. 37) – 'justifies the statement of Camillus that our Order needs *perfect men*, unified and centred, seduced by the merciful Christ and impassioned of the weakest and most in need, internally free, able to form healthy

and health-giving relationships and to live existence and pre-existence. We are thus called to rely upon the quality and truth of our being: authentic motivations, maturity in relationships; the way of managing our shadows and wounds; the meaning of life, attention directed towards our own spiritual needs; the way of posing to ourselves true and ultimate questions; and an intimate relationship with God through the practice of our vows and an intense and faithful life of prayer (liturgy, sacraments...) that privileges the contemplative and cordial dimension, that frees itself from an excessive *functional* charge'.

The Superior General,
Fr. Renato Salvatore

Chapter I

Between The Past And The Future

Some historical facts

1. The history of our Order is also the history of the ministry engaged in by Our Holy Father Camillus and our brothers who have gone before us. Notable transformations that have taken place in society and the Church from the sixteenth century to today, under the impact of socio-economic, political, cultural and religious factors, have created new situations to which the exercise of ministry has had to conform, experiencing in some cases notable negative effects but in others drawing from them important benefits.

The history of the Order is also the history of the *Camillian ministry,*

2. A look at the evolution of the service engaged in by our Order of 'witnessing to the world the ever-present love of Christ for the sick' (C 1) reawakens and strengthens in us awareness of being the heirs of, and participants in, a long tradition, which is rich in lights but not without its shadows. From the lights we can draw vigour and enthusiasm; from the shadows an admonishment to allow ourselves to be guided by the right discernment of the signs of the times and by an intelligent updating at the level of the contents and the methodology of our ministry.

whose implementation has been characterised by *lights and shadows,*

3. The charism transmitted by Camillus to those who worked with him immediately matured into corporal and spiritual assistance for the suffering, even before the *Company of the Servants of the Sick* was officially approved by the Church.

4. Notable modifications in the exercise of the ministry took place during the life of our Founder. After a period when ministry involved daily visits to sick people in hospitals as a complementary and supplementary, but not substituting

...subject to *modifications* corresponding to changed socio-cultural conditions,

to different interpretations of the *charism*...

function of, the hospital personnel, and assistance to the sick in private homes, St. Camillus wanted to take up the complete service of hospitals in the place of the lay personnel and spiritual and corporal assistance for the sick. Although with regret, our Founder accepted that the ministry of the fathers and the brothers should be differentiated in line with the recommendations of the Bull Bolla *Superna Dispositione* which assigned, although not exclusively, spiritual care to the priests and corporal care to the brothers.

and the clericalisation of the Institute with a *declassification* of the category of brothers

5. The decimation and the penury of the religious brought about by epidemics led to an abandonment of the complete service in hospitals. The cause of the circumstances was transformed into a programmatic choice to reject that kind of assistance, replacing it with periodic visits to hospitals. Assistance became allocated to a sector, with a preference for, and the prevalence of, spiritual care, in particular for the dying in private homes. This change went hand in hand with the clericalisation of the Order and the declassification of the brothers who were relegated to domestic roles or roles connected with worship. During the second half of the seventeenth century this situation crystallised and lasted for the whole of the eighteenth century and a part of the nineteenth century.

Camillian literature on pastoral care for the sick and above all of the dying

6. During the seventeenth and eighteenth centuries some Camillian religious offered a valuable contribution to ministry by publishing works in which suitable methods for the exercise of the ministry practised in the Order were illustrated. The works of Fr. Giovanni Battista Novati (1585-1648): *Adnotationes et decisiones morales, pro opportuno infirmis et moribundis auxilio prestando*; of Fr. Giacomo Mancini: *Practica visitandi infirmos (1630)*; of Fr. Carlo Solfi: *Il ministro degli infermi per aiuto della buona morte* (1680);and of Fr. Baldassarre Bosch de Centellas y Cardona (1645-1714): *Práctica de visitar a los enfermos y ayudar a bien morir*, all had an influence on pastoral care for the sick until the end of the nineteenth century. An order of the General Chapter of 1678 allocated these works, and above all the textbook of Fr. Mancini, to the number of basic texts to be used for the formation of candidates for religious life in our Order.

Return to the original spirit of the institute: the work of the Camillian father, Cesare Bresciani

7. During the first half of the nineteenth century important changes took place. Although, on the one hand, prominence was given, rather emphatically, on what was to be done by souls following the indications of the *Writings* of our authors, on the other signs appeared of a return to the origins. In Rome the religious returned to hospitals and took responsibility for ministry in the health-care institutions of St. John in the Lateran (1836) and of the Holy Sprit (1841), and in Verona Fr. Camillo Cesare Bresciani re-established the ministry of the fathers and brothers in the hospitals.

The beginning of a new form of Camillian ministry: *health-care and social/health-care institutions*

8. Towards the end of the nineteenth century a new field of Camillian ministry opened up with the rise of *health-care institutions owned by the Order*. In these both fathers and brothers could find easier forms of work and escape the various *vetoes* imposed by the secularist mentality that dominated the health-care world. This way of exercising the ministry was welcomed and praised in the Constitution of 1915, inasmuch as it offered 'the highest opportunity to exercise spiritual and corporal works with great freedom and greater perfection'. Health-care and social/health-care institutions experienced an important flowering during the twentieth century. In the Constitution of 1845 the possibility was envisaged of the exercise of the *corporal ministry* in private homes as well, something that had never been allowed before.

The *feasts of charity*: the heroic dedication of religious at the time of contagious diseases

At the beginning of the twentieth century the last 'feasts of charity' took place in the form of the heroic exercise of ministry in the assistance that was provided to the victims of contagious diseases. At the time of the so-called 'Spanish influenza', which caused millions of victims in Europe, some Camillian religious sacrificed their lives when helping those afflicted by this pestilence, and in doing this they followed a tradition that has never experienced crisis throughout the historical journey of the Order.

Discussions on the principal purpose of the Institute

9. At the General Chapter of 1923 it was affirmed, after a long discussion, that care for the sick was the *principal* but not the *only* ministry of our Institute, on the condition that this did not lead to a deviation from the principal purpose of

the Order. This discussion was taken up again in the 1960s following a document in which it was stated that the purpose of the Order consisted of corporal and spiritual works of mercy but that amongst these those concerning the sick, wherever they were to be found, were to be privileged.

Indirect ministry: pastoral care for health-care personnel

10. One had to wait for the 1920s to see a new field of Camillian ministry emerge: pastoral care for, and the formation of, personnel. This form of *indirect ministry*, which began in Germany – where the *Caritasverband* entrusted it to our religious – was discussed and accepted at the forty-ninth General Chapter of 1929, but it was neglected in the Constitution of 1935, an indicator of resistance to cultural mediation. This was a matter of taking up anew, in new forms, initiatives that went back to our Founder and were advanced, albeit with interruptions of continuity, down the centuries. In 1930, in Milan, the Nursing Catholic Union (NCU) was created under the patronage of St. Camillus and St. John of God who were proclaimed specifically that year, by Pius XI, the patron saints of nurses and their associations. Similar movements of associations which arose in different nations and above all in Latin America, involving various categories of health-care workers and volunteers, found that Camillian religious were effective animators.

Openness to *missions*

11. At the General Chapter of 1923 it was established that it was not contrary to the purpose of the Institute to engage in activities in countries of mission, but this was on the condition that the ministry specific to the Institute was exercised as part of such activities. During that period our religious exercised ministry in Aalborg, in Denmark, which was under the aegis of the Congregation of *Propaganda Fide*.

The Second Vatican Council and the revision of the *Constitutions of the Order*

12. Following the celebration of the Second Vatican Council, the revision of the Constitution, which began immediately after the General Chapter of 1965 and was approved by the Extraordinary Chapter of Seiano (1969) and subsequently modified until the General Chapter of 1983, led to clarifications about the charism and the exercise of the ministry. It was made clear that the charism of the Institute did not concern every work of mercy but, instead, those

directed towards the sick, even though it was specified that the Order 'in particular circumstances of time and place and in response to the more urgent needs of the Church, is open to other works, especially on behalf of those in need' (C 10). As regards the ministry it was stated that it 'has as its purpose, the complete service of the sick in the totality of their being' (C 43), including all the benefits that could be of advantage to this last: care for the families of sick people and personnel, the study of ethical problems, membership of Church bodies dealing with pastoral care in health, and influencing local and national health-care policy.

The reassessment of the *figure of the brother* in the lineage of the first inspiration of St. Camillus

13. In the final draft of the Constitution the role of fathers and brothers in the exercise of the ministry was also defined, with a return to the Bull *Illius qui pro gregis* of 1591, which, reflecting the original thinking of St. Camillus, made no distinction between the ministry of the fathers and that of the brothers, with the exception of that brought about by priestly ordination and the skills acquired by the religious.

Towards the poor and the Third World

14. At the last General Chapters (1989, 1995, 2001, 2007) a warm invitation was extended to the communities and the individual religious to extend the ministry to the poor and to developing countries in a more incisive way and to struggle for the promotion of solidarity and justice in the world of health and health care.

15. Bodies entrusted with the planning and the coordination of the ministry, such as the secretariats (both general and Provincial) help to give greater unity and continuity to the initiatives of the sector of the ministry.

The exercise of the ministry is attentive to the *recommendations* of the Church, with which *Camillian religious* work actively

16. The journey engaged in by Our Order as regards the ministry has not been solitary but, rather, has taken place in the company of the Church, in a climate of reciprocal influence and cooperation. Many projects and initiatives at a universal, national and diocesan level have worked together to create a climate that is favourable to the strengthening of the Camillian ministry. One need only remember the *Apostolic Constitution on the Sacraments of the Sick* of Paul VI (1972); the Apostolic Letter *Salvifici doloris* of John Paul II (1984); the 'Motu Proprio' *Dolentium Hominum* (1985) by which the *Pontifical Commis-*

sion for Pastoral Assistance to Health Care Workers, raised to being a *Pontifical Council* by the 'Motu Proprio' *Pastor Bonus* (1988), was instituted; the Apostolic Exhortation *Christifidels Laici* (1989), in which two important sections (53 and 54) were consecrated to the sick and health-care and pastoral workers; the institution of the *World Day of the Sick* (1992); and the numerous documents and initiatives of local Churches.

The Expansion of the Order and the Ministry

The geographical expansion of the Order and its effects on the ministry

17. One of the factors that exercised an influence on the ministry, both favouring its enrichment and making its exercise at times problematic, was the expansion of the Order. Until the twentieth century, the Camillian Order developed above all in Italy, with the exception of the foundations in Spain, Portugal and Peru. At the end of the nineteenth century and the beginning of the twentieth century, it entered a number of European countries (France, Germany and Holland) and then the Americas, with the foundation of the Province of Brazil (1922) and the Province of the United States of America (1929). The *implantatio Ordinis* in Asia began in 1946 with the first expedition to China, which gave rise to the presence of the Order in various nations of the continent of Asia. In Africa, where there had already been a Camillian expedition led by Fr. Stanislao Carcereri in the footsteps of St. Daniele Comboni, the Order was established in the 1950s and rapidly developed in a number of the countries of that continent. But it was only after the Second Vatican Council that the Order experienced a season of flowering.

The Camillian presence in the five continents of the world

18. At the present time, the Order is present in 38 countries of the five continents of the world: 12 in Europe (Italy, Spain, France, Ireland, England, Germany, Poland, Austria, Hungary, Holland, Armenia, Georgia); 10 in the Americas (the United States, Peru, Brazil, Bolivia, Colombia, Ecuador, Argentina, Mexico, Haiti, Chile); 7 in Asia-Oceania (Taiwan, the Philippines, Thailand, India, Vietnam, Indonesia, Australia); and 7 in Africa (Tanzania, Kenya, Burkina Faso, Benin, Uganda, Madagascar, Togo, the Ivory Coast, the Central African Republic).

The reduction in the number of religious in Western countries and their growth in developing countries

19. The reduction in the number of Camillian religious in Western countries and the steady growth of the Order in developing countries, have indicated, on the one hand, the steady fulfilment of the prophecy of St. Camillus who envisaged the diffusion of the little plant that he founded throughout the world, but, on the other hand, they have also made obvious the shift of the Camillian presence from the North to the South of the world.

The challenge of *acculturation* for the Camillian charism

20. The expansion of the Order has made possible an enrichment of the expressions of the Camillian charism. Contact with cultures different from that of its origins has led religious to new forms for the implementation of merciful charity towards the sick which are in line with the social/health-care conditions of the various countries of the world. Although in the Western world the process of adaptation of the charism to changed cultural and social situations has been facilitated by the presence of a rather homogenous culture that is rooted in Christianity, in many developing countries this is still underway and involves religious searching for ways of implementing the shared charism which are more respondent to their socio-cultural and religious contexts.

Our Presence

We are present...

21. Even though the field of action of our ministry is limited to the *world of health and health care*, it takes place in a multiplicity of contexts and knows a rich variety of expressions.

In public *social/health-care and health-car institutions,*

22. As in the time of St. Camillus and his first companions, health-care and social/health-care institutions are the setting where our presence is most concentrated. Most of our religious carry out pastoral activity in public hospitals and they are engaged not only in accompanying the sick in addressing their conditions of infirmity in a positive way but also in contributing to an assistance that is rich in human and spiritual values through the formation of personnel, projects of humanisation, and membership of ethics committees.

and in our *works*

24. Then there are *our works* which underwent a notable development during the twentieth century: hospitals, nurs-

ing homes, old peoples' homes, residential communities, hospices and other institutions.

Our ministry extends to *private homes,*

24. Although reduced, our presence in the *world of families* through health-care and pastoral activity is still alive in some contexts, inviting us not to forget what St. Camillus saw as the *mare magnum* of our ministry.

it is revived in dramatic circumstances,

25. In order to respond to the needs generated by natural disasters of various kinds (earthquakes, epidemics...), the spirit of initiatives promoted by St. Camillus in such circumstances is kept alive through special agencies such as the Camillian Taskforce and various NGOs.

it is expressed through *institutes of formation,*

26. During the second half of the twentieth century *institutes of formation* arose, some of which were of an academic character (the Camillianum International Institute for the Theology of Pastoral Care in Health of Rome and the *Centro Universitario São Camilo* of San Paolo, Brazil). Present in many countries, they contribute to the evangelisation of the world of health and health care. Publishing activity belongs to this ministerial project and it continues to be active through the publication of books and reviews.

some *parishes and rectories*

27. Even though this ministry does not form part of the specific goals of our ministry, special circumstances have led our religious to accept the invitation of bishops to take responsibility for pastoral care in a significant number of parishes and rectories.

and participation in *Church bodies*

28. Not institutionalised, but important, is our presence in Church bodies, in associations and groups of voluntary work and prayer.

Chapter II

Our Roots

Service to the sick is an essential part of our consecration to God

29. Our charism – a gift of God to Camillus and by him transmitted to the Institute – finds its most important expression in the practice of the ministry (cf. C 10). For our Institute, indeed, service to the sick is not an optional or an accessory element: it is an essential part of our consecration to God through the profession of evangelical counsels.

The example of St. Camillus, admirable imitator of Christ the Samaritan,

30. An experience of the Spirit (cf. MR 11), the charism led St. Camillus to reproduce in his life and in service to the sick the feelings and the approaches of the merciful Christ. With this specific exegesis of the Gospel of mercy, Camillus lived the *whole* of the Gospel with a special radical quality and concreteness, extending in time the therapeutic and health-giving mission of Christ, which was a distinctive sign of his messianic identity (cf. Lk 4:18; Mt 11:1-5; cf. AA 8c).

...served and contemplated in the person of the sick individual

31. In shaping his charismatic and spiritual experience, St. Camillus drank at the springs of the Word of God. What he handed down to us is thus the result not of a sociological outlook but of the outlook of God as revealed in Christ. In two Biblical texts he perceived, in the inexhaustible face of Christ, the unmistakable features of the identity to be impressed on his spirituality and his work. In Mt 25 and in Lk 10:25-37 Camillus found the suffering Christ to be served and the supportive and health-giving Christ to be served; he who hides himself and reveals himself in every sick person; the Christ who gives us the grace to serve and to feel like him; the Christ whose beauty and dignity are to be contemplated and venerated; and the Christ who restores to every wounded and marginalised person his or her lost or stolen dignity.

The *internalisation* of the charism impresses fecundity on the ministry

32. A welcoming of the gift of merciful charity towards the sick, which has been handed down to us by our Founder, infuses fecundity into our ministry. Indeed, internalised and lived with love, the charism enables us to perceive the attraction of Christ (C 25), the divine Samaritan of souls and bodies; to have the same feelings as him; and to imitate him in being and acting, placing ourselves in the same approach as him, in his familiarity with the Father, in his capacity for judgement, of discernment and of observation. Only if modelled on the ministry of Christ can the Camillian ministry be an authentic expression of the passion of God for man and a source of human and spiritual growth.

The charism and the ministry nourish each other,

33. As was the case with St. Camillus, in us as well the charism and the ministry nourish each other. Lived integrally, the charism of merciful charity transforms our outlook, making us able to see the Christ who is concealed and revealed in every sick person and who gives us the grace to serve as he served, to associate ourselves with the *pathos* of God, to move and be moved in front of our neighbour, to transform our humanity into a vehicle of the mercy and the tenderness of the Lord (MR 12), to see all that is human positively and to take on the human as a *setting* for salvation. Performed with competence and love, our ministry offers us an opportunity to explore our knowledge of the gift that has been handed down to us by Camillus, to appreciate its riches, to internalise it with greater intensity, and to live out new spiritual experiences.

...and are the terrain in which is rooted Camillian spirituality

34. We can now affirm that our way of living life in the Spirit, that is to say our spirituality, has its roots, on the one hand, in the charism when welcomed, explored and renewed, and, on the other, in faithful exercise of the ministry: outside these theological and existential reference points, it would be disembodied and would expose us to living a sterile exaggerated intimacy or a soulless pragmatism.

The promotion of health is a part of the ministry

35. Taking part in the therapeutic and health-giving mission of Christ, through the exercise of our ministry we cooperate in the fulfilment of his wish 'that everyone should have life in abundance', not only through the healing of illness-

es but also through the promotion of a model of integral health that reaches the vital centres of a person, his or her relational fabric, values and lifestyles. In service lived in this way, we recognise the dignity of every man, we foster his human and spiritual growth, and we help him to rediscover and strengthen his interior resources and journey towards his complete fulfilment.

Service to the sick, lived as an experience of God, contributes to the *personal growth* of a religious

36. When our ministry is exercised as an act of charity, it works effectively for our personal perfection, contributing to the growth of our spiritual lives. In this sense should be interpreted the words of *The Contemplative dimension of Religious Life*: 'The very nature of apostolic and charitable activity contains its own riches which nourish union with God' (n. 6). This is what St. Camillus meant when he invited his religious to 'leave God for God', pointing out that loving service offered to the sick can be an authentic experience of the Lord.

The efficacy of the ministry, which may *require heroism*, depends in large measure on a solid human and spiritual formation that is constantly nourished

37. The greatness of the ministry – to which the Constitution attributes a central place in exhorting us to commit ourselves to it 'above everything else', even at the risk to our lives and for the whole of our lives (C 12, 29) – justifies the statement of Camillus that our Order needs *perfect men*, unified and centred, seduced by the merciful Christ and impassioned of the weakest and most in need, internally free, able to form healthy and health-giving relationships and to live existence and pre-existence. We are thus called to rely upon the quality and truth of our being: authentic motivations, maturity in relationships; the way of managing our shadows and wounds; the meaning of life, attention directed towards our own spiritual needs; the way of posing to ourselves true and ultimate questions; and an intimate relationship with God through the practice of our vows and an intense and faithful life of prayer (liturgy, sacraments...) that privileges the contemplative and cordial dimension, that frees itself from an excessive *functional* charge.

The *community*, the first setting in which to exercise the ministry

38. In following the indications of the theology of consecrated life and the Constitution (C 9), we recognise that the community is the first context in which to learn and exercise our ministry. Indeed, our self-giving to God through the pro-

fession of the four vows is also an unconditional self-giving to the community (C 29). Because of our faith and religious consecration, in it we become *ministers of the sick*: in fraternal communion we learn service, share our charism and our spirituality, and exercise joint responsibility in making 'the gift of witnessing to the world the ever-present love of Christ for the sick' (C 1) attractive and effective.

Chapter III

The world in which we work

39. The world of health and suffering in which, today, we exercise the ministry has multiple faces. The expansion of the Order in the five continents of the world, indeed, has led us to work in contexts that are different as regards socio-economic, cultural and religious conditions.

The world of health: one of the most important crossroads of society

40. If we turn our attention to the countries of the West, the world of health is one of the most important *crossroads* of society, passed through by almost the whole of the population. It has been rightly said that human life has come out of the home to become itself, at its most critical and decisive moments, in the health-care world. It is in this world that the fundamental events of human existence take place (cf. DH 2): birth, a possible recovery of health, ageing, and death; that the most fascinating and worrying research is carried out; that one can hear the fundamental questions of men of our time concerning the meaning of life and the reason for suffering and death. It is not surprising, therefore, that the health-care world has become the setting where the various projects about man, his future and his happiness, as well as different conceptions of society, come into collision.

The progress of medical science and technology has been accompanied by the rise of a culture where care for the sick tends to be dissociated from a *Christian vision* of man

41. Amongst the factors that are at the origin of the present character of the health-care world, reference should be made to the process of secularisation of care and assistance for the sick, the progress of medical science and technology, and the development of the modern hospital.

42. These great social and organisational changes are also matched by the rise of a different culture, whose characteristics can be identified in a new concept of health and of

illness, in an increased awareness by the population of its rights of physical and mental wellbeing, and in a gradual dissociation of care for the sick from a Christian vision of man.

Challenges to pastoral care in health: **secularisation,*

43. A terrain favourable to the formation of this new vision has been the process of secularisation, which germinated during the Enlightenment and matured progressively during subsequent centuries. Like all the other human universes, the health-care world, as well, is dominated by awareness of its autonomy as regards the sacred and by the development of a series of forms of knowledge and technologies directed towards responding to the problems posed to humanity in this area of human life.

*a 'Promethean' approach to man which seeks to control life and death;

44. Side by side with decidedly positive aspects, in secularisation there are also visible seeds of ways of being and acting that are in contrast with an authentically human and Christian anthropological vision, a 'certain Promethean attitude which leads people to think that they can control life and death' (EV 15), the tendency to remove the negative aspects of existence – suffering, illness and death –, and the shift from a medicine of needs to a medicine of desires.

*the dehumanisation of service to the sick

45. In care and assistance for the sick – which have undergone an enormous positive development – certain limits produced by medical and organisational progress can be identified. On the one hand, the accentuated medicalisation of all segments of existence (birth, growth, ageing, death) and the reduction of human, relational and existential phenomena to phenomena that are merely technical is condemned; and, on the other, the need becomes increasingly evident to humanise service to the sick, which is made more problematic by the interference of political and economic interests, by a bureaucracy that is at times oppressive, by a work methodology based upon speed and efficiency, by conflicts over contracts, and above all else by a deterioration in the scale of values which makes seeing the patient as a person more arduous.

The situation of developing countries: the negative impact of poverty on the

46. The picture of the world of health and health care changes if we pass from Western countries to developing countries. In many of these countries, poverty has an important

bearing on the health of the population. Whereas a limited group of people can enjoy the most sophisticated instruments, the number of people who cannot use the most elementary health-care services is very great. They live in isolated regions, in rural areas or on the outskirts of large cities, in unhealthy environments which diminish the average age of people. Here hygiene is unknown and illnesses caused by parasites, bacteria and viruses cause massacres. In very large areas the populations in a resigned way endure situations that they do not have the power to change.

promotion of health and care for the sick

47. And it is to this world of health care, which is characterised by lights and shadows, that, because of the charism received by St. Camillus, we are called to open ourselves, animated by hope, by a spirit of cooperation and by the awareness of making, through our service, an essential contribution to the salvation of man.

Openness to the world of health and health care first and foremost with *dialogue* in order to understand its positive aspects and its limits, its supportive actions and its contradictions

48. In this openness we are helped by two approaches: dialogue and exchange. *Dialogue* fosters an objective knowledge of what takes place in the world of health and health care. Through an intelligent and respectful conversation with those who are involved in the health-care world, both as patients and as professional workers or volunteers, we can realise the complexity that characterises the world in which they care called to work, understanding both its positive aspects and its limits.

49. By overcoming emotional reactions or moralistic approaches, it will be possible to realise that in the world of health and health care one breathes in the cultural atmosphere of the society in which that world works. It has been rightly observed that it is not medical doctors but society that is judged according to how, within it, people suffer and die. Indeed, the behaviour both of patients and of health-care workers is rooted in the culture of the society in which they live and work.

50. In the world of health and health care, indeed, are present those ambivalences that characterise our culture. A universalist openness and an increased sensitivity to-

wards the rights of all citizens is opposed by a weakening of an ethical awareness of existence, with a consequent loss of the meaning of work, of faithfulness, of sacrifice and of sharing; an upholding of the value of life, of the dignity of the person, of health, of the accompanying of patients... is often contradicted by a banal view of birth, the removal of death, the reduction of health to physical vitality alone, and the marginalisation of certain categories of sick people. Deeds of great generosity are counterbalanced by forms of behaviour rooted in a subjectivist and relativist mentality, according to which the only and incontestable reference point for the choices to be made is one's own subjective or changeable opinion or even one's own selfish or capricious interests. In some areas of developing countries, laments, requests for help and the very desire to grow are often flanked by low levels of enterprise and the devastating impact of corruption.

The approach of dialogue must be combined with an approach of exchange in order to avoid an *exaggerated horizontal approach* that deforms the values of the Gospel

51. An alliance with the positive forces present in the world of health and health care should be accompanied by *exchange*. This approach becomes necessary when one realises that the new health-care context was created outside the Church and often against the forms that her charitable assistance had directed for centuries. How can one ignore that medicine and social services have extended their influence to the point of deciding which forms of human behaviour should be adopted? The professionals of these sciences define and solve problems that trouble people at all levels, including the ethical level, becoming specialists in matters of abortion, of sterilisation and of organ transplants.

52. Combining dialogue and exchange is a task that should be persevered with. If, in fact, *dialogue* disappears, we run the risk of being transformed into a presence of juxtaposition, intervening when the world of health and health care has already carried out its projects without us. Neglecting *exchange* leads to an abandonment of gospel values, opting for an exaggerated horizontal approach that deforms our evangelising mission. A harmonisation of these two approaches makes us ready to plan together with those who are involved in the world of health and health care, with humility, with a spirit of service, strong in the belief that faith is essential to the success of the projects of men.

The joys and hopes of the world of health and health care. These are our joys and hopes

53. It is with this spirit that we are called to read the words of the Second Vatican Council, applying them to ourselves and our ministry: '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. Indeed, nothing genuinely human fails to raise an echo in their hearts' (GS 1).

Chapter IV

Our mission

The purpose of the ministry is *evangelisation* in its various expressions

54. The aim of our ministry is the *evangelisation* of the world of health and health care. By this word we do not refer only to an aspect of the action of the Church, but, rather, to all of her mission which expresses in the proclaiming of the Word, actuates in the sacraments, and bears witness to in her life that integral salvation that Jesus Christ who died and rose again communicates to men.

55. In the Gospel the commandment of Christ, 'go and heal' is always joined to 'go and teach' and 'go and baptise'. Jesus never separates his therapeutic activity from the proclaiming of the Kingdom. 'Heal the sick', 'proclaim the Kingdom', and integrating men and women into the community of believers, are complementary aspects of evangelising action.

Promoting interaction between proclaiming, liturgy and charity

56. In the exercise of our ministry we are thus called to foster a better osmosis between proclaiming, liturgy and the service of charity. The interaction of these three functions is so important that without the other two, one function on its own runs the risk of losing efficacy. Words, sacramental gestures, charitable approaches and works are separate from each other but continue in a constant intercommunication. Indeed, what is proclaimed is God's plan of love for men; what is celebrated is the Lord's love for men, the broken body and blood shed; this proclaiming and celebration constitute love between brethren.

Pronouncing words of the Gospel on all the realities of the world of health and health care

57. We believe that it is our concern – which allows no forms of indifference or of accommodation – to infuse *gospel elements* into the fabric of the health-care world, uniting our energies to those of the Church, which is called

to communicate the gospel of salvation to all men, helping them to live their illness and health, pain and death, in a more human way, opening up to that hope that does not disappoint the deepest aspirations of the human heart.

Proclaiming

The riches of the Gospel message

58. The Gospel, which we are called to communicate, is a word rich in meaning: it evokes in the lives of men the gift of liberation; it expresses the project of God; it assures its presence and accompanying in the events of existence; it clarifies and illumines for men the pathways that are to be followed, the principles to be respected and the right solutions to adopt; it is of singular comfort during the difficult moments of life; it leads to the expansion and completion of the person; and it transcends human life and uncovers its horizons of eternity. It is not a word of man but of God. Its essential contents are Jesus Christ who rose again. The great event of the resurrection is not a fact reserved to Christ alone: it is destined to propose itself anew at the end of the human event of each person. While awaiting the resurrection, we are invited to compare the unfolding of life with the final outcome that it will have, and, in the meantime, to follow a policy based upon trust, upon hope and upon authenticity.

Not ignoring the *fracture* between the gospel and culture

59. In committing ourselves to proclaiming the good news in the world of health and health care, we are aware of 'the split between the Gospel and culture' (EN 20) which is typical of contemporary society and in particular of the Western world. 'The process of secularisation has also lowered the spiritual and moral sensitivity of by no means few believers, placing them in a stance of defence if not of rejection of transcendence and spiritual and moral values. Some typical realities of the health-care world have been affected: the concept of life, of health and of illness, the presence and the purpose of pain in human life, the meaning of death, the value of service for those who suffer' (PSCI 21).

Life

Contrasting approaches to life: *exalting it and fighting against it*

60. In the exercise of our ministry, human life appears in its beauty and its frailty. The hymn to life provoked by new lives is coloured by melancholy in accompanying people who die. Our meetings with people and attention to the ethical debates of our time make us aware of approaches opposed to human existence. Side by side with 'growth in esteem for the value of human life and awareness that its defence and promotion require greater commitment and solidarity on the part of everyone and at every level' (ECV 5, cf. EV 26-27), we observe 'very many forms of threat, of violence, and of rejection of life, the more dangerous the more they are concealed behind the false appearances of civilisation, beginning with the repeated appeal to 'quality of life'' (ECV 6). The forms of struggle against life that we witness in places where the ministry is carried out take a variety of names: contraception, abuses by genetics and techniques of artificial fertilisation, prenatal diagnoses to avoid the birth of malformed or sick creatures, the fear of having children or the claim to have them at any cost, abortion, exaggerated treatment and euthanasia, drug and alcohol addiction, violence against people, and the pollution of the environment.

Which *quality of life?*

61. Underlying many of these choices there is 'the dominant culture which sees the 'quality of life' as a primary and absolute value and interprets it prevalently or exclusively in terms of economic efficiency, being enjoyed at a consumerist level, at the level of the beauty and liveability of physical life, separated from the relational, spiritual and religious dimensions of life' (ECV 6).

Proclaiming the value and the *beauty* of life

62. Called to be involved in the evangelising process of life, we pronounce above all a *word* that proclaims its beauty and value, uniting ourselves to the joy and the wonder of women who give birth to a child, helping them to reflect, together with their husbands, on the miracle that has taken place from conception until the flowering of a new creature, and making them aware of the responsibility that is upon them to look after and bring up their children with love. Equally, in

accompanying sick people who are recovering their strength, we invite them to adopt an approach of gratitude and of greater appreciation of the gift of existence.

A gift of God and His love, life is *inviolable*

63. Recognising the exalting the miracle of life, its fascinating and mysterious character, we do not hesitate to proclaim that it is a gift of the Lord and His love. Indeed, 'no man comes to life by chance, he is always an end of the creative love of God' (ECV 22). 'For this reason, human life is inviolable: it belongs to God as a good that He entrusts to the freedom of man, so that it bears fruit according to His design of love' (ECV 22). God himself is the guarantor of every human life: 'of every man's brother I will require the life of man' (Gen 9:5).

Frankness and understanding in encounter with people who are faced with dramatic situations

64. in upholding the value of life and its inviolability, we know how to unite frankness (*parresia)* and understanding when we encounter couples called to address difficult situations, such as an unwanted pregnancy or one that is the outcome of violence; the prospect or the birth of a malformed child; and worries about a future that is made uncertain by economic difficulties. We adopt the same approach with those who want to end their existence by asking for euthanasia. Although at the basis of their request there is a wish to exercise a dominion over life, we must not forget the burden of suffering or a lack of meaning. A careful decoding of their request often brings out a fear of being abandoned or of being a burden for their loved ones.

65. In stating the limits inherent in the human condition, in situations in which they are not recognised – as happens in exaggerated treatment or in other practices which seek to defeat death in a definitive way – we help people to live the time that is granted to them in an intense way, avoiding falling into an approach without prospects or projected solely into the future, and adopting a lifestyle characterised by authenticity.

Helping people to aim *beyond* physical and mental wellbeing

66. We pronounce gospel words not only in situations where life is subjected to violence but also in those where its fulfilment is identified solely with the achievement of physical or

mental wellbeing. In recognising the positive consequences of that aspiration which refers to that existential fullness and qualitative absoluteness that characterise existence in its eschatological dimension, we know how to demonstrate its negative consequences for a vision of life.

Fullness of life is a *gospel value*

67. We do not hesitate to make people see that Jesus as well, in the carrying out of his mission, always aimed at the fullness of man's life: 'I came so that they may have life, and have it in abundance' (Jn 10:10). Although the salvation that he brings has the goal of raising man to sharing in divine life through a relationship that leads people to come out of themselves and to shoulder their responsibilities in the world, this does not mean that this is a disembodied salvation and that it does not solicit the joyous experience of living and of living in fullness. The experience of faith, in fact, involves the human person in his or her totality. The whole of Biblical revelation bears witness that every experience of God is an experience of life, of liberation from every kind of slavery to the point of sharing in divine life to the full.

Experience of faith involves the person in his or her totality

68. We help people to become aware that human life finds its full fulfilment in definitive encounter with the Lord, which is foretasted here on earth through the pursuit of positive values. From this point of view, the promotion of mental-physical health and wellbeing can become signs of the Kingdom installed by Christ, openness to welcoming salvation, and indicators of a condition that will find its full realisation during the eschatological age. Implementing everything that is legitimate to assure increasingly better conditions of life for all human beings thus forms a part of the divine project.

Consenting to reality, the outcome of a filial approach to the Lord

69. For a Christian, consenting to reality, even within its limits, is not the outcome of mere human wisdom, but, rather, of a filial approach to the Lord which leads us to welcome salvation in its fullness. If this is forgotten, one runs the risk of transforming faith into a *social service* or into an ingredient that is only capable of endowing a person with greater serenity, or a good relationship with oneself, exploiting it to achieve the mental-physical wellbeing of a human person

and cradling this person in his or her desire for invulnerability and immortality.

The promotion of a healthy *ecology*

70. The proclaiming of the gospel of life is also extended to the environment in which people have their existence, in an awareness that the defence and the improvement of the environment have become an imperative goal for humanity, to be pursued together with the fundamental goals of world peace and economic and social development.

Respect for the *creation* which has been placed by the Lord at the service of man

71. In pronouncing on these questions connected with ecology, we lay stress first and foremost on man's responsibility towards the creation, which God has placed at the service of his personal dignity, of his life, finding in the Bible a luminous and strong ethical indication for a solution that is respectful of that great good, life, every life: 'the dominion granted to man by the Creator is not an absolute power, nor can one speak of a freedom to 'use and misuse', or to dispose of things as one pleases...we are subject not only to biological laws but also to moral ones, which cannot be violated with impunity' (EV 42).

Educating in contemplation of the creation, discovering the traces of the *beauty* of God

72. In committing ourselves to an ecology on the human scale, we emphasise the beauty of the world in which we live, pointing to the horrible wounds inflicted on landscapes, the damage caused by pollution of the atmosphere or the massacre of families of animals. Ecological damage does not afflict only the bodies of people but also their spirits, making it more arduous to engage in the practice of contemplation, in which a landscape or a vision of nature cease to be simple natural facts and become means by which to understand and express ourselves, the mystery of life and reality, and the working presence of the Lord, in a better way. The *Song to Creatures* of St. Francis is an admirable example of an interior language expressed through images of nature.

Interior ecology: a precondition for the right approach to the environment

73. We do not fail to make people aware that appreciation of, and respect for, nature are possible inasmuch as an *interior ecology* is cultivated, which aims at respect for the unification of their beings.

Health

Health is one of the fruits most sought after by man, and is to be stewarded and promoted in a responsible way

74. In turning our attention to contemporary culture, and in particular that of the Western world, *health* is one of the *fruits* that is most sought after by man. In pronouncing a *gospel word* on this reality, we present it as a valuable possession, a sacred reality entrusted to men for them to steward with a sense of responsibility and lead to perfection in love and self-giving to God and their brethren, a gift that makes it possible for a person to live fully and to fulfil his or her human and Christian vocation. For this reason, we appreciate and encourage the efforts made by society to promote health, assuring that all citizens have a right to it.

The *evolution* of the concept of health

75. In our actions we take into consideration the evolution that the concept of health has undergone over the last centuries, to which has contributed the development of medicine and behavioural sciences. A summary of this evolution can be found in the definition given to it by the WHO (1946), a 'state of complete physical, mental and social wellbeing and not only the absence of illness and infirmity'

76. In making appropriate corrections to this definition of health, which had the merit of opening up a new field of reflection on this reality, we demonstrate that in the human condition perfect wellbeing remains an idea which it is difficult to achieve because health does not exclude disability and precariousness. In this way, we oppose the cultural tendency of our time which leads health to be seen as the ultimate good, almost a divinity from which one aspects salvation in the here and now of history, separating it from a vision of man where he is seen as a psycho-physical unity, as the bearer of intrapersonal and interpersonal relationships, as spirituality and as an essential relationship with the Transcendent.

The *body*, an essential dimension of the person, to be lived in unity with the spirit, in a concrete and harmonious integration

77. This cultural tendency leads to an approach to the body which is characterised by an at times obsessive attention, leading people to see it as the only or the principal messenger of their identity, to make it a subject of adulation, to show it off without modesty, and to reject it when it does not correspond to expectations.

Temple of the Holy Spirit, destined for resurrection, the body conserves its dignity even when it is made frail by illness or disability

78. In recognising the positive value of the recovery of the corporal, the outcome of modern and post-modern culture, we do not hesitate to show that the greatness of the human body depends on its participation in the absolute value of the person who is created in the image and the likeness of God; it comes from His hands as a 'good thing' to be welcomed and lived as a gift to be given in turn. An inalienable dimension of the human being, the body should be lived in unity with the spirit, in a concrete and harmonious integration. It is thanks to such an integration that it conserves all of its dignity even when, as in situations of illness and disability, it shows that it is a frail and precarious structure. This vision of the body is supported by faith which upholds its value inasmuch as it is a 'temple of the Holy Spirit' destined for resurrection (Phil 3:21).

A lack of physical or mental health does remove the *value* of life and the person

79. Convinced that health, understood as exuberant vitality and exemption from suffering, does not correspond to the needs of the person considered in his or her totality because it runs the risk of atrophying its full development, we affirm that life lived in suffering or in disability is not necessarily second rate, and we thus appreciate areas of growth, of quality of life, and of self-fulfilment that the human person can achieve in critical conditions as well.

Health and salvation

80. In the search for health, which in our epoch has reached exasperated tomes, we know how to understand a *dynamic* towards salvation which man cannot achieve on his own but which, rather, he can only receive as *grace*.

Suffering

Saying a *gospel word* on suffering in a cultural context that tends to remove it

81. Our personal experiences and the practice of the ministry constantly confront us with suffering in its most varied expressions. Although wisdom leads us to avoid easy analyses of this mysterious reality upon which so many dreams and projects break, this does not exempt us from saying a *gospel word* on human suffering. The warning of St. Paul: 'Woe to me if I did not evangelise!' (1Cor 9:16) also applies to moments when we are called upon to reflect, in the light of the word of God, on the negative aspects of life.

82. Before pronouncing our words on suffering, we set ourselves to listen to what the men and the women of our time think about it. A simple observation illuminates the tendency to remove suffering. *Algophobia*, or horror of pain, is one of the characteristics of our society. This attitude is supported by the progress of medical science and technology which in its most radical aspects leads to a rejection of the finite condition of man.

Combating suffering technically, striving, however, to understand its *meaning* as well

83. Suffering, which is expressed in physical, mental and moral pain, is a sign, a *message in code*, a cry of a person who is wounded not only at a corporal level but, rather, in the totality of his or her being. In a society that tends to treat suffering in a purely technical way, that is to say by seeking to eliminate it before trying to understand its meaning, it is difficult to understand this cry. Excluded from consciousness in which it is experienced, suffering is thus reduced to a pure symptom, and in this it alienates and dehumanises. In this case it is not a person who is the subject of care and treatment but suffering itself. Detached from man, it has only a medical, social and political meaning.

Consenting to reality, overcoming the illusion of being *invulnerable*

84. In the fight against pain, it is important to grasp the message that pain transmits. In the consciousness of those who suffer, indeed, the gap between what they are and what they would like to be is clear. Through suffering, the real irrupts into the imagination of the person, shaking or breaking his or her illusion of being invulnerable and immortal.

85. Awareness of one's own vulnerable and mortal condition provokes in those who are involved a multiplicity of reactions: sadness, fear, anger...Amongst the targets against which such feelings and emotions are directed there is also God. To Him the atheist and the believer turn, the first to confirm his or her non-belief, the second to ask the *reason* for so much suffering whose meaning escapes him or her. How can pain be reconciled with the omnipotence and the goodness of the Lord?

Looking for the answer to the many that are generated by

86. The search for an answer to this question involves reason and calls on faith, in a dramatic struggle which is well

illustrated in the Book of Genesis (Gen 32:23-32), where the clash between Jacob and the angel, which lasted the whole of the night, is described. This struggle takes place in darkness, a symbol of the mysterious character of suffering, and ends with the appearance of dawn, which opens up to hope.

suffering, not forgetting its *mysterious dimension*

87. While waiting for this light to illumine the reality of suffering, endowing it with meaning, we avoid any approach which involves an *exaggerated praise of pain*, which consists in interpreting pain as an element that has a value in itself, at times even exalting it, or, in extreme cases, even searching it out, and we adopt Jesus' way of behaving which opposed evil and sought to free man, its victim, from it. At the same time we should not forget that fighting against suffering is also becoming aware that on the cross Jesus took the side of the weak, the sick and the poor. On the cross he was not at *the side of* suffering, he was *inside* suffering, he experienced it and lived it anew in each sick person, after following the pathway of suffering until a tragic outcome. With the passion of Christ 'Human suffering...has entered into a completely new dimension and a new order: *it has been linked to love...* that love which creates good, drawing it out by means of suffering...The Cross of Christ has become a source from which flow rivers of living water' (SD 18).

Avoiding an approach based upon an *exaggerated praise of pain*

88. For the believer, who does not know a way by which to by-pass suffering, there is thus opened up a journey that traverses it and rises above it. In turning to the crucified Christ the believer can recognise that his or her own suffering is closely connected with the suffering of he who said: 'Was it not necessary first that the Christ should suffer these things and enter into his glory?' (Lk 24:26). United to the suffering of Christ, human suffering, as well, can be transformed into an expression of love, losing its connotation of scandal.

The role of *faith* in facing up to suffering

Death and Mourning

89. In the tradition of our Order accompanying the dying has always had a privileged place, and to such an extent

The rich tradition of the Order in *accompanying the dying*

as to lead our religious to be known as the *Fathers of the good death*. This noble tradition has weakened but it has not disappeared, and thus in the exercise of our ministry pronouncing a *gospel word* on death remains fundamental.

Obstacles and factors that are favourable to the evangelisation of death

90. Careful observation of the contemporary world enables us to identify, side by side with obstacles, also elements which, after a certain fashion, facilitate the evangelisation of death and pastoral relationships of health with the dying. Amongst the obstacles we should list the tendency to remove death, the weakening of religious practice, the growth in the number of people who do not believe in eternal life, the disappearance of preaching about ultimate realities, and disaffection in relation to the institution of the Church. It follows from this that our presence, more than in the past, can reawaken in sick people whom we draw near to, and their families, questions already put to one side, often provoking negative reactions.

The *pluralism* of 'experts' on death and dying

91. Further malaise arises from the fact that today we are no longer the only ones who speak about death and respond to the requests for spiritual health of the dying. Although in the past the religious approach enjoyed a privileged position, today the phenomenon of secularisation has fostered the emergence of other ideological stances which help to *govern* death and give it a *meaning*. In some countries health-care institutions employ *secular counsellors*, who are called *humanists*, and their task is to assist in a moral way patients who do not profess any religion.

The placing of *spiritual accompanying* in care for the sick

92. Moving to the positive side, it should be stressed that differently to what happened in other epochs, spiritual accompanying *tends* to be placed within therapeutic programmes. Amongst the many factors that have contributed to this change in approach, the most important is the establishment of the hospice movement and the philosophy of *palliative care*, in which it is emphasised that care for the dying must be physical, psychological, moral, spiritual and religious assistance, in relation to the crisis provoked in an individual by the prospect of his or her imminent death.

The search for *spirituality*, which is present in contemporary culture, as a factor that facilitates the spiritual and religious accompanying of the gravely ill

93. This change has also been facilitated by the important search for spirituality in our society, in which believers and non-believers are involved. These last uphold the possibility of living spiritual experiences and values without there being references to religion and to faith. Although this openness to the spiritual is not without the generation of confusions – because behind the term 'spirituality' is concealed an infinity of different conceptions which at times are also contradictory – it nonetheless allows a pastoral worker to find a shared platform from which to begin from which to start on a journey of spiritual growth, whose outcomes are entrusted to his or her capacities and above all to the grace of the Lord.

'Life is not removed but transformed'

94. The setting in motion of our message about death involves helping those that we encounter to see it as a reality that is not separate from the person but a part of his or her experience; a reality, therefore, that should not be eliminated but integrated. Reconciliation with this reality from which no human being, as St. Francis in his Son observes – 'Praise be to you my Lord, for our sister Death of the body, from which no living man can escape' – can withdraw, opens up the road to the Christian vision, according to which death, although it is accompanied by degradation and humiliation, does not mean the end of life but the passage to a different form of existence which is characterised by a dynamic of growth and complete expansion of the person.

To make death a 'friend' does not mean ignoring its dramatic dimension

95. For those who have faith, as well, death is a painful passage. To make it your *friend* does not mean, therefore, to ignore its dramatic character, which is present in the words addressed by Christ to the Father, 'My God, my God, why have you forsaken me?' (Mk 15:34), but to receive it as a outlet towards new and reassuring horizons, made possible by the passion, the death and the resurrection of Christ, who overturned the destiny of Heidegger's 'being-for-death' and reopened access to life that is not vain, to life that is anything but this, to *eternal life* (cf. SpS 35-40).

The experience of *mourning*

96. The death of a person means opening a wound in those who were linked by affection to that person. The human be-

havioural sciences have illustrated the dynamic of mourning, also holding up pathways to follow to achieve an appropriate and effective working through of the loss that has been experienced. Appreciating and using in a creative way the recommendations offered by psychology, we do not hesitate to pronounce *gospel words* about this experience of separation, a source of suffering and in many cases also an experience with pathological consequences.

Service to the Sick and the Humanisation of the World of Health and Health Care

The phenomenon of the *degradation of humanity* in service to the sick

97. Service to the sick also expects from us a *gospel word* so that the people who are living the difficult season of suffering are treated with greater humanity. The value of service, in fact, has undergone pollution of various kinds because of the imposition of adulterating elements in the medical-nursing profession, such as the rights of a science that is not prepared to receive ethical recommendations; a concentration of interest more on the clinical case than on the person of the suffering individual; the precedence given to considerations of a trade-union or political character more than efficiency in the face of the real needs of the patient...

Placing the human person at the *centre* of care

98. In following the recommendations of C 55 we strive, therefore, 'to ensure that the person is placed at the centre of attention in the health care world' and we offer our contribution to encourage 'society to promote the humanisation of health care structures and services and to guarantee, in the best possible way, the rights of the sick and respect for their personal dignity'.

The many *faces* of the phenomenon of dehumanisation

99. In becoming involved in the *humanisation* of the health-care world we allow ourselves to be guided by an appropriate knowledge of the complexity of this socio-cultural phenomenon, considering it in the variety of its aspects. Indeed, it does not only concern the relationship between health-care personnel and patients but also the conditions, which are often difficult, in which health-care workers are

often forced to work; the behaviour of sick people themselves and their family relatives, who are often characterised by unrealistic aims and by an inability to participate; medical technology which, rich in great merits, can, however, impoverish interpersonal relationships; a health-care administration which is by no means rarely weighed down by bureaucracy and disturbed by political interests which are in opposition to the wellbeing of patients; and architectonic structures which are often out-of-date and do not meet the needs of a more human service.

The *causes* of dehumanisation vary from one hemisphere to another

100. When we pass from the northern to the southern hemisphere, we realise the diversity of factors that are at the origins of the degradation of humanity in service to sick people. Although, as official data bear out, a billion people do not benefit from health-care services, live in isolated regions, in rural areas, or on the outskirts of large cities, and in unhealthy environments that notably reduce average life expectancy, there can be no doubt that the principal cause of such dehumanisation is poverty, to which are often added a lack of organisation and corruption.

Avoiding *moralising* attitudes

101. The complexity of the phenomenon of the humanisation of the health-care world stimulates us to avoid moralising attitudes and a pointing of fingers as regards health-care workers and the managers of health. In adopting an approach of observation which is as objective as possible, our actions and initiatives will be more effective.

Humanisation and evangelisation

102. Our role in this sector of the ministry finds its motivation in the evangelising value of all those deeds and initiatives designed to impress upon assistance for the sick, in its various expressions, a more human face (EN 21). They do not bear in only a marginal way on our ministry but, rather, are an integral part of it because we proclaim that man, when in a condition of physical and mental degradation as well, conserves all of his value, being in the image of the Lord, and as St. Camillus affirmed, is the *pupil of God*.

103. Understood in these terms, the humanisation of the world of health and health care belongs to the process of

salvation because every authentic, partial or sector-based, human liberation is a moment, a proclaiming sign, a demonstration of the profound liberation that Christ actuated in his paschal mission. In working for the cause of humanisation we contribute to the promotion of the Kingdom of God, whose achievement begins in history and then finds its full completion in heaven.

Reading the degradation of humanity in the world of heath and health care with reference to *theological* categories as well

104. In reading and explaining the phenomenon of the degradation of humanity which is present in service to the sick, we do not rely upon socio-psychological categories alone. In addition to the very many causes that are invoked – such as political and economic interests, the excessive bureaucratisation of the health-care system, inadequate administrative efficiency, conflicts over contracts, the deterioration of the scale of values which makes seeing the sick as persons more arduous...– we do not hesitate to refer to sin as well, deriving from it the conclusion that at the root of every humanising form there is the request for the conversion of hearts prior to the modification of institutions.

105. Convinced that in a believing vision of reality the first objective of humanisation of the health-care world is the promotion of the values of justice, of respect for the person, of fraternity and of solidarity, we do locate their achievement in material and technical progress, given that they can be implemented in conditions of poverty and expression.

Cooperation with those who are involved in this sector

106. In an intelligent way we provide our cooperation to various civil agencies that promote sensitisation to the rights of the sick (for examples tribunals for the sick), offering our specific contribution so that the human person is seen in the totality of his or her bio-psycho-socio-spiritual being and that the services offered to the individual patient on the basis of justice are accompanied by love in its expressions of gratuitousness and generosity.

The *positive aspects* of scientific-technological progress and of the rational organisation of work

107. In assessing the contribution to care and treatment for the sick and the promotion of health of science, medical technology and the rational organisation of work, we know how to take into consideration both their positive aspects

and their limits. Indeed, it would be unjust to ignore the great advances that have been achieved as a result of the technical applications of scientific research. One need only think of the possibility of prolonging life and of improving the quality of the social functioning of people. The use of increasingly sophisticated equipment offers patients new opportunities for recovery, an increasing number of alternatives, and greater possibilities as regards communication. Used well, technology can be a modern and effective vehicle for humanitarianism and charity. The modern rational organisation of work has also fostered real advances, making the implementation of care projects and the promotion of health more effective.

'More heart in those hands'

108. An honest recognition of the merits of science, of technology and of the organisation of work does not exempt us from adopting an approach of commentary, denouncing the negative consequences that they can bring. This takes place when medical technology seeks to be the only seeks to be the only response to suffering, neglecting attention being paid to the meaning suffering can have for the person and ignoring the importance of uniting intelligence and affectivity, *hands and the heart*, as St. Camillus put it. Similar commentary should be engaged in when observing the limits to the organisation of work, which can be identified in a bureaucratisation of systems of service that generates apathy and routine, resistance to change, and errors in communication. The same division of working activity and the standardisation of behaviour, which are useful in producing efficiency, when they are exasperated, which often takes place, makes it difficult to respond in a personalised way to the problems of sick people, which are individualised to the utmost because of their critical character and their affective resonance.

'Humanising ourselves to humanise'

109. Aware that the first instrument of humanisation is our person, we strive to bear witness to *competence in humanity* in the performance of our ministry, both individually and as a community. We draw near with respect and care to sick people, above all the most abandoned, thereby mak-

ing credible our message which seeks to proclaim the dignity of human frailty. We ensure that our communities are marked out by a spirit of welcome and *our works* stand out as a model of humanity.

Speaking more *humanly* about the sick

110. In the exercise of our ministry we help people to speak in more human terms about the sick, avoiding them being identified with sickness or a sick organ, and because of this fact deemed insignificant. In our actions and initiatives we persevere to ensure that suffering is not treated solely in a technical way, turned into a mere symptom, and because of this fact alienated and dehumanised. In our analyses we channel a concept of integral health. When speaking to those people who serve the sick, we know how to emphasise the complementary character of justice and love and the importance of providing a human and gospel touch to the rights of sick people.

Helping these who suffer but also acting of the *causes* of evils

111. We do not confine our role to immediate actions, which are needed to meeting individual needs: we also seek to act in institutions where philosophies and laws are developed that govern health care. The forms of action can vary: from formation imparted to our centres to participation in pressure groups, and on to the presence in associations of Catholic health-care institutions and health-care workers.

Ethics and bioethics

The breadth of the objectives of *ethics and bioethics* in the health-care world

112. The exercise of our ministry often requires us to pronounce on questions where the scale of values that direct the behaviour of the human person is at stake. Although the ethical competence that is required of us concerns in a particular way the strong problems regarding the emergence and eclipse of life, it is important that it does not neglect the daily practice of care for the sick and the management of resources intended for the promotion of health.

Illuminating and helping to take responsible moral decisions

113. Our task is not only to say a *gospel word* so as to illuminate ethical questions and issues but also to accompany people – the sick, personnel and men of science – to take

responsible decisions. The increasing progress of medical science and technology, together with a cultural, religious and ethical pluralism, makes the exercise of our ministry in this sector of human action very demanding.

The vision of *man* as a criterion and measurement of the solution to moral problems

114. Our involvement in the field of ethics and bioethics is guided by special attention being paid to man, who should be seen as a criterion of measurement and judgement as regards the problems that have arisen following the development of biomedical science and technology.

115. In offering our contribution in this sector, the point of departure, therefore, is the definition of the nature of man. Indeed, as the Second Vatican Council observed, 'According to the almost unanimous opinion of believers and unbelievers alike, all things on earth should be related to man as their centre and crown. But what is man? About himself he has expressed, and continues to express, many divergent and even contradictory opinions. In these he often exalts himself as the absolute measure of all things or debases himself to the point of despair. The result is doubt and anxiety' (GS 12).

Consideration of the person in his or her unified totality and in his or her condition of being *imago Dei*

116. The ethical model of reference to which we adhere is the personalist model which finds its moral criterion in man himself seen in his unified totality, inasmuch as he is a being who is inseparably corporeal-mental-spiritual; in his dimension of relationships, inasmuch as he is a 'living relationship' with other people; in his freedom and responsibility, inasmuch as he is endowed with intelligence, will and love; and in his ethical character, inasmuch as he is open to values.

117. In the light of reason one adds the word of Christian revelation by which man is created in the image and likeness of God, is intelligent and free, and is called to communion of life with God Himself. The Incarnation of the Son of God constitutes the supreme testimony to the dignity and the value of man, of all men and every man.

The settings where the word of the gospel should be said

118. There are a large number of settings where we can say our *gospel word*. In our institutions of formation – both ac-

ademic and otherwise – it is advisable to give a convenient space to the study of ethics and bioethics, fostering their exploration through research and the excellence of publications. The creation of *ethical committees* in *our works* and a presence in those such committees of other health-care institutions is another important way of taking part in the debate on the complex questions of a moral character that characterise the world of health and health care. Our words in these institutions can play a significant role, of support and of inspiration, as well as of dialogue and prophecy.

Respectful and honest *dialogue* with people who share different visions of life and the human person

119. In working with people who do not share our moral principles we show that we have a great capacity for dialogue, which is seen as an experience of mutual enrichment and which each party gives and receives from the other, whatever their point of view may be. In maintaining our identity and avoiding falling into an injurious syncretism, in authentic dialogue we are helped to understand what in our choices is acceptable in human terms to everyone, and what, in opposite fashion, is dictated by our beliefs, which not everyone shares. The efficacy of dialogue does not disappear, even if one does not reach an agreement.

120. Convinced that dialogue is an expression of love, we abstain from judging and condemning people, bearing in mind that in bioethics not everything separates believers from non-believers. Everyone's goals, indeed, can be the same: helping people who turn to us, with the greatest possible respect for what they are, what they request, and what they are ready to live.

Sensitising people to the principles of ethics and bioethics

121. Through teaching and individual relationships, we contribute in an active way to sensitising personnel as regards relationship ethics, a central element in the process of humanisation, and we do not hesitate to take the defence of sick people every time that we see that their rights are disregarded.

122. An important aspect of our involvement in ethics is accompanying people in discovering the meaning of their human and Christian vocation when a moral decision has to be taken.

123. in bearing in mind that ethical accompanying, like every other kind of accompanying, also has an *educational character*, we do not confine ourselves to offering a series of specific answers to the questions posed by people, but, rather, we seek to enable the individual to address in a morally correct way other situations of conflict that he or she encounters in life, transforming his or her experience into a *moral experience*.

124. From this derives the importance of examining the characteristics of the people who ask for our help. There are individuals who have lost, at least partly, their interior truths and seek a pathway to follow by which to exit from their problems and their *malaise of living*. Other people suffer from a profound existential emptiness. And there is no shortage of those who feel that they have been 'put in a trap' by morality and even by faith. In some people, the moral education that they have received has contributed to creating a tyrannical super-ego, with unattainable needs, which are transformed into a source of frustration and self-contempt.

Knowing in order to accompany effectively

125. Of great help is an identification of the conscience of the people who ask for help. Side by side with people inhabited by a *subjected* conscience, who wait to be guided by other people, and above all by priests, without in the least taking responsibility for themselves, there are others who call every law into question.

126. In bringing out the motivations underlying the decisions that people intend to take, we help them to discern in a responsible way the values that are present in the situation in which they are involved, seeking to coincide the subject morality of the person with objective morality. In the contemporary socio-cultural context, in fact, individuals are subjected to the influences of a large number of moral theories which are often opposing and generate confusion.

Understanding people and calling their behaviour into question

127. For our accompanying to be appropriate, in addition to approaches of positive consideration of the person, of understanding, and of respect, we also practice the approach

of *dialogue* when the decisions that the person intends to take are not in agreement with the scale of values that he or she adheres to.

128. We abstain from manipulating people and we do not take their place in taking decisions, aware that the ultimate criterion of morality is the *enlightened* conscience of the individual.

Not *abandoning* those who choose other pathways

129. In cases where the person has already taken, or takes, a decision in opposition to the objective values of morality, we know how to channel into him or her the certainty that the love and the compassion of the Lord accompany him or her despite the decision that has been taken, thereby fostering the possibility of a change.

Not avoiding *dialogue* with non-believers

130. In encounter with non-believers or people who do not practice their religion who ask for our help about problems of a moral character, we seek to work with human motivations, not hesitating to confront them in a respectful way with motivations that are more typically Christian.

Conditions for an effective proclaiming

Allowing oneself to *evangelise*

131. We honour our task of being preachers of the good news, allowing the gospel to penetrate our way of locating ourselves in relation to life, to health, to suffering and to death, and engaging ourselves so that our behaviour bears witness to that *humanity* that we seek to promote in the health-care world.

Reflecting theologically on one's own experience and the people who are encountered.

132. Aware that about our positive and negative experiences God has already spoken *words*, we strive to reflect theologically and spiritually on what happens to us and to the people that we encounter, allowing ourselves to be illumined by Jesus like the disciples of Emmaus and imitating the approach of the Virgin Mary who kept in her heart, in order to understand their meaning, the events that befell her.

Renewing language and methods of communication

133. We pledge ourselves to renew the language with which we proclaim the words of the gospel, adapting it to

the capacity for decoding of people and avoiding having to resort to abstract theological thoughts, common places and pre-cooked phrases.

through adequate formation

134. Attentive to the evolution of culture, we review our methods of bringing to modern man the 'Christian message to modern man. For it is only in the Christian message that modern man can find the answer to his questions and the energy for his commitment of human solidarity' (EN 3).

135. In order to reach the largest number of people we take to heart the development of the literature (books and reviews) on the subjects of health, of suffering and of death, and we combine this in a wise way with scientific studies and practical publications. We use the instruments of social communication with competence.

The Times, the Ways and the Places of Proclaiming

136. Our concern to introduce gospel elements into the world of health and health care finds forms, times and places that are suitable, in order to reach not only the sick and health-care workers but also their families and educational institutions.

Visits to the sick and the pastoral *conversation*

137. Individual conversations with sick people are certainly one of the most important and traditional ways of actuating our ministry. Through a well-led dialogue – free from pre-cooked phrases and common places, from paternalistic or moralising attitudes, but directed towards evangelisation, respectful of the freedom and the rhythm of the patient... – we channel the message of the redemptive love of Christ.

The preparation and organisation of *pastoral visits*

138. In health-care and socio/health-care institutions various factors can contribute to making burdensome and not very gratifying this important pastoral practice: the increasing number of people who have to be encountered following the decrease in the number of pastoral workers; the risk of falling into routine; and, at times, the absence of adequate training and method. It is therefore important to

subject this pastoral practice to constant revision and completion.

139. Although the daily visit to sick people remains an ideal to be borne in mind in the planning of pastoral activity, it should not constitute an absolute such as to absorb all our energies.

140. Upholding the principle that all sick people must be offered a possibility of encountering us, we study, as regards the organisation of meetings, realistic forms and ones in harmony with the other requirements of our apostolic work.

The pastoral *diagnosis*

141. In carrying out our delicate ministry of visits we avoid going in an unprepared way. Instead we prepare ourselves by drawing up a pastoral plan with clear and practical objectives, and we adapt it with flexibility to the various situations. We train ourselves to draw up a *pastoral diagnosis* of the people that we meet.

142. We know how to distinguish between a friendly meeting and a pastoral relationship involving help. Whereas it is advisable that the first is proposed to all sick people, the second is for a narrower group of people who are ready to engage in a more profound and more continuous journey. A wise discernment of different needs and the offering of differentiated responses allows us to offer our help in a rational way to the people that we meet.

From the *social* meeting to the *pastoral* meeting

143. We are helped in the shift from social conversation to pastoral dialogue by an ability to concentrate on the experience of the sick person, receiving his or her reactions, accompanying him or her in seeking 'to find an answer to the persistent questions regarding the meaning of pain, evil and death' (C 47), and helping him or her in addressing reality even though it is unpleasant; and by the assessment and appropriate proposing of spiritual resources.

Making one's own *humanity* an effective vehicle for communicating the pastoral message

144. Convinced that in an approach of faith our relationships with the sick and their families take on an almost sacramental value, becoming a symbol of that redemptive love that we proclaim in words, we strive to have towards

them attitudes rich in genuine humanity, characterised by profound respect, a capacity for listening and empathy, and nearness 'especially in moments of darkness and vulnerability so as to become signs of hope for them' (C 47).

145. Overcoming the temptation to barricade ourselves behind our role or to express only some of the aspects of our personalities, we work to be ourselves, attentive to our feelings which should be used in an appropriate way in our relationships with sick people and their family relatives. For the good of the sick person we know how to combine understanding with an appropriate capacity for dialogue.

Responding to the needs of the *sick* more than to our needs

146. In 'our earnest desire that the faithful who are ill live their lives in Christ and attain the holiness to which they are called' and trying to begin with them a 'dialogue of salvation' (C 47), our evangelising intent should be without calculations and undue pressures, respectful of the freedom and the inclinations of the sick person. Avoiding dogmatism judgement, condemnation and irony, we respect the religiosity and the way it is lived of the people that we encounter

Respecting the *rhythm* of people but not hesitating to reawaken in the people who are encountered that need for *self-overcoming* that is present in man

147. We know how to welcome with incumbent respect the gradual character of the spiritual journey of a sick person and the difficult pathway that has to be followed in order to make of the negative experiences of life an opportunity for human and Christian growth.

148. In imitating the behaviour of Christ in relation to the Samaritan woman (cf. Jn 4:1-41) and sick people (cf. Lk 5:5,17-26), we rely upon that need for self-overcoming that is present in every human being, even though it is not always perceived or perceived in a different way, opening up the sick person to *mystery*, to a deeper understanding of himself or herself and things, to allowing himself or herself be troubled by a question, by a message that goes beyond his or her habitual horizon, but which draws solicitation from it. This is a matter of helping those people who are met to perceive in the experiences of daily life a reference to a search, to a Presence.

149. In dialogue with sick people who belong to other religious confessions, we show that we are interested in their way of relating to the situations in which they find themselves, helping them, with full respect for their beliefs, to use the resources that are offered by the religious belief to which they adhere.

Respect for the sharing of common values with people of other religions, with agnostics and with atheists

150. in encountering agnostic or atheistic people, we try to establish with them a respectful relationship, anchored in a platform of shared values, accompanying them with payer so that in perceiving in their hearts a deep nostalgia for the Lord, they can find the joy of returning to the house of the Father.

Care for the *family relatives* of the sick

151. In the exercise of the ministry we turn our human and pastoral attention to the family relatives of patients as well, sharing their anxieties and supporting them with our solidarity. In need of support to live, without becoming dismayed, the burden imposed by the illness of one of their relatives can find in our caring accompanying – within the context of health-care institutions or at home – help in discovering in the painful season of suffering, valuable human and spiritual values (cf. GS 26-27).

152. A reawakening of their responsibilities in accompanying their relative both from a human and a spiritual and religious point of view, forms a part of the evangelising dialogue with the family relatives. 'The command of the Lord to visit the sick (cf. Mt 25:26) is, indeed, to be seen as addressed first of all the family relatives of a sick person. At home or in health-care institutions, their presence has an especial importance' (PSCI 33).

Catechesis and Preaching

Catechesis and preaching

153. We appreciate the catechesis and preaching in order to proclaim God's message about health, the meaning of life, of pain and of death, aware that the faith of a Christian is not improvised in a hospital when you go there to be treated but, rather, grows and develops in your own community.

The Proposing of the Sacraments

The *liturgy* and the *sacraments*, cardinal elements of the ministry

154. The proclaiming of the message of salvation opens up the believer to experience of the action of the Lord in the liturgy, from which 'as from a font, grace is poured forth upon us; and the sanctification of men in Christ and the glorification of God, to which all other activities of the Church are directed as toward their end, is achieved in the most efficacious possible way' (SC 10).

155. Our ministry, therefore, finds one of its cardinal elements in the liturgy, above all in the celebration of the sacraments, which realises the encounter of man with Christ. Through reconciliation, the anointing of the sick and the Eucharist, a sick person is led to live the paschal meaning of illness, being able, as well, to benefit from a recovery of health or of addressing 'with the most virile strength' his or her situation of illness (cf. *Premesse al nuovo rito dell'Unzione*, n. 1).

The *decrease* in the demand for the sacraments

156. Over recent decades, the celebration of the sacraments of the sick has undergone profound transformations. On the one hand we have witnesses a steady overcoming of sacramentalism, and, on the other, a major decline in the request for the sacraments. Both these phenomena, together with the implementation of a reform of the liturgy, have stimulated a better understanding of these substantial signs of grace and a more careful search for forms of celebration that are suited to the health-care context, which has become secularised and pluralistic.

The importance of *ex opere operantis*

157. In celebrating the sacraments we bear in mind that, according to the principle the sacramental, we are not only an instrument but also a sign of the grace of God. From this comes the need, in the celebration of the sacraments, for us to strive to reproduce the approaches of Christ who went to look for the lost sheep (Lk 15:4-8), who received and healed the sick, and who offered himself as food, a pledge of eternal life.

Appropriate service, relationships between

158. Between service to the sick and the sacraments there is a natural continuity and a reciprocal reference. The art

the personnel and the sick person, a favourable environment, the participation of those present and the adaptation of the celebration to the specific environment in which takes place...

of knowing how to give, of knowing how to serve, and of being able to listen, is a symbol of a larger and more total gesture, a gesture that comes from God to envelop man and transform him, making the sick perceive, at a second stage, that the sacraments are located in this movement of mercy, which inspires those who are near man and sacrifice themselves for him.

159. The celebration of the sacraments of the sick is not the responsibility only of priests: it is also the responsibility of those who are involved in pastoral and health-care service. They, too, have the duty to foster the presence of those factors that facilitate encounter with the Lord, such as 'favourable environmental conditions, a serene relationship between patients and those who care for them, the participation of family relatives, health-care workers and volunteers' (PSCI 21).

...help to make the receiving of the sacraments more effective

160. The reform of the liturgy implemented by the new rites of the sacraments leaves ample space for the creativity of the assembly and envisages numerous adaptations for those who preside over the celebration. Thus a faithful carrying out of the rites, alone, is not enough: we must know how to adapt the celebration at a spiritual level and to the real inclinations of each individual assembly.

161. Even when they are celebrated for only one sick person, the sacraments are always actions of the Church, which in them professes her faith in Christ who died and rose again and actuates in time, until his return, the care and the solicitude that he had for sick people during his earthly life.

The Sacrament of Reconciliation

The need for reconciliation

162. Made the subject of the mercy of God who has reconciled us to Him in Christ, we do not hesitate to feel that we are ambassadors of Christ, addressing to the sick people that we encounter the exhortation of the Apostle Paul: 'Be reconciled' (2Cor 5:17-21). With the forgiveness of sins,

indeed, man re-establishes his communion with God, with himself and with other people, and rediscovers his serenity and peace, to the point of experiencing that nothing, not even death, can separate him form the love of God and his brethren.

The sacrament of *reconciliation*...

163. This invitation to reconciliation can resonate with greater intensity in people who are in situations of grave illness. During the course of the final stage of existence, a look at the past brings out the complexity of a life that has often been contradictory, where victories and failures are intertwined: shadows and light. A sick person can easily nourish feelings of guilt, to which often is added an inability to accept himself or herself, to say 'Yes' to the past, and to recognise what is positive in his or her existence.

...fosters a *re-reading* of the past in order to achieve a serene acceptance of it

164. Bearing in mind that a situation of illness can contribute to an adjustment in a scale of values, we ally ourselves with the wish of the patient to review his or her own life, opening himself or herself to spiritual horizons.

165. In the celebration of the sacrament of reconciliation, our position as regards the sick person bears on the fruits that he or she can draw from confession. We thus show that we capable of listening, of understanding, of taking part in the spiritual debate that he or she is living through, abstaining from judgements and moralising attitudes.

The *mediation* of positive human attitudes and the efficacy of a physical context that assures privacy

166. In health-care institutions and in homes we are concerned to meet the sick in a setting where their privacy is respected, welcome is fostered, and a liberating conversation is allowed.

The Eucharist

The beneficial effect of the *Eucharist* for a sick person

167. 'The source and culmination of the whole of Christian life', the Eucharist acquires an especial value when it is celebrated with the sick and for the sick ', as a source of strength amid pain and weakness, hope amid despair, and as an occasion of joyful encounter' (CL 54).

168. Through union with Christ in Eucharistic communion, a sick person is healed of sin and its injurious effects, and is resupplied with a new strength to address the difficult situation in which he or she finds herself, receiving at the same time, the pledge of future immortality.

Attending to the celebration of the Eucharist and the distribution of communion...

169. A celebration of the Eucharist in hospitals has different moments, each of which requires special care. A celebration of the Eucharist in a church or in a ward or in the room of a sick person should be prepared and carried our with care, involving the participants to the extent that this is possible and using the time of homily to propose short reflections rooted in the words of God and relevant to the situation being experienced by the patients.

...should be done at the most suitable moments, assessing and respecting the outlook of sick people,

170. In distributing communion to patients in their beds at a team level and in cooperation with the personnel, agreement should be reached on appropriate methods so as to respond to the needs of the patients, respecting the sacrament and allowing each pastoral worker a sufficient space of freedom an creativity.

171. Well ordered resort should be fostered to working with extraordinary ministers of communion to achieve a more personalised and better celebrated administration of the sacrament (with prayer, moments of reflection...).

avoiding routine and hurriedness

172. In taking communion to patients we do not allow ourselves to be guided by routine, by the easiest and hurried approach. In taking into serious consideration the need for a good preparation of the Eucharist and privileging quality more than quantity, we know how to avoid offering the sacrament to people who, for various reasons, do not seem to be well disposed to receiving it or who are used to drawing near to this sacrament only occasionally.

The Eucharist offered in the form of Viaticum

173. Aware that the celebration of the Eucharist takes place 'awaiting his coming' and amongst its fruits are listed 'the pledge of a glorious future', we do not neglect to offer it to the gravely ill in the form of *viaticum*, overcoming the obstacles that are present in contemporary health-care institutions or in families. This, indeed, is the specific sacrament

of sick people who are going through the last stage of their existence. The Eucharist as *viaticum* is the conclusion of the ecclesial journey of the faithful, which began with baptism; it is the epilogue and the compendium of the process of Christian belonging; it is the definitive equipment for the passage from sacramental communion to physical communion with Jesus; and it is the waiting, illumined by the privileged presence of Christ, for the completion of the mystery of death and the resurrection of the person.

The Anointing of the Sick

The catechesis on the sacrament of the *anointing of the sick*

174. The anointing of the sick is the 'specific and most typical form of the total care of Christ (of Christ and of the Church In relation to the difficult and fundamental human experience of suffering. From the rediscovery of this sacrament – through a suitable catechesis and significant individual and communal celebrations designed to create a new mentality – great spiritual advantages will be gained, consolation and comfort, for those whose state of health is gravely compromised by illness or old age' (cf. ES nn. 137-140).

The special *grace* of this sacrament

175. The sacrament of anointing communicates a special grace of the Holy Spirit, whose specific effect is relief for, and the reinvigoration of, the patient; the reunification of his or her being lacerated by illness, whose meaning it reveals; and help to the patient in living that illness. The sick person is thus 'strengthened by trust in God and obtains new strength against the temptation of evil and worry about death; he can in this way not only courageously bear his malady and obtain health as well when he derives from it an advantage for his spiritual salvation; the sacrament also gives, if necessary, the forgiveness of sins and completes the penitential journey of the Christian'.

Undoing the *tandem* of the sacrament of the sick and death

176. More than any other sacrament, the anointing of the sick is a source of anxiety for the patient and his or her family relatives, and of malaise for health-care workers. This happens above all else in general hospitals where the pro-

posing of this sacrament is very much linked to the extreme gravity of a patient. Although the tandem anointing of the sick/death is still alive in the popular mind and in the minds of many pastors, the line that the liturgical renewal promoted by the Second Vatican Council impressed upon the understanding and celebration of this sacrament remains irreversible.

Avoiding *extremist positions* in the administration of this sacrament

177 Although perceiving the weight of this particular aspect of our mission, we see as our important duty the promotion of a new mentality towards the anointing of the sick. In order to achieve this goal, we adopt a balanced form of behaviour and we do not adopt extremist positions. We avoid administering this sacrament to those who have already died but we do not refuse it to people who are unconscious if it is requested by relatives or the personnel attest to the faith of that patient.

Making the *personnel* sensitive to this sacrament

178. We educate the nursing staff in discerning, on the basis of their own professional responsibility, the propitious time for the celebration of the anointing of the sick, and in seeing this sacrament as a free and responsible event which should not be placed on a par with medical/nursing initiatives.

179. Every time that the opportunity presents itself, we actuate a communal celebration of the anointing of the sick so as to involve the community in the celebration, cooperating in creating a new mentality in the participants as regards this sacrament.

The value of the *communal* celebration of this sacrament

180. The celebration of the sacrament of the anointing of the sick should not be a solitary act, engaged in with the indifference of those who are in the ward. The presence of Christ at the side of patients which is actualised by this sacrament should be made visible by a significant participation by those who surround them and should form a part of the service that is offered in a human way to patients.

The *commending* of the dying

181. The rite of the *commending of the dying* – which can also be presided over by members of the lay faithful – should not be compromised or sacrificed because of that

distracted, indifferent or fearful atmosphere which often characterises the wards where sick people die. Actuated with discretion and adapted to the specific situations that are encountered, it constitutes valuable help both for patients and for their family relatives.

The Deaconate

Proclaiming the Word and *works*

182. The history of the Camillian ministry demonstrates clearly that the proclaiming of the Word should be accompanied by works: 'believe me for the sake of the works themselves' (Jn 14:11)

183. The deaconate exercised through a variety of initiatives finds illumination in the Word that we proclaim and takes from the Eucharist its meaning and its style, encountering in it not only its source but also its norm. It is no accident that Jesus closely connected service to the Eucharist (Jn 13:2-16), asking his disciples to perpetuate in his memory both the *Lord's supper* and the *washing of feet*.

The deaconate draws its style from the Eucharist and the Virgin Mary

184. The example of the Virgin Mary helps us to locate our service in the project of God. In declaring that she was the *servant of the Lord*, she enables us to understand that unconditional surrendering to the sovereignty of God can provide to man the primordial alphabet for the reading of every other human service. A participant in the condition of the poor, and expert in suffering, Mary is the icon of vigilant care and compassion for those who suffer (cf. C 68).

The *deaconate* as cooperation with the action of God the creator

185. Through the promotion of health (preventive medicine, health-care education, primary care...), the treatment of illness and the relief of pain, we cooperate in the work of the God the creator (cf. C 45). Coming amongst men 'so that they may have life, and have it in abundance (Jn 10:10), the Lord acts in and through human mediations so that this fullness of life can be achieved.

The *fullness of life* seen in the light of the 'already but not yet'

186. The pathway towards such fullness of life is exalting, but it is not without suffering, as is indicated by the words of Paul: 'We know that the whole creation has been groan-

ing in travail together until now' (Rom 8:22). It follows that the perspective within which is written our service is eschatological. We are animated by the hope of a 'new heaven and a new earth' (2Pt 3:13), in the *already but not yet* of present time, while we care for the wounds of bodies and souls and we involve ourselves in the promotion of health.

Our Works

Our works are the fruits of creative faithfulness to the Camillian charism

187. Service exercised through health-care and social/health-care institutions that belong to the Order – *our works* – is relatively recent: the first, indeed, arose towards the end of the nineteenth century. Openness to a form of ministry that had never been exercised before that, this indicates that the faithfulness to the charism that was transmitted to us by our Founder is creative. A healthy discernment of the signs of the times makes advisable and also necessary new forms of apostolate. During the course of the last hundred years *our works* have grown in number and in importance, above all after the opening of missions in developing countries.

The purpose of our *works* is *evangelisation* through charity

188. The perplexity and the discussions that have accompanied *our works* since their creation, above all in the Western world and in the period immediately following the Second Vatican Council, have indicated the wish of the Order to continue to respond to the charism. In a gradual way, the debate took on a more constructive direction, leading to an emphasis to be placed above all on the criteria that should govern the management of our *works*, so that they respond to their identity of being *works of the Church* and to their evangelising purpose, proposing models of human and Christian assistance that are exemplary for the world of health and health care.

The 'Identity Card' of Camillian health-care and social/health-care institutions

189. To this end, with the contribution, of representatives of all of the Order, an 'Identity Card of Camillian Health-Care and Social/Health-Care Institutions' (2001) was produced. In this, first of all, their *mission* is enunciated, which lies in 'bearing witness to and embodying in the world of health and illness the salvific, merciful, therapeutic and

health-inducing action of Christ. This is achieved through the promotion of health, the prevention of illness, treatment and rehabilitation. Especial attention is paid to relieving pain, the human and spiritual accompanying of he sick and evangelisation, whose full form is the celebration of the sacraments in which the salvation proclaimed is actuated'

190. In a *decalogue* are summarised the values that must guide our *works* in order to be faithful to the charism of the Institute:

The centrality of the human person

*Camillian social/health-care institutions (CSI) place the *human person* at the centre of the attention of their administration and assistance and this is based upon recognition of, and respect for, the inviolable dignity of every human being, inasmuch as he or she is created in the image and likeness of God

At the service of life

*The CSIs are at the service of life and health in all their (physical, biological, mental, social and spiritual) dimensions and at all the stages of human existence. They are especially sensitive to their promotion, defence and quality in particular during moments of greater vulnerability.

The promotion of human and Christian values along the lines of the Camillian charism

*The CSIs are one of the settings where *gospel values* are implemented; first and foremost gratuitous love for one's suffering neighbour, caring and fraternal attention, solidarity and capacity for service. As works of the Church that are based on the rich Camillian tradition and Camillian spirituality, the CSIs seek to be places of humanity and of excellence, of the culture of health and of evangelisation.

Respect for the *ethical dimension* of service

*Respecting the *ethical dimension* of service to life and to health, the CSIs promote scientific research and dialogue to enlighten and to interact with the various bioethical questions and issues; they faithfully translate into practice the moral teaching of the Catholic Church, with resort to individual and institutional law for conscientious objection as well, and in this they are helped by their own ethics committees.

The appreciation of the *personnel*

*The CSIs appreciate in a special way the *people that work in them*. Indeed, the Order sees the individuals that work with it as an integral part of the 'healing community' that is present in a work. As a consequence, as centres of an authentic therapeutic and health-inducing alliance, the CSIs pledge themselves to promoting a climate imbued with humanity, dialogue and joint

responsibility; and implement a policy of human resources such as to foster personal motivation, the fulfilment, and the updating of the formation of, all those who work in them. Professionalism, expertise, an inter-disciplinary approach, team work, research, teaching and ongoing formation are values and tasks that the CSIs are pledged to promote and foster.

Management based on justice and fairness

*The CSIs adopt a model of administrative management that respects ethical values and is based on the principles of justice and fairness. Together with managerial transparency, they work towards the rational use of the resources that are available and towards improvements in technical, scientific, humanistic and religious knowledge which assure the highest quality of services.

The *pastoral accompanying* of the sick, respecting their person

*The ecclesial meaningfulness and visibility of the CSIs requires a shared effort to achieve a new evangelisation. As a consequence, the CSIs engage carefully in *pastoral action* for everyone, especially the sick, the hospitalised, their families and all the health-care workers. This service is offered in an ecumenical spirit to the believers of any religious confession, with a calling on the involvement and cooperation of the Christian community.

Integration into the *local area* and cooperation with other institutions

*The CSIs are an *open space that belongs to the local territory*, a place that irradiates the culture and promotion of health, and a place of alliances in favour of a better quality of life for everyone. Thus they belong to the health-care network and the fabric of society, they willingly cooperate with other similar institutions, and they foster action involving voluntary work within their walls and in the local area.

Care for *sick people who are poor*

*The CSIs preferentially offer their activities to the *poorest sick people* and sections of society that are excluded or marginalised, to whom they offer not only suitable care but also the opportunity of real human and social promotion. Sensitive to the needs of globalisation with a human and Christian face, CSIs promote forms of international cooperation and foster twinning initiatives with institutions in developing countries.

Openness to *assessment* of what is done

*As living, dynamic and provisional institutions, the CSIs study and establish, in a spirit of openness to the signs of the times, strategies and instruments for the *assessment and evaluation* of their work, so as to foster an improvement in their service and, where this is required, their renewal, transformation or even sale'.

Service at Home

A form of the *ministry* to be taken up again...

191. St. Camillus saw private homes as a *mare magnum* in which the ministry for the sick had to be exercised. Down the centuries this form of service has always had a great importance, and to such an extent as to take the place of ministry in hospitals. Fathers and brothers have alternated in caring for the bodies and spirit of very many people shut up in their own homes, taking advantage, as well, of the privilege granted by St. Pius X to our Order to celebrate the Eucharist in the rooms of sick people (GS 27).

...in cooperation with resources that are already present in the *local area*

192. Socio-economic transformations, together with a numerical reduction in religious, have contributed to reducing in a notable way this kind of ministry. In meeting the various requests that are made during meetings and Chapters and bearing in mind that modern health care is tending to reassess home service above all for those who are afflicted by chronic illnesses or are going through the terminal stage of their lives, we study new ways of exercising this service, cooperating, where this is possible, with associations dedicated to this kind of service (cf. GS 26).

Parishes and Rectories

Impressing a *Camillian* note on the ministry carried out in parishes and rectories

193. In exercising the ministry in parishes and rectories that are entrusted to us we place ourselves actively in diocesan life, offering a specific contribution to the pastoral care provided by the local church through the animation of communities that 'give special attention to the care of the poor and the sick' (GS 29). Through special initiatives (days for the sick, days for the elderly, communal celebrations of the anointing of the sick, parish missions...) we develop the sense of responsibility of the faithful towards the sick and the suffering. Care for the sick and the elderly is combined with the promotion of health through the implementation of projects for prevention and the promotion of healthy and health-inducing lifestyles.

194. In working with volunteer groups that are active in the field of charity and care, we reach the sick in their families and health-care and social/health-care institutions that are present in the local area of the parish so that they are assured the presence of the community.

Centres for Formation

The ministry of formation

195. In recent decades traditional ministries have been joined by new forms of service to the sick and the promotion of health: Institutes dedicated to formation in the field of the sciences of health care and pastoral care. Side by side with the *Camillianum* in Rome and the St. Camillus University Centre in Brazil, there has been, in many Provinces, a flowering of centres for *humanisation and pastoral care*.

Keeping alive the *evangelising purpose* of the centres for formation, albeit with respect for a healthy pluralism in initiatives

196. The recognition by the Constitution of these new forms of activity as an integral part of the ministry, is based upon the belief that we are called to combine a necessary and irreplaceable *proximity* to the sick with an *evangelisation* of personnel of every category and involvement in research and teaching of the disciplines connected either directly or indirectly with pastoral care, ethics and bioethics. This breadth of horizons constitutes an implementation of the *conversion to studies* of St. Camillus which down the centuries has encountered difficulties in being established in our Order.

Promoting a culture rich in human and evangelical values

197. Even though the nomenclature and the programmes of these centres for formation vary from place to place, there is an element which they have in common, namely the wish to promote a culture impregnated with values that are authentically human and Christian and to irradiate the Camillian spirit through an activity of formation and animation intended for all those people who, because of their profession or because of a personal choice, are involved, directly or indirectly in the world of health and health care.

198. The pastoral character of Camillian centres for formation, even in cases where this does not appear visibly, indicates their being part of the mission of the Church, whose task is evangelisation, that is to say the proclaiming of the

good news of salvation. This means that all the activities that we engage in are directed, explicitly or implicitly, to this end.

Making more evident the evangelizing dimension of the centres

199. The evangelising dimension of the formation engaged in within our centres is expressed in differentiated forms: the atmosphere that characterises the environment, personal witness, the anthropological approach that underlies the lessons and lectures, explicit proclaiming...Essential ingredients are respect for people; an approach involving proposals which opens up new horizons; and deciding in favour of progressive goals which invite people to an in-depth analysis of subjects and issues connected with the world of health and health care.

200. In the supply of various elements of formation we seek a healthy balance between initiatives that are specifically concerned with pastoral care (pastoral care in health, clinical pastoral education, relationships involving the provision of pastoral care, courses on spirituality, the planning of pastoral care, formation programmes in health-care ethics, pastoral care as regards liturgy in the world of health and health care...) and those which, because of their contents, do not have a specific pastoral characteristic, without neglecting research.

The recommendations of the *Church*

201. Our involvement in the sector of formation and animation finds encouragement in words to be found in the Apostolic Exhortation *Vita Consecrata*. Bearing in mind the great cultural transformations of our time, consecrated people 'should endeavour to make the practice of medicine more human, and increase their knowledge of bioethics at the service of the Gospel of life. Above all therefore they should foster respect for the person and for human life from conception to its natural end, in full conformity with the moral teaching of the Church. For this purpose they should set up centres of formation and cooperate closely with those ecclesial bodies entrusted with the pastoral ministry of health care' (n. 83). The message addressed by John Paul II in 1995 to those taking part in the General Chapter of Order and of the Congregation of the Daughters of St. Camillus is also important: 'I exhort you always to combine the irreplaceable nearness to the sick with the evangelisation of health-care

culture, in order to bear witness to the gospel vision of living, of suffering and of dying. This is a fundamental task that must be actuated in the institutes for formation of your religious families' (*L'Osservatore Romano*, 20 May 1995, p. 5).

Pastoral Care

Pastoral accompanying, a privileged form of the Camillian ministry

202. Amongst the forms of service provided by the Order, a relevant place is held by pastoral care, as recommended by the Constitution which invites us to hold dear 'pastoral care of ecclesiastical and civil institutions involved in the care of the sick and the poor' (C 54).

Growth in the identity of the *chaplain*

203. According to recent statistics, the ministry of spiritual assistants or chaplains at the present time has the largest number of Camillian religious and is exercised in all the countries where our Order is at work. These data indicate to us the importance of this service which really honours the gospel statement: 'I was sick and you visited me' (Mt 25:36).

204. Over recent decades, conditions have been created in many countries for an improvement of spiritual assistance in hospitals. The greater awareness that the Church has acquired of this ministry – and to such an extent as to place the figure of the hospital chaplain in the new *Code of Canon Law* – has been matched by a greater sensibility on the part of civil legislation in many countries which assures religious assistance to patients.

The support of the *human behavioural* sciences

205. Ecclesiological and pastoral reflection enables to see this ministry in a new light, expanding its fields and pointing out with precision the forms by which it should be put into practice. The sciences of human behaviour offer pastoral workers new instruments by which to make the communication of the message of salvation more effective. As John Paul II observed: 'It is necessary that this most precious heritage [love for the sick and the suffering], which the Church has received from Jesus Christ, "Physician of the body and the spirit", must never diminish but always must come to be more valued and enriched through renewal and decisive initiatives of *pastoral activity for and with the sick and suffering'* (CL 54*).*

The therapeutic value of pastoral accompanying

206. In the health-care institutions in which we work, we strive to ensure that our ministry is placed within the orchestration of the care provided to patients, aware that it can contribute in an effective way to the implementation of that overall approach to the person which is so recommended by the contemporary philosophy of care.

The hospital chaplaincy and the hospital pastoral council

207. In line with the ecclesiology of communion promoted by the Second Vatican Council, we are open to creating in *our works* and in health-care and social/health-care institutions, a hospital chaplaincy 'made up of one or more priests to whom can be added deacons, religious and lay people as well' (PSCI 79). The synergic action produced by the cooperation of various charisms impresses greater efficacy on the ministry.

208. One of the objectives of a hospital chaplaincy is 'to promote and coordinate all the forces that are present in the hospital community', using suitable instruments, amongst which the hospital pastoral council' (cf. PSCI 80).

The Camillian Taskforce

The response of St .Camillus to the needs created by natural disasters and wars

209. One of the ways adopted by St. Camillus for the exercise of the ministry was meeting urgent needs created by pestilences or natural disasters. Remembering some of them helps us to be aware of this special way of implementing our charism.

*In 1589, in some ships which had reached the port of Naples a violent epidemic broke out. Of the Camillian religious called to help its victims, three died in carrying out their ministry.

* Over the next two years famine and the plague spread in Rome. Camillus organised capillary aid 'from the Four Fountains until Porta Pia', and opened a hospital (300 beds) in Via delle Carrozze at S. Maria in Cosmedin. At the house of the Magdalene he created a centre of help for the sick and the poor of the area and also organised a nursing school in order to train his companions to care for sick people with skill and love. Another four religious and a novice lost their lives while helping the plague-stricken in the refuge of San Sisto.

*In 1600 Camillus hurried to Nola where a violent bubonic plague had broken out. The bishop appointed him vicar of the diocese for the whole of the period of the epidemic. Five religious died helping the plague-stricken.

* Later, in 1612, the General Council asked Camillus to go to Bucchianico, his native town, to comfort and help his fellow townsmen who were afflicted by a terrible famine.

* Assistance for soldiers who were wounded during military campaigns formed a part of the programme of Camillus. In 1595 he went to Trento to give practical directives to a group of his religious who had been ordered to follow the papal army into Hungary during the war against the Turks.

210. This spiritual dynamic which led the Founder to make attention being paid to emergency needs of priority importance has not been lost with the passing of time. Recently, it emerged in an official form at the General Chapter of 1995 with the invitation to 'create a team of Camillians with a view to humanitarian aid in cases of natural disasters and emergency situations' (cf. GS 17).

211. The tragedies that frequently afflict very many countries, provoking the solidarity of the international community. have led our Order to give practical form to this line of work with the creation of a task force directed to this end.

The validity of the Camillian Taskforce and the NGOs

212. Following this policy, support is given to bodies (ONLUSs and NGOs) which have arisen at a general and Provincial level to meet the needs of poor people and sick people above all in developing countries.

Our Elderly and Sick Religious

213. Following the indication of the Constitution (n. 18), 'we take especial care of our elderly and disabled brothers, we care for our sick brothers with fraternal charity'.

In situations of illness and disability as well, a *Camillian religious* is called to exercise the ministry

214. An inability to exercise active ministry because of age or illness does not exempt us from the duty to find other ways of cooperating in the growth of the Kingdom of God in the world of health and health care. Through prayer, sacrifice and goodness, we can cooperate in an effective way in the growth of the Camillian project, living with generosity our condition in the light of the paschal mystery and making available to individuals and communities the wisdom that has been accumulated during a long experience of life and apostolate (cf. C 59).

Activity not Specifically Connected with Our Ministry

Conserving the Camillian identity

215. Religious involved in activity not directly connected with our specific ministry are recommended by the Constitution to keep their *Camillian identity* intact and alive, avoiding running the risk of seeing their work more from the point of view of a profession than ministry or diminishing or even losing the specificity of the ministry typical of the Institute (cf. C 59).

Chapter V

The recipients of our ministry

The Sick and their Family Relatives

The sick are the first end of our ministry

216. The first category of people to whom our ministry is addressed is made up of the sick. In order to serve them physically and spiritually St. Camillus founded our Order. To care for the sick – the purpose of our heavenly vocation, as Fr. Camillo Cesare Bresciani observed – we dedicate our forces, in the awareness that in serving them we encounter the very person of Jesus.

The various typologies of sick people...

217. There are various pathologies that strike people and men and women react in many ways to illness. The Bible offers a rich typology of sick people. In addition to Tobias who accepts illness from the hands of God, there are those who fall into depression or rebel with strong tones of anger. When reading the Psalms we encounter many prayers addressed by sick people to the Lord. How can we not remember the troubled laments that echo through the words of Christ: 'My Lord, my Lord, why have you forsaken me?', together with a feeling of trust: 'into your hands I commend my spirit'?

...and the multiplicity of their reactions to infirmity

218. Our experience gives us an opportunity to meet the victims of suffering who lie at the edge of the road that goes down from Jerusalem to Jericho. Their condition often confines them to the margins of society. In developing countries this takes place because of poverty, in countries of the Western world because their presence disturbs the lifestyle typical of the culture in which they live. They are the lepers of the time of Jesus, who now have other names: AIDS patients, the victims of drugs, elderly people who are not self-sufficient, the mentally ill...Very many of them have

no voice, they are unable to proclaim their rights, they are without company, confined to a worrying loneliness, as though they were in a *land of exile*.

219. When leafing through the great book of physical and mental suffering, we encounter histories dealing with children young people, adults and the elderly afflicted by the most varied kinds of illness. Side by side with people who are the victims of transient malaise, one encounters cancer patients, the chronically ill, the dying, and the victims of new social illnesses. Our own communities offer us an opportunity to live with elderly and disabled brothers, to whom we are called to 'take special care' (C 18).

Common characteristics

220. The great diversity of sick people and of their relationships with illness does not impede us from seeing certain features which, after a certain fashion, are common to them all. A first effect of illness is a changed relationship with one's own body. A sick person can have the impression of being the victim of a *betrayal* carried out by an essential part of himself or himself which previously obeyed him or her. To a feeling of betrayal is also added a feeling of shame *because* the transformations caused by the malady have a negative impact of his or her self-image. This feeling is made more acute in cultural contexts where the criteria of evaluation are based upon vitality, beauty and physical perfection.

221. According to the scale of the malady, a sick person can perceive notable changes in his or her capacity *to meet his fundamental needs*, from the physical to the emotional and spiritual. The person's scale of values is often subjected to important modifications. What in a state of health the person saw as relevant, during moments of sickness can lose meaning and attractiveness.

222. The situation gets worse when the mind of the patient is filled with all the consequences caused by his or her illness, at an individual, family and social level. The illness, indeed, interrupts and disorganises, in a more or less brusque way, the habitual rhythm of life. This is a situation which, especially if it is of a certain gravity or lasts over

time, modifies professional situations and family relationships which have hitherto been held to be secure.

223. Whether light or intense, according to the personality and the nature and the gravity of the malady, the reactions of the sick person to his or her illness are always the expression of a *deep anxiety*. The condition of illness, indeed, induces in the sick person an acute awareness of not being at the centre of the universe, as a modern, but not Biblical or Promethean, anthropocentrism often would have us believe.

Defence mechanisms

224. Frequent reactions to the feeling of frustration and loss that is caused by illness are anxiety, aggression and depression. A rather common defence to which sick people resort is emotional and behavioural *regression* which makes them egocentric and dependent, concentrating their attention on their most elementary needs.

The effects of *hospitalisation*

225. These examples of strong emotional and spiritual malaise are often aggravated by the negative consequences of hospitalisation. The metaphor of the hospital in highly developed countries is that of an organisation of the human body into individual parts: do the various wards of the hospital not perhaps refer to an image of the human body cut up by 'physical areas' where the person disappears specifically because his or her corporal character is fragmented into individual objects that are separated from each other?

How can one sing hymns to life in a land of exile?

226. In such situations many sick people cannot but feel that they are in a *land of exile*, where the desire to sing to life has disappeared, leaving space to the question: why me? This question, often addressed to God, reveals the perception of the illness as a *mystery* and is an expression of an attempt to find a meaning to life in a situation that appears to be without one.

The Ministry for the Sick

227. The ministry for the sick commits us to adopting the attitudes of Christ and Camillus so as to mature our charism into expressions that are suited to the situations that

are addressed, serving the sick with love and expertise and teaching other people how to serve them.

The sick: our lords and masters

228. Our first task is to strive to translate into forms suitable to our time the statement of Camillus according to which *the sick are our lords and masters*. The *centrality* of the sick person, affirmed by modern health-care and assistance programmes as well, must find in us creative and constant promoters, actuating this objective first and foremost in *our works* and cooperating with humanising projects organised by other religious and lay agencies.

The defence of the *rights* of the sick, uniting justice and charity

229. Like our Founder, we uphold the value of the person of the individuals who suffer, adopting the *Charter of Patients' Rights* which was drawn up recently. The care due to a sick person is not a benevolent concession, but, rather, an inalienable right. The dignity of the person is never scratched by the malady of which he or she is a victim, and a sick individual should not suffer forms of discrimination or be deprived of his or her autonomy and the right to participate in a responsible way in the care and treatment that is provided to him or her. Never being an object alone of health-care services, he or she must receive sufficient information about what concerns him or her, on his or her state of health, and on the forms of treatment that are given to him or her and their related effects.

230. We do not fail to emphasise that the services provided by society to sick people on the basis of justice need to be accompanied by that little, but more, which is love, which, as the Gospel tells us, is necessary for what is right and essential to become possible.

231. The defence of the rights of the sick should be united to the help offered to them so that, together with their families, they shoulder their responsibilities towards their illness and overcome attitudes of passivity or of dependence (cf. C 46).

The sick person: an *active subject* of the mission of the Church,

232. We value the person of a sick individual and recognise that he or she is an *active and responsible participant in the work of evangelization and salvation* (CL 54). A Christian, indeed, through living participation in the paschal mystery of Christ, can transform his or her condition into a moment

of grace for himself or herself and for other people, finding in pain and illness 'a vocation to love more, a call to take part in the infinite love of God for humanity'. The negative events of life – not excluding illness, handicap and death – are 'realities redeemed' (SD 19) by Christ and taken on by him as a 'means of redemption' (SD 26).

Making it possible for a sick person to play his or her role in *the promotion of the Kingdom*

233. This appreciation of the sick, of their witness in the Church and the specific contribution that they can make to the salvation of the world, requires a work of loving education that should be carried out not only in health-care institutions through appropriate accompanying but also, and in a very special way, in parish communities and in the world of the associations which bring together sick people. It is advisable, also, that the sick be placed within Church agencies and that initiatives specially for them should be promoted: spiritual exercises, encounters involving formation, the press, audiovisual systems...

The holistic approach of the sick person

234. In imitating St. Camillus, we pledge ourselves to encountering the sick in the totality of their beings, aware that behind every illness there is the presence of a human subject that structures that illness in a unique way, making it an element of his or her biography. By our behaviour and our teaching we transmit the message that a sick person should be considered as a psycho-physical unity, as the bearer of intra-personal and inter-personal relationships, as spirituality and as an essential relationship with the Transcendent.

Uniting intelligence and love

235. In adopting the exhortation of St. Camillus, 'Brothers, more heart in those hands', we invest in service to the sick the totality of our being: knowledge and affectivity, technology and the heart. This affective involvement, the subject of attention and research in today's health-care world as well, and in which emphasis in placed on the importance of a synthesis of *caring for* and *taking care of*, should find in us effective promoters.

Helping the sick to transform illness into an opportunity for

236. The aim of our ministry is the salvation of all sick people. This goal becomes explicit in the relationship with 'sick people who are believers'. The Constitution exhorts us to hold dear that they 'live their lives in Jesus Christ and attain the holiness to which they are called' (C 47). The achievement of this goal is often obstructed by existential questions about the meaning of living, of suffering and of dying, by moments of doubt and by the desire to surrender. Amongst the various styles of acting, the Constitution suggests the maieutic one, which involves helping the sick person to engage himself or herself in a search – inspired by the Gospel – for answers that provide tranquillity to his or her spirit.

human and spiritual *growth*

Being signs of hope

237. The first instrument for the spiritual accompanying of a sick person is our person. A respectful and warm nearness (cf. C 44) makes us *signs of hope*, authentic mediators of the salvation worked by the Lord. The gospel message should thus be transmitted within a strong reality of relationships made up of empathetic listening. In becoming travelling companions, we respond to the invocation that the sick person addresses to us: 'Keep watch with me' (cf. Mt 26:32).

The Accompanying of the Dying and People in Mourning

Accompanying the dying: a strong point of the Camillian tradition

238. We pay attention to the various characteristics of the sick that come from the pathologies of which they are the victims and the culture in which they live, adapting our actions to their particular situations. With a careful look at the tradition of the Order, the Constitution exhorts us to assist 'With special compassion...the terminally ill and the dying so that, aware of the paschal mystery, they may entrust themselves into the hands of the Father' (C 49).

239. We try to understand the psychological characteristics and the special needs of this category of sick people so as to make our actions more effective.

Creating conditions for serene *communication* that allows the sick to express their fears and worries

240. Bearing in mind that awareness of the gravity of one's own malady can be an indispensable pre-condition for an appropriate preparation for one's death, we cooperate in creating 'a climate of solidarity, of trust and of hope', which is needed if the sick person is to feel ready to speak about his or her own fears and worries.

241. We know how to uphold both the inalienable right of a sick person to know about the state of his or her illness and the importance of adopting forms that take into consideration the emotional, spiritual and moral needs of the patient, helping his or her family relatives and the personnel to avoid both the systematic falsification of the truth and saying the truth at any cost. A *personalised* communication is a source of notable advantages both for the sick and for those who care for them, freeing communication from ugly reticence and lies.

Paying attention to little hopes opens the heart of the sick to that great hope that does not disappoint

242. Whereas when faced with the reality of death many people behave as though they are individuals 'who have no hope' (Ts 4:30), the believer knows that for those who have welcomed the Lord, the descending parabola of life can no longer be lived as a parabola of death but as one of new life, of grace and of resurrection. We transmit this certainty through our therapeutic deeds, accompanying that is rich in humanity, and the celebration of the sacraments, especially the Eucharist and the anointing of the sick. We are aware that caring for sick people and the dying, helping them so that while the *external man* is breaking down the *interior man* becomes renewed day by day (cf. 2Cor, 4:16), is already to cooperate in that process of resurrection that the Lord placed in the lives and history of men through the paschal mystery, which will find its full completion at the end of time.

243. Death throws its shadows over all the people who are connected affectively with a patient during the critical stage of his or her illness. Psychological research has shown that the members of a family go through the same emotional reactions as the patient. The pastoral worker who accompanies a dying person is thus called to provide care to the family members as well. In many cases – when one is dealing with the victims of grave accidents, unconscious patients or very small children – the family becomes the principal subject of pastoral care.

Accompanying the *family relatives* of the dying, helping the to live separation from their loved ones by entrusting to the resources of faith

244. During the stage that precedes death we are called to transmit to the family relatives the spirit of the words of Jesus: 'This illness is not mortal' (Jn 11:4). The pathway by which to announce this truth passes by way of empathetic participation in the suffering that has struck them; respect for the

ways by which they express their pain; absence of forms of moralising when their anger turns against the Lord; and a capacity to keep silent when this is appropriate, avoiding falling into vain comforting phrases. Of especial importance is our pacifying action at those moments when the death of a dear one draws near and provokes conflicts between members of the family and brings out forms of relational immaturity which were previously hidden. With sensitivity and tact, we help the members of the family to use the resources of their faith to face up to their pain and to make them responsible in the spiritual accompanying of their relative.

Being present with family relatives during the working through of *mourning* as well

245. Our ministry as regards the family relatives continues after the death of their loved ones as well and we help them live through the period of mourning in a creative way. A chapter from the Gospel according to St. John (Jn 11:1-44) is a source of inspiration for us. Before announcing to Martha and Mary that their brother Lazarus would rise again, Jesus shared their sorrow, accepted their reproofs, wept with the, and demonstrated the extent to which the death of a friend could cause him pain. The example of Christ indicates that the resources of faith can be more easily accepted when sincere participation is demonstrated and the typical reactions of the psycho-spiritual process of mourning, from the shock to the vortex of emotions, and on to a positive outcome, are accepted.

The celebration of the *funeral rites*: an opportunity for a catechesis about life, death and Christian hope

246. There are a number of settings where an opportunity is offered to accompany the family relatives in mourning: the hospital, the home, the funeral parlour or the church. Means of communication allow us to reach those who are far away. The funeral rites can be translated into authentic therapy for the family in mourning if we know how to utilise the elements that are involved well. There is the presence of the community, the symbolism of the liturgy and the word of God. In the homily one can engage in a catechesis on the fragility of life; on time which one cannot only seek but which, rather, one should also accept as a grace; the need to live the present with authenticity; the efficacy of community solidarity during moments when it is most difficult to live it; the Christian hope that does not disappoint; and the communion of saints.

247. Aware that the purpose of working through mourning is the development of a new interior relationship with the person who has died, we appreciate the doctrine of the *communion of saints*. The certainty that the lives of those who have gone before us has not been removed but transformed helps to keep our memory of them alive through an internalisation of their values, and nourishes an ability to go on loving them, even though they are no longer present in a physical sense.

Prayer for those who die *suddenly*

248. Taking into account, differently to what happened in the past, that people prefer a swift death, we commend 'to the Lord particularly those who meet a sudden and violent death '(C 49). The Constitution reminds us of a form of accompanying – that of prayers of intercession and suffrage – which are always possible for those who carry in their hearts the pain and the suffering of their brethren.

249. Following the instructions of the Constitution (C 49), we pledge ourselves to involving the Christian community in the apostolate for the dying. Living in a society in which the tendency is to deny and remove death and the suffering connected with dying, the exhortations of the text of the Constitution are an invitation to contribute to that process of the *re-socialisation* of death and dying which, even though with difficulty, is establishing itself in various parts of the world.

Sharing in the diffusion of *palliative care* with our own institutions and with an effective pastoral presence in hospices

250. One of the ways of responding to the invitation of the Constitution lies in supporting the caring philosophy of *palliative care* which has found one of its most important expressions in the hospice, an institution for providing care to the dying.

251. Basing themselves on this philosophy, there are numerous groups of professionals and volunteers who care for and accompany dying people in their homes. We have very advanced techniques for the control of pain and the perceptions proposed by the behavioural human sciences, and in promoting a valuable interdisciplinary cooperation those who follow the approach promoted by *palliative care* meet all the needs of the person of a dying individual, from those that are physical in character to those that are

spiritual, allowing patients to enjoy, albeit within the limits established by their malady, an appreciable quality of life.

Care for Social Illnesses and the Poor

Taking care of the victims of *social illnesses*

252. Attention paid to what takes place in the world of health and health care confronts us with new forms of illness that are also connected with lifestyles that are typical of contemporary society. One is dealing here with the so-called *social illnesses* (AIDS, various kinds of addiction...). Sensitive to the needs of these categories of sick people, we do not hesitate to promote initiatives to respond to them in a suitable way, aware that the culture in which we live tends to marginalise them and to define them in negative terms.

253. We provide care above all else to the 'poorest and most forsaken of the sick', responding 'to their needs in developing nations and mission lands' (C 51), remembering that the heart of St. Camillus beat wherever there were victims of suffering but that it bear with great intensity when the subject of his merciful love was the poorest and the least.

254. Convinced that the 'choice for the poor' is a gift of God, we ask it from Him with humility and trust, being ready to receive it with readiness to help, love and gratitude.

255. Our communities can better proclaim and communicate the gospel of salvation of God who loves life specifically beginning with the least and the most in need, being present where life is most threatened and defenceless. This is not a partisan or ideological choice but an authentic evangelical perspective which becomes a sign of hope and salvation for everyone in contemporary society.

In imitation of Jesus and St. Camillus, cultivating *preferential love* for the poor

256. In pursuing this objective, referred to in a vigorous way at the General Chapter of 1989, we allow ourselves to be helped not only by the wish to imitate Jesus and our holy Founder but also by an accurate analysis of the places and situations where we love and work in order to discover who the poor are and to draw up practical ways of responding to their needs.

The gospel choice

257. We know how to see the poor in the Western world as well, not allowing ourselves to be dazzled by the standard of living of the majority of people. Indeed, although many forms of poverty of the past have been overcome, others have also arisen. They are visible in the growing population of elderly people, who are often left to themselves, in former psychiatric patients, in illegal immigrants who because of their condition have no guarantees as regards their health and employment, and in the victims of the new social illnesses such as drug addicts and AIDS patients, for whom illness is often combined with conditions of abject poverty and abandonment. One condition that all these people have in common is *marginalisation*.

Reintegrating the *marginalised* into society and the community

Keeping the *missionary impulse* and charitable action in third world countries alive

258. We pledge ourselves to keep at a high level the involvement of the Order in developing countries and mission lands where the number of poor people is very great and the resources dedicated to care for the sick are less abundant.

A healthy *pluralism* in the practice of the ministry

259. In caring for the problem of poverty in the world of health and health care we allow ourselves to be guided by a healthy pluralism, aware that illness is a form of poverty for everyone, even though it weighs more heavily on those who are without the means needed to address it.

Welcoming the stimulus of *brothers* involved in service to the poorest

260. We respect and we support to the extent that this is possible those brothers who because of a special inclination are drawn towards forms of ministry for the poor. We know how to see in their initiatives the pointing out of new frontiers where charity should be exercised. We accompany them in discernment and in the implementation of their projects, being concerned to ensure that these are adopted by local and Provincial communities.

Fighting for *justice* in the world of health and health care and promoting *solidarity*

261. The ways of putting into the practice the preferential option for the poor are different. In no case, however, should there disappear the obligation to develop that *solidarity* which makes is draw near to them, becoming their *neighbours* and sharing with them, according to circumstances and opportunities, our lives, our time, our resources and our faith.

262. Following the recommendations of the General Chapter of 2007, we believe that it is our duty to fight for the promotion of justice and of solidarity in the world of health and health care, striving to practise them and to make them practised in the contexts in which we work and trying to influence those bodies that are concerned with the safeguarding of health and policies as regards assistance and care for the sick. Our appeals will be made more effective by our capacity to make ourselves near to weak and defenceless people.

263. One way of expressing our care for the poor lies in choosing to exercise our ministry not only in the major urban centres but also in less privileged places where economic and health-care resources are in short supply.

Observing the vow of poverty and *love* for the poor

264. Love for the poor in the world of health and health care draws its strength from the practice of poverty professed by the perpetual vow, avoiding believing that what is simply *superfluous* is *necessary*. In the exercise of our ministry we do not 'look for gain, nor for temporal profit'. We imitate St. Camillus and work 'for the love of God and neighbour, and out of the obligation that comes from our vocation' (cf. GS 20).

Health-Care Workers

The formation and animation of *health-care workers*

265. The maturation of the charism in the ministry does not include only service to the sick. It also involves the animation and the formation of those who, by their profession, work in the world of health and health care. For this reason, following the recommendations of the Second Vatican Council (LG 8; 23; 69; PO 6; AA 8), subsequent documents of the magisterium of the Church and the Constitution, we 'regard the entire local community, in hospitals and health centres as our trust' and 'we dedicate ourselves to the ethical formation and Christian animation of health care workers' (C 52 and cf. GS 12)

Service to the sick as *profession* and *vocation*

266. This form of our ministry acquires different connotations according to the people or groups to whom it is addressed. We help workers who are moved by a humanistic

vision of life to rediscover, enjoy and live the human and social meaning of their profession which has at its centre the person during the difficult moments of suffering; and to engage in professional deontology and ethics based upon the authentic values of man, a constant point of reference (cf. PSCI 53). Those who share our faith should find in our accompanying a stimulus to move from awareness of *belonging* to the Church to awareness of *being* the Church; to become conscious of their vocation which is implemented in truly ordering the world of health care to Christ (cf. LG 21); and 'to live their profession as vocation and mission, bestowed upon them by the benevolence of the Father; to acquire the broadest and deepest professional ability, in the belief that honesty and professional competence can only with difficulty be replaced by another kind of apostolic zeal; to cooperate with religious assistants so as to assure a journey of faith for patients who request it; and to cooperate with other professional health-care associations' (PSCI 53).

Planning *pathways of formation* for health-care workers

267. Amongst the initiatives than can foster the animations and the formation of personnel, the following deserve to be listed: the promotion of pathways of formation in our centres for pastoral care, membership of interdisciplinary teams (cf. GS 14), informal meetings, the teaching of ethics in schools for health-care and social/health-care workers, and an active functioning of chaplaincies and hospital pastoral councils. We do not neglect the accompanying of groups and associations of professionals, aware that the associated apostolate of lay people allows the achievement of objectives where individual action is not enough: 'Collective, intelligent, well-planned, constant and generous work is required' (DH 4). Specific literature and the means of social communication are valuable instruments of animation (GS 12).

268. The efficacy of this ministry depends not only on the initiatives that are promoted but also on our witness and our capacity to create communion and cooperation through a dialogue that respects the divergent positions and readiness to engage in the exchange of views and ideas.

Chapter VI

In union with the church

269. Allowing ourselves to be guided by the spirit of the ecclesiology of communion, we pledge ourselves to work with the universal and local Church, offering the contribution of our charism to the exercise of its mission.

Forms of cooperation with the Church in the health-care world

270. There are very many forms of cooperation inside the Church. There is, first of all, membership of ecclesial bodies, from the international to the parochial. The influence exercised by these privileged points of observation and planning of the presence and action of the Church can be great. Reference should also be made to the accompanying of associations and groups involved in the field of health and health care at both a professional and a voluntary level. In those bodies which are not specifically involved in the world of health and health care (councils of presbyters, pastoral councils...), we pledge ourselves to give voice to the sick and of health-care workers.

Cooperation with parishes

271. We establish meaningful contacts with parishes, making the parish communities sensitive to the problems of health and illness and attentive to the problems not only of sick people and elderly people resident in their local areas but also of those who are in hospitals or other health-care or social/health-care institutions.

Sensitising the local area

272. In the same way, those who work in *our works*, and above all those works that have elderly people and people with physical or mental handicaps, help to make the population sensitive to the human and spiritual needs of these categories of people.

Dialogue and exemplarity

273. The efficacy of our work with the Church has its points of strength in a humble and courageous dialogue, in a good capacity to make proposals, in a convincing exemplarity, and in the right recognition of authority, as an important resource for the ordered exercise of our ministry.

Chapter VII

Those who work with us

The Laity

The involvement of lay people in our mission

274. The involvement of the laity in the mission of the Order goes back to our Founder who understood the importance of transmitting to the 'seculars' the charism of merciful charity towards the sick so as to reach the largest number possible of suffering people. Even though it has been conditioned by the various ecclesiological visions that have followed one another down the centuries, the project of St. Camillus has never disappeared and indeed it found an impulse in the teaching of the Second Vatican Council. Attentive to the blowing of the Spirit, since then the Camillian order has engaged in a promising journey of growth so as to transmit the charism and the spirituality of St. Camillus to a growing number of the lay faithful, in the belief that consecrated life and the lives of the lay faithful enrich each other, giving but also receiving from each other (cf. VC 32).

275. If lay people are the supporting structure of *our works*, of the health-care and social/health-care institutions where we provide our pastoral service, and of the parishes that we preside over and many other apostolic initiatives, it follows from this that our Order is not a perfect sign of the presence of Christ if there is not at the side of the religious, working with them, an authentic laity (cf. AG 21).

Different groups of lay people

276. The members of the laity are not a uniform group and thus it is necessary to take into account the differences that characterise them. The most numerous group of lay people who work with us is the personnel that works in our health-care and social/health-care institutions. We are called to

establish with them a relationship of esteem and respect so that effective cooperation is achieved in order to achieve the goals of our institutions. They are required to have not only professional expertise but also adherence to that set of principles and values that come from the mission of *our works* and are based on the witness borne by St. Camillus. To those who show a wish to be accompanied on a journey of growth based on Camillian spirituality, we offer those resources that are needed to cultivate their lives in the Spirit.

Cooperation and joint responsibility

277. Our cooperation with these groups of lay people is also called to lead on to forms of joint responsibility and participation in our health-care and pastoral projects (cf. GS 24). This participation should not be braked by an excessive and unjustified prudence, by resistance to change and by an undue attachment to power. We ask the lay people who have positions of responsibility in our works to have not only suitable training at a technical and professional level but also to share our vision of life and mission.

The *identity* of lay people and their distinct way of living Camillian spirituality

278. In involving lay people in our mission, we respect their secular character and their specific spirituality, aware that their vocation involves 'promoting respect for the fundamental values of man – his dignity, his rights and his transcendence – both in scientific research and in therapeutic practice, impressing on the relationship with the patient that care and human warmth that reflect Christ's approach to the sick' (PSCI 41). Animated by charity, the activity that they carry out is participation in the creation and a contribution to the achievement of salvation for the advent of a 'new heaven and a new earth' (cf. Ap 21:1); it is a 'deaconate of charity', witness to the gospel, and a sign of the tenderness of God towards those who suffer (cf. EN 70). Accompanied appropriately, lay people can find in the exercise of their profession or of voluntary activity the instrument of personal sanctification.

Lay people who cooperate in *pastoral care*

279. A second group of lay people is made up of those who work with us in hospital chaplaincies and in parishes, performing tasks that are connected with the ministry of pastors but which do not require the character of the Order. In services to the sick which are the task of the Church community, the space that *can be reserved* to lay people is relevant: they can visit the sick in the name of the community, bring them the Eucharist, preside over prayers for the commending of souls, and participate actively in liturgical celebrations. In the dioceses where we work, we call on the competent authorities to institute the *ministry of consolation* for lay people, men and women, who are involved in service to the sick.

Promoting *voluntary work* and accompanying volunteers

280. The *volunteers* who work individually or are connected with an association are another group with which we establish relationships of cooperation. Their presence in the world of health and suffering is an indicator of a profound awareness of the solidarity that unites men in facing up to the difficulties of life. St. Camillus relied upon the cooperation of *pious and good men*, devoted to service to the suffering out of a pure love for God and Fr. Camillo Cesare Bresciani was for many years director of an important association of Veronese volunteers: 'The sacred brotherhood of hospital priests and laity', an authentic nursery bed of saints. Although we respect the associations that have already been created, we do not hesitate to create others which are more connected with the spirituality of our Institute.

The *proposing* of our spirituality should be respectful of the freedom of lay people

281. The document *Vita Consecrata* invites us to 'discern accurately the vocations to disinterested service', attracting them to us not only in our activities but also in our mission and charism. Forming them 'not only in the acquisition of practice and ability but also and above all else in order to make deeper the reasons for their choice and to promote the community and ecclesial meaning of their projects', we do not hesitate to propose consecrated life to them, above all when young, without concealing in any way its radical character (cf. nn. 33 and 4).

282. Moved by the desire to make the lay people who work with us in the world of health and health care participants in our charism, we avoid approaches that involve impositions and confine ourselves to proposing, in an implicit or

explicit way according to the circumstances, the values inherent in our spirituality. This desire of ours should be limited to making the Camillian message of mercy towards the sick resonate in their hearts and their spirits so that this message permeates their lay lives and the exercise of their profession. We are careful not to isolate the laity from the ecclesial fabric of their dioceses and parishes or from the movements and associations that enrich the lives of the People of God.

The specific contribution of *lay people* to the exercise of the Camillian ministry

283. Through the Christian witness of the laity, made up of expertise, respect for the person, and a deep sense of human solidarity, our hospitals, nursing homes, old people's homes, reception centres for people with physical and mental handicaps, drug addicts and AIDS victims, and our parishes can become effective models of an assistance that is animated by human and gospel values. Their style of being and acting in public health-care institutions can infuse in the exercise of their profession a spirit of service that is able to make it a mission or a ministry. It is through the vigilant presence of lay people that in parishes elderly people and the sick can benefit from the warm and fraternal assistance of the Church community.

Cooperation with *women religious*

284. Even though in far less numbers than was the case in the past, in a large number of health-care and social/health-care institutions where we work there is the presence of women religious. Accepting the invitation of the General Statutes (GS 13), we establish with them relationships marked by respect and we are ready to help them on their pathways of formation and to involve them in health-care and pastoral projects.

Institutes and Associations Based on Our Spirituality

The institutes that *share* our charismatic spirituality

285. The charism and the spirituality of St. Camillus have been fertile and have created religious Congregations and secular Institutes: the Congregation of the Women Ministers of the Sick of St. Camillus, the Congregation of the Daughter of St. Camillus, and the secular Institutes the

Women Missionaries of the Sick 'Christ Hope' and the *Kamillianische Schwestern.* Side by side with these Institutes of greater importance others have arisen, of lower membership but equally important.

The Lay Camillian Family

286. Amongst the associations that have acquired a significant profile in recent decades, there is the *Lay Camillian Family* 'which brings together those who feel that they are called, in the specific lay state, to live the commitments of baptism by bearing witness to the love of the Lord for the sick and suffering according to the charism of St. Camillus de Lellis received from God, transmitting it to the Order that he founded (*General Statutes of the Lay Camillian Family*, 1). This organisation, however, by now present in nearly all the countries in which our religious communities work, responds, even if partially, to a recommendation of *Vita Consecrata* which calls for 'lay people's...participation in various Institutes under the new form of so-called associate members or...This should always be done in such a way that the identity of the Institute in its internal life is not harmed' (n. 33).

The *autonomy* of the Lay Camillian Family and spiritual accompanying

287. Respecting the autonomy of the Lay Camillian Family, emphasised in the statutes that were approved by the Order and by the Congregation for Institutes of Consecrated Life, we show that we are ready to engage in the spiritual accompanying of the association and we do not hesitate to propose adherence to it to personnel and volunteers.

288. Although our relationships with various Institutes and associations has been satisfactory and there have not failed to be, and there still do not fail to be, forms of cooperation at the level of ministry, in particular in countries of mission, the journey to be travelled in this sector requires further endeavour and calls us to engage in the promotion of greater reciprocity, the exchange of gifts, and mutual enrichment.

Chapter VIII

Formation for the ministry

The importance of *formation* for the ministry during the existential journey

289. Formation for the ministry is a process that begins during the period of initiation into consecrated life and the priesthood and continues during the whole course of existence, adopting forms that correspond to each stage of life and affecting all the dimensions of the person, from the corporal to the intellectual and from the emotional and social to the spiritual. Indeed, 'At no stage of life can people feel so secure and committed that they do not need to give careful attention to ensuring perseverance in faithfulness; just as there is no age at which a person has completely achieved maturity' (VC 69). Aware that we our incomplete figures, mere drafts, we avoid the temptation to be completely satisfied with ourselves and to claim that we do not need any further formation.

Knowing

290. Formation for the ministry is a question of contents to be learnt (*knowing*), ways of being to be adopted through a process of steady growth (*knowing how to be*), and the abilities that are needed for the practice of the apostolate (*knowing how to do*).

Specific formation

291. In the area of knowing we give a privileged space to exploring questions and issues related to our charism and ministry. Overcoming the temptation of a self-referential approach, we compare them with the data of the human behavioural sciences, showing that we are suitably instructed 'in the currents and attitudes of sentiment and thought prevalent in social life today' (PC n. 18). We also give space and importance to experimental research concerning the practice of our ministry and emerging needs in the field of assistance and health (cf. GS 22).

Study and reading

292. We believe that it is our duty to acquire through 'study and a serious and disciplined familiarity with modern culture' (PDV 72) adequate formation on those sacred and profane disciplines which are necessary to knowing the world of health and health care and addressing the problems that are inherent in it (GS 11 and 16, C 85), aware that practice should be constantly made the subject of reflection and of discussion, illuminated and directed bearing in mind the great changes that have taken place in the world of health and health care and the religious and ethical debate about all the sectors of human life.

293. We cultivate a liking for study and reading, not proceeding in a disorderly way but by allowing ourselves to be guided by careful choices and ordered methodological choices, taking advantage in a wise way of resources (courses, meetings, conferences...) offered by the Order and/or by other Church and lay bodies.

Formation: a source of *creativity* and satisfaction in the exercise of the ministry

294. Without in-depth study and reflection it is not possible to understand the signs of the times, make choices and take decisions that are most in conformity with people's needs, with the principles of the Gospel and the Constitution. Convinced that the charismatic nature of consecrated life is 'happily in accord' with a 'fertile alacrity of invention and initiative', we nourish our mind and our spirit with those forms of knowledge that foster apostolic creativity, promoting renewal of the ministry, in harmony with the spirit of the Founder and the requirements of acculturation (cf. C 58). New forms of presence and action in the world of health and health care can be conceived for 'places where the evolution of the times and pastoral method suggest this' **(???)**.

Offering *opportunities* for formation

295. We offer the necessary support for their specialised formation to those brothers who are especially talented as regards the world of study and we accompany them so that they do not become lost in individualistic initiatives but place their gifts at the service of the projects of the Institute.

Knowing how to be

296. The mediators of a love that transcends us, we pledge ourselves to cultivate the desire to grow as persons and as

religious. *The area of knowing how to be* aims at a change that is not only cognitive but also one of attitudes, of ways of approaching oneself, one's neighbour and one's relationship with the Lord.

Our *humanity*: a vehicle for the redemptive love of the Lord...

297. Convinced that our humanity is a vehicle for the love of the Lord, we develop and explore a capacity to establish meaningful relationships with the people that we encounter in the exercise of the ministry, so as to be able to understand their needs and accept their requests, intuit questions that are not expressed, and share the hopes and expectations, the joys and the sufferings of living (cf. PDV 72). The way in which we encounter people has an especial importance for the fruits that they can obtain from our ministry, and this is also the case when one leaves unlimited space for the intervention of God. The presence of empathy, cordiality and respect has a positive impact on the results that are obtained through our words and sacramental deeds.

...and implementation of *agape*

298. Subject to the action of grace, our *humanity* becomes an implementation of *agape*, that is to say that pastoral charity 'Pastoral charity is the virtue by which we imitate Christ in his self-giving and service. It is not just what we do, but our gift of self, which manifests Christ's love for his flock. Pastoral charity determines our way of thinking and acting, our way of relating to people' (PDV 23). A freely-given gift of God, *agape* takes on, purifies and vitalises he seeds that already exist in our person, the seeds of welcome, of patience, of understanding, of forgiveness, of faithfulness, of devotion and of solidarity. Supernatural love, indeed, would not be true without the wise use of our emotional riches. In a context of cold, of acidity, of irregular bureaucracy, in a climate that is not familial and without psycho-physical, emotional and sense vibrations, charity would betray itself. And heath care would not be true if the emotional riches of people were repressed. It is authentic if such riches are channelled by intelligence, purified by grace and directed towards service to God and neighbour.

Liberating *ascesis*

299. Openness to the gift of *agape* and its transmission to those people who are encountered requires from us a work

of progressive ascesis which is needed to purify the motivations of our action, to manage our emotional lives in an appropriate way, to remain faithful to the encounter with the other even when there is not immediate gratification, to adapt in a creative way to changeable situations, to welcome the value of different lifestyles, to be flexible in our behaviour, and to *integrate our wounds*.

The *integration* of wounds

300. The integration of our wounds, which is indispensable for the exercise of a ministry rich in humanity, those wounds that come from our human condition and those connected with the exercise of the ministry, allows us to share the human experience of pain in the multiplicity of its expressions, from poverty to illness, from marginalisation to ignorance, and on to loneliness and to material and moral forms of poverty, and to master our fears and worries generated by nearness to the sick.

Knowing how to do

301. The Camillian ministry is also an *art*, and thus translating into action the principles that have been learnt and the approaches acquired requires the learning of appropriate working modalities. An inadequacy of knowing how to do is *often* at the origin of people's complaints about the exercise of the ministry (preaching, liturgy, catechesis, visiting the sick...).The dialogues that pastoral workers have with people are often ineffective because of a lack of adequate training.

302. We take part in those formation programmes that combine theory and practice in a wise way, helping those who take part in them to move from simple information to true formation. We pay especial attention to brothers who are beginning their ministry in the world of health and health care and we accompany them so that they can make of apostolic experience an effective source of learning.

Planning with intelligence

303. *Knowing how to* do finds one of its actuations in planning and organising the ministry. The quantity of pastoral work, indeed, is not always accompanied by an equal depth of vision and careful planning. Numerous projects remain ineffective because they have not been placed in the more general plans adopted by the local or Provincial community

or by the Order or because they have been promoted in a disordered way.

The ministry: an expression of a *community* project

304. In order to plan the ministry appropriately and effectively, a mature community spirit is needed which is expressed in a capacity to think about pastoral activity in a unitary way, harmonising personal projects and shared projects. Technical interventions related to the organisation of pastoral activity will be more effective to the extent that religious nourish a will to overcome individualistic impulses, distrust in others and fear of assessment and discussion.

Inter-community and inter-*Provincial cooperation*

305. In giving proof of wisdom and of openness to the Spirit that blows where he wants, and not only in our local areas, we promote cooperation between brothers, communities and Provinces. We broaden the horizons of our ministry, welcoming the contributions of other groups and institutions, and allowing ourselves to discuss ideas and projects that are valuable in other contexts.

306. The activity of pastoral accompanying requires notable physical and emotional energy. This is a matter, indeed, of a ministry where we are always in the position of those who give. Although, one the one hand, this can allow us to make of our existence a *pro-existence*, that is to say an existence for other people, on the other, however, it runs the risk of opening the doors to that psychological and spiritual phenomenon that goes under the name of 'burnout'. The energies that are *burnt* during work should be regenerated at all levels, from the human to the spiritual.

Taking care of oneself

307. We attend to our bodies, we nourish the spirit, being concerned not only to up-date our knowledge but also to enrich ourselves internally through the contemplation of nature, significant reading, listening to music, love for everything that is beautiful, the cultivation of friendships, and union with God in prayer and the sacraments. We do not forget the exhortation of St. Charles Borromeo to a priest of his: 'Do not neglect looking after yourself, and do not give yourself to others to the point that nothing remains of

yourself. You must certainly bear in mind the souls whose pastor you are, but do not forget yourself'.

A *balance* between professionalism and spirituality

308. We pledge ourselves to establishing a correct relationship between professional expertise and the action of grace. Although, on the one hand, we are called to *affirm ourselves*, preparing ourselves seriously from both a human and a theological point of view, there lies upon us the duty of *denying ourselves*, that is to say recognising the instrumental character of our action, and fleeing from the danger of making the validity and the efficacy of our work depend more on the carefulness of our training than the grace of God. In this way, we can avoid dichotomies, giving value in an undue way to spirituality alone or human formation alone.

Conclusion

Animated by *hope*

309. The invitation to have an optimistic vision of the future echoes through the inspired words addressed to religious by John Paul II:

'You have not only a glorious history to remember and to recount, but also a great history still to be accomplished! Look to the future, where the Spirit is sending you in order to do even greater things. Make your lives a fervent expectation of Christ; go forth to meet him like the wise virgins setting out to meet the Bridegroom. Be always ready, faithful to Christ, the Church, to your Institute and to the men and women of our time. In this way you will day by day be renewed in Christ, in order with his Spirit to build fraternal communities, to join him in washing the feet of the poor, and to contribute in your own unique way to the transfiguration of the world. As it enters the new Millennium, may our world, entrusted to human hands, become ever more human and just, a sign and anticipation of the world to come, in which the Lord, humble and glorified, poor and exalted, will be the full and lasting joy for us and for our brothers and sisters, together with the Father and the Holy Spirit' (VC 110).

Accompanied by the blessing of Camillus

310. On the journey that has led the Order into the new century and the new millennium, we know how to be accompanied by the paternal gaze of St. Camillus who, in his Testamentary Letter, which was drawn up a few days before his death, sent a *thousand blessings* 'not only to those of the present but also to those of the future who will be workers of this holy religion until the end of the world'.

Indice