HOSPITALLER ORDER OF SAINT JOHN OF GOD

CHARTER OF HOSPITALITY

Caring for the Sick and Needy
in the Manner of St John of God

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INDEX

INTRODUCTION **8**
I. THE PRINCIPLES, CHARISM AND MISSION OF THE HOSPITALLER ORDER OF ST JOHN OF GOD **9**
1.1. Planning the future in terms of our principles **9**
1.2. The Charism of the Order **11**
1.3. The Order's mission **12**
II. THE BIBLICAL-THEOLOGICAL BASES OF HOSPITALITY **15**
2.1. The philosophical and religious approach to suffering **15**
2.1.1 Man confronted by suffering 15
2.1.2 Suffering, and the suffering in Christianity 16
2.1.3 The Gospel message of liberation 17
2.2. Hospitality in the Old Testament **17**
2.2.1. God as Hospitality 17
2.2.2. The concept of Hospitality 18
2.2.3. The motivations of Hospitality 19
2.2.4. The main references 19
2.2.5. Institutional Hospitality 21
2.3. Hospitality in the New Testament **21**
2.3.1. The Gospel standpoint 21
2.3.2. Philoxenía 22
2.3.3. Hospitality and evangelization 22
2.3.4. The Good Samaritan 23
III. THE CHARISM OF HOSPITALITY IN ST JOHN OF GOD AND THE HOSPITALLER ORDER **25**
3.1. The charism of hospitality in St John of God **25**
3.1.1. Hospitality as the expression of mercy 26
3.1.2. Hospitality as solidarity 27
3.1.3. Hospitality as communion 28
3.1.4. Creative Hospitality 28
3.1.5. Comprehensive (holistic) hospitality 29
3.1.6. Reconciling hospitality 29
3.1.7. Hospitality as the source of voluntary workers and co-workers 30
3.1.8. Prophetic hospitality 31
3.2. Hospitality through history **31**
3.2.1. The hospitality of St John of God in his first co-workers and across the centuries 31
3.2.2. Our presence today 33
3.2.3. New forms of presence 35
IV. THE PRINCIPLES WHICH THAT ENLIGHTEN OUR HOSPITALITY **37**
4.1. The dignity of the human person **37**
4.1.1. Respect for the human person 37
4.1.2 The universal nature of respect 37
4.1.3. Welcoming-in the sick and the needy 38
4.2. Respect for human life **38**
4.2.1. Life as a fundamental good of the person 38

4.2.2. The special protection of the disabled 39
4.2.3. Promoting life in situations of poverty 39
4.2.4. Obligations and limits on preserving one's own life 40
4.2.5. The duty not to place the lives of others in jeopardy 40
4.2.6. Duties towards the resources of the biosphere 40
4.3. Promoting health and alleviating pain and suffering 40
4.3.1. The duty to provide health education 40
4.3.2. Our preferential love of the poor 41
4.4. Effectiveness, efficiency and sound management 41
4.4.1. Our duty to make people aware that healthcare expenditure is merely a matter of economics 41
4.4.2. Administration and effective and efficient resource management 41
4.4.3 The hospital viewed as a business concern must be geared to rehabilitating the person viewed in his entirety 42
4.4.4 Investing in creating a human and humanizing climate as a means of ensuring a better return on invested resources 42
4.4.5 The rights and duties of workers 42
4.5 The New Hospitality and new demands: Third and Fourth Worlds 42
4.5.1. Solidarity and cooperation 43
4.5.2. Cooperation and cooperators: rights and duties 43
4.5.3. Voluntary service: free giving and identification 44
4.6. Evangelization, inculturation and mission 45
4.6.1. The overall picture 45
4.6.2. Evangelization, inculturation and the mission of the Order 46
V. APPLICATION TO SPECIFIC SITUATIONS 48
5.1. Comprehensive care and the rights and duties of those in our care 48
5.1.1. The humanisation of care 48
5.1.1.1. Outreach 49
5.1.1.2. Welcome and receptiveness 50
5.1.1.3. The ability to listen and dialogue 50
5.1.1.4. An attitude of service 50
5.1.1.5. Simplicity 50
5.1.2. The rights of our guests 50
5.1.2.1. Confidentiality 51
5.1.2.2. Telling the truth 52
5.1.2.3. Autonomy 53
5.1.2.4. Freedom of conscience 54
5.1.3. Duties of our guests 55
5.1.3.1. Respect for the institution and its principles 55
5.1.3.2. Respect for the health care workers 55
5.1.3.3. Respect for the patients and guests 55
5.1.3.4. Respect in the clinical approach 55
5.1.3.5. Respect for the premises 56
5.1.4. Children's and adolescents’ rights 56
5.1.4.1. Children's consent and assent 56
5.1.4.2. Extremely underweight newborns 56
5.1.4.3. Conflicts of interest 57

5.1.4.4. Clinical trials 57
5.1.4.5. Futile treatment 57
5.1.4.6. Adolescence 57
5.2. Specific problems regarding our care work **58**
5.2.1. Sexuality and procreation 58
5.2.1.1. Responsible parenting 58
5.2.1.2. Voluntary abortion 58
5.2.1.3. Conscientious objection 59
5.2.1.4. Prenatal diagnosis 59
5.2.1.5. Interceptives and contraceptives 60
5.2.1.6. Assisted reproduction 60
5.2.1.7. Female genital mutilation 61
5.2.1.8 Gender reassignment 61
5.2.2. Organ donations and transplantation 61
5.2.2.1. Organ transplantation 61
5.2.2.2. Ascertaining death 62
5.2.3. The chronic sick and those in an advanced stage in their illness 62
5.2.3.1. Euthanasia 63
5.2.3.2 Advance instructions regarding treatment 63
5.2.3.3. Vegetative state 64
5.2.3.4. Palliative care 64
5.2.3.5. Palliative sedation 65
5.2.3.6. Terminal foetus 65
5.2.4. The ethics of therapy 65
5.2.4.1. Proportionality of treatment 65
5.2.4.2. Emergencies 66
5.2.4.3. Intensive care 66
5.2.4.4. Pain management 66
5.2.4.5. Aesthetic medicine 66
5.2.5. Research on humans 66
5.2.5.1. Clinical trials 66
5.2.5.2. Informed consent 67
5.2.5.3. Research on incapacitated persons and vulnerable groups 67
5.2.5.4. Foetuses and embryos 68
5.2.5.5. Stem cell research and therapy 68
5.2.5.6. Biobanks 68
5.2.5.7. Ethics Committees 68
5.2.6. Predictive medicine 69
5.2.6.1. Disclosure of the diagnosis 70
5.2.6.2. The gene pool and the protection of privacy 70
5.2.7. Social-ethical problems 71
5.2.7.1. Addictions 71
5.2.7.2. AIDS sufferers 72
5.2.7.3. Other infectious diseases 73
5.2.7.4. Orphan drugs and rare diseases 73
5.2.7.5. Persons with physical, mental and sensorial disabilities 73
5.2.7.6. The mentally ill 74

5.2.7.7. Older people 75
5.2.7.8. Abuse of children, adolescents, and the vulnerable 76
5.2.7.9. Immigrants, the homeless and other marginalised people 76
5.2.8. Pastoral care of the sick and needy 77
5.3 Management 79
5.3.1. Management 79
5.3.1.1. Organization and resource-use 79
5.3.1.2. Professionalism 79
5.3.1.3. Technical skills 79
5.3.2. Organization 79
5.3.2.1. The sound expression of the mission of the work through organizational facilities. 80
3.2.2 Defending pluralism 80
5.3.2.3 Delegation. Participation. Assumption of functional roles 80
5.3.2.4. Decentralization vs. Centralization 80
5.3.2.5 New types of legal status 81
5.3.2.6 Team work 81
5.3.3. Human resource policy 81
5.3.3.1 General criteria 81
5.3.3.2 Relations with our employees 82
5.3.3.3 Trade union activity 82
5.3.3.4 Personnel selection and work contracts 82
5.3.3.5 Job security 83
5.3.3.6 Remuneration 83
5.3.3.7 Motivation 83
5.3.3.8 Convergence of values between all those who make up the Centre 84
5.3.3.9 Creating a culture of membership of the Centre, Province, Order 84
5.3.4. Economic and financial policy 85
5.3.4.1 Non-profit entities 85
5.3.4.2 Its charitable and social character 85
5.3.4.3 Financial break-even 85
5.3.4.4 Managerial transparency 86
5.3.5. Social responsibility 86
5.3.5.1 Service to society as the means of legitimizing our works 86
5.3.5.2 Respect for and compliance with the law 86
5.3.5.3 Commitment to social justice in the distribution of resources 87
5.3.5.4 The function of denunciation of situations that demand it 87
5.3.6. The presence of society in the Centre 87
5.3.6.1. Our clients 87
5.3.6.2 Our employees 88
5.3.6.3 Benefactors 88
5.3.6.4 Volunteers 89
5.3.6.5 The local Church 90
5.3.6.6 The civil authorities 90
5.3.7. Verification 90

5.3.7.1 Heeding the signs of the times 91
5.3.7.2. Responding to the needs of man and society 91
VI. FORMATION, TEACHING AND RESEARCH 92
6.1. Formation 92
6.1.1. Technical, human and charismatic formation 92
6.1.2. Ethics Committees as instruments for formation 95
6.2. Teaching 97
6.2.1. Teaching: one of the constant features of the Order 97
6.2.2. Teaching: an essential need today 97
6.3. Research 98
6.3.1. Communicating the standpoints of the Order 98
6.3.2. Promoting research looking ahead to the third millennium 98
VII. PERSONAL RECTITUDE AS THE BASIS OF ACTION 102
7.1. Rectitude as an existential project 102
7.1.1. Living in harmony with the values which constitute the person 102
7.1.2. Man as a witness of the transcendency of love 102
7.2. Conscience as the driving force of all we do 103
7.3. Conscience and moral rectitude 104
7.3.1. Serving the sick and needy as a ‘conditio sine qua non’ 104
7.3.2. Degrees of personal involvement in the Order's mission 104
7.3.2.1. The Brothers 104
7.3.2.2. Our lay Co-workers 105
VIII. CREATING THE FUTURE WITH HOPE 108
8.1. The challenges of the present 108
8.2. The prophetic power of hospitality 109
8.3. The human-divine vitality of the charism of Hospitality 111

INTRODUCTION

Here is the "Charter of Hospitality" which I am offering to the whole Order. We wanted to give you a document that would address the various issues that have to be clarified in order to give us a clear idea of what kind of hospitality we are being called upon to practise today, as the Hospitaller Order of St John of God, as we enter the Third Millennium, if we are to continue embodying the prophecy of St John of God.

It is a document for which provision was made in the Government's Programme for the Sexennium, and three working groups were set up to work on it. They held two joint meetings in Rome and then formed a small “select” commit- tee to work on, elaborate and re-elaborate the text which is now before you, using the inputs supplied by the members of all three groups.

The Government's Programme for the Sexennium included a series of activities that were never actually implemented, because it proved impossible to draft this text by the scheduled deadline.

The General Council felt that instead of producing a new document for the General Chapter the communities and groups of co-workers should study the Charter of Hospitality throughout 1999-2000, in the light of a set of guidelines to be issued by the Chapter Preparatory Commission, so that in addition to studying the document, they could prepare the agenda for discussion and approval at the LXV General Chapter for the following Sexennium.

This idea was supported by the members of the Commission appointed to draft the text and by the Major Superiors of the Order at their meeting in Rome on 30 November-4 December 1998.

- The document contains several different chapters of relevance to our mission: the theme of hospitality, which is dealt with from a philosophical and biblical -- theological point of view, to shed light on the altitudes of John of God and those belonging to the tradition of the Order, finishing with the principles according to which we wish to perform our Hospitality today;
- the ethical dimension of the human being and of care. It describes the general principles underlying our Ethos and the specific situations in which, by virtue of being hospitality, we are called upon to respond in the manner of St John of God.
- the culture of hospitality, emphasizing above all the importance of formation and research in order to respond to the challenges of the Third Millennium.
- The need to ensure that we manage our facilities charismatically. We must apply the laws of management, but we must do so in terms of our charism. We must do so with the values which the discipleship of Christ and the following of St John of God bring to management, because these are the values which distinguish it. And we must manage our centres in terms of the Church's social teaching.

We feel that by so doing, we shall come away from the General Chapter with a practical programme that will help us live through the next Sexennium responding to the demands of our Charism into the 21st century.
The official publication of this document will be the Feast of St John of God in the Jubilee year, the Day of Reconciliation, in order to emphasize its great relevance to the way we practise Hospitality today.
May Saint John of God help us to reconcile what we are, so that we can transmit reconciliation to others by living hospitality ourselves.
Brother Pascual Piles
Superior General

CHAPTER I
THE PRINCIPLES, CHARISM AND MISSION OF THE HOSPITALLER ORDER OF ST JOHN OF GOD

1.1 Planning the future in terms of our principles

Humanity is moving towards the 21st century filled with both fear and hope. We have made outstanding progress in understanding and managing our world, which today looks more like a huge village – the ‘global village’. Yet individual and collective suffering still persists and is becoming more acute, as a result of war, class or group selfishness, and the limitations of human nature of which we are constantly reminded the abiding presence of pain, sickness and death.

The Hospitaller Order of St John of God forms part and parcel of this ‘global village’. We number 1,500 Brothers, about 40,000 Co-workers counting our employees and volunteers together, and 300,000 Co-workers-benefactors. We are present in all five continents, in 46 countries and in 21 Religious Provinces, one Vice-province, six General Delegations and five Provincial Delegations. We perform our apostolate on behalf of the sick, the poor and the suffering in 293 Centers. Although we are all members of one and the same body, our Order, we nevertheless live in widely differing situations. Some of us are in highly technically advanced societies and Centers, while others are living in developing societies and Centers; some live in countries that enjoy peace, while others are suffering from violence and war, or the aftermath of violence belonging to a recent past; some enjoy the benefits of a free society, but others have their freedom and their fundamental rights severely curtailed; some of us are devoted specifically to hospitaller work, while others are more concerned with social issues and marginalization; some are trying to help people to live, while the mission of others is to help them to die with dignity. Although all of us are working with the aim of providing comprehensive, holistic care, some concentrate more on physical health, others on mental health, and others still are helping to create the conditions to enable people to enjoy decent living standards. Some live in the North, others in the South, some in the cultures of the East and others in the West[1].

As we embark upon the third millennium of our era, men and women throughout the world are wondering about the future of our society, our institutions, and indeed our own future. All of us who are making it possible for the Hospitaller Order of St John of God to continue working throughout the world are also planning a future which will be capable of building in the coming millennium at the service of those who suffer or are in need, and are seeking help to rebuild their own personal life project.

Sometimes, when planning the future we may fall into the error of ignoring the past, not intentionally but simply due to negligence, or because we fail to give it due consideration,

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1 See PILES FERRANDO, Pascual Superior General of the Hospitaller Order of St John of God, *Circular Letter for the Sexennium* 1994-2000, § I, Rome 1994.

or because we are anxious to keep up with the times. On other occasions, the need for radical renewal and to redress failures makes it necessary for us to set aside approaches that have served us in the past but are no longer relevant, because the times now demand new responses and the past must be shed like ballast, leaving us with greater freedom to build up the future.

We have to plan our future here and now, drawing on everything that is positive from our past. We believe that this is the situation facing the Hospitaller Order today, intent as it is on planning its future based on an updated review of its principles and its values.

There are probably some areas in the Order and certain ways of doing things which will have to be changed, and in some places this change may have to be much more radical than in others if we intend to be present in the next millennium, offering people a service and handing them a message that is still relevant. There can therefore be no doubt that the whole Hospitaller Order of St John of God must necessarily be underpinned by the same values that have always characterized our Institution.

These values must be inculturated, updated in terms of the language in which they are expressed, and practiced in accordance with the situations that exist in different parts of the world, for this is the only way in which all those who come into contact with our Centers can come to know and accept them.

General Statute no. 43 lays down the following principles[2]:

‘As a consequence of their Catholic identity, the fundamental guiding principles which characterize the care given in our centers are as follows:

- the focus of the attention of all who live and work in our hospitals or other centers must be the person for whom we are caring.
- the rights of people who are sick or in need must be upheld and defended, taking into account their personal dignity.
- we are committed to the defense and improvement of human life.
- we acknowledge the right of the person in our care to be duly informed of his/her state of health.
- we fulfil the requirements of professional confidentiality, making sure that they are respected by all those who come in contact with the people in our care;
- we uphold the right to die with dignity, respecting and giving attention to the rightful wishes and spiritual needs of the dying, in the awareness that human life is limited in time and is called to fullness in Christ;
- we respect the freedom of conscience of those for whom we care and those who work for us, while insisting that the identity of our hospitaller centers be accepted and respected.
- we enhance and promote the qualities and professionalism of our co-workers, encouraging them to participate actively in the apostolic mission of the Order; in

2 HOSPITALLER ORDER OF ST. JOHN OF GOD, *General Statutes*, §50, Rome, 2009.

keeping with their skills and areas of responsibility we include them in the decision-making process in our apostolic works;
- we reject the pursuit of material gain; thus, we observe just economic norms and demand that these be respected.

We view our Co-Workers as the most important 'assets' that Order has to be able to carry through its mission effectively. This is why in all our relations with them, we strive to practice and promote the principles of social justice, out of a desire to share our charism with all those who are inspired by the spirit of St John of God.

Provided that they respect our principles, we are willing and ready to cooperate with any agency or organizations, ecclesiastical and secular, in the performance and scope of our mission, concerning ourselves more particularly with areas that are most neglected[3].

These principles have their roots in our Founder, and they have taken shape over the years backed by the reflection and the good done by his successors. Bearing our tradition in mind, we must also reflect on the definition of the mission of the Hospitaller Order.

In everything he did, St John of God's one desire was 'do good, and to do it well; not to provide lifeless assistance, neglecting its quality, but combining the sense of Christian charity and justice in order to offer the sick and the needy an efficient service of a high scientific and technical standard'[4].

1.2 The Charism of the Order

St John of God was a *charismatic* man: the way he acted attracted the attention of everyone who knew him, and his influence spread well beyond Granada into the villages and towns of Andalusia and Castile. His 'charism' and his 'charisma' transcended the man himself. And it was not just his humane attitudes and actions that expressed his love for the sick and needy which aroused everyone's admiration and inspired them to cooperate in his work.

Theologically speaking, a Charism is any form of presence of the Spirit which enriches believers and enables them to serve others. Brothers are consecrated to practice a specific Charism which is a gift they have received from the Spirit, by cultivating the grace they receive, living their lives in a relationship with God, and reaching out to and serving Humanity.

The Charism and hospitality with which St John of God was enriched by the Holy Spirit was embodied in him as a seed which was to remain alive in men and women throughout time, extending the merciful presence of Jesus of Nazareth and serving all those who suffer in the manner of St John of God.

3 See LXIII GENERAL CHAPTER, *The New Evangelization and the New Hospitality at the portals of the Third Millennium*, §5.6.3. Bogotá, 1994.
4 HOSPITALLER ORDER – GENERAL CURIA, *Brothers and Co-workers united to serve and promote life,* §13 Rome, 1992,

The Constitutions of our Order define the *Charism* in the following terms:
'In virtue of this gift, we are consecrated by the action of the Holy Spirit, which makes us participate in a special way in the Father's merciful love. This experience communicates to us attitudes of loving-kindness and self-giving, enables us to carry out the mission of proclaiming and bringing about the Kingdom among the poor and the sick, transforms our existence, and results in our lives manifesting the Father's special love for the weakest, whom we try to save after the example of Jesus[5].'

The Brother consecrates himself and lives in communion with others who have felt the same call to express the same charism. But love within this community (communion) has to be expressed outwards, because of the demands of a mission which sets out to provide liberating aid to other members of the Church and to needy people in general.

The Hospitaller Brothers, who are consecrated in hospitality, directly participate in the charism of St John of God. And the Co-workers also participate in the same charism as an 'irradiation' of it: 'those who know John of God… experience in their lives a kind of Light, which arouses within them the urge to live hospitality, imitating John or his Brothers… The laity who feel that they are being invited to live hospitality participate in the charism of St John of God when they open up to the spirituality and mission of the Brothers, embodying it in their own personal vocation.

Of course, different people participate at different levels and to different degrees: some will feel more closely linked to the Order in terms of its spirituality, while others will feel this bond through the performance of their mission. What is important is that the gift of hospitality, which is being received through St John of God established bonds of communion between the Brothers and the Co-workers which will urge them on to develop their vocation and manifest the merciful love of God for humanity, for the poor and needy'[6].

1.3 The Order's mission

The Constitutions of the Hospitaller Order define our mission in the following terms:

'Encouraged by the gift we have received, we consecrate ourselves to God and dedicate ourselves to serving the Church in the assistance of the sick and those in need, with a preference for the poorest'[7].

This overall approach, which applies to the whole of the Order, must then be put into practice. Since each Centre has its own specific character and is seeking to respond to the needs of people living in a specific place and at a specific time, and since we wish our mission to that of EVANGELIZING THE WORLD OF PAIN AND SUFFERING BY PROMOTING HEALTHCARE AND/OR SOCIAL CENTRES AND INSTITUTIONS

5 *Constitutions*, 2b, Rome, 1984
6 *Brothers and Co-workers united* ... §115-116, *loc.cit.*
7 *Constitutions,* 3, Rome, 1984.

WHICH PROVIDE COMPREHENSIVE ASSISTANCE TO THE HUMAN PERSON, we must find answers to the following questions in every specific situation:

- Why does this Centre exist?
- Whom is our service intended for?
- Who are we, the service-providers?
- What are the most appropriate structures?

This is the path we shall have to take to put into practice the principles that we want to promote and the mission we intend to perform in society.

Only if we embody these principles - that is to say, only if our service to the sick and needy in every region of the world is enlightened by the values we are setting out here - can we claim to have created a Centre of the Hospitaller Order of the Brothers of St John of God.

Consequently, the next major step forward must be to identify the persons for whom each Centre is to cater: the sick and the needy to whom we minister. We must also look beyond the people who use the services we provide in our Centers and reflect on those who are outside. For we not only minister to the sick, but also to their families and loved ones.

And we must also reach out to our society and the environment in which we live, and the individuals and entities that have relations with the Centre.

The services which the Centre provides must be dynamic and evolving, because we are living in a dynamic, evolving society, and because the men and women in our care are also constantly changing.

For reflection:

In Centres and Communities:

1) Describe the signs that show how the Charism, Mission and Fundamental Principles of the Order are being lived out.

2) Describe what is hampering or hindering us.

3) What actions can ensure that we will practise the Charism, perform the Mission and apply the fundamental Principles of the Order.

4) Indicate the signs of bonds of communion in Hospitality between Brothers and Co-workers.

5) What should be done to foster the growth of these bonds of union in Hospitality?

CHAPTER II

THE BIBLICAL-THEOLOGICAL BASES OF HOSPITALITY

2.1 The philosophical and religious approach to suffering

2.1.1 Man confronted by suffering. 'What is man? What is this sense of sorrow, of evil, of death, which continues to exist despite so much progress? What purpose have these victories purchased at so high a cost? What can man offer to society; what can he expect from it? What follows this earthly life?'[8]

Finding an explanation for human suffering has been a fundamental problem that all philosophical systems and religious creeds have tried to solve in various ways, without ever managing to wholly lift the veil of mystery enveloping it.

We may perhaps summarize the main answers that have been offered to this distressing issue in terms of five approaches.

A first approach, which we might define as being based on *magic* or *mystery,* is to treat suffering as essentially unavoidable and incomprehensible. It is often put down to a myth according to which it is considered as a 'punishment' inflicted by a god, or as the triumph of evil gods over other good gods. But whatever explanation is offered, everything is projected onto a supernatural dimension where the remedies to free man from suffering may be equally supernatural (witches, shamans, exorcisms, etc.). This view still persists among certain so-called 'primitive populations', and still lingers on as an ancestral substrate in many other religious ideas even today.

A second approach to finding answers, which has persisted throughout history since the ancient Epicurean philosophers to the individualistic hedonism of the present day, is what we might call *denial*. All painful situations in life are a limitation and a constraint on the conquest of pleasure, and it is therefore better to ignore them, seeking to enjoy the present moment as long as we can. This is an 'undoing' of pain and of the anguish which the presence of pain creates. In this cultural substrate, moreover, one finds the roots of so many other forms of contemporary 'despair' which, by denying the reality of pain and suffering have reached the point of denying life itself when the weight of existence itself becomes unbearable.

Another attitude which is the direct opposite to the second one is the *heroic acceptance* of pain and suffering. This was philosophically argued by the Stoics, and the 'stoicism' has now become synonymous with the uncomplaining acceptance of great suffering. This courageous acceptance was particularly attractive to Christianity which introduced elements of Stoic origin into its theological arguments that seemed to fit in very well indeed with the acceptance of the Cross by Jesus and the attitude of the Martyrs. But this 'contamination' was never really positive and was one of the sources of that pseudo-Christian glorification of suffering which we still find it difficult to shake off to this day.

8 VATICAN II : *Pastoral Constitution Gaudium et Spes,* §10, 1964.

A fourth approach to pain consists of *annihilating* it by an interior path which gradually leads to renouncing all passions and all physical and psychological suffering. Buddhism is where this approach reaches its fullest expression, but it is also found in other oriental philosophies and religions that are now exerting such a fascination on the western world. Caring for those who suffer is given particular emphasis in the Buddhist religion which makes ‘compassion’ one of the universal sentiments that bring man close to the divinity, even if the help given to the suffering person is that of rising above the desires that lie at the root of that suffering rather than finding a ‘solution’ to the problems, including the material problems, that are causing it.

The last approach, which we shall be speaking about in greater detail in the next section, is the one which is most fully expressed in Christianity which we may define as *perceiving the value of pain*. Without wholly revealing the mystery and without wishing to transform it into something positive in itself, Christianity provides ‘reasons’ for pain, changing the absurdity of it into a possible instrument for good for oneself and for others. This can also take the form of a mere psychological sublimation by individuals rationalizing a painful experience, or even behavioral compensation.

At all events, and quite apart from these interpretations, we cannot ignore the fact of an *absolutely personal* dimension of suffering whose meaning evades any kind of generalization, since it only has any sense at all within the existential universe of each individual. Suffering thereby becomes a biographical element whose deepest mystery can never be revealed or put down to some form of desired rationality.

2.1.2 Suffering, and the suffering in Christianity. According to the Judeo-Christian view, pain and the evil it expresses were not part of the original plan of Creation: in other words, pain does not come from God. Unlike other religions, then, Christianity does not have a divinity of evil at its roots. Pain and the evil which pain expresses pertain to the human condition, but at the same time express the mystery of something that God does not will, that God does not enjoy, and which is simply awaiting redemption. A negative reality, an ‘absence’ rather than a presence, as St Augustine perceived.

To express this, the Bible resorts to the mythical image of a human condition exempt from suffering of any kind, into which pain entered because man disobeyed a commandment of God, namely, because we distance ourselves from God’s love. The image of the serpent becomes the symbol of idolatry, the symbol of not ‘trusting in God’, preferring a created reality in His place and endowing it with a divinity of its own.

For many centuries, this ‘ontological’ connection between guilt and the suffering imposed as a punishment for it was perceived by Israel in a ‘personal’ sense, seeing every single instance of suffering as a punishment for some sin (an idea that is still quite common even today). And this was not all: by bringing out the paradoxical situation of ‘the happiness of the ungodly’ and the ‘suffering of the just’, the wise men of Israel explained it away by saying that the ungodly man would be punished in his descendants, and that the just man was expiating for the guilt of his forebears.
The first dramatic cry against this view of the issue was set out in the Book of Job. With a sensitivity that still amazes us today for its modernity, Job rebelled against this concept of pain and asked God to account for the fact that a ‘righteous man’ like himself should suffer in disproportion to any possible guilt he might have had. God's reply, however, was not explicit

but was fundamentally set out in his invitation to accept the mystery without demanding an explanation for it, and without giving up his faith in a God who only desires the good of his children.

This great archetype of the ‘suffering upright man’ is solemnly represented by the figure of the ‘suffering servant of Yahweh’ a person that later tradition identified with the image of Christ who ‘took on’ the sufferings of the people, thereby freeing them from their sufferings. This ‘vicarious expiation’, which is very powerfully identified by Paul in Rm 3:25 must be seen not so much as the ‘punishment’ of one man representing the whole people, but in the sense of the ancient sacrifices of expiation under which the holocaust of the victim became an instrument of God's pardon. The sacrifice of Christ and, by virtue of his Mystical Body, the pain suffered by all believers (but in the sense indicated in Rm 8:19 and Eph 1:7-10, the whole world as well) thereby becomes an instrument of God's forgiveness.

2.1.3 The Gospel message of liberation. The subjective dimension of liberation under which Jesus Christ freed man from sin in his own flesh, and hence redeemed man of all the consequences of sin, also has a practical side to it in the works and deeds he performed. Healing the sick, taking in the marginalize and defending the poor constituted an essential part of his mission. Indeed, his work on behalf of the poor, and ‘the least’ was taken as the specific sign of his Messiahship (see Mt 11:3-5). In this way, the power of the total liberation and redemption of man by God, of which Exodus had been the historical experience and symbolic evidence, was fully restored.

Jesus' attitude to the sick is not only meaningful but it also sets an example for us. He played a full part in the events of his own life and that of his kinsmen (See Mt 14:14; 15:32; Lk 7:13; Jn 11:36); he did not challenge, criticize or blame the sick for wishing to be restored to health; indeed, he often took the initiative (See Mk 10:49; Lk 8:49; Jn 5:6); he denied any linkage between individual sin and present sickness (See Jn 9:1-3); he healed the whole of the sick person (See Mt 9:1-7). In other words, his work was not limited to simply curing an ailment, but was aimed at the integral good of man, man's *salus* and not only his *sanitas*.

Care for the needy therefore took on a variety of different meanings, becoming above all a new sign of the covenant between man and God. The covenant between Creator and Creation is therefore re-proposed by the love of God who restores the poor, the sick and the excluded ‘to health’, so that they can live again, imbued with that love. It is in this entrusting to the *Christifideles* of the continuity of Christ’s healing mission that we find the ‘charismatic’ basis of Hospitality whose biblical and theological roots are worth a more thoroughly and systematic study.

2.2 Hospitality in the Old Testament

2.2.1 God as Hospitality. When we talk about Hospitality today, we usually refer to welcoming another person into our homes. But the real theological sense of this human attitude is found primarily in the ontological dimension of Hospitality.

It is no exaggeration to see within the Trinity the deepest roots of a divine life which becomes Hospitality. The Hospitality of the Father who ‘makes room’ in his essence from eternity to

generate the Son, but also the Hospitality of the Son who welcomes into himself the generational gift of the Father. Lastly, the Hospitality of the Spirit who makes the Father-Son reciprocal, and hence becomes the personal identity of a welcoming love.

This Trinitarian dimension of Hospitality not only relates to the divine essence but also its in-dwelling in man who becomes the host of the Godhead (See Jn 13:20). In the words of the old Latin Canon of the Mass, taking part in the Eucharist itself was likened to welcoming in Jesus under one's own roof, and ‘a guest of the soul’ was one of the names attributed to the Spirit[9].

On the immanent plane, Creation is seen as the fruit of this original divine Hospitality which by its very essence generated and at the same time welcomed a project brought into being outside of itself. It is Hospitality which traps eternity and places it in a historical dimension and therefore makes time itself, even before man, its guest. But it is in the creation of man that God most completely manifested Himself as Hospitality, giving man a widespread presence in and dominion over his creation. Indeed, this was done even earlier still, by hosting man in his creative mind of which man bears the impression.

And Creation was followed by the Covenant, expressed in so many forms symbolized in various ways in the biblical account. Precisely because it is a meeting between God and man, the covenant of which Scripture speaks becomes not only a meeting between God and his guest, but also between man and his divine guest. Even though it is expressed by ontologically different realities, hospitality under the covenant becomes a two-way act of giving, an exchange of gifts. And whenever that covenant is violated in the history of individuals or communities, divine forgiveness and subsequent reconciliation with man is witness of the inexhaustible resource of a hospitality and welcome that is always new.

2.2.2 The concept of Hospitality. The Old Testament was set against the cultural background of the Semitic world, in which there was a tension between welcoming the guest while harboring a certain suspicion, seeing the guest as a ‘threat’ to the identity of the people. What unified Israel's attitude to outsiders, in every instance, was the fact of considering them as *foreigners*. At least three expressions are, revealing three different attitudes. The first term is *zar*, which means a person belonging to another tribe or lineage, who is an alien, and sometimes an enemy (Deut 25:5; Job 15:19; Is 61:5; 25:2,5). The second term *ger* indicates a foreign resident in the country (the Israelites in Egypt, or the Canaanites in Israel); and the third term is *tosab* which is used for a foreigner who is temporarily resident in another country (Gen 23:4; Deut 14:21). The existence of these different terms indicates the difference in attitude towards the outsider or alien in terms of the specific status of the alien at the time. In short, we might say that Israel drew a distinction between alien peoples, aliens who had settled in the country, and individual aliens passing through. It was to the latter that hospitality was extended in its highest form. One only has to think of the episode in Gen 19:1-8 in which Lot is ready to offer his daughters to the men of the city, provided that they do not touch his guests. In reality, underlying this difference of attitudes was perhaps the same intention and purpose: to overcome the threat that the foreigner posed to one's own community or one's own identity, both by opposing him and considering him an enemy, and by lavishing attention upon him. We can also find traces of this ambivalent attitude in the later Latin reinterpretations of this concept,

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9 See the *Veni Sancte Spiritus*

with the common root of the term *hospes* (guest) and *hostis* (enemy).

Naturally, although this was the most specific and relevant view of hospitality within Israel, we should not forget how Israel lived and practiced it with its own people. Strictly speaking the 'neighbor' (whose concept was to be thrown into disarray by Jesus) meant a fellow citizen, a co-religionist. Practising hospitality to him was a fundamental duty precisely because of his status as a member of that people whose identity was not only ethnic but above all religious. By virtue of being the chosen people of God, Israel discovered the needs and demands of hospitality towards all the needy groups of persons (one only has to think of orphans and widows).

2.2.3 The motivations of Hospitality. Hospitality in the Old Testament context, as in all ancient cultures, must not be understood in the modern sense of merely taking in guests, and giving them food and shelter. It signified much more a radical 'inclusion' of the guest within one's own circle of interests, protecting him against his enemies, shielding him, deeply respecting him in an existential sense, and looking after him by catering to all his possible needs.

There are numerous reasons for such close attention (in addition to the reasons for caring for members of one's own people or nation mentioned earlier). First of all, there was a *cultural* reason which Israel shared with its neighbors. This was the idea that a divinity may be concealed under the outward guise of a stranger in search of hospitality. In the monotheistic re-elaboration of this idea, the divinities were changed into angels. One can see this clearly from Heb 13:2: *'Do not neglect to show hospitality to strangers, for thereby some have entertained angels unawares'*.

A second reason is more specific and clearly refers to the *history* of Israel. The 'wandering Aramean', Abraham, the father of the chosen people, lived as a stranger, and it was as strangers that Israel lived in the land of Egypt. Israel therefore fully understood the plight and the status of the stranger and knew how much they needed hospitality. Indeed, whenever it was tempted to scorn the stranger, the warning from Holy Scripture was very clear *'When a stranger sojourns with you in your land, you shall not do him wrong. The stranger who sojourns with you shall be to you as the native among you, and you shall love him as yourself; for you were strangers in the land of Egypt'* (Lev 19:34; see also Ezek 22:20; 23:9).
Lastly there was a *religious* motivation (which was subsequently to be developed in the New Testament), namely the example of God himself. He is the God of Hospitality, first and foremost, who welcomes in the stranger and asks to be his host (See Deut 10:18) and wishes to be given part of the goods consecrated to him (See Deut 26:12). The fact that Israel is also required to behave in this manner is nothing other than the implementation of God's will, one of the ways of being faithful to the Law (See Lev 16:29; 18:26; 19:10,33).

2.2.4 The main references. One of the most significant episodes to recall is the visit of the three men to Abraham by the oaks of Mambre. It should be noted that Abraham recognized his guest and called him 'my Lord'. Even before knowing the reasons for the visit, and despite being confronted by several men, he knew that it was the 'visit' of God. Everything he did stemmed from this and can certainly be interpreted in an openly theological sense: he bowed himself to the earth (worship), he personally took the calf and the curds and milk (offering), and he believed what the three men told him (faith) and begged them not to

destroy Sodom (prayer). To put this another way, hospitality becomes an occasion for meeting God.

The author of the episode regarding the widow of Zarephath who does not fail in her duty of hospitality towards Elijah, sharing with him the last piece of cake she had for herself and her child, is intended as an exemplary and educational story. But there is more too it than that: it is precisely by virtue of that hospitality that her son was healed by the Prophet (1 Kings 17:20). In many respects a similar situation can be found in the story of the harlot Rahab who hid the two spies which Joshua sent from Shittim to Jericho, in exchange for which her life and that of all her family were saved (See Josh 2:1-12). A relationship between the life of the host and the life of the guest can also be seen in the Book of Tobit, in which Tobit recounts that he had given one-tenth of his possessions to orphans, widows and strangers (See Tobit 1:8): Hospitality, which is an act of welcoming the life of another, is rewarded by the gift of life itself.

The Book of Sirach also offers a poetic invitation to show hospitality to all manner of needy people: *'Be like a father to orphans, and instead of a husband to their mother; you will then be like a son to the Most High, and he will love you more than does your mother'* (Sir 4:10). The hospitality to which Holy Scripture calls us makes us in some way 'relatives' of the guest, and at the same time enables us to experience the *maternal* tenderness of God. Let us not forget the strongly feminine connotations of the whole concept of mercy. For the Hebrew term *rachamîn* is etymologically cognate to the womb, which expands in order to take in or host the new life. Hospitality and mercy thereby unite to become one single icon of the God of Mercy, 'the lover of the living' (See Wis 11:26).

And this is this standpoint from which we must view hospitality shown to the sick, namely, as the attitude and the specific acts of hosting and welcoming the sick. Exemplary in this regard is the archangel Raphael who, as the 'medicine of God', is one who welcomes in addition to being the one who heals. He therefore becomes a symbol not only of the 'medical solution' to the problem, if we can define him in that way, but he is also the symbol of accompanying the sick, the marginalize, the dying, and the poor whose only medicine is sometimes the presence of a friend.

But this attitude of hospitality must also be shown even to the dead, as evidenced from the Book of Tobit, linking it very closely to the idea of hospitality in the traditional sense (Tob 2:1-4). For Tobit sent his son out to find a poor man to invite to dinner. But all he found was a dead man, one of his own people who had been strangled and thrown into the marketplace. So, he had no hesitation about what to do. He left his meal and removed the body to a place of shelter and then buried it. In a sense, this was the way in which he shared his table with the poor man.

Lastly, let us not underestimate another account that includes the dimension of hospitality even in the historical genealogy of the Messiah: the story of Ruth, the foreign woman who accompanied her mother-in-law Naomi to the land of her birth and married Boas in whose field she was gleaning the ears of grain. From that union was born the grandfather of David. Both spouses were 'rewarded' by becoming the ancestors of Jesus, because their hospitality was mutual: Boaz took in the foreign woman, but also Ruth took in the foreign land for

which she had left her own: hospitality, as a mutual act of welcoming-in sets aside all concern about security and certitude to seek new security in the novelty of the encounter.

2.2.5 Institutional Hospitality. One particularly interesting situation was the choice of six cities *'for refuge for the people of Israel, and for the stranger and for the sojourner among them, that anyone who kills any person without intent may flee there'* (Num 35:15). It was with the institution of these *cities of refuge* that hospitality ceased to be an individual or a community affair and became *structural*. It is no longer the person who is called to be hospitality or the people performing individual acts of hospitality, but the whole community which becomes an 'hosting institution'. The city becomes almost an icon of every future institution that is wholly dedicated to taking in the needy, giving them *everything* they need, not only a place offering temporary hospitality, but a 'city', a whole system of biographical coordinates where the individual can once again begin to live.

2.3 Hospitality in the New Testament

2.3.1 The Gospel standpoint. Before examining the actual deeds of hospitality performed by Jesus we should reflect on the event of 'hospitality' which underlies the whole of the Christian faith, namely, the 'Incarnation'. Mary became the great 'host of God' by welcoming him into her womb as Emmanuel, as 'God-with-us' became the great Host of the whole of humanity. It is no coincidence that from that welcoming act of Mary, poetically expressed in the Annunciation, there immediately followed the beautifully hospitable act of visiting Elizabeth, and the subsequent act of welcoming-in the mother of Jesus.

In addition to the motivations for hospitality that one finds in the Old Testament, the New Testament adds the innovative contribution of the message and the deeds of Jesus. Welcoming-in others, particularly if they are needy, takes on a three-fold perspective in the light of the Gospel.

The first stems from the way in which *Christ identified with the poor* (See Mt 25:31-45). By taking in the poor we take in Christ; to love Christ we must love the poor, whatever is done (or not done) to the poor is done (or not done) to Christ. There is a very real transfiguration of the poor person into Christ, no less symbolic than the transfiguration of which we are reminded in the well-known episode in the life of St John of God. (3. According to a tradition, John of God was washing the feet of a poor man who was transfigured into Jesus[10].

The second standpoint is that of the *Last Judgment*. Based solely on charity (and not on the formal observance of the Commandments) one of the parameters by which we shall be judged on the last day is precisely our hospitality. And that is not all: in a broader interpretation of the expression, we might say that hospitality - welcoming-in others and giving them all our attention - is the crux of the whole eschatological message.

Lastly, the Old Testament God-Hospitality who defended the stranger, the orphan and the

[10] According to tradition, when St John of God was washing the feet of a poor man he was transfigured into Jesus.

widow, *became visible in Christ*, whose life was devoted to serving others. His words are therefore not merely an exhortation, but take tangible form in his deeds, as an exemplary benchmark for all Christians. It would be impossible to summarize all Christ's acts of hospitality and welcome. Let us just recall his kindness when approaching every sick person, not merely healing their infirmities but encompassing the whole of their existence. He touched the lepers, breaking down the barrier of segregation that alienated them from society; he restored sight to the blind, opening everyone's eyes to the error of believing in some form of linkage between personal guilt and sickness; and he raised the son of the widow at Naim, moved by her plight. He took in prostitutes, accepting the criticisms of the righteous; he frequented publicans, sharing their table with them and accepting the hostility of his own people, the work of his killers whom he did not hesitate to pardon, the betrayal and cowardice of his friends, the abject humiliation of the Cross.

In short, Christ is the 'great host of history', and with him all those who wish to take the path of hospitality must measure up to him.

2.3.2 Philoxenía. Even though the various expressions used in the Old Testament may be translated appropriately with different terms in the New Testament, all of them are in a sense 'superseded' by one specific term that specifically stands for hospitality: *philoxenía:* love for the stranger. This decisive linkage between hospitality and love (*philoxenía* and *agàpe*) is the specific distinguishing feature of New Testament hospitality.

We might therefore say that *philoxenía* is almost a 'technical' term that has entered the Christian vocabulary to indicate a particular capacity to welcome-in our fellow men in general, and those most in need in particular. It is no coincidence that this is included in the examples of charity in St Matthew's Gospel in relation to the judgment of the last day (Mt 25,35); Paul places it amongst the exhortations following the practice of charity (Rm 12:13); Peter does the same, emphasizing the duty of reciprocity (1Pt 4:9); the letter to the Hebrews deems it inseparable from *philadelphia*, namely love for our brothers. Every one of us is required to practice it, but at the same time it is a particular prerogative of the Bishop (1Tim 3:2; 5:10; Titus 1:8).

In essence, then, Scripture shows that what is a generic demand for charity can also become a specific charismatic expression on the part of certain persons who are called to it.

2.3.3 Hospitality and evangelization. Apart from this dimension which closely links hospitality and charity there is another particular New Testament motivation which expresses the value of this virtue: the demands of evangelization. They are never separated in the Gospel message from the command to heal: *'Heal the sick ... and say to them, 'The Kingdom of God has come near to you''* (Lk 10:9; see Mt 10:7-8). Rather like today's 'parish missions', the houses of Christians became 'listening centers. This duty to take people in is specifically indicated in 3Jn 7-8: *'For they have set out for his sake and have accepted nothing from the heathen.*

So, we ought to support such men that we may be fellow workers in the truth'. There are a number of testimonies about this practice (Rm 16:4, 23; Phil 22) and because of this evangelization strategy whole families were sometimes converted (See Acts 16). In this way

hospitality becomes a tool of evangelization, both in terms of witness and word, and the structures of hospitality become, for the whole community, the sign and the place of the proclamation of total liberation in the Gospel sense of the term.

2.3.4 The Good Samaritan. The great parable of hospitality is the story of the *'Good Samaritan'* in which later Church tradition identified Christ himself, and the ideal Christian11. First of all, the motivation which underlies this story is important. Jesus had been asked to say who was our *neighbour*. According the contemporary Jewish idea, only fellow nationals or a person bound by particular ties (of blood, friendship, etc.) could be considered to be 'neighbours' and hence deserving of the love of Israel. Jesus, with a totally novel paradox, to indicate the 'neighbour', namely the person who is most 'nigh' or 'near', chose the example of the 'the most far', namely, the hated Samaritan enemy.

This parable is interesting because it also offers ideas for a kind of *methodology of hospitality* which could be relevant to us today. First of all, the Samaritan places acceptance of the wounded man before and above his personal interests (he was on a journey, he stopped, he deferred all his commitments) and he did so by not following the same behavior as the others (not only the priest and the Levite, but also the Samaritans themselves). In other words, he did what he considered to be his duty without side-stepping it with the alibi that 'everybody does the same thing'.

Then he tried to make the best use of the resources available to him. He bound up the wounds with improvised bandages, and he washed them and medicated them with the only remedies he had with him, loading the wounded man on the back of his horse and then setting out to find suitable accommodation for him.

Lastly, he set up a care structure, and by so doing he involved the whole community. The innkeeper therefore became the prototype of every situation in society which becomes a welcoming and hospitable institution if appropriately urged to do so by those who possess the charism of hospitality. Then the highly practical Samaritan set about collecting funds to help the wounded man, which then become his money: in other words, he acted as a channel for social solidarity.

The conclusion of the parable is the perennial invitation which became history in the life of St John of God and all those who have received the gift of the charism of hospitality: go and do likewise.

11 See JOHN PAUL II, *Salvifici Doloris*, §7, 1984

For reflection:

1) Illustrate with examples the most common attitudes we see among us (Brothers, Co-workers and Guests) when faced with human pain. (Cf. 2.1.1)

2) Indicate the way Hospitality progresses between the Old and the New Testaments (differences, similarities, superseding concepts).

CHAPTER III

THE CHARISM OF HOSPITALITY
IN ST JOHN OF GOD AND THE HOSPITALLER ORDER

3.1 The charism of hospitality in St John of God

The charism of hospitality is to be seen as a gift of the Spirit for the performance of a specific ecclesial mission on behalf of the poor, the sick and the needy.

This charism and the mission relating to it were lived by our founder in his own manner, and in such a characteristic fashion that he set in train an original and highly efficient hospitaller 'culture'. St John of God's hospitaller 'culture' has an original prophetic value for renewal in the Church and in society[12].

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12 The Hospitaller Order has a rich source of documentation to study and research the main thrusts and the vitality of the Hospitaller charism. Documentary sources thus become the means whereby we can draw on the sources of the Hospitaller charism of St John of God and its features.

In chronological order, and in order of importance we have six *Letters of St John of God*, and written by St John of Avila to him. These letters are available in a number of commentated editions and provide us with a very vivid portrait of St John of God. They help us to see and love a person, a living follower of the first Hospitaller in history, Jesus Christ. They show us his passion for needy and suffering mankind, for his mother the Church, and for all his sons.

The second source in order of importance is certainly the *Biography of the Saint*, by Francisco de Castro published in 1583. This is historically a very reliable biography and offers a thorough account of the Saint's human and spiritual progress, in the course of which divine hospitality towards him is emphasized as the source of the boundless hospitality he showed to all the poor and sick.

Since 1995, the Hospitaller Family also has another very valuable source on the life and hospitality of St John of God. This is the *Documentation from the Archives of the Provincial Council of Granada which formed part of the Lawsuit between the Brothers of the Hospital of John of God and the Brothers and Convent of the Monastery of St Jerome*.

This documentation is dated 12.03.1570 (even though the lawsuit began in 1572) and comprises 171 handwritten sheets which were transcribed by José SÁNCHEZ MARTÍNEZ in his book: *Kénosis y Diakonía en el itinerario espiritual de San Juan de Dios*, Madrid 1995. Of the 17 witnesses who answered the 26 questions, 10 were personally acquainted with St John of God. This documentation and other evidence has been used by Sánchez in another book on the lawsuit, and constitutes the third source in order of importance for studying the hospitality of St John of God.
We also have the first three Constitutions of the Granada Hospital and the three fundamental Bulls:

1. Pius V's *Licet ex debito* (1 January 1572)
2. Sixtus V's *Etsi pro debito* (1 October 1586)
3. Paul V's Brief *Piorum Virorum* (12 April 1608).

These are extremely valuable documents because they enable us to get very close to St. John of God and the theological and juridical principles of our hospitality. In addition to these there are also the requests made by the Superiors General for various authorizations and for approbation which finally led to the promulgation of these Bulls. Both are considered to be sources of our hospitality.

For the Hospitaller Family this must continue to be the leaven that revitalized the services of the Order throughout the world. Here are some of its main features.

3.1.1 Hospitality as the expression of mercy. St John of God's hospitality stemmed from the Christian experience of God's mercy towards our founder which revealed to him his condition as a sinner and the great mercy and love of God who freely pardons and creates a communion of life with all his children. This experience is the fundamental feature and the source of all the wealth of hospitality of St John of God.

'If we reflected on the breadth of God's mercy, we would never cease doing good while we were able'[13].

We are tempted to consider St John of God as being fundamentally merciful, compassionate, understanding, forgiving, and capable of helping people, and we are right to do so. But this is a consequence of his awareness and his permanent experience of the mercy and forgiveness of God and of Christ towards him. He saw life and everything in life as freely

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The early Constitutions include:

1. Regla y Constituciones para el Hospital de Ioan de Dios, desta ciudad de Granada ... 1585;
2. Constituciones hechas en el primer Capitulo General hecho en Roma año de 1587;
3. Costitutioni et ordini da osservarsi dagli Frati dell'Ordine di Giovanni di Dio ... 1589;
4. Costitutioni del devoto Giovanni di Dio - d'Italia, 1596
5. Regla del Bienaventurado Padre San Agustín y Constituciones de la Orden de Iuan de Dios, Madrid 1612

There is plentiful contemporary documentation, too, but in order to keep the account short we will only recall one or two of the most important publications following the 1976 General Chapter, in chronological order.

- P. Marchesi, *The bases of renewal* (1978).
- P. Marchesi, *Humanization* (1981).
- *The Apostolic Dimension of the Order of St John of God* (1982).
- *The Constitutions of the Hospitaller Order of St John of God* (1984).
- P. Marchesi, *The Hospitality of the Brothers of St John of God towards the year 2000* (1986).
- *The Declarations of the LXIII General Chapter* (1988).
- B. O'Donnell, *Servant and Prophet* (1990)
- B. O'Donnell, *John of God lives on* (1991).
- *The Brothers of St John of God and Co-workers together to serve and promote life* (1992).
- *The New Evangelization and the New Hospitality* (1994).
- P. Piles, *The power of charity* (1995).
- P. Piles, *John of God: Called to the New Hospitality* (1996).
- P. Piles, *Let yourselves be led by the Spirit* (1996).
- *The missionary dimension of the Hospitaller Order. Prophets in the world of health care* (1997).

Critical research and study carried out across the centuries and also recently into the life, spirituality and hospitality of St John of God provide further invaluable contributions to probe more deeply into the subject matter of this 'Identity Card'. But in order not to overburden it, we refer the reader to the bibliography at the end for some of the most important titles.

13 1st Letter to the Duchess of Sessa (1 DS), 13. See also A. GAMIERO, *Koinonía, filoxenía e martyrion em S. Jaão de Deus e na sua Ordem nascente* (tese de doutoramento, Rome 1996, in the press).

given divine gifts of God's mercy:

'Our Lord Jesus Christ ... shows so much mercy towards us, giving us food, drink, clothing and everything else, although we do not deserve it ...'[14]

The one thing our Founder desired and sought most frequently during his conversion was the forgiveness and mercy of God, as we see from Chapters VII, VIII and IX in Castro's biography. He yearned for mercy and requested our Lord to show it to him, and once he had received it he became the mediator for it with all the needy.

The merciful hospitality of St John of God is certainly the one thing that most strikes the reader when carefully looking at the extraordinary work he did for the benefit of all kinds of needy and suffering people.

We can truthfully say that his profound experience of God's merciful hospitality towards him changed him into a merciful hospitaller for the benefit of all, without exception, and we might even say without limits.

From all we know of his deeds, he set no limits on the numbers of needy and suffering people he helped. The list of the needy people in Granada and the area around it who received help from St John of God given in Chapter XII of Castro's biography and the list which the Saint himself provided in his second letter to Gutierrez Lasso coincide with and cover virtually all the categories of people who lived in Granada in his day.

3.1.2 Hospitality as solidarity. This experience and the revelation of the mercy of God towards him produced two responses: one was *kénosis* (annihilation)[15] or the penitential humiliation which comes out very clearly in the sources, and subsequently the response of merciful hospitality towards all the needy, suffering and sinners16. F. de Castro tells us how, on the day of his conversion, from being a poor bookseller, John of God detached himself from everything he had in order to become a disciple of Jesus Christ. He also says:

He always went around barefoot both in the city and in all his travels, bareheaded and with his head and face shaved, without a shirt, or any other clothing apart from a rough grey overcoat and woollen trousers. He walked everywhere, without ever going on horseback, even on his journeys, however tired he might have been and however sore his feet. However bad the weather, whether rain or snow, he never covered his head from the day on which he began to serve Our Lord until the day he called him to himself. Yet he felt compassion for the slightest sufferings of his fellows, and tried to help them, as if he himself lived very comfortably[17].

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14 2nd Letter to the Duchess of Sessa (2 DS, 18.

15 See J. SÁNCHEZ MARTÍNEZ, *Kénosis y Diakonía en el itinerario espiritual de San Juan de Dios,* Madrid 1995.

16 See 2nd Letter to Gutierrez Lasso (2 GL, 5). But these lists are certainly not complete. In Chapter XVI of Castro's biography, he seeks to add other needy people. The Saint assisted people suffering from the most acute moral evils. We know his concern and mercy towards prostitutes, prisoners, the deprived and marginalized, the *moriscos* and probably also the 'New Christians' of Jewish ancestry, the slaves and other people suffering from social exclusion, such as the incurably sick.

17 CASTRO, *op.cit.* Ch. XVII

His first house was a pathetic place where he could invite in other poor people like himself. Castro explains this in a few words:

Having decided to truly comfort and succour the poor, John of God spoke with a number of devout persons whom he had comforted in their distress, and with their help and their religious fervour, he rented a house by the city fish market because it was near Piazza Bibarrambla, from where he went out to look for the poor, abandoned, sick and lame wherever he they were; and he bought some rush mats and some old blankets for them to sleep on, because at that time he had no money to do more or to provide them with any other form of care[18].

We might say that St John of God was embodied in the poor and the sick, by taking them in and catering for their needs as if he was one of them. He treated them and looked after them despite all his limitations, with the wealth of the charism of hospitality given to him by God. He never refused to help anyone in need but gave them everything he could in his poverty.

3.1.3 Hospitality as communion. As an intermediary between the rich and the poor, between the wealthy and the needy, between the powerful and the despised, St John of God practiced the *hospitality of communion*.

With St John of God, begging for alms has become part of the heritage and spiritual wealth of the Order which it cannot do without, even though we have had to adapt its methods to every age and culture. It must be considered as a form of circulating goods for the construction of society on the basis of solidarity and on spiritual foundations.

When he went around the streets shouting, *'Do good brothers to yourselves for the love of God'* he wanted to disturb and provoke people's consciences not to sleep on the miseries of their own fellow men, giving and taking on a mutual basis.

When he wrote letters to thank people for the gifts he had received and to tell them of the pain he felt for the suffering of the poverty-stricken whom he could not help unaided, and when constantly asking for loans that he found difficult to pay back, his intention was to build up a community of communion in which everyone felt that they were brothers and sisters, loved, helped and pardoned by God, as he had felt. He knew that if everyone had experienced the mercy of God to the depths he had, the Church and society would truly become the family of the children of God, with divine life and communion indwelling it, overcoming all the needs of the needy.

3.1.4 Creative Hospitality. In a city with ten hospitals and poorhouses it is incredible how the sensitivity of St John of God discovered so many sick and needy people left to their own devices. And it is also surprising to see how he managed to carve out for himself a new way of practicing hospitality. He was the precursor of all those who had the responsibility for going before him to solve the problems of the sick, the poor and the needy.

His hospitality was a response to those who were unable to find it elsewhere (the

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18 *Ibid*. Ch. XII

abandoned) and catered for those with new needs to which the others were not yet sensitized (suffering because of guilt, hatred or vendetta). St John of God saw every kind of suffering both in the body and in the spirit[19].

3.1.5 Comprehensive (holistic) hospitality. We might say that one of the most characteristic values of the hospitality of St John of God is the comprehensive manner in which he treated the suffering person as a whole. For him, the sick and the needy were not just a body and soul, sinners, seekers of revenge, liars or unworthy. They were all persons, his brothers and sisters, and all were worthy of being helped and pardoned by him and by his co-workers. Why was this? It was because God did the same, providing for the needs of everyone every day20, pardoning and saving[21]. And because seeing them suffer without help 'broke his heart'[22].

The hospitality of St John of God was, as we might say today, both *preventive*, and *emergency*, *curative* and *rehabilitating*, because he healed the curable and accompanied the incurable. And it was also *educational* and *formative* for the orphans, the abandoned children left to die and the prostitutes whom he helped to release of their sense of guilt, to build up and carry forward a project of formation and social rehabilitation. In his hospital he offered a bed and food, firewood and premises to take in the pilgrims, with medicines, nurses, physicians, chaplains and spiritual aid for the sick[23].

The hospitaller practice of St John of God shows us that the Chinese story about the fish and the fishing rod is a false issue when interpreted solely as a dilemma (either ... or ...). Hospitality to provide relief for the suffering and needy must always be inclusive (both ... and ...), depending on the circumstances of the place, the time and the persons concerned.

3.1.6 Reconciling hospitality. St John of God was understanding, treating everyone, whether sinners, oppressors or oppressed, the way God had treated him: he forgave and helped, he assisted and healed the physical and moral wounds of all. Very often the moral and spiritual wounds were healed first, and as a condition for obtaining the healing and the harmony of the body.
In a world divided by so many kinds of ideology, fundamentalism and ethnic discrimination which generate hatred, resentment and the desire for revenge, St John of God's capacity to pardon, reconcile and build bridges of brotherhood deserves to be studied and experienced by all of us in the Hospitaller Family. He was a profound healer of wounds, tensions and conflict among all those he assisted and those who worked with him.

Like Christ, he healed with his own wounds. His biographers always point out the way he was wounded by his separation from his parents, by loneliness, by the frustrations of military life, but above all by guilt, the hardships he had to endure, his suffering for the many debts that he had taken out in order to help the poor and the sick, his brothers and

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19 See (2 GL, 8)
20 See (1GL, 2)
21 Letter to Luis Bautista (LB, 19).
22 1 DS, 15
23 From Chapter XII to XX of his book, Castro provides us with a beautiful illustration of all these different dimensions of the hospitality of St John of God.

sisters. These experiences of existential wounds also made him a Hospitaller who was specialized in healing and reconciling enemies, to make them his co-workers, as he did with Antón Martín and so many others.

To the Duchess of Sessa, his benefactress, he spoke of how he healed with the wounds of Christ crucified, and he counselled her to do likewise:

'When I am troubled, I find no better antidote or consolation than considering and contemplating Jesus Christ crucified'[24].

'When you are troubled or distressed, turn to the Passion of Jesus Christ Our Lord and to his precious wounds, and you will feel great consolation'[25].

This is how he managed to persuade Antón Martín to forgive and reconcile himself with Pedro Velasco, winning them both over to become his direct co-workers of his own hospitality, as his first Brothers.

And it was with the passion and suffering of Christ that on Fridays he healed the wounds of prostitution from which so many women had been destroyed by their way of life. Through his charism of merciful hospitality he pardoned the woman whom he had rescued from and who insulted him: *'Sooner or later you will have to forgive yourself, and that is why I forgive you immediately'*[26]. He thereby converted her a second time, as she testified at his funeral.

When reported to the Archbishop, accused of taking in people who were unworthy into his 'house of God' he said that he was the only unworthy person and that *'as God tolerates the wicked and the good and every day lets his sun come out to shine on all, it is not reasonable to chase away those who have been abandoned and the afflicted from one's own house'*[27].

3.1.7 Hospitality as the source of voluntary workers and co-workers. The boundless merciful love of St John of God was of such vitality that it generated love, Christian charity and cooperation. It was a hospitality spread far and wide, as a charism that was increasingly shared with others.

This charismatic strength which St John of God received from God and to which he remained radically faithful made him a beacon that irradiated hospitality at different levels of solidarity and cooperation with him in the work of helping the poor and the sick.

We can distinguish between different types of co-workers: those who helped him practically and with alms from time to time, and those who became permanent co-workers, like Angulo and all the others mentioned in his letters, and by Castro and the document of the *Lawsuit* against the Jeronymites. Some embraced the work of volunteers for St John of God and others became *full members,* identifying with his charism.

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24 2 DS, 9.
25 1 DS, 9.
26 CASTRO, loc.cit. Ch. XV
27 CASTRO, *loc.cit.* Ch. XX

His closest co-workers were his first companions or Brothers of the habit, benefactors who identified most closely with his charism who felt that his work was also theirs. And this sense of belonging to his hospital and to his work generated a powerful dynamic surge of solidarity. This identification with his charism led many of his co-workers to foster it, and to defend its originality with material and personal help[28]. This sense of identity as a member of the Family of St John of God remains as sound a model for today and for the future as it was then.

3.1.8 Prophetic hospitality. One of the most original features of the Hospitality of St John of God was prophecy. As a penniless immigrant alien, with a reputation of being raving mad, giving himself entirely to Jesus Christ and to those who suffer, he blazed new trails in the Church and society.

His Hospitaller attitudes were surprising, disconcerting, but they acted as beacons to point the way to new paths of care and humanity towards the poor and the sick. He created from nothing an alternative model for the citizen, the Christian, and the Hospitaller serving those who were abandoned by all. This prophetic hospitality was a leaven of renewal in the world of care and in the Church. The model created by St John of God also acted as a critical conscience and guide to sensitize others to take up new attitudes and practice new ways of aiding the poor and the deprived.

3.2 Hospitality through history

3.2.1 The hospitality of St John of God in his first co-workers and across the centuries. The first Brothers[29], the companions of John of God, participated in his Hospitaller charism, practised it and spread it. The Act of the foundation of Antón Martín's hospital in Madrid speaks about the state of need of ‘the sick with contagious wounds. In his testament, Antón Martín stated that John of God had left him to run his hospital in his place as if it were himself[30].

His companions were remembered by the witnesses as Hospitallers who were *very close* to the poor and the sick for whom they cared. His person, as a humble, poor and lowly man living in total voluntary annihilation (kénosis) detached from all greatness in order to lower himself to the level of the poor and to be able to continually serve them and be an example to his own companions and co-workers.

The witnesses of this first stage in the Order's existence were unanimous in declaring that *‘the Brothers received all the poor without exception, with great charity and generosity, and anyone who was a stranger or a native, whether curable or incurable, whether sound of mind or mad, small children and orphans. And this they did in imitation of John of God,*

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28 This solidarity of identification comes out very clearly in the letters to Gutierrez Lasso and the Duchess of Sessa, in Castro and in the *Lawsuit*, and related to dozens of co-workers.

29 However, the *Lawsuit*, which predates Castro's biography, mentioned many Hospitaller attitudes of the Brothers of the habit of St John of God. John of Avila (Angulo) also mentions the names of four of them: Antón Martín, Pedro Pecador, Alonso Retingano and Domingo Benedicto.

30 ORTEGA LÁZARO, L., OH, *Antón Martín* pp.17-18 and 31.

their founder. They received all, both the 'moriscos' as well as old Christians'[31].

Since that first stage in the life of the Hospitaller Order, and throughout almost five centuries of history, hosts of Brothers and Co-workers of the Order, some of whom have already died and others are still alive, some famous and others who have spent their lives almost unnoticed, have borne precious testimony of faithfulness to the charism of hospitality[32].

Assistance on the battlefield, on board ship and in the armies, even in peacetime, became a constant feature of the Hospitaller services provided by the Order, in Spain, Portugal and France, beginning in the first few decades of its existence.

The Order's work has also been combined with two other forms: emergency and relief services in times of epidemics, and running hospitals in mission lands, some of which were there to cater for the indigenous peoples[33].

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31 Statements made in the Lawsuit between the Brothers of the 'ospital de Juan de Dios' and the 'frayles e convento del monesterio de san Gerónimo', 1572-73. In SÁNCHEZ MARTÍNEZ, José, *loc. cit.* pp 181-188 and 285 et seq.

32 In order to gain some idea of the identity and originality of the Order, we feel that we should be even partially familiar with some of the most outstanding Brothers in terms of the values of hospitality. The *Saints, Beati and Venerable Brothers* deserve to be recalled first of all: St John Grande, St Richard Pampuri, Blessed Benedict Menni and our many Beatified Martyrs. Among the Venerables and those whose cause of Beatification is now being introduced are Francis Camacho, Antón Martín, José Olallo Valdés, Eustace Kugler and another group of martyrs, in addition to all those many others throughout the history of the Order who have suffered martyrdom or persecution for Christ and for Hospitality in Brazil, Colombia, Chile, Poland, the Philippines, France, Spain and more recently in other countries.

So many other Brothers who have been *'founders'* and *'re-founders'* of communities and centres in the Order deserve to be better known as the living expression of the vitality and the values of our charism. These include Brothers Bonelli (France), Gabriele Ferrara and Giovanni Battista Cassinetti (Italy and Germany), Francisco Hernández (America). In more recent times we would recall Fr Giovanni Maria Alfieri (Italy), Paul de Magallon (France), Eberhard Hacke and Magnobon Markmiller (Germany), Blessed Benedict Menni (Spain, Portugal and Mexico).

In the field of the *historical research* into the Order several Brothers stand out prominently: Juan Santos, Cote y Parra, Gabriele Russotto, whose love for the Order and scientific minds have familiarized us with the path that our charism has taken throughout history.

Another group of distinguished Brothers have been outstanding doctors, surgeons, pharmacists, botanists, dentists, and far too many to name individually. Some of their names are given in Chapter 6 (note 11) where we deal with training, formation and research in Order.

After these names of Brothers who have been prophets of Hospitality, we ought perhaps to list the names of Co-workers whose love for the Order and its values deserve to be remembered.

33 ANTIA, *Juan Grande* in 'Labor Hospitalario-Misionera de la Orden de San Juan de Dios en el mundo, fuera de Europa', AA.VV. Madrid, 1929.

'The Hospitaller Brothers, from the reign of Philip II to Fernando VII were automatically chosen for the military *medical corps* particularly in expeditions to the East Indies and in times of war and epidemics.

In addition to the hundred or so hospitals in the newly converted indigenous communities in America (the so-called *Hospitales-Doctrinas*), where care was provided for Spanish soldiers and indigenous people, with a very large and well-cared for indigenous community, they also had pharmacies and clinics and dispensaries in order to look after and administer to everyone. The indigenous people were not only given care for the health of their bodies in these hospitals-communities, but also for their souls. Remaining always faithful, the zealous Brothers of ST JOHN OF GOD lived according to the principle inherited from their Father and from their Elders and always continued as good Hospitallers to administer *'to bodies and souls'*.

Another form that has developed in many countries has been the establishment of *medical and surgical schools and colleges,* and courses for nurses for the members and Co-workers of the Order.

In the 19th and 20th centuries, with psychiatry becoming an increasingly specialized branch of medicine, the Order has been sensitized to founding and running specific centers for the mentally ill. In France this developed considerably thanks to Paul de Magallon in the 19th century when the Order was restored after being snuffed out by the 1789 Revolution. The same applied to Spain and Portugal thanks to Benedict Menni.

Following the restoration of the Order in various parts of Europe in the 19th century (Germany, Poland, Austria and Italy) other Provinces founded centers exclusively devoted to the mentally ill and disabled, children, young people and adults. The Provinces of Ireland, England and Australasia have specialized in providing services for the mentally disabled and have done a great deal in helping to draw a distinction between these and the mentally sick, and also to change the terminology used to describe them, in order to enhance their dignity and their rights as persons.

Benedict Menni's response in Spain was to provide care for *physically disabled youths and children* which was very urgently needed until only a few years ago, and is still a feature of some of the general pediatric hospitals, some of which are in the avant-garde, as well as orthopedic and rehabilitation hospitals.

One of the ways in which the charism of St John of God has been highly developed in the last few decades has in the provision of *night-shelters* for the homeless, and *homes for the elderly and centers for people with learning difficulties or mentally impaired* .

One of the dimensions which the Order has been increasingly developing is the *missionary* dimension. One might say that the missionary expansion of the Order dates right back to its beginnings. The foundation at Cartagena (Colombia) in 1596 was the first of many dozens which were created in America, Africa and Asia until the last century.
After a period in which the missionary foundations became extinct, they resumed again in America, Africa, Asia and Oceania. The Order wishes to continue evangelizing the world of healthcare today, just as St John of God did, and as Jesus Christ commanded us.

3.2.2 Our presence today. The demands of the new evangelization which the Church is planning for the beginning of third millennium have led the Order to respond by setting out a New Hospitality. The 'New Hospitality' must be expressed in two directions: in innovative centers in the community and offering new responses where care is not being provided by others.

Since the 1976 General Chapter, and increasingly since the Extraordinary General Chapter in 1979, the Order has made an enormous effort to update the care it provides in its traditional centers. Many areas have been developed. It may be useful to recall the main ones.

Humanization and *pastoral care* have been revitalized in the past twenty years, to meet the

need to complement the great technological and technical developments in the hospitals and also to cater for the specific sufferings of the sick and their family members.

The care provided by the Brothers of St John of God has always been comprehensive, and holistic, which means that it can never be provided without updated pastoral and spiritual care.

The humanizing and pastoral dimension, coupled with the necessary continuing formation and education of our Brothers and Co-workers can, if carried forward properly, renew the Order's presence in traditional centers. These are ways of providing the renewed presence of the Order in the world of care, if they are implemented properly, a New Hospitality and a New Evangelization.

In recent years humanization has been completed by formation and education in *Bioethics and the ethics of healthcare* and its application to the service of the sick.

Many of our hospitals and centers have been helped to renew themselves by *upgrading their facilities* to cater to new needs and new technical and human requirements, together with *new management criteria* giving priority to allocating resources under clearly defined programmes.

The developments through which our traditional centers have passed have affected every area of them. Technological innovation in the field of the sciences of human health is reflected in the constant changes that have occurred in our centers. Their physical structure has changed considerably by incorporating technical teams, changing care and assistance techniques, and new working methods particularly by introducing multidisciplinary teamwork. And all of this has been designed to improve the care provided to individuals as persons.

The most important change has come about with the integration of the Co-workers. Until only a few years ago the Community of Brothers, with the support of a handful of lay persons, was able to serve the sick. Today it is our *Co-workers* who have the main responsibility for running the centers, and they are excluded from nowhere, and in many cases, management has now been taken over by our Co-workers.

Our Co-workers and Payees are also being joined by increasing numbers of *volunteers*, who are working in our Centers taking on humanization and pastoral ministry duties.

This renewed and updated presence in our traditional centers is giving excellent results thanks to local provincial and international *formation* courses.

The future of our centers therefore depends partly on keeping our technical instruments and facilities, working methods and management systems constantly up-to-date, particularly with regard to the facilities for communication and computerization.

Scientific research is another area that is being developed, under programmes that are sometimes carried out in conjunction with university departments.

The Brothers must be ethical/moral guides, act as a critical conscience, as creative and innovating precursors, and be a prophetic sign of the Good News to the poor, the sick and needy of today, whatever their culture or religion.

3.2.3 New forms of presence. Over several years now, the Order has adopted innovative forms of care stemming from its sensitivity to new social needs and its desire to find new responses based on our charism to cater to existing needs.

In some cases, this has taken forms practiced formerly by St John of God. But now we are broadening our outreach to the social community, to families and to their needs.

Our hospitality is increasingly leaving the hospitals and the centers to spread to *healthcare prevention and education, rehabilitation and social reintegration, and community healthcare*. St John of God placed great stress on caring for the orphans, and for educating them, for reintegrating prostitutes, etc.
Today the Order is extending its field of action to day hospitals, home care and multiple outpatients departments. It is also promoting forms of caring for persons suffering from new contemporary diseases: drug addicts, AIDS victims, the chronic terminally ill.
People suffering from loneliness, despair, and a lack of meaning in their lives, are finding answers thanks to help-lines, bulletins and pamphlets carrying human and Christian messages, magazines dealing with issues on which to reflect, and providing ethical and hospitaller formation.

One of the areas in which the Order is trying to meet new social needs is integrating the Brothers and the Co-workers into centers, projects and programmes run by the Church and other national and international organizations in the field of healthcare, research and assistance.

These are being run by groups in one or several Provinces, their foundations or associations in conjunction with NGOs, and governments of other countries, particularly in the developing world.

The charism of St John of God is so rich and has so much vitality that when the Order, Brothers and Co-workers allow themselves to be led by the spirit of God and are sensitized to the newly emerging needs of society, the fruits of the hospitality of St John of God multiply abundantly, even where the resources appear insufficient.

For reflection:

How does the Order (Brothers and Co-workers) continue to re-create the distinctive features of the Charism of Hospitality?

ACHIEVEMENTS SHORTCOMINGS OR SUGGESTIONS
STRENGTHS AND WEAKNESSES

1) Merciful hospitality

2) Hospitality of solidarity

3) Hospitality of communion

4) Creative hospitality

5) Holistic hospitality

6) Reconciling hospitality

7) Hospitality that gives rise to volunteers and co-workers

8) Prophetic Hospitality

CHAPTER IV

THE PRINCIPLES WHICH ENLIGHTEN OUR HOSPITALITY

Accepting the Church's call to become increasingly more conscious of the evangelising mission of every group or centre/activity within the Church, the Order feels committed to clearly developing its identity as it plans the New Hospitality in the light of what we call the 'Culture of the Order'. All of us are committed to this hospitaller culture, Brothers and Co-workers together embodying the principles which enlighten our hospitality in all we do. We will now examine these principles one by one.

4.1 The dignity of the human person

4.1.1. Respect for the human person. The creation of man and woman in the image of God (Gen 1:27) gives them an undeniable dignity. Of all the living beings, the human being is the only one which resembles God, is called to communication with God, and is able to heed and respond to God. The dignity of every human being in God's eyes is the basis of their dignity in in the eyes of man, and in their own. This is the ultimate reason for the fundamental equality and fraternity of all humanity regardless of ethnicity, nation, sex, origins, culture and social class. This is the reason why no human being may use another human being as if they are things or objects. On the contrary, everyone must be treated as autonomous beings responsible for themselves and be shown respect.

Our duty of self-esteem and self-love comes from the dignity of the human being in the eyes of God. Consequently, we must all consider ourselves to have worth, and take responsibility for looking after our own health. And our duty to love our neighbour as ourselves also comes from the dignity of every human being in the eyes of God, as is the fact that human life is sacred and inviolable, essentially because in the face of every human being there is a ray of the glory of God (Gen 9:6).

4.1.2. The universal nature of respect. Respect for the dignity of the human person, created in the image and likeness of God, requires everyone, without exception, to consider our neighbour as 'another self', primarily taking care of their lives and providing them with the means they require to be able to live in dignity.[34] It has to be made clear that the dignity of every human being is a fact, whatever may afflict them, whatever limitations may be imposed on them, and to whatever level of social alienation they may be reduced.

Respect for the dignity of the human person created in the image and likeness of God is present in the philosophy and increasing international awareness of the wide range of human rights.
As persons, all men and women are equal and deserve equal consideration and respect. Dignity is inherent in the human being by virtue of being the subject of rights and duties.[35]

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34 Cf. SECOND VATICAN COUNCIL. Pastoral Constitution *Gaudium et Spes (GS),* 27
35 The concept of human dignity and rights of the person are intimately connected in the Universal Declaration of Human Rights (1948), The International Convention on Economic Social and Cultural Rights (1966), The International Convention on Civil and Political Rights (1966), The Convention on Human Rights Biomedicine, better known as the "Oviedo Convention" (1997). Even though these Declarations do not make

4.1.3. Welcoming the sick and the needy. Since the value and human dignity of the sick and needy are being more frequently questioned today when suffering from pain, disabilities and death, and run the risk of being overshadowed, by taking care of the sick and needy, the Hospitaller Order declares to all humanity the wonderful legacy of faith and hope it has received from the Gospel.

Following the example of St John of God, the Hospitaller Order sees Jesus' attitude to the weakest and the socially marginalised as a call to us to be committed to defending and fostering fundamental rights based on respect for human dignity.

Considering the different ways in which the Order expresses its charism today, we feel that there are a number of areas in which there are particularly meaningful signs of the Gospel in terms of the New Hospitality:

- *the homeless:* expressing the dimension of free-giving which our society, driven by the need for efficiency and productivity, almost denies;
- *the terminally ill,* expressing the value of life at the moment of death;
- *AIDS victims:* overcoming marginalisation due to fear and irrational prejudice;
- *drug-addicts:* loving people who are unable to love themselves;
- *immigrants:* welcoming in Jesus, in the stranger, as the genuine expression of hospitality;
- *the elderly:* affirming the value of human life in every stage of existence;
- *the chronic sick and disabled:* expressing the value and dignity of the human person.

Wherever there is poverty, disease, or suffering is a special place in which we, as Brothers and Co-workers, making up the St John of God Family, practise and live the Gospel of mercy.[36]

4.2. Respect for human life

4.2.1. Life as a fundamental right of the person. Life is a fundamental right of the person and a prior condition for enjoying other rights. Everyone must be acknowledged as possessing the same rights as all other men and women as far as life is concerned.

The duty to self-fulfilment incumbent on everyone – viewing our existence as a gift but also as a commitment to act – presupposes our obligation to preserve the fundamental right to life as an essential condition for fulfilling our duty as custodians of the mission given to us with our own existence.

For the believer, human life is a gift of God, and must be respected from its beginning until

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it clear and explicit on what human dignity is based, they recognise all of them as being inherent to the human being and also and also recognise the equal and inalienable rights of all the members of the human family as the foundation of freedom, justice and peace in the world.

36 Cf. LXIII GENERAL CHAPTER. The New Evangelisation and the New Hospitality on the Threshold of the New Millennium, Bogotá. 1994. D.6.1.

its natural end. Since the right to life is inviolable it is the strongest basis for the right to health and the other rights of the person.

4.2.2. The special protection of the disabled. In every person with physical or mental health difficulties or intellectual disability we must see a member of the human community, a being who is suffering and who, more than any other person, needs our support and our signs of respect, to help them believe in their own value as human persons. This is very important today because our society is showing increasing intolerance towards people with *disabilities and other challenges*.[37]

The Hospitaller Order must distinguish itself by virtue of its readiness to help as far as possible to bring about the practical and effective realisation of the principles of integration, participation, inclusion and personalisation. The *principle of participation* is contrary to the tendency to isolate, segregate or neglect the disabled. The *principle of inclusion* entails the commitment to rehabilitating the disabled by creating as normal an environment as possible. The *principle of personalisation* emphasises the fact that when dealing with the disabled their dignity, well-being and personal development occupy the pride of place, and that it is our duty to protect and foster their physical, mental, spiritual and moral faculties.[38]

4.2.3. Promoting life in situations of poverty. In the New Evangelisation the Hospitaller Order must make visible the Gospel of life by making every possible effort to ensure that unjust, dehumanising structures are eliminated, and creating the possibilities for a dignified life wherever people are experiencing poverty, sickness, marginalisation, deprivation and abandonment.

By virtue of our discipleship of Christ according to the charism of St John of God, human life must be supported and promoted by the *service of charity* which is manifested in our individual and institutional testimony through different forms of voluntary service, social leadership or political commitment.

The service of promoting life must be carried out by promoting preventive activities and measures, helping invalids and rehabilitating people with disabilities. Whatever we do to help the disabled play a full part in life and in the development of the society to which they belong, and to create a social environment which fully accepts them as members of the community with special needs that must be met, will therefore never be sufficient. There will always be more to be done.

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37 The WHO defines an impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function", and a disability as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" is a particular individual taking account of age, gender and cultural factors ".

38 In December 2006, the United Nations promulgated the Convention on the Rights of People with Disabilities. It identifies numerous rights and, in article 3 it summarises the following guiding principles: Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; Non-discrimination; Full and effective participation and inclusion in society; Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; Equality of opportunity; Accessibility; Equality between men and women; Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

4.2.4. Obligations and limitations on the conservation of one's own life. Life is a fundamental good of the person and a prior condition for the use of other goods, but it is not an absolute good. Life can be sacrificed for others, or for noble ideals which give life a meaning. Life, health, and all temporal activities are subordinate to spiritual ends.

We repudiate the notion of man's absolute and radical control over life, and we cannot therefore consent to anything which presupposes any total and independent right over life, such as the right to destroy it. At the same time, we can affirm the 'useful' right of control over one's own life, but not the duty to preserve it whatever the cost. Life is certainly *sacred*, but it is equally important to consider the quality of this life, namely, the possibility of living it humanly and giving it a meaning. There is no duty to preserve life under particularly distressing conditions which demand disproportionate or futile treatments.

4.2.5. The duty not to place the lives of others in jeopardy. Human life is sacred because from the very beginning it was the fruit of the creative action of God and always remains in a special relationship to the Creator, its only end and purpose. God alone is the Lord of Life from the beginning to the end. No-one, under any circumstances, may claim the right to kill another human being directly.[39] Since the Hospitaller Charism reaches out and welcomes all, the Order is always opposed to the death penalty regardless of the circumstances.

4.2.6. Duties towards the resources of the biosphere. The protection of the integrity of creation underlies the increasing interest shown in the environment. The ecological balance and the sustainable and equitable use of the world's resources are important elements of just dealings with all the communities in our global village; they are also the object of justice to be shared with future generations who will inherit what we bequeath to them. The irresponsible exploitation of natural resources and the environment degrades the quality of life, destroys cultures and reduces the poor to abject poverty.[40] We must foster strategic attitudes which create responsible relationships with the environment in which we live and which we share, and of which we are merely its stewards.

Since our structures are places in which we consume all kinds of material things, we can send out concrete and meaningful signs of our concern for the environment by setting up committees for this very purpose, giving pride of place to using biodegradable and recyclable materials, and sensitising everyone, Brothers and Co-workers alike, through courses and workshops.[41]

4.3. Promoting health and alleviating pain and suffering

4.3.1. The duty to offer health education. Among the activities to improve the health of the population we have to stress the need to keep the public well-informed and run educational programmes which promote healthy lifestyles such as healthy diets, physical exercise, appropriate immunisation of babies, and reducing the risks to health which can be avoided, including the use of tobacco, alcohol and other drugs, as part of our work to promote the

39 Cf. JOHN PAUL II, *Evangelium Vitae (EV)*, 5.23
40 Cf. JOHN PAUL II , *Octogesima Adveniens* 21; JOHN PAUL II, *EV* 27, 42.
41 The New Evangelisation and the New Hospitality... *Op. Cit*, 5.6.3, Concrete situation

health of the population. This also includes avoiding sexual activities which increase the risk of contracting AIDS and other sexually transmitted diseases.

In many countries, healthcare education is one of the means used to reduce infant mortality and morbidity by breast-feeding and informing parents about appropriate nutrition and the risks of contaminated water.[42]

Those of us who work in healthcare have an ethical duty to foster the good of the patient at all times, and to incorporate that responsibility into a greater commitment to fostering and guaranteeing the health of the population.[43]

*4.3.2. Our preferential love of the poo*r. Our mission of making John of God present in a world of suffering and poverty, which is the world in which most of the world's population live, is particularly important because oppressive poverty – due to unjust social structures which exclude the poor – is generating systematic violence against the dignity of men, women and children and the unborn, which cannot be tolerated in the Kingdom willed by God.

"Our Order exists for the very purpose of evangelising the poor, accompanying them and assisting them in their sufferings in the style of St. John of God (...) We see some efforts being made to adapt our life and our structures to better serving persons who are sidelined from society: day hospitals, night shelters, care for patients with AIDS, drug addiction and terminal illnesses, the promotion of improvements in services and the environment in marginalised zones – from the bases of existing centres (...) These efforts always require very consistent action on the part of the Order if it is to present itself unmistakably to the poor as those who can provide support to alleviate hardship and provide assistance; so that by means of its life, its service, its mission of announcing and denouncing, it can exercise an increasingly greater influence in this field on the Church and the structures of society."[44]

4.4 Effectiveness, efficiency and sound management

4.4.1 Our duty to make people aware that healthcare expenditure is merely a matter of economics. In every country the demand for healthcare services exceeds the national capacity to provide them. It is a major duty to cooperate in drawing attention to the whole of society that the cost of providing medical care must not be considered purely in financial terms. Such costs are an investment in human resources to reduce individual suffering and to offer people the opportunity to devote themselves to productive work or to live in their own homes or to reduce the cost of treatment. Medical expenses therefore reduce other social costs.

4.4.2 Administration and effective and efficient resource management. The healthcare professions must accept responsibility to guarantee the effective management of

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42 Document of the World Medical Association, "Draft Declaration on Health Promotion, 10.75/94, August 1994.

43 *Ibidem*

44 *The New Evangelisation and the New Hospitality...*, op. cit, 3.6.3.

expenditures on care and assistance, which includes using efficient diagnostic and therapeutic methods, and maintaining high quality standards in compliance with viable and realistic operating parameters.

4.4.3 The hospital viewed as a business concern must be geared to rehabilitating the person viewed in his entirety. The whole hospital, viewed as a 'firm', must be directed or redirected to reintegrating the individual person viewed as a whole, namely in somato-psychological, social and spiritual terms, which in the ultimate analysis is the very essence of the humanization of medical care. In the hospital, viewed as a corporation, investing in the creation of a human and humanizing climate boosts productivity and enhances the effectiveness of the work performed there. [45]

4.4.4 Investing in creating a human and humanizing climate as a means of ensuring a better return on invested resources. As in any other firm, creating a human and humanizing atmosphere in a hospital also contributes to sound resource-use and to improving the working conditions of the healthcare workers. By humanizing themselves, they can also help to create more humanizing conditions for the patients. [46]

Among the improvements that must be made, particular attention should be focused on refresher courses to keep the personnel up-to-date in terms of knowledge and skills through continuing education tailored to the circumstances of every age and of every places.

4.4.5 The rights and duties of workers. The right to work is provided by labour contracts under current legislation. Specialists in labour law must find the best technical and legal solutions to reconcile the right to conscientious objection and the right to work when drafting labour contracts, or subsequently revising them, and when bringing into force new collective labour contracts. Respect for the rights of workers which our hospitals, homes and treatment and welfare centres must show to an excellent degree in order to enhance social justice must not be at the expense of its own existence which would be against social justice.

4.5 The New Hospitality and new demands: Third and Fourth Worlds

The gap between the developed North and the developing South is widening all the time. The abundance of goods and services available in certain parts of the world, particularly in the developed North, is matched in the South by an unacceptable backwardness, and it is precisely in that geopolitical area that most of mankind lives. When one looks at the wide range of different sectors: food production and distribution, hygiene, healthcare and housing, the availability of drinking water, working conditions particularly for women, average life expectancy and other social and economic indicators, the general picture is depressing, whether we consider it in itself or in relation to the equivalent data on the more highly developed countries of the world. [47]

45 JOHN PAUL II Centesimus Annus §§ 40; 20; 32
46 MARCHESI Pierluigi, Humanization 1981
47 JOHN PAUL II, Sollicitudo Rei Socialis, §14

Even in the developed countries, millions of people making up the so-called 'fourth world' are excluded from social benefits by the economic and social forces: these are the men, women and children living in poverty and misery who 'not only live under conditions of very serious physical and psychological discomfort but have also lost their rights as subjects of law, because they are not guaranteed by any legal or social protection'. The most evident examples of these are those who lose their jobs, young people without any employment prospects, street children exploited and left to their own devices and fate, old people living alone and without any social protection, former prisoners, drug victims, AIDS sufferers, immigrants in general and particularly the illegal ones ... all of those who are condemned to live a life of dire poverty, social marginalization and cultural precariousness. [48]

4.5.1 Solidarity and cooperation. The Gospel of Jesus Christ is a message of freedom and a power of liberation. Liberation is mainly and above all else liberation from the radical slavery of sin. This logically involves liberation from many other types of cultural, economic, social and political slavery which ultimately derive from sin and are all obstacles which prevent men from living in a dignified manner. [49]

'Solidarity is an eminently Christian virtue. It brings about the sharing of spiritual goods even before material goods'. The principle of solidarity is a direct demand of human and Christian fraternity. Solidarity is shown primarily in the distribution of goods and in remuneration for work performed. Socio-economic problems may be solved only if all forms of solidarity are brought into play: the solidarity of the rich with the poor, but also between the poor; solidarity of employers with their employees but also between workers themselves; solidarity between countries and peoples. International solidarity is a moral requirement. To a large extent, world peace depends on it. [50]

4.5.2 Cooperation and cooperators: rights and duties. The document of the LXIII General Chapter spells out sufficiently clearly the main thrusts of what is demanded of Brothers and Co-workers of St John of God.[51] Here are a few of them. We must: *humanize ourselves in order to humanize others:* to be witnesses of holiness in terms of the radicalism of the Beatitudes following the example of St John of God a poor man amongst the poor, a servant and a prophet.

Promote every aspect of the human person: looking after the sick, lovingly taking in the chronic sick, paying special attention to the weakest and poorest, accompanying those who are living out the last moments of their earthly life, transforming care and treatment into acts of evangelization.

Put across our *hospitality culture* as an alternative to the '*hostility culture'* which is not only increasingly dominating relations between peoples, nations and ethnic groups, but also interpersonal relations. We must demonstrate a new capacity towards receptiveness and

48 Letter of Card. CARLO MARIA MARTINI, The Pastoral Biennium 1991-1993.
49 INSTRUCTION OF THE CONGREGATION FOR THE DOCTRINE OF THE FAITH, Christian freedom and liberation, Rome 1986.
50 CCC 1939-1942
51 *The New Evangelization … loc. cit* § 4.4

welcome, creating communities of open faith that will be inviting to all those who have relations with us: the sick, their relatives, co-workers, friends. Every center must be a small domestic Church that can create Christian communion in which all share each other's joys and sorrows. Today, more than ever before, the Brothers of St John of God is called to be a witness of God 'Lover of life' (Wis 11:26) in all his human relations, merging with his own people and through his presence making the land welcoming and man truly human.

Enhance and foster the qualities of our operators and volunteers working with the Order and enable them to become involved in service to and evangelization of the persons living in our centers and in special events in the life of the Community.

Prepare professionals who identify with the philosophy and values of the Order so they can take upon themselves managerial and leadership functions in our centers.

Promote and act in compliance with the principles of social justice.

Our Co-workers must:

Perform their professional duties in respect for the principles of hospitality, which are translated mainly into humanized care.
Show the desire to respect or implement the Gospel spirit.

4.5.3 Voluntary service: free giving and identification. A volunteer is a person who, in addition to his or her occupational duties and those of their state of life, devote on a continuous and disinterested basis part of their time to activities not for themselves or for their associates (unlike what occurs in associations) but on behalf of others or of collective social interests, according to a project which is not designed as an end in itself (unlike charity) but which is designed to eradicate or modify the causes of need and social marginalization. [52]

Our philosophy is identical to that of any other form of voluntary service. The only difference is that what is fundamental for all of us becomes specific in our case because it is a Hospitaller and a social activity performed in the Order's centres, according to the spirit of St John of God. In our voluntary service there must be:

The principle of voluntariness: volunteers belong to the same organization, and join it freely, because they demand it;
The principle of free giving: dedication stems from an interior need, a personal commitment with no external obligation;
The principle of solidarity: this stems from the need to be present in the needs of others, and to show sympathy with them and take on their needs;
The principle of complementarity: this sets out targets which society is unable to achieve alone, enriching it and thereby promoting social justice;
The principle of personal integration: the intention is almost always to give, but very often we see people more interested in what they get out of it;

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52 CARITAS. C M. del Carmen Furés: El voluntariado en nuestra sociedad en Labour Hospitalaria 1985; 198(4): 206

The principle of preparation: this demands adequate training and preparation to acquire the necessary historical knowhow, the apostolic dimension and the values of our Order, and the capacity to be at ease within it under all circumstances;
The principle of partnership: working on a coordinated basis, forming a group without any individualism;

The principle of the Gospel: since our voluntary service is non-denominational, it is based upon the Gospel in the way in which St John of God lived his devotion to the poor, the sick and the needy. The places in which voluntary service is performed are denominational centers: *freely-given service and identification with the charism of the Order sum up the fundamentals of our voluntary service*. [53]

4.6 Evangelization, inculturation and mission

4.6.1 The overall picture. Evangelizing is the vocation of the Church, and marks out her most profound identity. She exists for *evangelization*, namely to bear witness, to teach and to preach the Good News of Jesus Christ. As the core and centre of this Good News, Jesus announces salvation, that great gift of God which is the liberation from everything that oppresses man, which is above all liberation from sin. [54]

Evangelization is based on the missionary mandate given to us by Christ Himself: 'Go therefore and make disciples of all the people. Know that I am with you until the end of the world' (Mt 28:18-20; see Mk 16:15-18; Lk 24:46-49; Jn 20: 21-23).
To fulfil this mandate, the Gospel must be embodied, incarnated, 'translated' (without betrayal) into different cultures.[55] Evangelization is not possible without inculturation.

The split between the Gospel and culture is without any doubt the great drama of our age, just as it was in other ages.[56] Secularization also *de facto* entails the establishment of a culture of non-belief as we have indicated above, in which the cultural premisses are based on the idea that the world is purely immanent, in which any statements regarding transcendency are culturally and socially irrelevant. In such a situation, those who wish to be Christians without renouncing their own age, and without wishing to become exiled from the culture in which they live, must make the effort to inculturate Christianity into the cultures that have been created by modernity.

Inculturation makes it possible to bring the Good News in terms of each culture, thereby making a contribution of its own riches to the historical incarnation of the Gospel. This means that when the Gospel is concretely incarnated, it undergoes powerful transformations in comparison with its previous forms of inculturation. Inculturation in this way makes it

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53 PILES F. Pascual *Origen y trayectoria del Voluntariado en la Orden Hospitalaria de San Juan de Dios*; Congreso Nacional de Voluntarios de San Juan de Dios, 18-20 October 1995.
54 PAUL VI, *Evangelii Nuntiandi* (EN) § 9, 14

55 Culture is the way in which a group of people live, think, feel, organize themselves, celebrate and share life. Every culture has an underlying value system, system of meanings, world views, which are expressed outside in the form of language, acts, symbols, rites and lifestyles.
56 *Ibid* § 20: *Gaudium et Spes,* § 43

possible to understand and transform ‘through the power of the Gospel, mankind's criteria of judgment, determining values, points of interest, lines of thought, sources of inspiration and models of life, which are in contrast with the Word of God and the plan of salvation.’ [57]

Inculturation, when it is performed rightly, must be driven by two principles: ensuring the compatibility of the various cultures to be taken in with the Gospel, and ensuring communion with the Universal Church. [58]

4.6.2 Evangelization, inculturation and the mission of the Order. Contemporary man believes more in witnesses than in teachers, more in experience than in doctrine, in life and more in facts than in theories.[59] In this world, the Order is in a specially privileged place for the evangelization and inculturation of the faith precisely because it is present in so many cultures, in 46 countries and in all five continents. The culture of technology, which is probably the one which is most resistant to Christian values, is nevertheless sensitive to the living testimony of our concrete commitment to man.
The Order’s charism imposes this commitment fully upon us, since the advancement of men and women from every point of view is our mission: caring for the sick, lovingly taking in the chronic sick, paying special attention to the weakest and the poorest, accompanying those living out their last moments of life.

Only fidelity to the charism will make it possible to evangelize and inculturate the world of technology in which the culture of hostility confronts the culture of the New Hospitality.

The question we shall have to answer in the future is how to change our acts of care into authentic acts of evangelization, how to transform the places in which we work into meaningful places of evangelization. Humanization and evangelization must, for us, belong to one single indivisible unity because ‘where there is no charity God is not there, even though God is everywhere’. [60]

57 *EN.* § 19
58 See JOHN PAUL II, *Redemptoris Missio,* § 54
59 *Ibid,* § 42
60 SAINT JOHN OF GOD, *Letter to Luis Bautista* §15. See also *The New Evangelization* ... §4.3

For reflection:

1) Describe the signs of how the Principles of Hospitality are being lived in the Centres and Communities of the Order:

- The dignity of the Human Person
- Respect for Human Life
- Health promotion and pain relief
- Efficiency and sound management
- The New Hospitality
- Evangelisation, inculturation and mission

2) Describe what is hampering or hindering this experience:

- The dignity of the Human Person
- Respect for Human Life
- Health promotion and pain relief
- Efficiency and sound management
- The New Hospitality
- Evangelisation, inculturation and mission

1) How do we disseminate and educate Brothers, Co-workers and Guests in the principles that inspire our hospitality?

2) What should be done to improve the dissemination and education in the principles that inspire our hospitality?

CHAPTER V

APPLICATION TO SPECIFIC SITUATIONS

5.1. Comprehensive care and the rights and duties of those in our care

Our contribution to society will only be credible if we are able to embody the progress made in technology and the development of the sciences. Hence the importance for our response in terms of care and assistance to constantly strive to be continually up to date in technical and professional terms.

Based on this, we must provide care that considers every dimension of the human person: physical, psychological, social and spiritual. Care that takes account of all these dimensions, at least as a working criterion and as an objective to be achieved, can be deemed comprehensive or holistic.

Perhaps this is where the Order's Centres have managed to cultivate our best tradition. Their level of care has always been a feature which has made them stand out across the years.

The first Constitutions emphasised the way in which the sick was to be treated, and this is how things have continued ever since, giving pride of place to this aspect throughout history.

5.1.1. The humanisation of care. The concept of "humanisation" is a key element in the holistic, comprehensive care provided today. In the Hospitaller Order, particularly, this is the distinctive feature of its charismatic identity both because it has been implicitly present ever since St John of God first began his care ministry, and because it was so effectively relaunched in the 1980s by the Superior General at the time, Brother Pierluigi Marchesi.

While there is no doubt that a hospital which fails to keep abreast of scientific and technological progress cannot rest be complacent, and will find itself obsolete, it is equally true that science and technology also entail risks.

The continual development and the constant emergence of new working teams and techniques threaten to leave the human person on to one side, which includes both the practitioner and the patient or guest. Since in many cases, our work may relegate the patient or guest to a secondary and non-central role and, in the case of certain technologies or techniques, even to an unimportant role. This is referred to all the diagnostic services or information procedures where the practitioner played a vital part in the past to ensure that the work was done properly, whereas in many cases today, the patient's role is secondary or nonexistent.

But none of these developments are neutral with respect to the response of the person, and they do not desensitise people, even though there is a risk of becoming desensitised. The tendency towards a certain isolation and segregation, and towards technological tyranny may arise particularly against patients, who are passive subjects of all this professional activity: everything being done for the sick person, but without that sick person.

That is why it is vital to implement humanisation programmes in our Centres. We are referring here not only to the implementation of services as such, but to planning effective humanisation programmes.

We must succeed in ensuring that all the practitioners involved in providing assistance feel called to care for the patients or guests, as persons, and their families. This is what the humanisation of the St John of God Centres means, which ensures that all the healthcare workers work for the sick and with the sick, placing the best possible technical resources at the service of those in their care.

In this connection, increasing attention has been paid in recent years to a particular movement known as NBM (*Narrative Based Medicine).* It is not a movement contrary to but complementary to *Evidence Based Medicine,* combining the specifically scientific results of medicine with the human and personalised approach to the patient, taking account of all the patient's essential component parts. The patient’s account of her illness and personal and family circumstances is therefore decisive for the purposes of adopting the most appropriate clinical approach. This approach adopted in the form of a two-way narrative is therefore not only based on treatment of a "traditional" medical-therapeutic character that takes account of all the biographical aspects of the way the sickness is experienced by the patient. In this way, increased scientific skill must be linked to ever-increasing "human skills" by combining *high tech* with *high touch*, which is exactly what the Hospitaller Order has been saying since the 1970s about the humanisation of care.

Meeting personal (including spiritual and transcendental) needs is a key element in all welfare and health care work.

Man is a relational being, and it is to the extent that we are in contact with others that we consolidate ourselves as persons. It is by converting this contact into an encounter that we achieve the fullness of our relational dimension.

Hence the importance of meeting, listening, accepting, welcoming-in, and knowing how to channel all the positive and negative aspects that are present in every individual person who lives and perceives the needs of others.

Sickness, whatever external form it might take, isolates the person concerned, and expresses human limitations and weaknesses, and it is in this specific special circumstance that we place an explicit and implicit demand for mutual assistance.

Everyone experiencing their limitations and suffering look for someone with whom to share their plight, on whom to unburden themselves. Hence the need for all those who make up the Hospitaller Order - Brothers, Co-workers, Volunteers, etc. - to acquire, nurture and enhance the following qualities:

5.1.1.1. Outreach: to the new aspects and developments of society, to new criteria for action, to the new needs of mankind, and to other cultures. We are outreaching when we know how to welcome what society and the world are offering us, and to discern what is positive in this offering, to make it our own. The institution is also outreaching, if it knows

how to adopt the same attitude, even though in this case it will require dialogue between the persons concerned, in order to be able to discern together what is positive for all.

5.1.1.2. Welcome and receptiveness. Welcoming-in and receiving those who arrive in a spirit of hope to give them confidence and trust in the individuals and the institutions taking care of them. This first contact is very important and can open or close doors. In their state of need, this first contact with the sick and the guest is extremely important to them. Being in difficulty, feeling themselves accepted and welcomed is an essential means of instilling a sense of security and confidence in those taking care of them. We must be careful to ensure in particular that bureaucracy and administrative formalities do not become stumbling-blocks to the welcome we offer our guests.

5.1.1.3 The ability to listen and dialogue. Allow people to express their own plight, needs, fears, and to hear in us an echo of confidence and peace of mind, both at times of joy and in more difficult situations.

The sick and our guests must understand that none of this fall on deaf ears, but is listened to, considered, and borne in mind. They will only tell us what they are able to at that moment, possibly telling us everything about themselves.

There will also be situations in which the sick or our guests ask for or desire something that is not the most appropriate for them. On the basis of our own reflection we must be capable of understanding and getting the sick and our guests to understand what we intend to do even in cases in which we may be acting according to different criteria altogether.

5.1.1.4. An attitude of service. Always being at the disposal of the sick, our guests, and their loved ones, always ready to give our technical skills, our knowhow and ourselves as persons, to serve them for their overall good.

We must not and cannot always do what the sick or our guests want of us, but from the attitude with which we treat the sick, they will be able understand whether we are acting for their good or for our own convenience.

5.1.1.5. Simplicity. Having the humility of those who know they are helping people in need with the main purpose of preventing a state of dependency from arising.

We must have the simplicity of those who are moving forward in search of the truth, and the good of all.

5.1.2. The rights of our guests. The rights of our guests form part of the broader framework of fundamental human rights. From the point of view of human rights, the right to the protection of health is one of the so-called second-generation rights, namely, rights of an economic and social nature. With greater sensitivity towards this issue, in the 1970s there was an increase in interest in the rights of the sick and our guests, bearing in mind that as persons, the sick and our guests are entitled to the same universal rights, but in their case there are certain particulars due to their plight which demand greater sensitivity and

solidarity. This has led to the production of national, regional and local declarations of rights.

The Order takes on board all these acknowledged and proclaimed rights, and in order to provide comprehensive care, it emphasises the following:

5.1.2.1. Confidentiality. Confidentiality comprises three intimately related values in the relationship of care: *privacy*, *secrecy* and *trust*. Respect for individual persons demands the respect for the patient or guest's privacy,[61] namely, that area in which everyone can have the opportunity to affirm and reinforce their own identity. Respect for the privacy of each person makes it possible for a wide variety of different individuals to live together in society. The veil of confidentiality and privacy safeguards mutual respect, and opens the possibility to trust, as the path to accede to the private sphere of other people.
Mutual respect and trust open the way to the right to communicate one's own secrets, knowing that they will not be disclosed. This is the obligation of professional secrecy which is taken for granted and is implicit in the commitment not to divulge to others what one learns during one's professional practice.

The obligation to secrecy coexists with the obligation to disclose a secret only when there is no other way of preventing damage and harm being unjustly caused to another person or to society, for example, to prevent contagion or another evil from which society could not free itself unless it knew the secret.

The increasing specialisation and technological sophistication of medicine is increasing the number of cases in which medicine is practised as a team. This creates *shared confidentiality*, which demands special attention by everyone involved in order to guarantee that guest's or patient's privacy is not violated.

Every healthcare worker in hospitals or healthcare and social residences and facilities must be sensitised to understand the ways in which the right to privacy and confidentiality can be violated. One only must think of conversations in public places about guests or patients, or ease of access to clinical records by unauthorised personnel. Care should be paid to protecting the lists of patients whose diagnosis or treatments are held in computer files.

In order to facilitate respect for the guests' or patients' privacy, our Centres must, as far as possible, have fixed or mobile facilities (which might be individual bedrooms or private rooms, or curtains or screens) so that patients can be isolated when needed. Account must also be taken of the age and the seriousness of the illness of those sharing the same room or ward.
Patients and guests may ask to be left alone or with a person of trust when they are examined by their doctor, or when they receive nursing care. In this way, they can talk privately with the administrative staff. One must also remember that any hospital, and particularly

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61 Some prefer to use the term *privacy* to refer to a more global, comprehensive set of aspects of the human personality which, considered separately, might not have an intrinsic value in themselves, but linked together in a coherent manner, reflect a picture of the personality of the individual which the latter has the right to keep confidential.

university or teaching hospitals, are training centres, and that their cooperation is vital in this regard.

5.1.2.2. Telling the truth. The patient's or guest's right to know the truth goes hand in hand with the right to confidentiality that we have just examined. They are complementary rights and provide the most solid basis for the necessary trust to be established in the doctor, but both may clash in terms of the fundamental rationale of the doctor-patient relationship: restoring the patient to health.

The first point to which priority must be given is the right of the patient or guest to be told the truth about their state of health, but not at the expense of what it is appropriate to the patient as a person. Sometimes there are reasons of genuine love which make it advisable to remain silent: the truth might cause unnecessary harm.

Several factors influence what it is appropriate to tell the patient or guest: the assessment of the patient and his/her inner strength, personal convictions and mental balance, and the type of relationship existing between a given physician and a given patient. Neither must the economic, family and social circumstances of the patient, following the medical consultation, be neglected. However, the diagnosis and the prognosis take on importance.

When it is necessary to tell a patient that death is inevitable and drawing close, this must be done in such a way that they can fulfil themselves in the final act of their life. This duty presupposes that the patient can take on and adequately expressing their role at that decisive moment in their existence. Leaving the patient a glimmer of hope ('a little open sky' as someone has put it) may help the patient, but it should not be forgotten that giving up false hopes can give another type of hope which enables us to accept the truth with greater ease and thereby wholly fulfil ourselves as human persons. This also occurs in the case of people who do not believe in a future life, but who have managed to give their own lives sense and meaning in relation to others.

The patients and guests are the *holders of the right* to know the truth, provided that they are adults and their own masters. When patients or guests do not have the capacity to take on this responsibility because they are not sufficiently mature or for any other reason, the information must be disclosed to those who can or must take decisions on their behalf, as their guardians or as the persons most concerned for their good and their welfare. If the patient or guest has the capacity, the only information that should be given to their relatives and loved ones is what we reasonably believe the patient or guest would wish them to know.

5.1.2.3. Autonomy. Enhancing and respecting autonomy, particularly in the field of medical care, is one of the great achievements of the modern world. Until only a few decades ago, there was a strong sense of paternalism in the relationship between the doctor and the patient, or with the guest, with the result that it was generally the doctor who decided, and the patient or guest who trustingly followed the doctor's advice, aware of not being either competent nor sufficiently well-informed to be able to choose the best course of action. The patient or guest was also fully convinced that the doctor would always act in their best interests.

Today's 'post-modern patient' no longer reasons in this way. They are now aware of their 'rights', including the right to life and the protection of health which are certainly their priorities. And they are also aware that they are not only the holders of these rights whose defence cannot be delegated to others, at least while they are able to take informed decisions themselves.

But this change in attitude has not been painless, and even though the former paternalism is no longer acceptable today, it has often been replaced by an extreme form of *'contractualism'*, where the relationship between the physician and the patient is seen merely as a 'contract' requiring both parties to comply with the terms and conditions. Obviously, this polarisation can only be superseded by establishing a *therapeutic relationship of trust* in which the doctor cooperates with the patient for his higher good, respecting mutual decisions and choices. A fundamental condition for this to occur in the best possible manner is that a very clear understanding must exist regarding what is meant by patient autonomy.

According to a classic interpretation a decision may be considered autonomous when it meets three conditions. The first is *intentionality*. In other words, it must be a 'voluntary' choice and not merely a 'desired' choice. Secondly, the person must *know* what is being decided. Naturally, all this raises the question of the problem of telling the truth to the patient or guest, which was discussed in the previous section, to which the reader is referred. Lastly, it must take place in the *absence of any external constraints*. This means that there must be no form of coercion (not even the coercion that might stem from the authority which the physician may have over the patient or guest, or the fear that the patient or guest might stop taking the treatment) nor manipulation (such as changing or manipulating the truth, even if this is done considering that it is in the patient's or guest's best interests). These criteria often include the absence of 'persuasion', even though we believe more prudently that a balanced and respectful attempt at persuasion might even be a duty, whenever it is really intended for the good of the patient or guest.

In practical terms, of course, these criteria that are inherent in the autonomy of the patient or guest are fully manifested in their *consenting* to the action taken by the physician, whether this is diagnostic or therapeutic. For a more organic way of obtaining consent it might be advisable for the Houses in the Provinces to produce specific forms for use in clinical practice in the Centres. It is very important for all the health care workers to understand that the request for consent is not a legal procedure to protect the doctor but one of the rights of the patient or guest, and as such it places specific ethical duties on the health care workers themselves.

Lastly, we should reflect on the limits to autonomy. Even though this is the first principle of bioethics, and the one around which most bioethical problems hinge today, it cannot be considered an absolute principle, or be treated as if it were paramount in respect of the others. There are objective limitations on the autonomy over choices such as, first and foremost, one's own life, and this cannot be left unconditionally and immediately to the choice of the guest or patient. This would legitimise suicide of all kinds. What must be considered, instead, is that in relation to the sick and the guests the supreme value to be respected is not their autonomy, but their rights, which certainly includes their autonomy.

Moreover, within the bounds of autonomy we also must include religion and culture. Regarding religion, then may be conduct deemed illicit according to the individual's own religion alone, while in other cultures, autonomy does not always have an individual character, but takes on a collective dimension. The individual is considered to form part of the group; it is the group which holds full decision-taking powers in respect of the individual concerned.

5.1.2.4. Freedom of conscience. The right to freedom of conscience which is clearly enshrined in Article 18 of the *Universal Declaration of Human Rights* and in most Constitutions of modern States is demanded by the ethical dimension of the human being and the realisation of their own existence as a gift and a project to be implemented. Everyone is therefore entitled to respect for their ideas, and their philosophical, ideological, political and cultural choices, provided that they do not infringe any fundamental human rights. This has become particularly important today faced with multiculturalism and the wide variety of ethical options that exist in contemporary society.

This sphere relates to the religious dimension of existence. We should remember that the declaration *Dignitatis Humanae* of the Second Vatican Council began by stating that ‘the person has a right to religious freedom’.

The exercise of this freedom is naturally dependent upon the general principle of personal and social responsibility, the fact that every individual or social group is obliged to take account of *the rights of others and their duties* to others and to the common good. These restrictions take the form of the need for a legal order which provides specific protection for this religious freedom and the defence against unjust proselytism.

Every person and the whole Church are entitled to bear witness to their faith. The right to religious freedom includes the right to bear this witness while always respecting the justice and the dignity of the conscience of others. But ‘proselytism’ is a corruption of this witness, because it comprises any form of abusive and impertinent conduct in the exercise of Christian witness which threatens the religious freedom of others. The main attitudes to be condemned, according to the World Council of Churches and the Secretariat for the Unity of Christians, are:

- any kind of physical, moral or social pressure leading to the alienation or the deprivation of personal discernment, free will and full independence and responsibility on the part of the individual;
- any material or temporal benefit openly or indirectly offered as the price for accepting the faith of the person bearing witness;
- any benefit resulting from a state of need in which the person receiving the witness may be or resulting from their weak social status or lack of education, to convert that person to the other's faith.
- anything that might give rise to suspicion regarding the other person’s good faith.
- any unjust or uncharitable allusion regarding members of other Christian communities or non-Christian religions to attract followers.
- any offensive attacks which wound the feelings of other Christians or members of other religions.

5.1.3. Duties of our guests. While patients and guests have rights, they also have *duties*, even though these have been less thoroughly elaborated in bioethical and practical terms.

5.1.3.1. Respect for the institution and its principles. The Hospitaller Order's health care facilities are declaredly Catholic denominational institutions. For this very reason, its mission, as the expression of the universal mission of the Church, is available to all without any form of ethical, ideological and religious discrimination. But at the same time, even those who do not share the Catholic faith or the principles on which the care it provides is based, are duty-bound to respect the spirit driving all these facilities. They must therefore avoid any conduct which is in blatant conflict with the principles professed by the Order. This clearly does not mean that they may not complain or claim against it in the event of negligence or wrongdoing they may have suffered (but which remain such, regardless of their religious faith) nor that they are not entitled to full respect for their own religious allegiances, as has already been affirmed in relation to the patients' and guests' rights.

5.1.3.2. Respect for the health care workers. The health care workers who assist the sick, in whatever capacity, are also entitled to have their professionalism, dignity, honour and their work respected, above all when this is particularly burdensome because of the post they occupy. They are therefore duty-bound to respect this, knowing at all events that the health care workers are devoting themselves to looking after people in need of care. If this may not appear to be optimal sometimes, (except in cases of malpractice), the understanding which patients and guests demand be shown towards them must also be shown towards the personnel. It is true that this is an asymmetrical relationship, but the personnel are people, with their own weaknesses, tiredness, family problems, financial and work problems, anxieties, concerns and the discomfort that can often be reflected in their relationships which should always be cordial and empathetic. It is precisely the esteem and understanding received from the patient that can help them to perform their work in the most humanising manner possible.

5.1.3.3. Respect for the patients and guests. Individual patients and guests are not alone in making use of the healthcare facility and must therefore take account of the other patients and guests who share it with them. They must therefore avoid disturbing them when they are resting, particularly in the night hours, compatible with the demands of their treatment. They must avoid making a noise and disturbing others during visits from their relatives, or raising the volume on the television, or doing anything else that may annoy the other patients and guests. But in addition to these "negative" indications one should not underestimate the positive ones. The joint presence of patients and guests sharing the same facilities is also a huge psychological resource and is therefore a therapeutic aid. Establishing good relations, particularly in long-term units, can be helpful to make it easier to accept their stay in hospital, which is always distressing, and to enable patients and guests to help one another while they are in care.

5.1.3.4. Respect in the clinical approach. Relations between the healthcare worker and the patient or guest while treating them entail the use of a series of clinical instruments of various kinds: talking with the patient about their clinical history, lab tests, diagnosis by imaging etc. In so doing the guest or patient must fully cooperate with the care-givers acting with due diligence, which means always bringing their clinical records with them, carefully

looking after them (without creasing or soiling them etc), not concealing them to see whether the doctor is able to work properly without them, not placing their relations with the doctor on the same plane as relations with the Internet where they can find any information they need, and diligently complying with the doctor's treatment instructions.

5.1.3.5. Respect for the premises. Patients and guests quite rightly want the hospital environment in which they stay to be "hospitable", with clean and welcoming rooms, efficient services and common areas for their relatives, etc. For this reason, they should be the first to show concern for keeping the premises clean and in order. The "public" facility is not something that belongs to no-one, but it belongs to everyone. As such, the patients should not only treat it with care, as if it were their own home, but indeed with even greater care because the common areas also have to be used by other people. Moreover, the need to show this respect involves the other patients and guests living there at the same time, who must be encouraged to do the same, almost "handing over" the facility to them in the same optimum conditions in which they found it. This care and attention applies to the way the furniture is used, keeping the rooms clean (as far as the patients' and guests' responsibility is concerned), not to scribble on the walls, to treat the lawns, where they exist, with respect, not to ignore conduct which could prove damaging (leading to fires, flooding, etc).

5.1.4. Children's and adolescents' rights. When addressing the question of patients' and guests' rights, the specific rights of children are of particular importance. These include the right to be given information on their health, the right to determine their own state of health (within the bounds, and in the manner, set out in greater detail in the following section dealing with consent), the right to confidentiality of their clinical records, the right to religious freedom and physical integrity. It is also essential for a child admitted to hospital to be accompanied by relatives and be able to continue their schooling. With respect to these rights, here are a few of the main emerging issues:

5.1.4.1. Children's consent and assent. In most countries, consent to, and refusal of, treatment is the responsibility of the people exercising parental authority over the child, namely, their parents or, in their absence, their legal guardians. But this does not mean that the child has no right to decide for itself or must not be asked when treatment is proposed. In strictly legal and forensic medical terms, in countries in which even emancipated children are subject to parental authority the child may only *assent*, which does not exclude the consent of the parents, but in all instances we are duty-bound to take account of the child's preferences, desires and wishes. Obviously, this has to be proportionate to the child's ability to understand, linked among other things to the child's age. As the Oviedo Convention (1997) provides, the child's opinion must be taken into consideration as a factor whose importance will depend on the child's age and level of maturity[62]. The request for assent is particularly important when trialling drugs. It is possible to test drugs on children provided that the child will at least potentially benefit, and that any harmful effects are acceptable.

5.1.4.2 Extremely underweight newborns. In the most scientifically advanced Centres in the Order, one problem that will arise with increasing frequency has to do with procedures for the resuscitation of pre-term and extremely underweight babies (< 24 weeks and 500 gr.)

62 Council of Europe, The Convention on Human Rights Biomedicine, Oviedo 1997, op. cit 6.2

which until not long ago were classified as ‘miscarriages’. This problem refers mainly to the outcomes of resuscitation procedures which, while enabling babies weighing only a few hundred grams to survive, may also leave them with permanent disabilities. According to the general criteria of proportionality of treatment, we are ethically bound to do everything which is "proportionate" to the situation before us, avoiding futile therapy.

5.1.4.3. Conflicts of interests. When caring for children and adolescents, their best interests must also be to the fore. There are numerous situations causing conflicts, whether in the practice of ordinary daily care or those relating to the more sensitive and clinically more complex situations which can create a conflict of interest between the parents and the children. For example, a more painful, but quicker and more "convenient" treatment for the relatives, corrective plastic surgery merely to satisfy a patient's narcissistic demands, the use of sedatives which are clinically unnecessary, and forms of withholding or conversely increasing treatments which have no medical justification.

5.1.4.4. Clinical trials. Here again, the interests of the child or adolescent must always prevail. In paediatric care, clinical trials differ from those conducted on adults. They may refer not only directly to the person taking part in the trial in the case of adults, whereas in the case of children and adolescents there must always be possible benefit to the patient. In randomised studies which also make provision for the enrolment of healthy participants, no child or adolescent enrolled with their consent may be subjected to any dangerous or invasive treatments. In all instances, even though in purely legal terms a child or adolescent may not have the capacity to give their valid consent, which is always given by those acting *in loco parentis*, the child's or adolescent’s *assent* must be formulated within the limits and in the forms permitted by their capacity. Without it, even if the parent’s consent, the trial must not be run.

5.1.4.5. Futile treatment. Problems relating to futile or excessively invasive treatment of children and adolescents must be addressed. While such treatment is controversial in adults, it is even more questionable in children and adolescents subjected to futile treatment which will not produce a positive clinical outcome. Even though the parents might decide to pursue such treatment out of love for their child, it is not always really in the child's interests but is merely to give the parents the illusion of having done everything possible for the good of the child's life or health.

5.1.4.6. Adolescence. Today, teenagers have not only taken on a radically different role from what they used to have, but they are most risk-prone in respect of certain issues such as dependencies, sexually transmitted diseases, unwanted pregnancies, eating disorders, etc. Furthermore, even if they are still subject to parental authority (although the law varies from country to country, according to their age), under certain conditions they can authorise certain actions such as organ donation, or abortion. The particular psychological sensitivity and issues of this age group, their need for autonomy, religious crises, family problems etc. demand that all the people who deal in any way with them must have a special sensitivity and particular human skills, as well as a thorough familiarity with the younger generation and their demands, questions and critical traits. They must therefore be given clear and comprehensible explanations on the diagnostic and therapeutic procedures to which they

may be subjected, and their rejection of any proposed treatment must also be recognised and respected.

5.2. Specific problems regarding our care work

5.2.1. Sexuality and procreation

5.2.1.1 Responsible parenting. Human procreation is the way through which God cooperates with the couple who freely place themselves at God's disposal as an instrument for his creative act through generation. This explains the high value of human procreation which, by this token, is entrusted to the couple's responsible parenting.[63] This procreative responsibility means that the couple must be very attentive to the two-fold significance of conjugal sexuality: to unite them and to procreate. In the performance of this important task, the couple will have to be guided by the Word of God and the teachings of the Church which they responsibly take upon themselves in the unique singularity of their own conscience.

In the Order's Centres encouragement must be given to all those structures which can encourage real procreative responsibility, which includes adequate *counselling*, according to the specific procedures and methods that are appropriate to the healthcare and cultural situations in each country.

These criteria will also form the basis for the professional services offered by the health care workers to both outpatients and inpatients and guests.

5.2.1.2 Voluntary abortion. Human life is a universally recognised value, even though it is perceived with different historical and cultural sensitivities. Respect for life and protecting it lie at the basis of all the health care professions and organisations.

Protecting life runs throughout the whole of life from its beginning until its natural end, independently of the procedures and circumstances in which conception takes place, or of the state of health before and after birth, its expressions in terms of relationships and social acceptance. Indeed, every situation in which an existence is at risk, following the example of St John of God, constitutes a reason for individual and community commitment to preserve and protect the gift which God has entrusted to human care.

When we say that for us human life is inviolable, we are laying down an ethical principle with which compliance is demanded, independently of the complex theological issues relating to the moment of its 'animation' (that is to say the infusion of the supernatural soul, whether this occurs at conception or subsequent to it). According to the balanced and prudent views set out in *Donum Vitae* and *Evangelium Vitae*, human beings must be respected 'as persons' from their conception because they possess the dignity that is vested in the human person from the moment of conception.[64]

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63 JOHN PAUL II, *Evangelium Vitae* (EV), 44.
64 Congregation for the Doctrine of the Faith, *Dignitatis Personae* (2009) 5.

It is, nevertheless, necessary to ensure that our disapproval of voluntary abortion does not lead us to despise the person who has an abortion. Indeed, with Christian charity, our works should become Centres not only to welcome in life, but also to 'rebuild' an existence which is often profoundly upset as a result of having been through an abortion. Not only must we ensure that our condemnation of the wrongful act does not lead to condemning the wrongdoer, but we must assist that person, through love, to become aware of that error while trusting in the unfailing pardon and forgiveness of God.

The unlawfulness of procured abortion does not mean that pharmacological or surgical measures may not be adopted to safeguard the health of the mother which may *also* have the effect of leading to the death of the foetus, provided that the latter is not the direct intention, and that it is not achieved *through* the operation or pharmacological treatment, and that the measure cannot be postponed.[65]

5.2.1.3. *Conscientious objection.* The inviolability of human life not only prevents voluntary abortion being performed in the Hospitaller Order's centres but also other types of intervention which suppress life. The personnel working in these centres are therefore required to be conscientious objectors. This consists of refusing to perform a statutory obligation whose effects are considered to be contrary to one's own ideological, moral or religious convictions. In the field of health care, this applies not only to abortion but also to certain assisted procreation practices, euthanasia and certain measures suspending life-maintaining therapies. Conscientious objection is permitted in some legislations governing its scope and its application. However, as a mere "conscience clause" it can also apply to any situations in which the physician feels unable to comply, in conscience, with certain statutory requirements. In this case, the physician accepts full responsibility for so doing which also includes legal liability. By its very nature, conscientious objection is always a matter for the individual. Possible local agreements and, more recently (2010) a resolution adopted by the Council of Europe, provide the possibility for "institutional" conscientious objection, permitting a whole healthcare facility, and not only its individual staff members, to be exempted from performing actions which are against the specific identity of the facility.[66]

5.2.1.4. *Prenatal diagnosis*. Prenatal diagnosis today is one of the most sophisticated tests performed, and in the future, it is bound to be more widely practised and be methodologically perfected. It can be performed with non-invasive methods such as

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65 Pontifical Council for the Pastoral Ministry of Health Workers, *Charter for Health Care Workers*, Vatican City, 1995, N°142.
66 Cf. Benedict XVI. Audience for Catholic Pharmacists at their 25th International Congress. 29.10.2007.

Resolution 1763/2010 of the Council of Europe states, "No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo…"

In December 2011, the Order's General Bioethics Commission publish the document entitled *Conscientious Objection* (available on the Order's website) which sets out not only the general principles but also a detailed analysis of matters relating to the so-called "conscience clause", pharmacists' conscientious objection to prescribing the "day after pill" and cooperation in evil, etc.

morphological echography, or echocardiography; or with invasive methods (amniocentesis Chorion Villus Sampling) and biochemical tests (tri-tests, etc.). Very often some of these are used in combination.

Amniocentesis, when immediately applied, is not immune from the threat of an erroneous approach in principle by intending it to be used to justify an abortion. Putting the problem in these reductive terms is a radical betrayal of the spirit of service to people which scientific research embodies to such a high degree. The greatest expectations, however, lie with the prospects of intrauterine therapies which already beginning to emerge, and for which prenatal diagnosis is the indispensable precondition. Particular care must therefore be taken to ensure that prenatal diagnosis procedures are not designed exclusively for abortion purposes in the event that foetal malformations are identified. Indeed, a positive commitment to life and to welcoming the weakest and neediest, which includes a malformed person, require us to give it a more concrete and practical welcome, faithful to the Charism of St John of God. This is more necessary because the dominant culture and the policies of many governments are tending to deny life to people who are in some way "imperfect". The possibility of performing these diagnostic tests in the Order’s centres requires us to ensure that the centres themselves should set up experienced counselling centres for couples and families in difficulty because of the birth of a malformed child. Recently, prenatal diagnosis has also been used, particularly in certain countries, to destroy female foetuses, even if completely healthy.

5.2.1.5. Interceptives and contraceptives. These are two types of drugs whose effect is to prevent implantation of the embryo or to provoke its detachment in the initial phases of implantation.

RU 486 is the acronym for a drug which, in the early stages of pregnancy, can detach the embryo that is already implanted in the uterus lining. For a moral assessment, then, that judgement will be no different from the one used regarding the voluntary interruption of pregnancy. Furthermore, abortion could become trivialised to a certain extent by classifying this drug as an “abortion pill” and make women feel alone once again considering that the abortion as such can also be procured outside the hospital environment.

The term "interception" refers to all the methods intended to prevent the implementation of the embryo after "unprotected" intercourse. To be effective they have to be used within 72 hours of intercourse. The most common form of interception is the so-called "morning after pill”. The latest studies are not sure whether the action is, in fact, interception because it may also be contraceptive for all intents and purposes.

5.2.1.6. Assisted reproduction. There are many childless couples who resort to assisted reproduction techniques as an effective means of overcoming a problem which is not of their making.

No Centre in the Order may offer this service unless it is highly qualified to do so and legally recognised for this purpose. In this case we consider it ethically acceptable to help

couples, using assisted reproduction techniques, to enable their sexual intimacy[67] to have a procreative outcome, using the couple's own gametes, and respecting the life of the embryo.

Where public health policy requires other types of action, acceptable solutions must be found, or alternatives chosen. The Ethics and Bio-ethics Committees can be an excellent source of help here.

5.2.1.7. Female genital mutilation (FGM). This is an ages-old practice, but only recently has it caught the attention of public opinion. It refers to several types of action, sharing the common feature of mutilating the woman's external genitals. In addition to the immediate damage caused (infection, haemorrhages, algogenic shock etc), it can also have serious long-term sexual and reproductive effects on the woman. But it is above all in psychological terms that FGM can be seen as being wholly valueless because it constitutes a brutal and unmotivated form of female domination. In addition to robustly condemning this practice, we must therefore pay particular attention to providing medical treatment to women who have undergone this operations whenever they come to the Centres of the Order, not only in the regions where this is practised, but also in other regions where FGM victims may have migrated. Furthermore, in the areas where women are most at risk, measures must also be taken to provide such women with adequate hospitality as well as psychological and human accompaniment.

5.2.1.8. Gender reassignment. In some centres in the Order ethical/clinical problems have been posed in the case of transgender persons seeking various types of medical or surgical operations (mutilation or reconstruction) in order to adapt their somatic sex to their psychological gender. There is no single opinion on such cases. For in terms of respect for the anatomical integrity of the individual, such operations are damaging the body for reasons other than the treatment of a pathological condition. But with the broader consideration of the overall welfare of the patient or guest, to which all our care must be devoted, it may be seen as the restoration of a kind of lost unity, removing what the patient or the guest consider to be an irreversible and untreatable psychosomatic laceration.

5.2.2. Organ donations and transplantation

5.2.2.1. Organ transplantation. The possibilities offered by modern transplant technology today constitute one of the greatest ethical challenges of our age and invite us to adopt a new dimension of interpersonal solidarity. Transplantology today offers numerous options:

Transplants from a dead organ donor. This is the most common and widespread form. All men and women, and *indeed* all Christians, should consider that donating their organs after death is a duty. The Hospitaller Order supports the efforts of the whole community in advocating, disseminating and embodying a 'donation culture'. Apart from the legal aspects which require explicit consent to the removal of one's organs after death, this dimension of donation should never be lost from view.

67 Cf. Charter for Health Care Workers, 21

Since the Order has a double dimension, as a Church entity and as a healthcare structure, it can therefore help to overcome this reluctance. The reverence due to the dead, with which Christian piety is richly imbued, must not become a cult of the corpse. There nevertheless remains one unlawful area for particular types of transplantation which it might become possible to perform in the near future (and which might pose problems for the more advanced Centres in the Order), such as brain, gonad and face transplants. For these are operations which, to some extent, transfer a person's identity and not merely an organ.

Transplantation from a living person. A different problem arises regarding transplants between the living. Even though it is an extremely generous and sometimes heroic act to donate one's organs to another, precisely because it is an extraordinary act, it cannot be given the same ethical status as donating one's organs after death. It is therefore one of those extraordinary acts which one is not obliged to perform in the strict sense of the term, but which are nevertheless an expression of great and extraordinary generosity. In several countries, legislation reserves organ transplants only to members of the same family or with a few exceptions, to people with bonds with the patient (partners, etc). Only recently has it become possible to envisage offering this possibility to unknown donors, but there are several ethical reservations.

Transplantation from animals. First of all, it must be made clear that there is no a priori reason for considering that such transplants are, in themselves, unlawful. However, there are certain specific problems. The first one might be of a psychological and emotional character, which may be easy to come to terms with, when the recipient must live with an animal organ inside. Secondly, a general issue could relate to the use of animals for this purpose, for which there are quite a few opponents. Even though the life of an animal is worthy of protection, however, in a hierarchy of values, animal life is subordinate to human life and in the case of conflict between the two, or at a moment of crucial necessity, a healthy anthropocentric approach gives pride of place to the human species over the animal species.

5.2.2.2. Ascertaining death. For the purposes of removing organs from a corpse, the delicate problem of ascertaining brain death arises for most transplants, even though in itself this diagnosis does not apply to the case of transplants alone. Quite clearly, it is only possible to remove an organ from a person who is truly dead. For this reason, there are various rigorous criteria, which have been codified in most legislations. There are those which accept "brain-death" as a criterion validated by the international scientific community and fully accepted by the Catholic Church. An individual is deemed dead when, according to certain clinical and/or instrumental parameters, there is no longer any activity in the cerebral cortex and in the brain stem.[68] For *death is a process*, and not an event, and the end of one's earthly existence is not therefore the death *of the whole organism* (because some components may continue to live on even after the brain ceases to be active) but is the death *of the organism as a whole*.

5.2.3. The chronic sick and those in an advanced stage in their illness

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68 Ibid, 129.

5.2.3.1. Euthanasia. Respect for life which begins from its beginnings continues throughout the whole of existence until its natural end.[69] The expression 'euthanasia' means the act of procuring death using procedures which deliberately and voluntarily cause it (improperly called *active euthanasia*) or by omitting or refraining from procedures which might prevent it. The latter case is equally improperly called *passive* euthanasia, which is an ambiguous and improper term, for it is either the deliberate suppression of human life (by commission or omission) or it is merely the avoidance of useless aggressive therapy to no purpose (in which case it is not euthanasia). The term *assisted death* or *suicide* is being increasingly used to indicate euthanasia at the request of the patient and to a certain extent this places the burden of responsibility entirely on the patient. But in reality, it does not remove the physician's responsibility and liability for directly cooperating in it.

Applying the same principle of double effect already used in relation to abortion, it is not euthanasia to take action to improve the pathological status of an individual (for example to suppress pain) when it is *also* likely inevitably, but not deliberately, to lead to anticipating death.

The duty to guarantee everyone a dignified human death means, at all events, that every person *must be treated* until their last moment in life. In view of the radical difference between *curing* and *caring,* there are no sick people that cannot be cared for, even though there are those who cannot be cured. Appropriate feeding, cleaning wounds, bodily hygiene and suitable environmental conditions are inviolable rights of every patient, who may not be deprived of them until the very final moments of their existence.

5.2.3.2. Advance instructions regarding treatment. These are set out in a document, known as a living will, which sets out the wishes of an individual to ensure that his or her values and convictions are respected if, as a result of an injury or of illness, they were to become incapable of manifesting them. More specifically, in the living will people request compliance with their right under those circumstances not to be subjected to disproportionate or unnecessary treatment; that the death process should not be unreasonably prolonged, and that suffering should be alleviated using appropriate drugs, even if the effect of this might be to reduce their life expectancy.[70] Moreover, a proxy may be appointed to take decisions whenever the patient is no longer able to do so personally.
Formulated in this way and as a declaration of intent, these advance instructions are certainly good and to be recommended. In the countries with legislation that permits this, a broad section of society is insisting, with good reason, to be given the statutory protection of a living will.

The Church cannot accept any action to provoke death, even if this is the will, freely expressed by the person concerned. Limited freedom to dispose of one's own life through the intervention of third parties in the event of an incurable and permanent disease or incapacity, to the point of directly causing a person's death, and the lawful rejection of disproportionate treatment, marks the difference between advance instructions which are acceptable for Catholics, and its other forms of expression.

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69 Cf. EV, 57
70 Cf. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 5 May 1980, III- IV.

The problem of assisted feeding, which in itself should be considered an ordinary and proportionate procedure, because it cannot be governed by any rules set out in advance, remains an open issue.[71] However, many people are of the opinion that the purely medical ways in which this is performed could be equated with a therapeutic measure.

5.2.3.3. Vegetative state. The vegetative state is a condition following a fairly long period in a coma in which the vegetative activities are still being controlled by the brain while the cortex activities (consciousness, voluntary movement etc) are absent. Sometimes a patient can "awaken" from this condition, which may have lasted for several years, leaving deficits varying in gravity, according to the patient's condition. But awakening becomes increasingly more difficult as time passes from the event which produced the coma. After a few years this is possible only exceptionally. Any intervention on the patient in a vegetative state is therefore performed on a biologically living individual, albeit in a purely vegetative state, and without any subjective relationship with the surrounding environment. All treatments must therefore be limited to ordinary and proportionate therapies avoiding any futile or excessive treatments.

5.2.3.4. Palliative care. We may say that from the very beginning man has practised palliative treatment whenever dealing with the ‘terminal’ phase of an illness, supporting it with all the remedies possible but also helping, comforting and accompanying the dying until the last moment. Today we have a more elaborate idea of this kind of treatment, together with a more highly structured system to deal with it (in hospices, palliative treatment units, etc.) which enables us not to leave people suffering from an incurable disease to their own devices. Palliative care is therefore ‘total care’ offered in a global system of relations providing aid to meet all the patient’s care requirements.[72]

Palliative care is applied not "when there is nothing more to be done" but it is precisely *what is needed to be done for that patient*. It will certainly not cure the patient, because that is impossible. But it involves a whole series of treatments (sometimes technically very demanding) which will guarantee a good quality of life for the time remaining.

One particularly sensitive phase is the process of moving from treatment to palliative care. What has been called *simultaneous care* is particularly important in this phase, in which two types of treatment are applied – whether therapeutic or palliative – thereby offering the benefits of both with a net benefit in terms of a clinical improvement on the one hand, and a better quality of life, on the other. This dual approach includes the possibility of taking part in clinical trials, etc. This enables the patient to retain the possibility of receiving further treatment opportunities, while at the same time it does not necessarily require the patient to choose between two different types of care.
In view of these considerations, all the institutions of the Hospitaller Order dealing with patients in an advanced stage of their illness should as far as possible provide palliative treatment units to make the final phase of a patient’s illness bearable, while at the same time providing patients with adequate human company.

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71 Cf. Congregation for the Doctrine of the Faith, *Responses to certain questions of the United States Conference of Catholic Bishops concerning artificial nutrition and hydration*, 14.09.2007.
72 Cf. EV 65.

5.2.3.5. *Palliative sedation*. This is also known as "pharmacological sedation" or, improperly, "terminal sedation" and is a therapeutic procedure to be used in every situation in which the final phases of life are accompanied by pain, anxiety or fear which cannot be otherwise overcome. Even though it is better to live this final phase in one's existence with complete lucidity and an awareness of what is happening, in persons for which this is only a source of suffering, treatment can be agreed with the patient, but without any euthanasia-oriented intentions. If this treatment leads to a possible acceleration of the process leading to death, this will always be lawful, if the conditions of the so-called principle of double effect are applied. [73]

5.2.3.6. Terminal foetus. This expression is used to refer to all the pathological conditions of a foetus which are incompatible with life, whether genetic or due to malformations (anencephaly, renal agenesis, certain chromosome diseases, etc.) or as a result of mother-foetal disease (serious retarded growth, placenta or umbilical cord disease, etc.). These conditions raise sensitive bioethical issues which always refer to respect for human life, and hence the rejection of abortion even when it is labelled "therapeutic", but in some cases the possibility of an early delivery without directly killing the foetus which is bound to die very shortly thereafter.

5.2.4. The ethics of therapy

5.2.4.1 Proportionality of treatment. Insofar as our hospitals are intended to promote and protect health, they cannot consider death as something to be psychologically displaced, but view death as an integral part of the course of life which is particularly important for the full and transcendental fulfilment of the patient. Consequently, every patient is entitled to the right not to be prevented from taking responsibility for the event of his or her own death, and indeed must be helped to do this in accordance with their religion and their sense of life. This means that unless it is truly and urgently necessary, the truth must not be concealed from the patient or denied to the patient, and the patient must not be prevented from enjoying their usual relationships with their families, friends, religious and ideological communities. This is the only way in which the humanisation of medicine can be guaranteed in these defining moments of a person's existence.

Naturally, this means that the patient must experience death with total responsibility and dignity. Although death may not be directly provoked, treatment must not be provided which does not have a significant effect on extending life or the improving the quality of life, but merely protracts the death throes uselessly with futile treatment. Everyone has the right to die with dignity and in peace without unnecessary distress, and all the treatment must be provided proportional to the needs of the patient.[74]
We would consider disproportionate measures to be those which have little prospect of bringing about an improvement in the clinical condition of the patient, and the use of drugs and devices that are particularly costly or hard to come by, the absolute psychological rejection of treatment by the patient (in the case of serious mutilation, etc), extreme difficulties in the provision of care etc…

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73 Cf. Pius XII, *Allocution to the Società Italiana di Anestesiologia,* 24 February 1957*;* Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia, 5 May 1980, no. III
74 Cf. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia, ibid.*

Disproportionate treatment can therefore be nothing short of *futile* treatment in the clinical sense. In this case, refusal may in fact be a moral duty.

5.2.4.2. Emergencies. In many centres in the Order there are Accident and Emergency units. Most of the ethical problems that arise there have to do with the state of the emergency in which the patients find themselves. In many cases, for example, their state of need makes it impossible to ask patients for their consent, with all the formalities this requires, and very often the relatives can only be given summary information. When there is strong opposition, the provisions of the Medical Code of Conduct and the laws of the land must be applied. Care must also be paid to the psychological state of the people accompanying a patient, who are often overwhelmed by emotion.

5.2.4.3. Intensive care. Intensive care units (cardiology, resuscitation, etc) demand a great deal of attention not only to the clinical conditions of the patient but also their psychological state. For these are facilities in which the patient knows perfectly well that they are in a critical situation and could even die. This state of anxiety nearly always threatens to aggravate the patient's clinical condition. Even the relatives can only play a minor part because of the frequent need to isolate them from direct contact with their loved one. In these cases, we must be sure to apply the humanising approach which will form an integral part of the treatment received during the period spent in intensive care.

5.2.4.4. Pain management. Physical pain and psychological suffering have always afflicted humanity which tries to treat it and very often becomes “resigned” to it. A poorly understood form of Christian ascetics (*dolorismo*) has misinterpreted the teachings of the Gospel and considers pain and suffering to be unavoidable. For the truth is that if pain must be addressed firmly and robustly, it must be fought against with all the means that contemporary medicine makes available to us. The healthcare facilities do not always, unfortunately, adequately apply pain therapy. In the Order's Centres, one major sign of care for the sick and humanisation must also be the fact that they provide adequate pain therapy.

5.2.4.5. Aesthetic medicine. In many social environments today, particularly in the West, concern for one's own image, together with the desire for an increasingly more sophisticated quality of life has led to a heightened demand for both medical and surgical treatments in the field of *aesthetic medicine.* This discipline belongs more to the *medicine of desire* rather than medicine catering for the *healthcare needs* in the strict sense of the term but, even though it is a branch of medicine and is practised in certain Centres in the Order, it must not be underestimated. The criteria used to conduct ethical discernment of requests for aesthetic treatment and practising aesthetic medicine referred to the purposes of treatment, an adequate proportion between the costs and the benefits, but above all the significance in terms of the overall wellness and well-being of the individual concerned.

5.2.5. Research on humans

5.2.5.1. Clinical trials. Research is one of the main ‘locomotives’ that have driven progress in medicine. Together with a few chance discoveries, such as antibiotics or x-rays, research is responsible for all the achievements of science today. Research is no longer being carried

out only behind laboratory doors or on animals, but directly on people. This experimental procedure is not an option which certain researchers wish to carry out, but has often become a vital necessity, particularly about new drugs. After laboratory and animal experiments, every drug must be trialled for the first time on humans. Clearly, in this case the person is not being used as a guinea pig but simply to find the best possible way of applying the treatment being tested, which can subsequently be used for other people. This can only be done under certain strict conditions that have now been enshrined in international Charters and Declarations.[75] And since this research is carried out mainly in hospitals, our Centres should be aware of these conditions and apply them carefully.

The first condition is that every experiment must be carried out presuming that the effects will be beneficial. In other words, putting a previously nonexistent treatment or drug on the market should be done because it is better than another one for various reasons: more effective, less risky, cheaper, easy to administer, etc.

5.2.5.2. Informed consent. Obviously, all experiments must be carried out with the consent of the person concerned. To ensure that this consent is valid, the person must be essentially free. This means that no influence should be brought to bear, even implicitly including 'moral' pressure, such as the influence of the physician speaking with authority, or the fear that otherwise the patient may not be properly treated.

This consent must also be 'informed', so that patients or guests know clearly that they are part of a clinical trial and are acquainted with the risks and benefits, the alternatives, the insurance guarantees, etc. As a prior condition to ensuring that consent is truly informed, the patients and guests must be given exact details of their medical condition. One cannot indefinitely and routinely conceal the truth from them. They must always be aware of their health status. This does not mean that the truth cannot be revealed gradually or deferred in time and shared with the relatives. And it certainly does not mean that they must be told at all costs when they have made it clear that they do not wish to know the truth. Neither should the truth be explained by going into distant and possible collateral effects. It is enough for the truth to be adequate.

5.2.5.3 Research on incapacitated persons and vulnerable groups. Everything that has been said above naturally refers to clinical trials carried out on individuals who are legally and ethically competent, in other words, able to fully understand what is being said and done to them, and to give their fully informed consent. But it cannot refer solely to them. This would exclude such patients as children, the mentally ill and people in a coma, or other incapacitated persons, who also need newly discovered treatments. Therefore, forms of 'proxy' should also be thought out to be entrusted to individuals whose specific bonds of affection with the patient or guest or because of an institutional function presumably always enables them to be concerned with their interests. Under these conditions and having appraised the acceptability of the risk which the patient or guest is likely to run in terms of potential benefits, experimental trials of this kind may be lawfully conducted.

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75 Cf. Nuremberg Code, the Helsinki Declaration, Geneva Declaration, Good Clinical Practice, etc. In addition to the criteria of the Magisterium see also *The Charter for Health Care Workers,* 75-82.

One specific problem arises about experiments carried out on healthy individuals. It is difficult to find people willing to subject themselves to trials of this kind in exchange for nothing. Often, these individuals are prisoners, who are offered a reduction in their prison term. This practice is often justified as a sort of 'tribute' which they repay to society. At other times they are students who are paid for a service, or they may be 'human guinea pigs', recruited in developing countries for a paltry sum. It is unnecessary to say that the fundamental requirement in these cases is that the individuals concerned must freely accept to undergo the clinical trials and that in no case should their human dignity be impaired. In our Centres, we must always be very vigilant to ensure that any experimental trials carried out on healthy subjects is always done with their totally free consent and with adequate guarantees that no significant risks are involved.

5.2.5.4. Foetuses and embryos. Regarding prenatal experimentation there are two fundamental situations. Firstly, experiments carried out on 'spare' embryos produced in excess by *in vitro* fertilisation techniques. Very often this is done using the alibi of pseudo-humanitarian interests, claiming that it is much better 'to use' the embryo rather than destroying it or subjecting it to the risks of freezing. The second situation that may arise is experimentation carried out on pregnant women who have asked for an abortion. Here again, a foetus is 'used', claiming that it would at all events be destroyed. However useful such research might be for the benefit of other human beings, the actual result is to deliberately instrumentalise the human person, albeit for a noble cause, no longer viewed as an 'end' but simply a 'means'.[76]

The situation is quite different with experimental therapy, despite all the risks that may be involved, where it is possible to benefit the foetus on which a trial is being carried out. Obviously, the benefit must be potentially better than the situation without the trial or with the use of some other form of therapy.

5.2.5.5. Stem cell research and therapy. For quite some time now it has been possible to envisage the use of stem cells in the future treatment of certain tumours, neurodegenerative diseases, cardiac diseases etc. Stem cells are totipotent cells present in the embryo in the early stages of its existence (blastocysts), in the embryonic-foetal tissue of the umbilical cord and in certain adult tissues (marrow and adipose tissue, etc.). Apart from the scientific aspects of stem cell use and possible therapeutic applications, removing themselves from the embryo inevitably entails destroying the embryo against the possible benefits. As far as the use of cells from a miscarriage is concerned, even though this is lawful, one has to be sure that this does not constitute a means of legitimising abortion.

At all events, even for the use of adult cells, it is necessary to very carefully set off the risks against the possible benefits.

5.2.5.6. Biobanks. One newly emerging problem, at least in industrialised countries, but which could also affect developing countries as well, at least from the point of view of ensuring the supply of biological materials, has to do with biobanks. These are operating units or structures in which biological materials, such as stem cells, human tissue, surgical

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76 Cf. EV 63.

residues and DNA, are preserved and catalogued in special databases. These are intended to be used for study or research. And since the data is stored together with the biological data on the individual from whom the materials have been taken, a sensitive issue of privacy arises as well as the problem of making known the genetic information, especially when it presents pathological features.

5.2.5.7. Ethics Committees. There are two types of Ethics Committees: Research Committees and Clinical Ethics Committees. In some countries there is one single body to address both these spheres, while in others they are kept separate. To promote the various areas of clinical and pharmacological research, hospitals should set up research committees. These Committees are also a source of training and formation which encourage and foster opportunities for reflection, providing information, innovation, and awareness-building in relation to care, science, teaching and administration.
The Ethics Committees, which should be set up or promoted in every Centre of the Order, are also there to defend the independence and autonomy of the patients and guests and to ensure that their rights are respected. They must be structured so that they adequately represent all the members of the Centre to which they belong, and above all they must be made up of ethically competent individuals.

Not every country has legislation on ethics and the composition of these Committees will often vary. In some countries there are ‘national’ Committees while others have hospital-based Committees. Some deal only with research, and others with clinical problems. Some are wholly independent, whereas others are linked to some other institution, etc.

Ethics Committees in all instances have three main functions.
The first has to do with *assessment and authorisation*. They are responsible for examining experimental medical and surgical trials. The Committees are therefore asked to give their considered opinion taking account of all the conditions permitting the experimentation (the rationale of the research, the proportion between risks and benefits, the protection of the patient, informed consent, etc.).

Secondly, they provide *consultation and make proposals*, when specifically requested by third parties (healthcare personnel, patients or guests, external entities, etc.) to offer opinions on issues of major ethical concern, or to shed light on situations of conflict where the healthcare workers' consciences are involved (ethical advice) and may lay down guidelines on important ethical behavioural matters.
Lastly, these Committees can have an *educational* and *cultural* function, and can be considered to be educational instruments to instil ethical sensitivity in the Brothers and the Co-workers/Employees in the Centres, promoting greater ethical competence on the part of personnel and health care institutions through various initiatives (conferences, publications, etc.).
To perform all these functions (except for those relating to trials) in some Centres, the Committees are flanked by *Bioethics Services* under various names.

5.2.6. Predictive medicine

5.2.6.1. Disclosure of the diagnosis. Modern predictive medicine practised in many of our Centres raises bioethical problems that have never arisen before. The first of these is notifying the diagnosis. Who should be notified? The person concerned, their relatives, or both? The general ethical criterion regarding telling the truth to the patient or guest is that they are the first owner of this right, albeit not the only one, regardless of the seriousness of the illness. Indeed, it is precisely when the prognosis is bad that the problem is particularly urgent.

The question of genetic diseases should not be an exception to this rule. However, the feature of many of these diseases, where several members of the family may be affected by it, in clinical terms, raises the same question. Obviously it is not possible here to examine the problem in depth, and every individual situation must be carefully examined taking account of the 'rights' of all the persons affected, giving absolute priority to the patient or guest (who may never be robbed of something which relates so intimately to them) but also taking due account of the needs of their relatives, if the situation demands this.

Even more than in the case of other pathologies, when communicating the diagnosis of genetic disease account should be taken of the particular psychological and emotional state of the parents, and the most appropriate language has to be used which they can clearly understand without "terrorising" them, and while the truth is never to be concealed or manipulated, it has to be communicated "gently", respecting the decision taken by the couple but at the same time without saying anything to induce them to interrupt the pregnancy but, on the contrary, to help them to accept life even if it is affected by a serious pathological condition.

5.2.6.2. The gene pool and the protection of privacy. In the forthcoming stages of medical research, the possibility is opening to have a complete knowledge of the gene pool of every individual, not only in terms of their physiological structure, but more important still, the possibility of appraising possible pathologies. While this is an indispensable condition for ensuring that they can be corrected some time in the future (through genetic engineering) the possibility also raises serious ethical problems.

The first has to do with the privacy and confidentiality of this data which, kept in 'gene banks. The problem is the same as gaining access to clinical records or a computer. What it does, however, is to raise an old issue, namely the confidentiality of private information, in different terms. Perhaps what is most noticeable here is the depth and the 'intimacy' of a possible invasion of the most secret fibres of the human structure. But the criteria to be applied to other situations must also apply here.

Very closely linked to this problem is the matter of a kind of 'genetic identity card' of each individual and even devices for genetic self-diagnosis which are now beginning to appear on the market. What problems might such an instrument cause? How can it affect the psychological health of an individual, knowing that he or she is the bearer of various genetic illnesses which are not always clinically present but are potentially there? How will it influence problems relating to the choice of a life partner? Hitherto it has always been said that it is correct to prevent genetic diseases by a pre-matrimonial medical examination. This would be the last resort. But could it condition the choice of an individual in terms of love

and affection? There is no doubt that the scenario is still a long way off, but we should be prepared for it in good time.

One final and more practical aspect, but no less important for that has to do with the professional implications and matters relating to insurance. It is not out of the question that at some future time an employer might be able to request the ‘genetic identity card’ (as one does today with a medical certificate) and as a result exclude any workers who are not suitable, either now or in the future. This would be a serious form of discrimination in the workplace; faced with this eventuality our Centres' care philosophy must ensure that guarantees are in place to protect these workers, because this could otherwise constitute one of the new forms of poverty in the future.

5.2.7 Social-ethical problems

5.2.7.1 Addictions. In every age and in every community, there have always been forms of physical or psychological dependency on various substances, often with a magical/religious connotation, but only today has the problem taken on ethical and social dimensions of such vast proportions. The main reasons are the widespread use of drugs today, particularly among the younger sections of the population, causing harm both to individuals and to society at large.

This is a very complex issue and the Hospitaller Order is required to examine it from various points of view, primarily in terms of the healthcare aspects raised by it: emergency services, clinical weaning-off procedures, and the medical treatment of complications.

Secondly, because of the psychological and educational measures to be adopted to help people overcome their psychological dependency. Although it is comparatively easy to overcome physical dependency, this does not apply to psychological dependency. For unless there is a powerful desire to fill the value vacuum which leads to drug addiction, an individual will never win the battle against substance abuse. This is also the reason why the Church is present throughout the world in a number of structures (homes, therapeutic communities) which have made it possible for former drug addicts to be completely rehabilitated and take their place in society again.

Lastly, let us not ignore the social dimension of this commitment by the Hospitaller Order, which is wholly consistent with its charism. For there is no doubt that addictions are among those ‘new’ forms of poverty of which we speak so much today, and to which the Order feels it is being powerfully called to respond.[77]

None of these activities must be carried out in conflict with public services, of course, but they must complement them. This does not mean that we must necessarily endorse the legislative or social measures that are adopted if they are not considered to be in harmony with the charismatic mission of our Centres.

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77 Cf. P. MARCHESI, The Hospitality of the Brothers of St John of God towards 2000, Rome 1986, Appendix III

Among the cases of abuse of psychotropic substances today, close attention is being paid to the abuse of psychopharmaceuticals commonly used as sleeping pills or ansiolytics of which, particularly in the highly industrialised countries, indiscriminate use is often made in the form of self administration without a prior medical examination or instructions from a doctor.

Another important form of addiction is *alcoholism,* for the problem of alcoholism in some countries in the world is so widespread that it is vastly superior to that of drug use. Moreover, the social classes concerned are much more varied, and this is yet a further stimulus to the Order to effectively commit itself to this area.

In addition to these forms of dependency we must not forget tobacco addiction, above all because of the physical harm this causes (cancers, cardiovascular diseases etc) and new types of dependency (Internet, video games, compulsive shopping etc).

5.2.7.2 AIDS sufferers. The present spread of this disease and its social stigma require our Order to find a viable response to it which may be summarised in terms of various initiatives.

The first must be cultural, to avoid allowing a mental attitude and our resultant external behaviour to discriminate against these people. This becomes very necessary in all healthcare situations in which HIV positive or full-blown AIDS victims are in a general hospital for various reasons (first aid, needing surgery, etc.), sharing their in-patient status with other patients and visitors.

This attitude of welcome and outreach must also be more appropriately expressed in a spirit of specifically implementing a charismatic dimension, in special programmes to accommodate the patients or to accompany those who are in the terminal phase of the disease. The Order should promote these structures, imbued with that Christian spirit which it has always shown when caring for the most deprived and marginalised. Indeed, from the point of view of our historical legacy, let us never forget that it was precisely to individuals affected by infectious diseases that many of our Brothers stood out so heroically in past ages.

In addition to looking after these patients, the Order must also contribute to preventing the disease, mainly by educating people in sound values. If such strategies prove ineffective or inadequate, any further harm may be reduced by making people aware that since all these measures in themselves are fallible, they will never provide an absolute guarantee of prevention from infection.

Furthermore, as far as possible the Order should cooperate in research carried out by other healthcare organisations or institutions to identify new remedies and therapies, or preventive remedies so that this disease can be finally beaten.

Social and ethical problems arise in developing countries. Above all in relation to the antiretroviral drugs, in terms both of their cost and the resultant difficulties of acquiring them, and the existence of certain political problems which hamper their procurement.

Another problem is breastfeeding. Even though this is not suitable for HIV-infected mothers in developing countries, it is at all events preferable because, given the high child mortality rates it does have a protective effect on newborn baby's health, which outweighs the risk of infection.

Lastly, we must be particularly careful to ensure that our genuinely deep human understanding and acceptance of AIDS sufferers and our rejection of all forms of marginalisation and of any notion that AIDS is some kind of ‘punishment from God’ does not lead to sanctioning as lawful the behaviour that gives rise to it.

5.2.7.3. Other infectious diseases. In some parts of the world there are various infectious diseases such as malaria, tuberculosis and a number of new viral diseases (SARS, bird flu, haemorrhagic fever from the Ebola virus etc) which cause numerous deaths. In countries where these pathologies are widespread, and in which the Order is also present, medical care and human attention for the patients affected by these diseases must be an absolute priority in our care work.

5.2.7.4. Orphan drugs and rare diseases. Rare diseases, most of which are genetic in character, are defined as such because of the very few numbers of sufferers (generally fewer than one case in 2000 inhabitants). Even though each one of these is rare, they become numerous when taken as a whole (over 7000) and many of them are very debilitating. But it is precisely because of their rarity that they are very often difficult to study, in addition to the fact that they are of little "economic interest" to the drugs industry which is reluctant to invest in studying and treating them. To these conditions is related the problem of the "orphan drugs" which are only effective for treating or improving the symptoms of the disease, which are not manufactured or produced in an adequate manner because of the lack of a sufficient return to the pharmaceutical industries. It is mostly patients' associations and voluntary organisations, which are also concerned with raising funds for research and treatment, that are engaged in sensitising society to rare diseases and orphan drugs.

5.2.7.5. People with physical, mental and sensorial disabilities. Even though contemporary society seems to have rediscovered attention to people with disabilities today, while generally accepting them as being ‘different’, by special measures such as removing ‘architectural barriers’, in terms of culture and people’s mindsets there still remains a certain rejection of them. This extends to the promotion of prenatal eugenics, pushed to the point of destroying embryos affected by any anomaly, and demanding euthanasia to dispose of malformed new-born babies or disabled adults.
But there would be no point in pointing the finger of blame for all this unless, at the same time, we work to ensure that welcome and love is shown to all the disadvantaged members of any society wishing to be called civilised. A society really made to the measure of mankind cannot be directed to the ‘strong’ but must be directed towards the ‘weak’. In addition to taking specific measures to support the disabled, the Order should have this function of bearing witness.

In compliance with the principles of *participation, inclusion* and *personalisation*, the Order is being called upon, in particular, to encourage people with disabilities to lead a more autonomous life by encouraging their incorporation and participation in social life and in the

world of work. For this reason, it is necessary to encourage de-institutionalisation, by converting large-scale structures into smaller and more homely facilities, in which adequate protection can be provided in every respect.

One particularly sensitive problem refers to the exercise of sexuality an essential condition for this is that it must be freely chosen. There are various levels of restriction on the freedom of choice in this regard while sexual stimuli are simultaneously present. While any action intended to mutilate a person's functions is disrespectful of human dignity (in this particular case, a person's reproductive function) on the other hand, a person who is mentally impaired is not only unable to freely exercise that faculty, but its use, while its biological potential is unaffected, can lead to pregnancy. This is precisely why, when seeking to guarantee the maximum respect due to every human being's full bodily identity we must responsibly prevent a person with mental disabilities from causing self harm and damage to others precisely because of their particular existential conditions.[78]

5.2.7.6. The mentally ill. Because of the personal experience of our Founder, the mentally ill have always been particularly cherished by our Order. We have therefore built up a great deal of experience and skills with them, and indeed have often been in the vanguard in heralding in new ideas and solutions which are now being used by the public health authorities themselves. Yet, apart from a number of specific care problems relating to the legislation in various countries, they also raise specific ethical problems.

The first is what might be considered the common denominator shared with all the others, namely, their capacity to give their consent. Overcoming the medical paternalism of the past and the present appreciation of the autonomy of the patient also applies to the mentally ill. Indeed, it applies to them even more radically, because of their limitations when having to take autonomous decisions. There may therefore be a temptation to return to the old form of paternalism in their case, even though this may well be for charitable reasons. But this must not be done and should only be limited to cases in which the state of need or the lack of any other relatives or Bioethics Committees, etc., means there are no alternatives and no one else with whom to share decisions. In all cases, the patient must be part of any decisions taken in so far as their faculties permit, or we must involve persons whose bonds or role suggests that they would always work in the best interests of the patient.

This is evident in the case of sedation with psycho-drugs, electro-shock treatment, physical restraint measures and the deprivation of freedom. But when this is done, it is sufficient to have a general and often implicit consent expressed by those authorised to issue it whenever it becomes indispensable to admit the patient.

At all events, and apart from these specific problems, the Order's psychiatric or social facilities must always be imbued with profound humanity in the treatment shown to the mentally ill. This is part of the perennial charismatic practice of that sensitivity that St John of God showed to these persons, as well as being a renewed prophesy in an environment

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78 John Paul II addressed the sensitive issue of the sexuality of people with disabilities in his message to the delegates to the International Symposium promoted by the Congregation for the Doctrine of the Faith on "The Dignity and Rights of the Person with Mental Disabilities " (8 January 2004).

which is constantly in need of humanisation. This should not be viewed merely in terms of guaranteeing sick people adequate living space, a satisfactorily hygienic environment, food of good quality, freedom of movement and the possibility of maintaining links of affection with their family, etc., but must also extend in positive terms to the person's 'self-fulfilment'. To achieve this, we must appeal to the potential of the individual, to all his or her resources, including spiritual resources. This is a process which should lead us to appreciate a personality which, despite impairment, always allows the face of man to shine through.

In this perspective the importance of de-institutionalising these patients must always be borne clearly in mind. With rare exceptions, they should always be admitted to facilities in which they are not "confined" but live in sheltered communities where they can also have the opportunity to find employment wherever possible. With regard to the exercise of sexuality on the part of the mentally ill references made to the comments in the previous section dealing with persons with mental disabilities

5.2.7.7 Older people. The older generation is continually growing in contemporary society, not only increasing the diseases and illnesses from which they suffer, with an increased commitment that this entails in terms of healthcare, but also creating specific social and welfare problems as a result. The real difficulties faced by certain families in looking after old people within the family, or the selfish rejection of them by others, often make it necessary for old people to retire in a rest home. There are now many such facilities managed by the Order in different parts of the world.

Naturally, there are many reasons why an old person ends up in a home. Even though we have no right to judge the families that have chosen to put their elderly relatives in a home, the Order must as far as possible encourage the bonds of affection between them and their family, also by helping to remove any possible obstacles to this.

We should not view the stay of an old person in a House managed by the Order as a solution to a housing problem alone, but it must be fully imbued with its charismatic meaning and sense. This means that we must appreciate the 'third age' which must not be masked by the illusion of some eternal youth, but experienced as a specific and different age in life, with all its riches and problems, the same as every other stage in life. At the same time, however, we have to avoid the tendency which is known today as "ageism", considering old people useless, unproductive and therefore not particularly important for the development, especially the economic development, of society.

In old age, people suffer from the experience of loss (of physical strength, social role, affection, work, a home, etc.) which they must internalise and compensate for by other forms of enrichment (experience, memories, the good they have done in the past, etc.). Moreover, particularly when one considers the many forms of neglect and maltreatment to which old people are subjected, our Centres must stand out as shining examples of respect for the dignity of the elderly and the humanisation of their care.

Lastly, looking at it from the point of view of the faith, this time can also be seen as a long vigil in preparation to encounter eternity.

5.2.7.8. *Abuse of children, adolescents and the vulnerable*. One of the problems that has emerged in recent years (because of a greater understanding of the problem or because it has really increased) is the abuse of children, adolescents and the incapacitated, and violence in general. This may take the form of physical, psychological, and sexual abuse. As far as the Order's facilities are concerned, one form of abuse is of an institutional nature. In hospitals, all these kinds of abuse can occur together with specific kinds of institutional abuse, such as:

- failure to respect privacy.
- inappropriate isolation.
- intimidation.
- inappropriate dietary treatments.
- refusing food.
- indifference when nursing them.
- failure to respond to requests for help.

It is unnecessary to stress the seriousness of any kind of abuse, by whomsoever it is committed, even more so the particular seriousness of abuse when it occurs in an institution, both because the institution should guarantee children and adolescents a welcome, care and protection, and because the abuses is committed in institutions belonging to the Order. When any cases are discovered, in line with what the Church is doing, all the necessary disciplinary measures must be taken against the perpetrator of abuse, but above all the victim of abuse must be given care and attention. For while abusers must be treated with appropriate severity, it must not be forgotten that it is the abused person who is always at the heart of the problem and needs to process and be properly healed of the traumatic experience.

It might be appropriate, as some countries already doing, to draft special protocols for the prevention and treatment of any cases of abuse. [79]

5.2.7.9 Immigrants, the homeless and other marginalised people. The presence of *immigrants, refugees and political asylum-seekers* is a sharply increasing phenomenon in every Western country. Although the problems this raises are mainly social (cultural and religious integration, employment problems, etc.) it is also an area in which the charism of hospitality may find specific expression. Responses to this problem vary enormously, depending upon the creativity of those who heed the promptings of the Spirit, and they may also be encouraged by the specific needs of each individual country or social situation. Naturally, in addition to the fact of making migrants welcome, there are also healthcare problems for people who often are unable to use any other form of public assistance or care. The Order must also work to solve these needs both by setting up special structures where possible, and by finding appropriate solutions to these problems within its own Centres.

A similar situation arises with another group of persons classified variously as *homeless, vagrants, squatters,* who share the common feature of suffering from such radical poverty that they cannot possess any form of stable abode because they are forced to live in the streets, in doorways. Perhaps the scenario of this suffering humanity, despite the passage of so many centuries, is very similar to what St John of God or St John Grande was confronted

79 Cf. The Order's document on "Care and Protection in Hospitality: guidelines for care policies and the protection of children, vulnerable adults and older people in the Order's Apostolic Centres and Services. 2010

with. Every measure to care for these people (material, accommodation, healthcare, etc.) falls in the line of absolute charismatic continuity for this very reason.

In addition to these situations it is quite likely that in future years the Order may well be required to make a prompt response to other situations which at the present time are still rare or less noticeable. For example, the women who are victims of violence, children who have suffered abuse, individuals who have tried to commit suicide, the loneliness of widowhood, psychological eating problems (anorexia and bulimia) etc. Adequate attention to the needs of suffering mankind must necessarily also take account of these 'new forms of suffering' which may arise as time passes, and which the Order must always be ready to address with creativity and love.

5.2.8. *Pastoral care of the sick and needy.* A sick or needy person has impaired health, and this throws the whole person into crisis.

But since we are convinced that faith in Jesus Christ as a source of health and life it follows that the person who is in crisis due to sickness can be put into contact with his or her dimension of faith, if this exists, so that the meeting between them both (faith and crisis) can be converted into a source of total health.

One of the great values of our society is the pluralism that has been established. The time has long since passed when political regimes were imposed upon us, or when authority and even the faith and religion were an imposition. Faith is a gift, and as such it can be accepted or rejected, set aside or cultivated in order to enable it to grow and mature.

In our centers we have decided on a pluralist presence of professionals. We therefore have persons who have accepted the gift of faith and have nurtured and matured it, as well as those who have not. There are also those in our centers who have received the gift of faith and have nurtured it and made it grow, and others who have not. We want to serve and help them all. We want to travel along a path with them to enable them to re-run through the whole of their personal history, making the most of this moment of crisis that arises when their health is impaired.

By accepting the restrictions and the dependency which illness or deprivation bring with them, we can accompany the sick to enable them to rediscover their history, their being and the meaning of their lives. This must be done with sensitivity and respect, at the pace the sick and the needy are able to move along at, at their own pace. With all these persons who feel within themselves the gift of faith, we can explicitly celebrate this process, but it will always be in terms of their level of growth and maturity.

Our healthcare and social Centers are works of the Church, and therefore their mission is to evangelize, which starts by paying comprehensive attention to, and treating, the sick and the needy in the manner of St John of God. When we talk about comprehensive care we mean being concerned with and taking care of the spiritual dimension of the person as an existential reality, organically correlated to the other dimensions of the human person: biological, psychological and social.

The spiritual dimension is much more than what is commonly put down merely to the 'religious' dimension, even though it comprises it. Many people find in God the answers to the great questions of life, while for others the fact of believing in God is of no significance to their lives, and they therefore seek the answers elsewhere. God does not have the same meaning for everyone, moreover, and God is not the same to all, and neither is the experience that one might have of God the same for all.

We must deal with the spiritual needs of all the sick and marginalized, respecting them and their freedom, without trying to be heroes or protagonists, and giving them what they need to the extent that we are able.

There is no doubt that disease, marginalization or poverty are opportunities for asking many questions about the meaning of life and the saving presence of God. This is why we must find different ways of accompanying and responding to these situations, if we can. Hence our concern for the pastoral care of the sick and the marginalized.

Pastoral care means evangelizing by accompanying people who are suffering, offering them the Good News of salvation through our words and our witness, just as Jesus did, but always fully respecting the beliefs and values of each person.

The Pastoral Service is designed primarily as a means of catering for the spiritual needs of the sick and the needy, and of their families and of the healthcare workers. This requires an adequate structure, including personnel, resources and a plan to guarantee the fulfilment of its mission.

The pastoral team is made up of trained persons who are totally dedicated to the pastoral work of the Centre, with whom other persons committed to the project collaborate and cooperate, either on a full time or a part time basis, or as volunteers. There must be a pastoral action plan and a specific program tailored to meet the needs of the Centre and the persons being looked after there. There will also be pastoral guidelines regarding the philosophical as well as the theological and pastoral contents of the plan. On the basis of these guidelines a pastoral plan must be drawn up seeking to respond to the real spiritual needs of the sick, their relatives and the healthcare operators. The objectives, and the programs and projects with their parameters for evaluation must be identified, drawing distinctions between different areas or types of users of the Centre, and programming for each area the most specific and appropriate pastoral care.

The pastoral team must pay particular attention to its formation, so that it can keep pace with progress, be updated in professional and spiritual terms in order to be able to improve the service provided. One sound form of aid to the pastoral team could be a Pastoral Council made up of groups of professionals from the Centre, but not exclusively so, who are sensitive to the pastoral situation whose main function is to reflect on and steer the work of the team.

5.3 Management

5.3.1 Management

5.3.1.1 Organization and resource-use. Our founder knew how to be a precursor for assistance and care in his age and he did this by laying down criteria for organizing and distributing resources. Like him, we are also being required to introduce avant-garde innovations into our society. In our age even more than in those days, organization and management must be an important component to the contribution we are making.

One of the mottoes of our Centers could be this: showing our capacity to work by correctly allocating available resources, giving pride of place to the aspects which are most specific to each of our institutions. At the level of each Centre, this will guarantee their future, as far as our services and units are concerned, they must be designed to provide integral and comprehensive assistance to the sick and needy.

Remuneration and training for our personnel, providing the products needed to run our Centers properly, keeping up with the times in terms of technology and promoting humanization - all of these must run hand-in-hand. If any of these falls behind the others we shall be heading for splits and crises.

Striving to ensure equity in a local and regional dimension, without losing sight of our universal vocation, must be present when we take any decisions, even though at certain times and in certain circumstances this may prove difficult.

The priority concern of managers must be to obtain these resources, and therefore a substantial part of their time and their work must be devoted to it. They are also responsible for defending the work performed by our Centers, while at the same time promoting the Centers and their projects.

5.3.1.2 Professionalism. Since we aspire to provide comprehensive care and feel called to make a vocational response in our works, our professionalism must be absolutely beyond all doubt and dispute.

By making a professional response consistently with the ethical principles of our profession and animated by the philosophy of our Institute we can make sure that our Centers possess the identity they are supposed to have. Technical and human skills and capacity are the essential basis to make this professional response possible.

5.3.1.3 Technical skills. In the same way, every Centre must ensure that its technical and technological equipment and facilities are adequate to provide the level of care they require. Only if we possess adequate technical skills shall we be able to make the specific contribution we intend to.

Continual technological changes make it necessary to make extra efforts in order to keep pace with them. Our workers must be committed to keeping up to date with their technical training and take refresher courses in order to become familiar with the new achievements of science.

5.3.2 Organization

5.3.2.1 The sound expression of the mission of the work through organizational facilities. Our mission in every Centre is very rich and diversified, and therefore the way we organize our Centers must be in the direction of pluralism. Not all the environments of our mission are compatible with the same organizational system.

To the extent that our organization is imbued with the philosophy of our mission we shall be able to facilitate communication throughout the whole of the Centre and its staff with that philosophy.

The approach, which has already been implemented, of separating the functions of superior and general manager has demonstrated that this is a very effective and appropriate solution, and at the present time it is vital for the management of many of our Centers. The Superior of the Community and the Director of the Centre are required to work as a team, together with all the other members of the Management Committee or Board. The main function of this body is to work on an interdisciplinary basis and to promote this kind of work in other teams in the Centre.

5.3.2.2 Defending pluralism. Diversity of opinions and cultures are an appropriate path to follow in order to understand the diversity between men.

We must therefore make room and provide the organizational facilities to enable this pluralism to be expressed.

Our values, the culture of each Centre will be the specific are in which to articulate this pluralist dimension.

5.3.2.3 Delegation. Participation. Assumption of functional roles. We must work with the aim of getting every person to acquire all the skills they are capable of exercising, from the person with the smallest responsibilities to those with the greatest.

We must do what we can to make this assumption of responsibilities possible, providing the organizational means to facilitate it, and ensuring that this delegation of powers and responsibilities becomes consolidated in appropriate functional arrangements for everyone making up the Centre.

5.3.2.4. Decentralization vs. Centralization. We must proceed in such a way that managerial staff oversee the initiatives and expectations of our Co-workers, and protect them.
We must implement working programmes which make it possible for our Co-workers to grow and take on tasks which we often set aside for higher roles.

In order to enable the professionals to enhance their skills and authority, and to enable the working team to have more scope for its work, and intermediate roles have greater capacity to take their own initiative, and managers increase their responsibilities - all of this must be achieved.

We must also ensure that one of the values that is particularly closely linked to the Christian tradition - subsidiarity - is a fundamental feature of the way our Centers are run.

The Order wishes to foster adequate decentralization, integrated with effective centralization according to the principles and values we are endeavouring to foster.

5.3.2.5 New types of legal status. Our benchmark has always been Canon Law. At the same time, there are other formulae which make it possible to introduce new forms of management, delegation and participation.

Traditionally, our Centers have had the legal status as properties of the Hospitaller Order. But in the age in which we live today, and the size that our Centres are now taking on, plus the constant evolution in the field of healthcare and social services, advise us to be receptive to the new developments that are taking place in this area.

Foundations, Associations, non-profit entities or NGOs are all legal formulae which may be more appropriate in some cases and could even be more convenient. Experience in each Centre has shown this. We should be very careful to discern the most appropriate formula to meet the different needs at different times and in different places.

5.3.2.6 Team work. If we really want to look after the person and cater for his or her needs, we can only do it if we work together:

- *At the management level.* When the senior managers of a Centre are capable of structuring a working team they will be able to inspire and encourage the other staff in the Centre to do likewise. The temptation to strive for efficiency above all on an individualistic basis is very strong, as are the chain reaction effects to that temptation.
- *In intermediate roles.* The most difficult role played in Centres is by those who are in the middle. They also must be given teamwork which will enable them to look after the needs under them in order to be able to make the needs known to the superiors: in the same way, they must hand down the management's plan of work to those beneath them.
- *In care and non-care services.* When everyone looking after the sick and needy are capable of working together, that is when we are able to provide integral or comprehensive service and care.

In the more complex Centres we cannot belong to the same team, but we can all be members of a team which feels that it is called to make a comprehensive response to the needs of the sick, and which incorporates everyone for whom the team is set up.

5.3.3 Human resource policy

5.3.3.1 General criteria. The Hospitaller Order of St John of God as an organization:
- is essentially a human work because it is the fruit of human endeavour and composed of persons who are the load-bearing element;
- is aware that its works are imbued with a specific character because being a non-profit entity it must combine its entrepreneurial objectives with its social and economic responsibility, and its responsibility as an ecclesial institution;
- is receptive to the present ideas coming from the world of business - sociology, human relations, psychology - because it must be geared to the present times, introducing all the necessary organizational changes to meet the management needs of certain works based upon efficiency and effectiveness as businesses, while maintaining its own philosophy, style and culture;
- is present with a staff working in its Centres, and for this reason it proposes to establish a relationship between the organization and the staff which will meet the requirements and satisfy the rights of both parties, laying down procedures to facilitate the joint action of all in order to achieve its purposes and its aspirations.

For all these reasons, we must openly demonstrate a sincere readiness to clarify relations with our employees, in the light of current legislation, the Church's social teaching, safeguarding and protecting the rights of the sick and the needy, which is the main purpose of all our Centres and work.

5.3.3.2 Relations with our employees. Bearing in mind that the human person is the fundamental element in the whole of our organization, we must ensure that human resource management is designed to motivate, attract, promote and integrate the employees consistently with their needs and the purposes of our Centres, always based on the criteria of social justice.

Management involves managing people, because without the people it is impossible to complete any action or undertaking. This is why human resource management at the present time involves a number of managerial roles with an adequate level of professional skills together with balanced skills in human relations.

One aspect which must be enhanced in every Centre of the Order is communication. We must establish structured communication, developing appropriate instruments for communication to reach every level of the organization and every employee. Specific communication channels must at least be set up, and true and comprehensible information circulated.

Another important feature of the Order and its Centres must be the fact that its welcomes in and incorporates the whole person when they begin to work with us, accompanying that person throughout the early stages of work.

5.3.3.3 Trade union activity. The Church's social teaching for many years has recognized the rights of workers to set up associations to defend their common or working interests. Trade unionism is a social reality worldwide. The Order therefore recognizes and respects the right to trade union freedom.

The social teaching of the Church supports this reality and considers it to be indispensable in contemporary social life, as a constructive force for social order and solidarity, which is capable of ensuring not only that the worker *has* more but that he *is* more. Trade unions are not only negotiating instruments, but they are also places in which the personality of the workers is expressed. Their services constitute the development of a genuine culture of work, and help the workers to play a full human part in the life of the company for which they work.
By accepting this we must find ways of ensuring information flows and communication between the management and the unions, with an honest and realistic attitude, but always safeguarding the rights of the sick and of our guests.

5.3.3.4 Personnel selection and work contracts. The personnel must be selected in terms of their technical and human qualifications, ensuring that their motivations, skills and conduct respect the principles of the Order.

very Centre should have clear rules to be implemented with regard to personnel selection, and it is to be hoped that everyone knows the procedures adopted for personnel selection: the staff postings, rules and regulations, contractual arrangements, etc.

Particular attention should be given to the following contractual criteria:

- *Technical.* In order to assign a person to a post we must ensure that the person is in possession of the academic or occupational qualifications required by current legislation. Independently of qualifications, we must ensure that the person has the right capacities and professional skills to carry out that work.
- *Human qualities.* We must fully appreciate and make the most of such human qualities as the skills and capability for establishing human relations, an emotional balance, sense of responsibility and capacity to take decisions as well as a healthcare and/or social vocation.
- *Ethical qualities.* Those working in the Order's Centres must promote the principles of the Code of Conduct of their respective professions, respect and promote the principles of the Institution, since the respect of both sets of principles is the minimum condition for working in the Order's Centres.
- *The religious dimension.* We must ensure that the skills of individual persons are such that the religious attention shown in the Centre is strengthened.

5.3.3.5 Job security. Our basic starting-point is that everything we do in the Order with regard to labour must be compliant with current national legislation provided that this does not violate the principles of the Order.

Despite everything that has already been done here (even though this has mainly been to benefit our Centres and the persons we care for in them) we must avoid situations that create instability and lack of motivation of the people involved, by offering them conditions of job security and stability which they need in order to ensure that they perform their personal work as well as they can.

However, the way the healthcare and social Centres operate, open round the clock, makes it essential to introduce a complex network of replacement staff and locums which makes it difficult to guarantee job stability to those occupying temporary posts. But even here, systems must be studied to limit temporary employment.

5.3.3.6 Remuneration. Fair pay for work performed is a key problem throughout social ethics. Pay problems are those which are most frequently raised by workers.

The Church's social teaching considers the wage as the specific verification that social justice exists in labour relations. It not the only one, but it is certainly the most important.

It is not easy to quantify what the right or just wage should be because it is fluid because of such factors as the economic situation of the country concerned, the expectations of various markets - including the healthcare and social care markets, the state of each Centre, the expectations and needs of each employee, etc.

All this makes it essential for us to pay our employees a wage which as far as possible meets their demands, even though sometimes their expectations cannot be fully met. But quite apart from specific existing remuneration, we must remain open to a real attitude of commitment to improving the financial and social conditions of our workers. Their comfort and well-being will always be a positive factor as far as the comfort and well-being of our sick and needy are concerned.

5.3.3.7 Motivation. The motivation of an employee depends upon the degree to which his fundamental needs are met and his perception of the attractions which a company or organization offer to enable him to develop his human and professional capacities.

Personnel motivation is a fundamental tool for achieving one of the objectives of the whole organization, namely, the human and professional development of the workers.

The remuneration systems (wages, incentives, premiums, etc.), working conditions (environment, security, climate, teamwork, etc.) and individual stimuli (security, job stability, consideration and respect, self-fulfilment, etc.) have a fundamental influence on the level of satisfaction and motivation. We must therefore make all the necessary efforts to ensure that these three fundamental areas of such a sufficient level that they meet the needs of our workers.

As an instrument for motivating the employees, the Order places particular stress on personal enhancement. This is a specific area in which management must act, particularly personnel management. We must ensure that people are able to see that they can look forward to a future in our Centres in professional and vocational terms. For this reason we must identify the most appropriate instruments: for some this will be training, for others research, for others teaching, etc.

5.3.3.8 Convergence of values between all those who make up the Centre. One of the features of our society today is pluralism. We might say that the age in which one culture has predominated over another is about to close. For a long time now, in many of our Centers we have been adopting managerial and care functions seeking to group together and integrate this multicultural reality.

It is urgently necessary to continue along the same lines, and that all of us should be committed to this project of combining and unifying efforts and cultures, capable of integrating all the different cultural elements simultaneously present in our Centres. Every convergence project requires union: values cannot be established by imposition.

It will probably be necessary to lay down a number of minimum points which cannot be modified. But on the basis of these, it is necessary to work to establish a culture with a number of specific values which are promoted and endorsed by all.
To the extent that our Co-workers have possibilities to express their ideas, their values, we shall be committing ourselves to pursuing a shared project. It is equally necessary for them to feel responsible regarding issues, areas and other matters delegated to them.

5.3.3.9 Creating a culture of membership of the Centre, Province, Order. Present day research into management sciences have discovered the importance to institutions of developing an ‘organizational culture’ which is consistent with the mission and the values of an institution. As an Institution, the Hospitaller Order has been examining this approach in terms of its founding charism.

In the past we have perhaps been too paternalistic, too protective towards our workers because of an unconscious defensive attitude to everything that is ours, and particularly of our culture. Without losing all the values of that culture, we must overcome this defensive attitude, and one appropriate way of doing this is to set up a group of professionally qualified individuals who know how to direct and steer the creation of a common culture.

One vital element that cannot be missing from this process is compliance with and enforcement of existing labour legislation, particularly with regard to safety at work and workers’ health legislation.

This will boost the defence of workers' rights.
Personal satisfaction, job satisfaction as a result of work well done, the sense of pleasure when one sees objectives being achieved, in other words peace of mind and that interior peace which floods through us when we feel fulfilled in our profession, and when we see that what we are doing together with our colleagues is helping to build up our world, to improve healthcare and to improve social services - all these are things that we must enhance.

One word of warning is needed in order to ensure that our labour situation does not hamper the integration of professionals. As time passes, people rest on their laurels, and lose their original enthusiasm. It will be the responsibility of management to awaken and animate these people so that this situation does not obtain and in extreme cases the necessary decisions must be taken.

Any Centre in which there is no guarantee of stability, however, will never be an appropriate place to invite Co-workers to commit themselves to a joint project.

The Order must support and defend its employees if they should be taken to court, except in the case of manifest professional negligence. When they are reported, and this unfortunately does happen in our Centers, we must comply with the principle of honesty regarding the practice of our Institution, and show open support for the persons involved.

In the same way, if we wish to implement the specific culture of our Centres we must institute special ways of acting in moments of difficulty and tension that may always arise in working relations. Even in the case of conflict, there may be a specific form of commitment in order to resolve such situations.

5.3.4 Economic and financial policy

5.3.4.1 Non-profit entities. Our Institution is always defined as a 'non-profit entity', in other words its primary purpose is not to accumulate wealth.

All the resources that we obtain must be given to the Centre so that we are sure that at all times its equipment, its teams, its working methods are consistent with and adequate to the place in which it is situated, and the territorial classification.

5.3.4.2 Its charitable and social character. The origin of our Institution lies in charity, in generous cooperation between different people to enable the Centre to perform its mission. We would do well to promote this dimension of Christian charity so that we can continue to pursue the original initiative of the Order.

The time has now come to give a more universal dimension to our solidarity. In today's world inequalities are increasing and differences are widening all the time. This charitable-social dimension of our Centres could find a topical relevant form of cooperation between our Centres or between different countries in the field of healthcare or social necessities.

5.3.4.3 Financial break-even. The art of management is the art of allocating resources to different needs. In the case of our Centres, it is the allocation of resources to different activities performed in that structure.

A decision has to be taken on allocating resources to each of its parts while guaranteeing the future of the Centre as a whole, which is simply stating in other words the need to establish financial break-even.

If the Centre does not have enough funds to cover the allocations we have decided upon we threaten the future of the Centre and all the people belonging to it.

5.3.4.4 Managerial transparency. If all the values that we wish to promote in our Centres and which give sense and meaning to our mission are fulfilled, there is no reason why we should disclose the reality of Centres to professionals, users, society and the government authorities.

This is precisely because our management must be transparent: if the principles are clear, and if we intend to put them into practice, that is yet a further reason for wishing to make them known.

Statistics on our Centres (activities, income, expenditure, results, investments, financial resources) form part of the whole reality of our Centres, and can therefore also be disclosed.

One appropriate way to spread familiarity with our Centres and encourage transparency and simulate co-responsibility might be to draft an annual report on the activities of each Centre.

5.3.5 Social responsibility

5.3.5.1 Service to society as the means of legitimizing our works. Every institution and every Centre runs the risk of becoming inward-looking and of entering into a process of self-legitimation, cut off from reality.

Indeed, one often finds entities planning something in this isolation which is not necessary and which no one has even asked for. That must never happen in our Centres. The whole reason for our Centres lies in the service that we offer and they must therefore remain receptive to the changes and to developments that occur in order to ensure that the service they provide is always topical and relevant.

The Constitutions specify that we are the stewards of our goods, and not the owners, with the specific mission of guaranteeing that the resources are properly used in our Centres.

5.3.5.2 Respect for and compliance with the law. Since we wish to make a specific contribution to society it is essential for us to comply with all statutory provisions.
If we take the law as that common minimum that governs all those who make up our society, we must stand out among everyone else in the way we allocate this minimum common denominator. But we cannot merely restrict ourselves to applying this common minimum. As far as we can we must overcome it trying to promote our principles way above and beyond what the law proposes.

A particular situation arises when the law is opposed to the identity and the values which the Institution promotes. In such cases, recognizing that we endorse the idea of pluralism which we try to promote in our society, we must appeal to conscientious objection regarding the application of that particular law in our Centres.

5.3.5.3 Commitment to social justice in the distribution of resources. It is not easy in our society to guarantee a fair distribution of resources. Pressure groups on the one hand and large inequalities on the other can ensure that the scales balance fairly.

We must make an effort in terms of management and value education to make sure that the law of the strongest is not always the one which prevails. We must bear in mind all the different situations that exist in an attempt to guarantee a fair distribution of resources.

We must be aware in particular of the universal dimension of our lives and of our Centers. We must admit that there are signs of injustice in the worldwide distribution of resources. We must not allow ourselves to become part of this unjust distribution. We intend to work for solidarity, with a universal mission and with a universal view of the problems.

This must be one area in which we can apply the social doctrine of the Church, and to the extent that we develop that doctrine we shall promote it. And we will be able to make our contribution to put this doctrine even more widely into practice, as a compendium of values for our society.

5.3.5.4 The function of denunciation of situations that demand it. Let us make our contribution in terms of ideas and suggestions for situations which we can clearly see to be wrong and where there are shortcomings. We must not only complain, however. In addition to highlighting the shortcomings and the wrongs, let us make suggestions and offer guidance.

If we are capable of providing concrete solutions, and then manage to implement them, our function of denouncing wrong will have reached its maximum level of expression.

5.3.6 The presence of society in the Centre

5.3.6.1. Our clients. The associations of the sick and their families. Traditionally, the ‘clients’ of the healthcare service and social facilities have been called ‘patients’. But today they want to stop being ‘passive’ and to become actively involved themselves, and it is only right that they should.

At the moment there are two types of patients’ associations:

- general patients’ associations, with an important function of making demands and claims, and frequently with a certain tendency to take legal action;

- specific associations relating to one particular type of illness, generally chronic diseases or very serious illnesses.

Both of these must be given room and scope in our Centres.

It is quite likely that the first will come to us with a complaint, claim or lawsuit. Our task is to enable them to speak out, so that they feel that they are valid social spokesmen, and can constantly cooperate with the way we work and operate, and are able to take part in the work which we are performing.

The second type of association must be given special support in our Centres, particularly

when they are first created. In the way in which our societies operate today, it is only when people group together that they can achieve certain goals, and in many cases it is very difficult to set up the initial grouping. Our Centres can always be a platform to enable them to overcome these initial difficulties.

In both cases, dialogue and open-mindedness will enable both the parties involved - the Centre and the Association - to know how each other lives, and their mutual possibilities, limitations and also their mistakes.

Unfortunately, we can never avoid lawsuits, very often initiated merely to make money, but we can find different ways of relating based upon mutual trust and confidence.

When performing services in which we relate to the public, allowing the public to express their opinions in various ways, we are doing something which is particularly suitable to attract citizens to be present and interested in our Centres.

5.3.6.2 Our employees. Our employees have a number of organizations to represent them, which are recognized by the law, through which they organize their cooperation with the Institution.

It is therefore to the extent that we consider our Institution as a reality which is built up by and shared by everyone that we will be able to properly organize links, relations and procedures with these associations to give scope to this new project that we are trying to carry out in every Centre of St John of God, without neglecting the needs of the employees.

In some cases, the employees will be working on an exclusive basis with the Centre. These employees will be linked to us by statutory ties.

Others will be motivated by a vocational response which goes much further than their professional interests alone. With these employees formal and informal means should be established to enable them to increase their commitment to solidarity with the sick and the needy.

Lastly, some will work within our Centres as an expression of their own commitment to the faith. Here again, they must be left sufficient scope to express what it is that motivates their lives to serve the sick and needy in a group, and why they desire to be present in a Centre of St John of God.

Notwithstanding the former situation, which is dictated by the law, the other situations which must be created in every Centre will be the most secure way of expressing this linkage which is established in the Centres of St John of God.

5.3.6.3 Benefactors. They enabled our Founder to forge ahead with his work. They were capable of carrying out all the infinite commitments and tasks which St John of God took on to minister to the sick and needy.

In the course of the centuries they have always continued to be close to and to support our work. In some countries more than others. But until the welfare state was established, most of our works only survived thanks to generous donations from those who had placed their trust in the Hospitaller Order and in the service which it provides to man.

Today, most of the Centers no longer depend upon on financial donations as they formerly did, but nevertheless this still continues and is fundamentally important for solidarity and charity. The principle still remains, and the principle is that of the man or woman who wishes to show solidarity with other men and women, and does so through the Hospitaller Order.

The form this takes may change, and indeed has changed, and will continue to change. But it is our responsibility to make this solidarity effective in the fairest and most equitable manner possible, and hopefully increase it.

Perhaps the time has now come when, for the sake of greater effectiveness and solidarity, we should give this solidarity a more collective character to enable us to help where the needs are greatest.

This is certainly an issue which is still wide open for debate and creativity, to try to find out new ways of fund-raising and new ways of making this work of solidarity ever more effective.

It has always been, and still remains, an issue that is deeply rooted in the mentalities of many of our Centers and Provinces, and it is a commitment on all of us to ensure that it is promoted. The new means of communication will probably be one way of carrying out this work successfully, particularly in order to strengthen links between these people and our Centers.

5.3.6.4 Volunteers. The Order has always known how to attract altruistic cooperation from others, in some cases as an expression of solidarity and in others as an expression of Christian charity.

Our Founder was able to carry forward his work thanks to the generous cooperation of many people, some with financial contributions as benefactors, and others who freely gave their work and their own efforts, as volunteers.

The Order has managed to make an initial response to the new voluntary service movements. In some countries the Order has pioneered the involvement of volunteer movements within the Centers. However, we must constantly keep up to date and be ready to change, in order not to remain attached to outdated or outmoded ideas and structures.

Every Centre is different, and each one must promote a creativity and originality among its volunteer workers. In this case, diversity will be the proof of its wealth.

The process of guiding and selecting candidates, the profile of the voluntary worker, their mission in the Centre, the time devoted to that mission, the training and formation they need are all issues to be discussed in the Order, and in every Centre.

Perhaps the time has come for associations of volunteers and their members to be able to address their observations to the management of the Centre. They are able to see the situation differently from the way in which the Centre sees itself. It would be a good idea if appropriate instruments could be put in place in order to become acquainted with their vision.

5.3.6.5 The local Church. We are an institution that does not fall under the jurisdiction of the local Ordinary. This is a starting point that we must always bear in mind, but it is nevertheless true that if the Order really wishes to have a meaningful presence in the next century, it must work jointly and in coordination with the Church.

If as Church we are the people of God and are all called to be members of this people, we must reflect on how we can work together as the people of God.

This can be done most easily within the structure of the diocese and the parish community.

Perhaps there is still much more work to be done to be able to cooperate together in the same project: pastors, brothers and laity alike.

It is not a matter of giving up our identities or giving up any particular pastoral projects. Everyone has their own place and in that place everyone must work together to build up a common pastoral project. If we do not do this either it will not be a common project, or it will not be a project at all.

5.3.6.6 The civil authorities. Our Centres work with the public, and in many cases they have been brought within the national health services or the public social services.

This situation requires a level of relationships with the authorities which must be flexible enough to enable us to keep informed on what is happening now, on the plans and projects for the future, and to enable us to keep the authorities informed of our situation and on our future projects.

We must continue along this path of relating to and communicating with the authorities. This will demand honesty, clarity and transparency on our part. *Honesty* as an expression of consistency with the principles we defend; clarity of our position and our expectations and demands; and lastly transparency in our criteria when it comes to applying the resources we receive.

In everything that refers to its institutional relations, the Order must reflect on the role that it has to play. There are two opposing risks here: remaining trapped in these relations, and because of this allowing the essence of our identity to become watered down in time; or we run the risk of weakening these relations and allowing both the Centre and its care project to be watered down, cut off from reality.

One thing is obvious: in order to be able to nurture these institutional relations, sufficiently comprehensive professional, human and religious formation is needed. Otherwise our presence will be counterproductive. Once again this shows that if we want to say something, we have to do it in a language which is consonant with our society.

5.3.7. Verification

If we wish to be faithful to the mission that we are gradually updating and recreating, we must periodically review our past achievements.

We must see how we are applying the philosophical principles and general criteria of the Order in management and in the care we provide.

5.3.7.1 Heeding the signs of the times. Our society is a very dynamic reality. Science is continually evolving and new working methods, new professional techniques and new technical instruments are emerging daily.
A message or a philosophical principle is only topical and relevant if it can be transmitted using topical and relevant means, methods and techniques. If not our proposal will just become wasted words.

In this process we must evaluate the appropriateness of the means which society provides us with, because it may happen that while wishing to work much more effectively, we are using instruments that are contrary to the philosophy of our Institution.

5.3.7.2 Responding to the needs of man and society. In this constantly evolving society, man is also changing and evolving, even if we are not able to see whether it is changing society that is leading man on or whether it is changing man which is leading to a changed society.

One thing is certain: in this general process of change, the following are appearing:

- new diseases with which we have to deal;
- new ways of contracting diseases, which require new forms of care and assistance;
- new problems in the family, to which we have to be able to respond, providing our support, enlightenment and accompaniment;
- new needs which demand our creativity and our solidarity, if we are to respond adequately and properly to them;
- new forms of selfishness, which require us to find new ways of responding with solidarity at the institutional level.

Responding to the needs of the person using modern contemporary means and methods, maintaining the style and the values of the Order means remaining faithful to the New Hospitality, which is the summary and synthesis of our apostolic project.

For reflection:

1) Identify the achievements and difficulties in their "application to concrete situations" in terms of the actual situation of our Centres and Communities:

- In our holistic care and in terms of the Rights of the Sick
- With regard to specific problems
- In management

2) What should the Order's priorities be, based on the diagnosis you just made?

- In our holistic care and in terms of the Rights of the Sick
- With regard to specific problems
- In management

CHAPTER VI

FORMATION, TEACHING AND RESEARCH

6.1. Formation

6.1.1 Technical, human and charismatic formation. In addition to what has been said elsewhere in this document, we would also like to emphasize a number of specific aspects regarding the responsibility on the members of the Order and on our Co-workers to be properly trained and receive adequate formation. We shall not be emphasizing the need for human formation, in the sense of formation which leads us to become aware of ourselves and to deepen the ways in which we relate to other people and to society, which is essential if we are to be agents of humanization in the Centres of the Order.

Some of the features of our age are the result of the fast pace of scientific progress in general, and bio-medicine in particular, as well as the speed and ease of communications, the globalization of issues, the scientific-technical mentality when approaching reality and the idea of man – scientific reductionism – and religious fundamentalism – spiritualist reductionism. We can see that the only ethical criteria that can be considered to be globally shared today, at least in theory, is respect for the dignity of the person who demands not to be instrumentalized as a means to an end, however lofty that end may be or may appear to be. This is not something new, but it does take on a particularly important colouring today in terms of relationships between healthcare professionals and the sick.

Since the '70s we have witnessed the most radical changes occurring in the relationship between doctors and patients of the past few centuries. Gradually an awareness has dawned that a capable patient has to be recognized as an autonomous moral decision-taker with regard to health. Now priority is given to giving proper information to the patient. The role of the doctor in providing care has also, at least in the western world, lost that unique and dominant position that it used to have. Today we have to talk about relations between a care team, a patient, and a social environment. The ambiguous nature, as far as human advancement is concerned, of certain technologies which even if used properly do not prevent terrible conflicts from arising between life values and spiritual values. There is also an increasing importance given to nursing in cities, to laboratory technicians in diagnostics, all of which demand much more rigorous training than used to be the case. The level of comprehensive care both in hospitals and in primary healthcare services or social/welfare centres, depends very greatly on the level of training that the healthcare workers have received.

Technical and professional training and formation on the one hand, and human and ethical formation on the other, must move in parallel along the path of continuing formation and lifelong education which will require it to be directed, as a matter of priority, towards the technical/professional side or the human/ethical side as the case may be. Sometimes it will be in the first direction, but on other occasions particular emphasis will have to be placed on the second, when updating the knowhow we require to be able to provide the comprehensive healthcare services that meet our current criteria.

Each Centre must undertake a commitment to promote training and formation plans at every level , for which they must make the necessary appropriations in their budgets.

Whereas the updating of scientific and technical knowhow does not generally require any excessive effort or motivation, in the case of human/ethical formation extra motivation is required in order to become imbued with the Order's philosophy of care and charismatic criteria. This must be provide the opportunity to enhance the sense of belonging, and this instrument for updating the values which run throughout the culture and the identity of the Order must be promoted by the management of our Centres, and be fully integrated into the formation plan of the Centre.

As far as possible to be kept briefed on programmes and experiences from different regions of the globe in order to see how they can be adjusted and tailored to suit local conditions. Since instructors and teachers who are capable of understanding the health issue and at the same time have leadership in areas of contemporary philosophical, theological, pastoral and spiritual thought are a scarce commodity today, efforts must be made to set up teams and to enhance the qualities of different individuals working on a common programme. This program must be realistic, effective and efficient. Hospital ethics committees can perform this task perfectly well.

At a time when the Church is particularly conscious of the need for inter-faith dialogue in order, as Vatican II put it, that 'the spiritual and moral values in other religions be recognized, preserved and promoted, together with their social cultural values and in order to cooperate and research for a world of peace, freedom, justice and moral values'. [(80)] It is vital not only to provide relevant professional and technical training but also to offer a more solid formation in the charism of the Order, philosophy and theology, focusing especially on the person and mystery of Jesus Christ.

The great schools of philosophical thought[(81)] must be the fundamental pillars of all formation and training, in which the charism of the Order and thorough familiarity with it must always inspire attitudes to and dealings with the poor and the needy.

This will place us in a position to be able to embark upon a dialogue in four areas which is necessary in a world of religious pluralism.[(82)]

- A dialogue of life, in which everyone endeavours to live in the spirit of receptiveness and good neighbourliness, sharing their joys and their sorrows, their problems and their human concerns.

- A dialogue of action, in which the Christians and the others cooperate for people's comprehensive development and freedom.

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80 Vatican II, *Nostra Aetate,* 2 *et seq.*
81 See JOHN PAUL II, *Faith and Reason* 1999, Chapter 1.
82 Pontifical Council for inter-faith dialogue and the Congregation for the Evangelization of peoples, *Dialogue and Annunciation*, BCDR (1991), 210-250)

- A dialogue of religious experience, in which everyone involved, true to their own religious traditions, share their spiritual wealth in relation, for example, to prayer and contemplation, faith and paths for seeking God and the Absolute.

- A theological dialogue, in which experts endeavour to become increasingly more thoroughly familiar with their religious inheritance and appreciate their respective spiritual values.

6.1.2 *Ethics Committees as instruments for formation*. Even though this has already been dealt with in Chapter 5 of this document, we would like to approach this issue here from the standpoint of research and formation that these committees adopt.

In the clinical field, the word 'bio-ethics' has always been linked to the idea of interdisciplinary dialogue as a method of work and, since 1978, to the usual principles of contemporary of Bio-ethics: autonomy, benefit/non-harm and justice. According to the anthropological paradigm of the human person from the Christian point of view, these principles translate into practice the principle of respect for the dignity of the person, serving the good of the patient viewed as a whole, and solidarity.

The need to protect the persons who are taking part in clinical trials or research, and the relevance and scientific soundness of the research protocol led to the institutionalization of committees with responsibility for these tasks. These are the Clinical Research Ethics Committees and the Bio-ethics Committees. In the American literature these are called Institutional Review Boards and Institutional Ethics Committees. The latter are also known as Clinical Ethics Committees. The Clinical Research Ethics Committees vary from one country to another in terms of their composition, their duties and legal status. All of them are required to comply with and ensure compliance with clinical good practice. The decisions taken by these Committees are legally binding. The members of the Clinical Research Ethics Committee must be qualified to review research projects, primarily to see that there are sufficient scientific data, pharmacological and toxicological tests on animals, to ensure that the risks that the patient undergoing the trials is likely to run are admissible, and that the patient concerned has been properly informed and is taking part in the trials of his or her own free will. Other aspects to be borne in mind are to see whether the problem that it is intended to investigate is important or trivial; whether the experimental plan proposed is appropriate for what it sets out to attain; whether there is insurance coverage in respect of any harm or damage that may be caused as a result of the clinical tests on the person taking part in the trial.

There is no doubt that membership of these Committees has a pedagogical and enriching value. At all events, wherever bio-ethics dialogue plays a major educational function in a hospital it is when actual cases are discussed on the Care Ethics Committees. These Committees are in themselves a source of training because of their multi-disciplinary composition, and because they use the methodology of information and formation. But also because of the mutual respect, the importance of the cases to be discussed, and the need to find solutions to any clashes between different values that may arise and which need to be regulated in one way or another.

The teaching function is very important. Primarily because it is a place in which the Committee members themselves receive an education. Secondly, but equally important, is that it is on these Committees that the Province plans its bio-ethics teaching for the Centres, and implements it. Interdisciplinary dialogue as a working method is necessary. Generally speaking decisions must be taken by an ethical agreement, and not merely a strategic accord. The consultants on specific cases – physicians, nurses, psychologists, must be *ad hoc* members when the Committee is deliberating to ensure that the decisions are morally binding. The composition of the Committee may vary depending upon the type of hospital involved, or whether it is a residential centre or a social/healthcare centre.

Ultimately, the Care Ethics Committees are as old as the modern collegiate consultancy system, while being as new as the recognition of the health team and patient-oriented medicine where the patient is considered to be an autonomous moral agent who does not lose his or her rights by being hospitalized. The Committees that operate properly can be effective instruments for defining the *lex artis* of the hospital with all the corresponding juridical implications that stem from this.

The Committee's purpose is to establish the system of benchmark values to be used in the event of a conflict: Christian principles, human rights, professional codes of conduct, national versus international, etc. The Care Ethics Committee must pass the consistency test as far as its decisions are concerned.

It is essential to make sure that the Committee works properly by adopting a number of different measures, one of the most important of which is the Committee for resolving on urgent cases.

At this point we would like to specify a number of particular aspects. We believe, firstly, that it is necessary to analyse the pre-requisites for reaching a sound ethical decision: a) a proper clinical history, b) professional competence for discussing the scientific aspects of the particular clinical case, and c) quality control. Having established the clinical problem and the possible alternatives for dealing with it, it is then necessary to consider the ethical dimensions referring to problems relating to quality of life, and this is done both from the professional viewpoint and from the viewpoint of the family and the patient, whose value systems must be respected. Non-clinical factors, mostly of an economic and social nature, must also be given special consideration in any medical practice which is to be holistic.

Consent by third parties, because of the incapacity of the patient, raises very difficult problems in areas such as neonatology, psychiatry, patients in a coma, mentally deficient patients, etc. In these cases, where one is dealing with extreme cases of problems, the Care Ethics Committee is particularly useful in serving a medicine of a high scientific, technical and human quality.

The training required to resolve conflicts in the field of research and clinical practice requires the following fundamentally important components: 1) professional skill and capacity to understand the problem raised from the viewpoint of the person concerned; 2) reflection upon one's own ethical attitudes and a minimum rational basis for that attitude. Here it is necessary to draw distinction between the fact itself (a consistent attitude in life between being and doing) and the possibility of conceptualization. This must be helped with a

programme to provide training in anthropology and philosophical ethics and/or theological ethics. 3) A method to resolve conflict in a climate of dialogue which does not exclude confrontation.

We are not only referring here to this last section. There is no doubt that the bio-ethical principles mentioned earlier are pedagogical tools which can be useful in the dialogue held on the Ethics Committees. The solution to problems can be focused in terms of a discussion of principles which clash and the ranking of these principles in a specific case (for example, giving priority to the principle of autonomy, or the principle of patient benefit) or a case history analysis. We consider that this is the most appropriate when discussing clinical cases.

6.2 Teaching

6.2.1 Teaching: one of the constant features of the Order. Teaching in the Order began with the Founder, St. John of God, who *allowed himself to be taught before he taught*. He studied in Guadalupe which, from the end of the 15th century, 'provided a scientific and charity-based approach with the backing of its (School) of Medicine whose quality was highly praised by modern researchers. What it provided was unknown in any other hospital in Spain at the time, and it provided both theoretical and practical lessons to students'.[(83)]
The first follower of St. John of God, Antón Martín, was extremely interested in teaching. Around the year 1553 he had the idea of setting up a 'School for Minor Surgeons' in Madrid for his 'Love of God' hospital. This was implemented by his successor, Pedro Delgado.[(84)]

'This School of Surgery was highly acclaimed and very soon it attracted those *who wished to receive training to qualify* before the "Tribunal de Protomédicos" as surgeons, who applied to practise in clinics and receive education there. The hospital in Plaza de Antón Martín was the first teaching hospital in Madrid in which medical specialities were instituted.[(85)]

As the Order began to expand, firstly throughout Spain and immediately afterwards in Europe and Latin America until it reached all five continents, it never gave up its concern for hospital education. Its teaching was predominantly oral, but also written, using an obviously practical language which was easy to understand for staff. It also drafted important manuals in different areas of medicine.
The Order brought its interest in teaching to many different Schools at different levels of education which it continues to encourage and to set up in different places to this day.

6.2.2. Teaching: an essential need today. In 1956 the World Health Organization defined the hospital as a school for medical, healthcare and researcher workers.

Since 1956 healthcare legislation in every country sees teaching to be essential. No healthcare model exists which does not devote a great deal of room to this. Teaching the things that are done day by day and disseminating this knowhow throughout the community using the many means that we have available to us, is a task on a par with treatment,

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83 JAVIERRE, José Maria *Juan de Dios, loco en Granada*, Sigueme, Salamanca, 1996.
84 PLUMED MORENO, C. '*Jornadas Internacionales de Enfermeria',* San Juan de Dios, 1992.
85 ALVAREZ SIERRA, José *Antón Martín y el Madrid de los Austrias*, 1961.

prevention and research.
Every day within the healthcare facility, teaching acts as a guarantee of quality. Indeed, if we fail to show society what we are doing through our teaching we cannot work with the vitality that others demand of us. Hence our commitment to make provision in our annual budget for our Centers for teaching purposes and our desire to work jointly with public and private entities, by being receptive to a 'teaching vocation' which came into being when our Institution was born.

Looking ahead to the future, teaching will become the responsibility of every Centre. It is the one thing which will give us credit and justify our presence in society, as a basic element of high quality care, which demands effort. A commitment to teaching or to thinking and acting in a new way, for the good of those who suffer.

6.3 Research

6.3.1 Communicating the standpoints of the Order. The care, and the technical and scientific work carried out by the Hospitaller Order has, for five centuries, provided a wide variety of excellent contributions for the improvement of health and life. John of God himself began his 'hospitaller adventure' when he went to Baeza and Guadalupe to receive training, acting on the advice of Master John of Avila. The Master, according to some authors, was a man of well known scientific curiosity, and he also knew the class of hospitals that were run in Guadalupe by the Brothers of Saint Jerome, and sent John as a pilgrim and an apprentice hospitaller in order to see how hospitals should be run.(86)

On his return to Granada, he put into practice his plan to serve the sick. Bearing in mind his contribution to care, organizing two hospitals using very advanced methods for the time, history recognizes John of God as the Founder of the modern hospital.

During the process of expanding the dynamic legacy of Saint John of God throughout time and space, the Hospitaller Brothers and Co-workers have been perfecting his methods, building up experience and enhancing their knowledge. 'One might say in general terms that the evolution of the Order reflected the evolution of psychiatry and neurology' (87)
The Hospitaller Brothers were the first to set up a hospital for epileptics in Europe.(88) From the moment they set up their first hospitals, they complemented their healing work with training and education: as early as the 16th century there is news of the first schools for surgeons set up in the Order's hospitals.(89) They also set up other schools of chemistry, pharmacy, medicine and nursing, some of which have been founded much more recently and are still operating.

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86 JAVIERRE, *ibid* p.413.
87 RUMBAUT, Ruben, D. *John of God: his place in the history of Psychiatry and Medicine,* 1978, bilingual edition (Eng/Spanish), p.115.)

88 ALVAREZ SIERRA, José. *Influencia de San Juan de Dios y de su Orden en el progreso de la Medicina y de la Cirurgia*, Talleres Arges, Madrid, 1950, p.148.
89 RUSSOTTO Gabriele OH. *San Giovanni di Dio e il suo Ordine Ospedaliero* Rome, 1969, second volume, p.124.

Outstanding Brothers, together with others not so well known, have also been physicians, surgeons, dentists, nurses, some of them outstanding examples of how to relate the charism of hospitality with a scientific and research-oriented spirit.[90]

The Hospitaller Order is an institution that has been present for centuries in the world of healthcare and social services. This is why it can and must encourage the constant quest to improve healthcare by promoting research. It must give up no area of research, but perhaps the more specific areas for the Order are comprehensive care, humanization and bio-ethics viewed from the clinical, epidemiological, management and educational aspects, both in medicine and in nursing, pastoral care, inter-face dialogue in providing services to the poor and the needy, the values of the institution in general and so forth.

Creatively studying this document, guaranteeing high quality human resources to deal with every situation, and motivating our Co-workers to enhance the innovating dimension of the Hospitaller Order which has been one of the characteristic features of the Order throughout its history, will constitute the most appropriate guidelines for cooperation.

6.3.2. Promoting research looking ahead to the third millennium. Constant progress in science and the commitment of healthcare workers, not only in providing care but also in their experimental work, make it indispensable today to promote research properly. There can be no progress in medicine unless this is preceded by appropriate and considerable research efforts (theoretical, laboratory, on animals and on man). Comprehensive care for the

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90 Fr Gabriele Russotto's History of the Order contains 73 pages of names and a great deal of documentation. The best known Physicians and Surgeons are Brother Gabriele Ferrara (Italy), Brother Alonso Pabón (Spain), Brother Bernard Fyrtram (Austria), Brother José López de la Madera (Spain), Brother Konstantin Scholz (Silesia, Austria), Brother Ambrogio Guivebille (Austria), Brother Lazzaro Nöbel (Germany), Brother Matias del Carmen Verdugo (Chile), Brother Michele Isla (Colombia), Brother Probo Martini (Germany, Czech Republic, Silesia), Brother Bertrand Schröder (Austria), Brother Norberto Boccius (Hungary, Czech Republic), Brother Manuel Chaparro (Chile), Brother Ludovico Perzima (Poland), Brother Eliseo Talochon (France), Brother Odilone Wolf (Czech Republic), Brother Giusto Sarmiento (America), Brother Fausto Gradischeg (Austria), Brother Giovanni Luigi Portalupi (Italy), Brother Benedetto Nappi (Italy), Brother Celestino Opitz (Czech Republic), Brother Prosdocimo Salerio (Italy), Brother Celso Broglio (Italy), Brother Giovanni di Dio Sobel (Silesia), and Brother Francis de Sales Whitaker (Ireland and England). The list ended with St Richard Pampuri.

Among the Pharmacists and Botanists, the most famous ones in the history of the Order are Brother Agostino Stromayer (Czech Republic), Brother Innocenzo Monguzzi (Italy), Brother Ottavio Ferraro (Italy), Brother Gallicano Bertazzi (Italy), Brother Atanasio Pellicia (Italy) and Brother Antonio Matia dell'Orto (Italy).

There are two famous Dentists: Brother Giovanni di Dio Pelizzoni (Italy) and Brother Giovanni Battista Orsenigo (Italy) who was very popular in Rome.

In Colombia Brother Miguel de Isla (18th c.) Was a physician, a Professor of Medicine and restorer of the Medical Faculty at Rosario University. In Chile, Brother Manuel Chaparro introduced inoculation that had never before been used and was unknown even in Europe, to control a devastating outbreak of smallpox which lasted from 1765 to 1772.

It is worth noting that in 1821 a pharmacist, Brother Ottavio Ferrario discovered Iodoform, even though it was attributed to a Frenchman who discovered it the same year. In 1882 Brother Ferrario was the first man in Italy to extract quinine, isolating the active components of chinchona bark.

sick and the needy necessarily requires these preliminary phases to be completed first.

Even though traditionally the Order has mainly worked by directly helping the sick and the needy, new social and healthcare events today mean that research is vital, not targeted towards ‘other’ professionals, but forming a natural part and parcel of the activities which can be performed and promoted in our existing Centers.

This is already the case, and has been for some years, to the great benefit of the sick and to the gratification of Co-workers who are fully incorporated into the international research circuits and hence participate in that ‘progress in the field of healthcare’ in which the whole of the scientific community is interested.

The main means of carrying this work out will be the following: clinical trials, agreements with research establishments, linking up with international research programmes, and providing specific and exclusive qualifications for some of our Co-workers in this area. In order to promote research more profitably, associations can also be set up with the purpose of carrying out research more organically, and in a more coordinated and inter-disciplinary manner, drawing on the support of qualified professionals who do not work in the Centre.

One particular problem is ear-marking funding. Such funding is not ‘siphoned off’ from helping the sick. On the contrary, research funding is used to provide better treatment for the sick even when one cannot immediately see the ‘return’ on the investment, because sometimes it may appear that resources that have been used may not have given the expected results immediately.

It is precisely for this reason that the Order not only appreciates and encourages experimental research in its Centres but it can also foster this research in its dealings with the entities that lawfully operate in this area as part of their institutional duties. This must be borne in mind whenever the typology of a given Centre makes it possible, when concluding contracts with governments under which part of the budgetary resources are devoted, however small that may be, to research.

For reflection:

1) What training, teaching and research programmes exist in your Centre or Province? Evaluate their implementation and effectiveness?

2) What should the Order's priorities be in this area?

   - In Formation

   - In Teaching and Education

   - In Research

CHAPTER VII

PERSONAL RECTITUDE AS THE BASIS OF ACTION

7.1 Rectitude as an existential project

7.1.1 Living in harmony with the values which constitute the person: By 'personal rectitude' we mean that moral quality of the individual whose deeds match the principles and spiritual values he professes: '*operari sequitur esse'* (*doing follows being).* This rectitude, or uprightness, demands an undivided heart, honesty and fairness in all one's doings and remaining faithful amid trials and difficulties. The upright man is the one who lives in accordance with the commandment of love of which Jesus gave us: 'Love one another as I have loved you'.

Unity of mind and heart, consistency between feeling and acting demands a fairly long process of human, psychological and spiritual maturity depending on the individual, his level of vocation to service and the generosity of his response.

Integrating action and union with God according to the charism of St John of God is a lifelong task.

If we act only, or mainly, in the interests of social utility, efficiency and effectiveness, eliminating the dimension of our witness to our love for Christ according to the charism of St John of God, we act against our rectitude and uprightness as an existential project, and our deeds and our work will no longer have the evangelizing power that they should have. If a person is upright he is upright for what he is, and not for what he says or does.

7.1.2 Man as a witness of the transcendency of love. Man's vocation is to attain the divine life: 'irrequietum est cor nostrum donec requiescat in the' *('our heart is restless until it rests in you').* The discipleship of Jesus Christ, the fulness of God's revelation, is man's path to the fulness of his self-fulfilment. Discipleship of Jesus Christ in the manner of St John of God identifying with the poorest and the needy, is the exemplary model of the Hospitaller Order.

Giving oneself unconditionally to others as a sign of the love of God demands a certain level of human and spiritual maturity: the intimate experience of God, realizing and feeling that we are loved by God and knowing ourselves and accepting ourselves for what we are, are the necessary conditions for attaining that necessary level of identity, confidence and freedom required by the apostolate. Prayer is necessary to galvanize, to unify and integrate the spiritual life and the active life.

Our experience of God's mercy towards us and his unconditional love for us gives us the measure of the relationship which we must have with the needy, helping them to build up their lives, to appreciate their dignity and to reveal to them their capacity to love. The experience of the unconditional love of God helps people to discover their vocation as sons of God.

The Gospel of Christ reveals to human beings their status as free persons called to enter into communion with God, which arouses within them the awareness of the depths of human freedom: liberation from all slavery, liberation from sin, liberation to proclaim the Gospel, liberation to grow in freedom according to the Spirit.

7.2 Conscience as the driving force of all we do

‘In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience. Always summoning him to love good and avoid evil, the voice of conscience when necessary speaks to his heart: do this, shun that. For man has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged’.[91]

‘The dignity of the human person implies and requires uprightness of moral conscience. Conscience includes the perception of the principles of morality (synderesis); their application in the given circumstances by practical discernment of reasons and goods; and finally judgment about concrete acts yet to be performed or already performed. The truth about the moral good stated in the law of reason is recognized practically and concretely by the present judgment of conscience. We call that man prudent who chooses in conformity with this judgment’. [92]

‘Man has the right to act in conscience and freedom so as personally to make moral decisions. He must not be forced to act contrary to his conscience. Nor must he be prevented from acting according to his conscience, especially in religious matters’. [93]

In the formation of conscience the Word of God is the light for our path; we must assimilate it in faith and prayer, and put it into practice. We must also examine our conscience before the Lord's Cross. We are assisted by the gifts of the Holy Spirit, aided by the witness or advice of others and guided by the authoritative teaching of the Church.

Personal and community reflection, one of whose manifestations are the Ethics Committees, can shed light on the difficult problems which evade the ethical laws in the pronouncement of the Magisterium. Professional competence, respect for and compliance with the Magisterium, and a spirit of dialogue are essential prerequisites for discerning specific courses of action to take in cases of particular conflict in which it is necessary to rank the values which are in conflict.

Since the most important ethical problems of natural law are not explicitly settled in the Bible, greater insistence must be placed on a convincing and rational basis which is not based merely on authority. Without this condition it will become increasingly more difficult for contemporary man, with his awareness of his own autonomy and responsibility, to freely give his assent.

91 VATICAN II: *Gaudium et Spes,* § 16
92 *Catechism of the Catholic Church,* § 1780
93 *Idem.* § 1782.

7.3 Conscience and moral rectitude

7.3.1 Serving the sick and needy as a 'conditio sine qua non'. The term 'servant' in the early Church community formalized and defined the status of the believer who, out of love, placed himself at the disposal of his fellow brothers and sisters. This attitude was made all the more evident by the care and attention paid by the ecclesial community to the sick and needy.

In reality the most authoritative testimonies of the past, (the oath of Asaph, the prayer of Maimonides, etc.) had emphasized the ethical commitment of service on the part of the health worker and the very idea of social/healthcare ministry is common to many ideological and cultural schools of thought. But it was in Christianity that this idea took on a wholly particular importance by reference to the ministry of Christ, the 'deacon' of the Father for man, the servant of God to serve his fellows. It was no coincidence that Policarp (end of the 1st century) called him 'the deacon, and servant of all'.

It was for this very reason that within the Religious Order that has made *hospitality* its specific charism, the dimension of service becomes absolutely essential and expresses the very *raison d'être* of the works of the Order and the interior attitude of its most committed Co-workers.

Different vocations exist in this regard, and so pluralism becomes a source of charismatic wealth, and individual existential events, states of life, and the working environment become so many opportunities and commitments to 'ministry' and service. Where professional and ecclesial commitment involves such a direct participation in catering for the existential needs of others, as in the case of the Hospitaller Order, service becomes a specific guideline for its action.

7.3.2 Degrees of personal involvement in the Order's mission

7.3.2.1 The Brothers. Obviously these are the persons most radically involved, by virtue of their religious profession. This term (*profession*) is deliberately identical to the expression used for the practice of an occupation. Both situations are characterized by three elements: the belief, openly and formally declared, in the existential reality which the Brothers freely embrace; membership of a particular social group which makes this reality its whole *raison d'être*; the commitment to express the professed reality in their lives.

The first dimension - belief - relates to the *intellectual* sphere and we might say that it is performed by 'believing in hospitality'. One cannot live and act according to the manner of St John of God so concretely embodying the charism of hospitality if we do not believe in that hospitality first and foremost. In other words it is a matter of renewing a testimony which stems from the depths of the source of one's vocation, renewed daily and reformulating daily our 'yes' to hospitality.
The second perspective - belonging - has to do with the *relational* environment, namely, the sense of membership and belonging, and more specifically the community dimension of our

lives. This is primarily the reflection of a vocation even though it does not remove the personal dimension of a God who ‘calls us by name’, while being performed within a community. Furthermore our response involves specific community membership which becomes reality. It entails a real membership of a community: as far as its being is concerned, within the organic structure of the Order, and as far as its acting is concerned, it is expressed through fraternal life and the common Hospitaller commitment.

Lastly there is the perspective of *free choice* - commitment - expressed through the profession of vows. It is necessary to emphasize once again the oblative dimension rather than the ascetical dimension of the vows, seeing them as a ‘gift’ rather than ‘renunciation’. This being so, they can stand as a *set of exemplary values to be imitated by our Co-workers*, in which they can find a dimension of communion which is far broader than merely working together. The Brother can thereby share with the laity his obedience as the acceptance of the circumstances of life in which it is possible to perceive the will of God in the events that take place there; poverty as a gift of one’s own interior assets, one’s time, intellect and heart; chastity as the offering of one’s corporeity and the specific resources of one’s very being as a man or a woman, and hospitality as the expression of outreach and service to the sick and needy.

7.3.2.2. Our lay Co-workers. We can include here all those who work in the Houses of the Order and take part as ‘externs’ in events and work promoted by the Order and thereby help them to pursue their purposes. ‘The levels of this participation obviously vary widely: there are some who feel particularly tied to the Order through its spirituality; others, on the other hand, live their participation by performing the Order's mission. But what is important is that the gift of hospitality received from St John of God should establish a bond of communication between the Brothers and the Co-workers so that it can act as a stimulus and an incentive to both to develop their Christian vocation and to be a visible sign of the merciful love of God towards men and women, the poor and the needy’. [94]

Quite apart from the faith, the Co-workers in our Centers play a decisive role in helping the centers to perform their work by becoming actively involved in their mission. They establish a relationship with the Order based essentially on work, since most of them are the people who perform the service which the centre offers to the community. In view of their numbers and the way in which they actually promote and foster the centers, they make a major contribution to the works of the Order without seeking a deeper sharing of the charism, using in manners and styles which they would probably not find consistent with their own personal life situations. But out of respect for their choice of values and without attempting to bring pressure to bear on their own consciences, it would be appropriate to provide them with all the instruments they need so that they can embark upon a path which, in time, will be able to lead them to freely take on a more direct involvement in the mission of the Order.

Our most sensitive and committed Co-workers who wish to fully share the mission of the Order can certainly say that they participate in the charism of St John of God which encompasses them and lives in them and is spread within them no less than it is within the

94 GENERAL CURIA, *Brothers of St John of God and Co-workers together to serve and promote life,* § 116.

Brothers. It is precisely for this reason that we can also establish particular forms of associations with these Co-workers recognized by the Church and more directly expressing witness to the Hospitaller charism in the secular way of life, thereby contributing to performing and revitalizing the Order's mission. In this perspective, collaboration between Brothers and the Co-workers is no longer a haphazard and spontaneous affair, but makes is all fully integrated institutional members of the life of the Order.

This is very strongly felt at the level of the Universal Church today: ‘Today, often as a result of new situations, many institutes have come to the conclusion that their charism can be shared with the laity. The laity are therefore invited to share more intensely in the spirituality and mission of these institutes. We may say that, in the light of certain historical experiences such as those of the secular or third orders, a new chapter, rich in hope, has begun in the history of relations between consecrated persons and the laity.’(95)

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95 JOHN PAUL II, *Vita Consecrata*, § 54.

For reflection:

1) What resources are we using to promote this personal Integrity?

2) What other resources should we be using?

CHAPTER VIII

CREATING THE FUTURE WITH HOPE

8.1 The challenges of the present

When reflecting on the future, and more specifically on the relationship between creativity and temporality, we must take note of and resolve one contradiction: the time that we wish to examine is not an abstract and distant mental space, but it is our very present.

It is the age in which we live that prepares the way for the future: it is in the values upon which our witness is founded that the seed for the future is to be found. Because commitment and witness must not be continuously pushed forward to some hypothetical future which would continuously relieve us of the duty of taking on our present responsibilities.

We have to enter the new millennium with the vocational and prophetic courage to take on new roles and to bear new forms of witness. (96) In the world of Hospitality, hope as the enunciation of salvation can only create a possible future if, as a result of it, healthcare structures are created which are able to take in contemporary suffering man. Creating means instituting and promoting processes that are able to make time fruitful, so that it can produce initiatives that are faithful to the Will of God and to the signs in which this Will is manifested in time.

Being creative in hospitality means generating and constantly bearing witness to a living, productive and constructive love for our brothers and sisters in pain; constantly stopping *to plan and think out* the future without creating something NEW might place the Order outside history.

The epoch-making changes through which we are living forces us to evaluate and then decide and concretely produce the most appropriate responses stemming from growing cultural pluralism, the human rights movements, population ageing, the increase in old and new forms of poverty, the desire for peace and the decline in available financial resources to defend the welfare state.

As stated elsewhere in this document, bioethical dialogue is essential as a parameter by which we can guarantee that we shall act correctly as religious and as professionals, precisely because it imposes a more universal point of view to our behaviour and to our decisions, designed at all times to promote the humanity of man.

Man, as the witness of St John of God demonstrated, is not an insignificant object in the panorama of nature, but an original vantage point from which to oversee the whole of creation.(97)

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96 We can find a first approach here in the document *The Hospitality of the Brothers of St. John of God towards the Tear 2000* which was submitted to the Brothers in April 1987.
97 See 2nd *Letter of St John of God to the Duchess of Sessa*.

In order to bear witness to the future horizons of our hospitality we must more thoroughly consider the demands of needy humanity, linking the ethical and the spiritual to a coherent anthropology.

Today, our task as Brothers and Co-workers is to be prophets of hope, prophets of the dignity of those who suffer, prophets of love which is often snuffed out by technology and by the laws of the market, which have penetrated the world of healthcare.

In the past, in many circumstances, we have replaced or anticipated the sphere of government authority. Today we must enter this sphere and the organization of the market with the culture and the spirit of St John of God, to defend the poor, the old and the chronic sick. The Order must lay follow a path which will translate into practice the social teaching of the Church, using competent technicians, who will leave scope for the creativity of love and the spirituality of the Order.

All this could lead us to rethink the Order's presence in certain specific Centers, but at the same time it will perhaps lead us to a *refoundation* at the dawn of the new millennium.

Creating the future means entering like leaven into the dough of humanity, refusing to remain silent observers on this side of our tiny windows, behind which we often imagine that we are looking at the whole of the world.

We have been mandated to evangelize the world of healthcare, and we must announce to the poor that salvation is among us and is manifested through welcoming Christ in through our brothers and sisters: every act of hospitality is a sign of hope that true health, wholeness and salvation can be achieved.

8.2 The prophetic power of hospitality

In order to live in the New Hospitality we need to redesign our presence in the world of healthcare which is changing all the time, by throwing ourselves into a fast- moving process that might well destroy us, unless we define our projects and lay down adequate strategies for implementing them. It is not a matter of saving our 'works' and Centres, but of making it possible to announce the Gospel through the practice of the charism of hospitality as a service to God through the needy. After having seen so many demands for change, today we are being called to go further than change alone: we must trigger off a process which will eventually enable us to 'reinvent' ourselves, and reinvent hospitality.

If we sit back waiting or trying to be 'perfect' in this process of change, it means that we have failed to hear God who is thinking of us in our personal history and not only in the history of our Centers. Time and the future will not play in our favour unless we know how to live boldly and fully through the present moment.

For the power of prophecy is not merely expressed in our capacity to interpret the signs of the times but above all in knowing how to move beyond the present and to 'read the future' through the eyes of God.

'... Even if renewal has not disappeared from the vocabulary of the Order and from its projects, and is being sought after by individuals and by Communities, we must emphasis more than ever before its necessity and demand the needs to achieve it'.[98]

Reflecting on renewal with a prophetic spirit brings to mind so many things on which we must carry out the work of discernment. Renewing hospitality means offering high quality services to meet human needs, to properly appraise our economic resources, to consider the demands of social justice, to guarantee the formation of the Brothers and the Co-workers, and to adjust our organizational structures.

A real effort to provide 'new formation' for our Brothers and Co-workers is an absolute priority choice that we must take. We can no longer have 'provincial' formation. It must be worldwide in scope. It is therefore indispensable to exploit the value of the experiences of all the Provinces of the Order, with cultural and pastoral exchanges for the Brothers and for the lay Co-workers, in order to receive a fresh boost, new enthusiasm, which are able to inspire a New Evangelization and a New Hospitality.

But none of this can be sufficient to produce a real lasting innovative movement of itself.

For this reason, inspired and driven on by genuine love for our charismatic service, we must not simply make proposals to correct or redress situations that are inadequate or insufficient.

We must get to the roots of the problems, challenging the very thing which we find most difficult to challenge: namely, ourselves as persons, as Brothers and Co-workers, our mentalities, the way we view our Communities, and the Centers which we animate.

The Brothers must weave a new Community fabric in which our role as 'proprietors' of the Centers is balanced against our function as 'animators'. We must therefore open up to sharing with greater conviction and with greater consistency with all those who wish to join us with closer bonds than cooperation pure and simple.

The renewal of the New Hospitality which is demanded of us, re-inventing our existence in the field of healthcare means not only redrawing the visible structures but also the invisible and cultural structures. We must think of a kind of transformation that will enable us to maintain the improvements throughout time, independently of changes in the economic or healthcare external environment.[99]

The ultimate purpose of life for the Brothers of St John of God is to make present the love and charity of Christ in their apostolate, which invites them to commit the whole of their existence to the evangelization of the poor and the sick. [100]
In the light of the New Evangelization, the Church is now urging them to ascertain:

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98 LXVIII GENERAL CHAPTER, *The New Evangelization and Hospitality on the Portals of the Third Millennium*, Bogotá 1994, §3.3, last paragraph.
99 The full weight of the suggestions contained in these words can be found on the final pages of document *The New Evangelization and Hospitality, loc. cit* § 5.6
100 *Constitutions*, § 41

- whether their apostolate has a true evangelizing value in every way in which it is expressed;
- how far the Communities are aware of their evangelizing role in their apostolic work;
- how far individuals perceive and appreciate themselves as witnesses to the Gospel;
- how far they are able to be motivated animators, rooted in the Gospel but at the same time sensitive to the human and management sciences;
- how far they have managed to harmonize the apostolic dimension with the contemplative dimension of their lives.

Lastly, it is important for them to rediscover the sense of joy that the prophet feels at having discovered the sense and meaning of his calling: ‘Yahweh, you have seduced me, and I am seduce, you have raped me and I am overcome!’ as the Prophet Jeremiah put it (Jer 20:7).

Sharing in management, witness, mission or spirituality, is essential if we are to perform the ministry of healthcare and salvation which we are prophetically announcing to suffering humanity.

We must convince ourselves through actual practice that the participatory solution involves individual persons and makes it essential to review the hierarchical system which has so often conditioned relations between the Brothers and the Co-workers and also between the Brothers themselves.

Participation must take a path which involves both the cultural and the communication aspects, and the organizational aspects, and lead towards maturing more modern relations between the hospital and the Hospitaller Community.

This means that we must all constantly look at the concrete problems of productivity, the better use to be made of technical facilities, the quality of our work and service, and our recognition that the sick are the focus of our interest. Satisfying our patients must be sought in every manner with the same intelligence, insight and constancy with which we seek to create a satisfactory working environment.

Participation can enhance the satisfaction felt by our staff and patients if it is underpinned by professional enhancement and career development, by a remuneration system which is closer to the participatory forms of management and by paying very careful attention to the spiritual formation of all and fidelity to the charism of hospitality.

But more than this and on another plane, participation means spreading information far and wide, with more interactive communication than we have managed to achieve in the past.

8.3 The human-divine vitality of the charism of Hospitality

There is no guarantee that we shall be successful when we take up the future challenges or that we shall be able to keep any successes and achievements that we make, except Man radically faithful to the Father. We can invest in everything, but if the men are not up to standard, everything will come to naught. In our convinced and integral response to the call of God we involve the whole of our being and the whole of our resources to serve humanity.

In this, the charism of hospitality becomes grace which is distributed through us to suffering mankind, and it commits us to become moral guides. Being moral guides means that we must conduct ourselves consistently in our daily lives, in performing our duties, and in all we do and propose in the course of our work as evangelizers in the world of healthcare.

Rooted in fidelity to Christ, the man-God Saviour of man, we must build up opportunities to ensure that human dignity is respected, and that the meaning and the transcendent destiny of every man is recognized.

It is here that we see the spiritual and the more specifically theological dimension of our charism. The human vitality of the charism, the *visible* aspect of our particular style, must be a manifestation of the *invisible* character of our relationship to God. From the way we recognize and stand for the figure of God, and the 'sense' of his function in history, nature, the existence of men, we determine His role in our personal lives.

The model of apostolic action that we must formulate and implement must be based on the theology of service. For if our vocational choice is directed towards relieving suffering, we must decide on the way in which we must view this task as a specific service to God. For it is written:

'When the Son of man comes in his glory ... then the King will say to those at his right hand, "Come, O blessed of my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me". Then the righteous will answer him, "Lord, when did we see thee hungry and feed thee, or thirsty and give thee drink? And when did we see thee a stranger and welcome thee, or naked and clothe thee? And when did we see thee sick or in prison and visit thee?" And the King will answer them, "Truly, I say to you, as you did it to one of the least of these my brethren, you did it to me".' (Mt 25:31-40)

But what seemed to be so instinctively close to the mentality of the early Church according to the Gospel, within which the Gospels came into being in the first place - namely the spirit of communion and the living sense of witness - is much more difficult to implement in the modern age.

Because our world view, modern culture, has led us to exclude the vital divine and transcendent dependency of earthly things.

We therefore have to review the way we think and act, so that we can transform our existence as Brothers or Co-workers to become truly 'transparent' living witnesses of the merciful love of God [101].

We cannot put off creating our own effective model of the theology of service.

The concept of service lies at the very heart of the Christian tradition.

101 *Constitutions*, § 2

In the immense complexity of contemporary society, the search for a model for the theology of service must be carried out almost in detachment from doctrinal habits, like a risky leap we are making towards inventing something new. We are all called to take a fresh approach to thinking out the fundamental and founding relationship, which is always very specific, between Christian faith and the forms of religious, political or intellectual service made to the world by Christian social practice.

It will demand fresh courage to risk taking this step forward through both doors which combines in one single movement both God, who is totally other, and man who is totally similar to ourselves. This requires a theology hinging around the hospitality of God in man and of man in man.

It is only on this risky openness and outreach, like a superb adventure, that we can found our service.

In this way, the sick, the suffering and the needy become a source of life through faith in God.

Making room for others, exercising the charism of hospitality, to a certain extent means giving our place up for them and letting them live with us and in us.

Translating these principles or these adventurous risks into practice would change and revolutionize our very being, enabling us to bear witness that could fascinate and attract young people of our age and give our Centers the very feature that our Founder wanted for his own hospital.

An attitude of readiness, but also the readiness to struggle for find a place 'for the others', in our prayers, our words, the practise of profession, in our outreach towards, care for and accompaniment of the seek and needy.

In this way, hospitality becomes the theological place where God, who has gathered us together, has always inspired acts of hospitality which make Him feel that he has been welcomed-in by men, and make Him present in the world[102].

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102 JOHN PAUL II, *Redemptor Hominis*, 1979. In this regard see also Vita Consecrata, § 73: At the service of God and man.

For reflection:

1) What current signs cause us to look to the future with trepidation?

2) What current signs cause us to look to the future with hope?