

Issue 1, 2014

Message from the International President

28 April 2014

My dear friends,

Indeed it is still the Easter season and I wish you all peace and joy.

'Peace I leave with you, my peace I give you. I do not give to you as the world gives. Do not let your hearts be troubled and do not be afraid' (John 14, 22). These were the words Jesus said to His disciples before he ascended to heaven. The world is still searching for this lasting peace in different areas.

CICIAMS has chosen the family as the theme for the forthcoming world congress. May the Holy Family, the perfect model family, challenge us to look to ourselves and to our own family life anew. We are called to rediscover the simple joys of being together as an

everyday expression through shared meals. Let us ask the question, 'what is the quality of my family life?' Let us prepare ourselves for this great event that will take place in Dublin, Ireland, where we healthcare workers as a family will meet from all over the world to rediscover the healing ministry of the Church and how each one can be an instrument of peace and joy.

I look forward to see you all in Dublin. May the Peace of Jesus our Divine Healer be with you all always.

United in Love and Peace,

Yours affectionately in Jesus and Mary,

Sr. Anne John RJM

CICIAMS International President

CICIAMS XIX World Congress & General Council Meeting 2014

Theme: Protecting Family Life: the Role and Responsibilities of Nurses and Midwives

Venue: Purcell House, All Hallows College, Dublin 9

Hosts: Catholic Nurses Guild of Ireland

Dates: Tuesday, 23 – Friday, 26 September 2013

23 September: General Council Meeting

**24 – 26 September 2014: Congress
for further information contact
ciciams@eircom.net**



web images

CICIAMS XIX World Congress

Protecting Family Life: the role & responsibilities of nurses & midwives

All Hallows College, Drumcondra, Dublin 9. Ireland

23 – 26 September 2014

PRELIMINARY PROGRAMME

Tuesday, 23 September

09.00 – 17.00 hours	Registration
09.00 – 17.00 hours	General Council Meeting
18.00 hours	Opening Mass
19.00 hours	Welcome Reception

Wednesday, 24 September **Family Life: International and Regional Perspectives**

08.00 – 09.00 hours	Registration
09.15 hours	Morning Prayer
09.30 hours	Opening Ceremony
11.00 hours	Tea/Coffee Break
11.30 hours	Protecting Family Life: International Perspectives Keynote Speaker 1: Msgr. Jean Marie Mupendawatu Secretary, Pontifical Council for Health Care Workers
12.30 hours	Keynote Speaker 2: WHO Regional Office for Europe – to be announced
13.30 hours	Lunch
15.00 hours	Protecting Family Life: Regional Perspectives Round Table Presentations from CICIAMS Regions: Africa, Asia, Europe & Pan-America
16.30 hours	Close
16.45 hours	General Council Meeting – Elections
18.00 hours	Mass
19.00 hours	upper
20.00 hours	Concert: Dublin Diocesan Choir

Thursday, 25 September **Family Life: Ethical Perspectives**

08.00 – 9.00 hours	Registration
09.15 hours	Morning Prayer
09.30 hours	The Nurse as Promoter of the Family: Ethical Challenges and Opportunities Fr Thomas Nairn OFM, PhD, <i>Acting Ecclesiastical Adviser, CICIAMS</i>
10.30 hours	Domestic Violence: the challenge Ms Reiko Joh, National President, Japan Catholic Nurses Association

CICIAMS XIX World Congress

PRELIMINARY PROGRAMME

11.15 hours	Coffee/Tea Break
11.45 hours	Faith based intervention: HIV/AIDS and Abortions Ms Justina Mooya Yamba, National President, Catholic Nurses Guild of Zambia
12.30 hours	Open Discussion
13.30 hours:	Lunch
15.00 hours	Support Structures for Families in Crisis Round table presentations from Africa, Asia, Europe and Pan-America
16.30 hours	Catholic Nurses & their Role in Ethical Decision Making Fr Anselm Etokakpan, Nigeria
17.15 hours	Close
18.00 hours	Mass
19.30 hours	Hospitality Night

Friday, 26 September

Healthy Family Life

08.00 – 09.00 hours	Registration
09.15 hours	Morning Prayer
09.30 hours	Education & Support of the Family: the role of the nurse & midwife Ms Anne McDonald RGM RM PHN MSc Community Health Adjunct Lecturer, University College Dublin
10.15 hours	The Family as Carers of the Elderly Round table presentations from Africa, Asia, Europe and Pan-America
11.45 hours	Tea/Coffee Break
12.15 hours	Catholic Solidarity in Health Care Ms Mary Farnan, National Secretary, Catholic Nurses Association of England & Wales
13.00 hours	Discussion
13.30 hours	Lunch
15.00 hours	Review of the Congress Mrs Jane C Harkin. Chairperson, CICIAMS Professional Committee
15.30 hours	Closing Ceremony
17.00 hours	Closing Mass

Languages: English. Simultaneous Spanish/English translation will be provided if there are more than 20 Spanish speaking participants.





COUNCIL OF EUROPE REPORT

2013 -2014

Mrs Isabelle Wilson represents CICIAMS at Council of Europe's Non Governmental Organisations (NGOs) sessions to which CICIAMS.

CICIAMS received an invitation to attend the Summer Session Conference of NGOs in June 2013 but because the invitation came very late it was not possible to attend or to appoint another person. In October 2013 Mrs Wilson attended the Parliamentary Assembly as an observer as it was not open to NGO's. The subjects of particular interest to CICIAMS were:

- a) Migrants and the fight against AIDS: There was a great deal of discussion on this subject due to the high number of migrants coming into Europe and the financial strain on the health services.
- b) Prohibition of same sex marriage in Croatia.
- c) Freedom of religious practices.
- d) Stepping up action against global inequalities and Europe's contribution to the Millennium Development Goals process.

Mrs Wilson attended the Conference of NGOs in Strasbourg from 20 - 24 January 2014. It was a very full and interesting conference. Many of the subjects had impacts on health care:

(i) The situation of migrants and the fight against AIDS were discussed at length. It was stated that a big problem was the lack of precise data on migrants' health throughout Europe with many countries presenting evidence that migrants are disproportionately affected by HIV due to the epidemiological situation in their countries of origin and the problems migrants encounter in accessing information and treatment in their host country. It was also asserted that those living with HIV/AIDS suffer multiple forms of discrimination and stig-

matism including denial of entry and refusal to renew residence permits in some countries. It was emphasised that Member States should have a Human Rights based approach to fighting HIV/AIDS and ensure full and affordable HIV treatment and care, and adapt prevention treatment especially to vulnerable groups of migrants including women, sex workers, men having sex with men and undocumented migrants and refugees.

(ii) Prohibition of same sex marriage .in Croatia: In December 2013 a majority of Croatian people voted in favour of an amendment to the Croatian Constitution which prohibits same sex marriage. The question sent from the conference to the committee of ministers was – does the Committee of Ministers find this amendment incorporated in a Constitution compatible with the European Convention of Human Rights and Fundamental Freedoms? If not, the question asked was how to persuade the Croatian Government to comply?

(iii) Freedom of Religion and Religious Practices: In October 2013 the Parliamentary Assembly adopted resolution 1952 (2013) on Children's Right to physical integrity in which circumcision of young boys for religious reasons is also detrimental to the physical integrity of children, although Faiths such as Judaism and Islam have been performing circumcision for centuries and still practise it as a religious rite which does not present risk to children and should be respected. Enhanced dialogue and cooperation regarding tolerance of different religious practises encouraging mutual understanding was recommended.

(iv) Combating Hate Speech: The draft decision for the adoption by the Human Rights Committee

on 29 January was debated on and the conclusions made were:

a) To include the fight against hate speech in its 2014 - 2016 programme

b) To work together with the Emergency Care Research Institute (ECRI) in preparing a General Politic Recommendation on combating hate speech for member states of the Council of Europe

c) To carry out a programme of work with a view to preparing a Civil Society White Paper to combat hate speech and prepare a Civil Society Forum, together with the media and political parties, for the purpose of launching the White Paper and drawing up a Charter of good conduct for tackling hate speech more effectively

d) To instruct its Human Rights Committee to organise the work and report it regularly.

(v) Lampaduso: There was a long discussion on the situation of migrants on the island of Lampaduso, the impact on its population and of the situation in camps there and in other countries. The Human Rights of the migrants was discussed. It was said that the residents of Lampaduso did their best but the situation was very serious as there was no hospital on the island and that medical sup-

plies and food had to be brought so resources were strained.

(vi) History Teaching: This session was interesting but nothing to do with health. The discussion was about the First World War – should it be celebrated and if so how best to celebrate it?

(vii) A Europe without Torture and Cruel, Inhuman and Degrading Treatments - what is today's reality? This was the main side event and everyone's responsibility.

It was a very lively event and was followed by a session in which young student protesters from the Ukraine gave their testimony on the riots in Kiev on what was started as a peaceful demonstration and the actions that followed. There was also a person who spoke in defence of the government. Later the students were invited to speak with the Minister of Justice.

Mrs Wilson made contact with several Catholic NGOs while in Strasbourg. These included the World Union of Catholic Women (WUCWO), the Association of Catholic Women and the Association of the Laity.





English Speaking African Region

Juliana Nwazuruoke
Regional President.

The member nations of the region have been carrying on their activities as follows:

Kenya: The executives have been meeting and planning activities in the country. They have a change of name. They are now known as Catholic Nurses Association of Kenya (CNAK) and no longer Caritas Nurses Association. They conducted field visits to Machakos, Nakwu and Narok in Ongong Dioceses. At these visits talks were given and the members were encouraged to promote the activities of CNAK among their colleagues to increase membership.

CNAK collaborates with the Kenya Conference of Catholic Bishops in capacity building and other activities. Over the year CNAK has been called as lead trainers and experts in diverse areas of family life program. It was during their meeting with the health commission of Kenya Conference of Catholic Bishops that they were informed that the Bishop Plenary has changed their name from Caritas Nurses Association to Catholic Nurses Association of Kenya.

CNAK had their Annual General meeting in Embu Diocese. They have also elected new office bearers in their branches.

Nigeria: The newly elected executive committee as part of their work plan have formed various committees to ensure smooth running of their activities. Committees on the family, ethics and midwifery have also been established to work with CICIAMS corresponding committees.



They had their Annual General meeting in Benin Archdiocese in September 2013 and awards were presented to some deserving personalities. They have paid the CICIAMS subscription on dues up to 2014.

The guild at the meeting launched their vocation magazine with international standard serial number (ISSN) 1442-8159.

The guild was invited to the Maiden Health Summit organized by the Catholic Bishops Conference of Nigeria. The Regional President, Juliana Nwazuruoke presented a paper titled Challenges and Opportunities in Catholic Schools of Nursing and Midwifery.

Conclusion: The above member nations celebrated the world day of the sick. However, they have problem getting and sustaining membership.

In Nigeria a new national chaplain to replace the retired one is yet to be appointed and efforts to get a national secretariat is still in progress.

There is still a problem in linking up with Catholic Nurses Guild of Ghana. The email addresses available are non functional.

One of the major tasks of the region is to reach other African nations.





Asian Region

Catholic Nurses Guild of Singapore

Theresa Cheong

National President & Asian Regional President

The Annual Nurses Day Mass was held on 25th August 2013 at Church of the Risen Christ followed by dinner. Our new Archbishop William Goh celebrated Mass with blessing of hands. A video report by Mrs Theresa Cheong was presented to 250 Catholic nurses who attended the event.

ACTIVITIES

Meetings: Monthly meetings were held at East Asia Institute of Management. Total number of meetings was 24 since 2012

Overseas Mission Trips: Three trips were undertaken in 2013 - Kathmandu, Nepal in June, Myanmar in July 2013 and China (Guizhou /Shanxi) in October, The Guild donated \$2500/ for this latter project.

CICIAMS Committees: Ms Nirmala Nair was appointed to the Committee on the Family and Ms Patsy Lim to the Ethics Committee. Their names were submitted in January 2013.

The Humanitarian Forum and Fair: On 10th September 2013 the forum was held at Catholic Junior College. The theme was 'One Human Family, Here and Overseas.' The Guild had a booth and Mrs Cheong was given 30seconds to showcase the Guild's role and activities.

AGAPE: The Guild accepted Caritas offer to accommodate it at the Agape Village which will be completed in 2016 for outreach activities related to health perspectives in Singapore.

HADR (Human Assistance and Disaster Relief Workshops) May 2013: Members attended the workshops and reported that the experience was both interesting as well as an eye opener.

PASTORAL CARE AND COMMUNITY PROGRAMMES

CARE (Catholic Aids Relief Effort): There were regular visits of at six to eight weeks intervals to the centre by Guild members. Lunch treats were given at each visit. Whilst gifts and bows were distributed at Christmas and Chinese New Year.

ACMI (Archdiocesan Commission of Pastoral Care for Migrants and Itinerants) Project: Health care classes were conducted by Guild members to care givers in the Church of the Nativity for the whole of 2013 with graduation in July and Dec 2013 to about 60 domestic helpers. The project is ongoing, for 2014.

ACMA (Archdiocesan Commission for Missionary Activity) LMF (Lay Mission Formation) Programme 2013: Ms Laura Tan was the Guild's representative for this programme. Mrs Cheong attended and shared her experiences at the Second Leadership Forum that was held from 5-7 May 2013 at Batam. It was conducted by Sr. Maria Lau and the theme was Jesus' Way of Leadership.



Catholic Nurses Guild of Malaysia

Francisca Malantin

National President

The 44th Annual General Meeting and Retreat was held from 22nd to 25th August, 2013 with the theme Towards Faith Commitment: nurses as God's instruments of healing.

The retreat master was Rev Fr Aloysius Fidelis. We were also honoured by the presence of his Lordship, Bishop Cornelius Sim, who is the Bishop in charge of pastoral and health care for Malaysia, Singapore and Brunei.

All groups throughout Malaysia are involved in activities in their respective parishes. Some members are Natural Family Planning teachers; some are involved in pre-marriage courses.



Japan Catholic Nurses Association

Reiko Joh

National President

The Catholic Nurses Association of Japan (Osaka Region) collaborated with the Japan Catholic Medical Group Association for its 2nd General Meeting. A booklet *Budo Hakush : The Grape and the Grape Vice*, A White Paper (General Editor Joseph Mitsuki Takami, Archbishop of Nagasaki) was distributed, and an address was given by Ms. Reiko Joh, National President, covering the Commandments, Gospel and Agape, and also included the CICIAMS meeting held in Zambia. The Kagoshima Regional Head, Ms. Seiko Matsumura, spoke on Facility for life ending. The Tokyo Region, Sr. Prof. Taeko Higashino presented her Spiritual Support based on a thesis with Prof. Nishiyama of Sophia University. The Nagasaki Region, Sr. Hiroko Ishioka (Director, Saint Francis Hospital) spoke on Spiritual Care of Priests in Hospice.

The Japan Catholic Nurses Association (JCNA) with Sendai regional officers held a general meeting in Sendai in October on the theme Reconstruction after the disaster and the spirit of life sharing. The keynote speech was by Rev. Hiroshi Katayanagi, The Glow of Jesus and the Heart of Nursing as learnt from Mother Teresa. The speech was recorded and uploaded onto You Tube by a Divine Word Father for all to see and hear. Another keynote speech was by Dr. Harutsugu Yamaura Experiencing the Super Tsunami. A symposium was held by Catholic nurses caring for patients of the disaster. The theme was based on the wish of Pope Francis Eternal Life is the source of Hope. It is the light to shine on our lives. We wish to show the Eternal hope of Jesus Christ to all people includ-

ing non-baptized students, clients and families. An Archbishop of Zambia expressed his message in the CICIAMS meeting on love, dedication and the role of Catholic nurses leading people to baptism.



JCNA Regions

Sapporo: Faculty of Tenshi University is a member including Tenshi Hospital Nurses and all are supporting the Catholic activities. The University Festival held a bazaar for disaster aid. Rice also was sent. Missionary activity was held. Our consultant priest, Fr. Ken, supported our activity with his nursing knowledge and qualification.

Sendai: Supported the general meeting. It continues aid for disaster victims in temporary facilities, including listening to people, blood pressure measurement, health consultancy, hand tapping, siding support, distribution of aid goods and clothes.

Niigata: Aid and support for disabled people were given at a parish meeting at the centennial Mass in Niigata diocese. We served with parish churches for Christmas, health and care consulting.

Map from the Web

Tokyo Region: A lecture was given at the Board Meeting by Advisor Priest Fr. Valentine

D 'Souza. Joint meditation was held with JCMA, a Christmas Party and seminar cooperation. We joined in the seminar at JCMA. A newsletter was issued. Ms. Nishimura, regional head, addressed the NPO Rescue Dog Association on dementia patients. (The present dementia population of 4,620,000 is a big issue in Japan.) We are preparing for our 2014 Tokyo General Meeting. The Theme is The Meaning of Life in Prayer, Joy and Grace.



Yokohama: The 150th Anniversary Mass, rescue activities, and a meditation assembly were held. Ms. Yae Ibuka is the first president of JCNA. It is meaningful to look back to the start of the activity. A general meeting is expected in 2017.

Nagoya: Members carried out voluntary activities in disaster areas and served as a rescue group at memorial events. The group further served as rescuers for events and counselling for parents and their children at St. Teresa Kindergarten. The group visited the memorial house of Chiune Sugihara, a Japanese diplomat who saved refugees from Europe by issuing transit visas. He is called the Schindler of Japan.

Kanazawa: Supported distressed families by consulting with mothers at kindergarten.

Kyoto: As the result of great effort, the number of members increased. The age-range is now larger. Many members were advised to attend regular meetings and lectures.

Osaka: This group had a bazaar with 80 cakes and 600 madeleine cakes. The bazaar was held on the following day of the seasonal bonus at the Gracia Hospital. Everything was sold out in one hour. Proceeds went for the activity of the Nurses Association. Communication is vital for stronger life.

Himeji: Members along with Maria Hospital supported street residents in Kamagasaki. The carried out blood pressure checks, meal service, and gave food for 700 to 1300 people, blanket, candies, and tissue papers with the vegetables from the monastery.

Hiroshima: There is no Catholic Hospital in this region. Ten members work for hospitals and other facilities and rescue

work with the diocese. They are now preparing for the 2015 General Meeting. 2015 will be the 70th anniversary of the atomic bombing. The General Meeting theme is Catholic Nurses and their direction

Takamatsu: Monthly meetings are held to discuss the gospel with Liturgy. Members visit the sick in hospitals. And provide rescue service for church.

Fukuoka: Rescue services are provided for the diocese. Members undertake study on spiritual care bi-monthly with their Advisor, Fr. Kippes.

Nagasaki: In January 2013 a lecture was given by Archbishop Takami. The members studied Gospel and Life. In February 2013 a Rescue Service for 26 Martyrs Memorial Mass was held.

Oita: In May, Lourdes rescue service was held. Blessed Kibe Festival and children's assembly was held in July and in October 2013 there was an Oita joint meditation assembly with Fr. Hayashi.

Kagoshima: For two decades, the region has held health check services for priests and faithful of nearby churches. Now, care is given to people of advanced age including those with dementia. Young people are needed for driving assistance as the nurses are getting older. Ms. Muramatsu, chief member, spoke on Care of the Dying Person. Issues are how to lead patients to Jesus, and how to assist with consoling families in bereavement.

Photos from the Web



NEWS FROM EUROPEAN REGION

Isabelle Wilson
Regional President

There were no meetings of the European Region during 2013.

There are only six paid up Member Associations in the region and the following are verbal reports:

Croatian Catholic Society of Nurses:

After CICIAMS Executive Board very unfortunately had to cancel the World Congress, the Croatian Association is still active and held their National Conference in the summer. One of their members will be a speaker, sponsored by Catholic Nurses, Midwives and Health Visitors of Scotland, at the World Congress in Dublin.

The Association of Catholic Nurses of England and Wales are 65 in number and are very active in holding study days for Catholic nurses and retreats for members.

Associação Católica de Enfermeiros e Profissionais de Saúde (ACEPS), Portugal: In spite of several attempts no contact was made with this association but am happy to report that they may be in Dublin for the World Congress.

Catholic Nurses Guild of Ireland:

Having offered to host the World Congress in Dublin in September 2014 the Nurses Guild of Ireland have been extremely busy organising what will be a great event. They are to be congratulated and best wishes are extended to them for every success and our extreme gratitude for undertaking this onerous task.



VERENIGUNG DE FRAUENORDEN KONGRATIONS OSTERREICH

(Austria):

There has been no contact from this association. Catholic Nurses, Midwives and Health Visitors Guild of Scotland: This Guild has very few members but are very active. There is only a National Guild because of the few members but bi-monthly meetings are held with very interesting speakers. An annual retreat is held and there is an annual Mass for the Day of the Sick and a Mass at the National Pilgrimage Centre at Carfin to which all nurses and carers are invited.

It is hoped to have a meeting during the World Congress and all European associations will be contacted.

2014 will be an exciting year for CICIAMS when there will be a General Council Meeting before the World Congress and there will be elections for various positions including the Secretary General so it is hoped that all associations will respond with favourable outcomes.

TRANSFORMING HEALTH CARE THROUGH THE POWER OF CATHOLIC NURSING

BRO. IGNATIUS PERKINS, OP, PhD, RN, FAAN, ANEF, FNYAM, FRSM



BRO. IGNATIUS PERKINS, OP,

Professor and Dean, School of Nursing;
Aquinas College, 4210 Harding Road,
Nashville, TN

(PAPER PRESENTED AT THE NATIONAL ASSOCIATION OF
CATHOLIC NURSES -USA CONFERENCE (MARCH 2013))

OVERVIEW

Today's health care environment is becoming increasingly overwhelmed by an ethical paradigm of moral relativism fueled by the collapse of the citadel of ethics and the erosion of a moral compass, high technology, financial algorithms, and the governmental encroachment on the free exercise of one's conscience and even the freedom of expression rather than on the dignity of the human person who is suffering and sick and in need of healing. An informed review of the emerging regula-

tions of the Patient Protection and Affordable Care Act, approved in January 2010, fraught with obligatory rules that violate the freedom of conscience, the exercise of religious liberties, the requirement for faith-based organizations to follow the law regardless of their mission and core values, and the use of an Independent Payment Advisory Board (e.g. the Death Panel) are only a few of the threats to human dignity and the healing relationship now memorialized in this law. Ironically, yet unknown to most Americans, the ACA does not now nor was it ever intended to guarantee a basic level of health care for Americans.

The epidemic and exponential influence of these forces on the current health care delivery system has led to the systemic violation of the dignity of the clinician (and ultimately that of the sick person), created moral distress, and alienated persons from receiving needed care, oftentimes resulting in the collapse of the healing relationship. Guided by the teaching of the Catholic Church these violations can be addressed and corrected by applying the Church's moral tradition in health care and by reaffirming the principle of human dignity and freedom as the moral center of the healing relationship between the person who seeks hope and healing and the clinician who promises to care and to heal. This work, protecting human dignity and freedom of all persons, remains at the critical center of the Church's health care ministry and the New Evangelization.

Though health services in the United States and the current state of the global economy are experiencing draconian threats to the integrity of our present system of health care, there are critical moral issues that first must be ad-

dressed if health care reform is to be achieved, sustained, and fulfill the call for the common good and answer the question “who do we really care about.” Are we willing to actively advocate for positive changes that will ultimately protect our most vulnerable brothers and sisters among us – the unwanted and the unloved in our midst?

Threats to Human Dignity and Dehumanization

While systemic changes in health care financing and alternatives to the current formulas for the just and equitable distribution of finite resources from acute care to preventive care have been identified as critical variables in the economic recovery and stabilization in the United States, the intrinsic dignity of the human person who seeks healing and hope in the moment of illness and death, is rarely considered. An even more appalling finding when reviewing mission, vision and value statements of many health care service organizations in the United States is the absence of any obvious reference to human dignity and human freedom as the foundational and guiding principle for the work of these organizations.

In recent years, there has been a growing moral shift from a focus on the person who is sick to a focus on diseases. Within this moral shift, health care services often commodifies the human person through statistical formulas, disease aggregates, and financial algorithms in reducing use of health services and a rapidly growing technological imperative rewarded by sentinel advances in expensive health care technology which fail to serve the most needy persons in the United States.

As we know, the present US health system is currently driven by an economic ethic, rather than a moral ethic. Commonly referred to as

managed care, but more accurately described as managed cost, this system selectively influences and governs choices of who will receive care and treatment. This system has more to do with establishing profitable cost-benefit ratios rather than assuring moral choices that promote and protect vulnerable human life regarding care and treatment of both the person who is sick and the clinicians who provide care. As a result, the dignity of both the patient seeking healing and hope and the clinician who has promised to help and to heal is compromised leaving both dehumanized. The special charism that links the patient with the clinician in a covenant of trust is compromised.

I have written elsewhere that the phenomenon of dehumanization is fueled by an ethical paradigm of moral relativism that espouses a set of personal and subjective standards that are applied independently, and at times arbitrarily, in each situation resulting in the complete absence of a universal set of standards, moral norms or principles that are consistently good or evil regardless of circumstances. This prevailing ethical paradigm abolishes the intrinsic dignity of the human person, vitiates the person's autonomy and freedom to exercise the conclusions of a properly formed conscience and the right to make informed choices grounded in the natural law and Church teaching. Moral relativism categorically dismisses any moral codes that identify moral absolutes that are unchangeable and ought to be binding upon all persons.¹

Concomitantly, the dehumanization of the nurse occurs when the promise made to the person who is sick through a covenant of trust,

1 I. Perkins, “Dehumanization of the Clinician, The Demise of the Healing Relationship,” *The National Catholic Bioethics Quarterly* 8.3 (August, 2008): 479-490.

the moral center of the healing relationship, has also been vitiated, resulting in the collapse of this relationship. The patient and nurse become strangers to one another. The relationship becomes an encounter between a disease and a technician.

Dehumanization in health care is the result of multiple causes, for example:

the relentless pursuit of technological competencies and the diminution of interpersonal communications;

indifference to or abandonment of the virtues of human caring and the promotion of human flourishing of the sick person;

education programs for health professions that focus largely on the science and treatment of illness and disease and minimizes the importance of re-establishing and re-affirming the integrity of the person and families devastated by a terminal illness;

unbridled economic competition to produce quantifiable rather than qualitative outcomes at less cost;

clinical outcomes that reward the commodification of health care;

treating the sick as data in actuarial algorithms;

behaviors in clinical practice that compromise human flourishing through unsafe and inappropriate health care services;

allocation of health care resources and treatment decisions which discriminate on the basis of illness, age, color, station in life, ability to pay for services;

moral distress, moral malaise and the disappearance of relationships among patient and clinicians;

dubious informed consents in questionable research protocols, unreported clinical errors, accidents and deaths; and

questionable truth telling, deception, risk of loss of employment as a result of reporting unethical practices, and civil litigation and threats to the free exercise of an informed conscience.²

We are confronted with threats to human dignity through euthanasia, physician-assisted suicide, malnutrition and under-nutrition, assisted nutrition and hydration, persistent vegetative states and post coma unresponsiveness, in the terminally ill, the mentally and physically challenged, those stigmatized by cancer, AIDS, substance use, those who have had abortions, women, children and the elderly, persons of color, the homeless, minorities, single parents, and the list goes on and on. At some point in our own history you and I may be on a similar list of the marginalized, victims of an ethic of indifference - persons who are invisible and who no longer matter in life.

Regardless of the reason for illness or the absence of decisional capacity, a living person is never less than fully human. If the doctrine of human dignity is only casually applied in caring and treating persons who are seriously ill, how are we then to care for those who are victims of discrimination, stigmatized and marginalized because of life style, color, ethnicity, age and reason for their illness who have the capacity to speak but whose voices remain unheard. Those who ask us for hope and healing number in the hundreds of millions. Their human dignity is at risk every day. They live a lifetime in a culture of vulnerability.

The just and moral allocation of health care services built on the respect for the dignity of the human person in the current culture is a daunting challenge. The influence and insidious power of the technological imperative in health care, profitability in health services, the creep of utilitarian and impersonal ethical paradigms which influence health care decisions,

2 Ibid. 481.

escalating costs of health care, remains an ever present threat to human dignity. The appropriate development of a moral conscience both in those who are sick and clinicians who have promised to help and to heal them is also compromised in this culture. Such a culture selectively and exclusively affirms some persons while it discriminates against others because of their socio-economic status, their age, color, ethnicity, gender, diagnoses or station in life. Health inequities in the distribution of health services (e.g. cardiac care for black women and men and white women, persons with AIDS, unexpected deaths of African Americans) unemployment, poor housing, and gender, color and class discrimination all contribute to the violation of human dignity. Are not these weapons of mass destruction? We do not need to look to other cultures for such instruments and systems that annihilate human life across the continuum of human life.

The application of the doctrine of human dignity requires clinicians and all others who participate in health care decisions to continually re-examine the direction of their moral compass and focus on the question “who do we really care about?” How this challenge is embraced and applied in light of caring for persons diminished in any way by reason of illness, will speak loudly about how we are willing to care for one another and, indeed, ourselves.

Reclaiming the Dignity of the Human Person in Health Care

In response to these growing threats three integrated strategies are offered, namely: (a) the moral formation of the nurse; (b) the development of intentional communities of support among nurses; and (c) the implementation of the healing relationship model in clinical practice. While time does not permit a more thorough explication of these strategies, I have written about them in detail in the *National*

Catholic Bioethics Quarterly (Vol. 8(3), August, 2008, 479-490).

These strategies by no means are meant to be the exclusive responses to address the challenges facing clinicians and our healthcare delivery system. These strategies however, grounded in the natural law, are linked with the centuries-old moral tradition of the Catholic Church, and offer the best hope to respond to the culture of moral relativism that, unless removed from our world’s current practice and ethical frameworks, will see the continuing erosion of the doctrine of human dignity and the exercise of freedom of conscience which belongs to every person who has ever been born.

Explicating the Church’s moral tradition and the principles that guide ethical decision-making in health care for clinicians is essential. However, in the absence of a solid grounding in the philosophical, theological and anthropological understanding of what it means to be a human person and in the formation of conscience, the presentation of the Church’s moral tradition in health care alone is not likely to provide an enduring foundation for clinicians to respond to the ever growing array of ethical issues which will continue to confront us in clinical practice.

The doctrine of human dignity and the centuries-old moral tradition of the Catholic Church remain the consistent foundation and benchmark for the moral re-construction of health care. The writings of Pope Benedict XVI indicate that much foundational work remains to be accomplished in providing the infrastructure for human dignity and human freedom to flourish in the current cultures of our global world. Such work is vitally important in the early educational formation of students, but especially in programs for the healing professions such as for physicians and nurses.

Catholic Nursing: Preferential Option for the Human Person

Effecting global and systemic change to reaffirm the dignity and freedom of the human person and those who care for the sick necessitates a radical paradigm shift. The three strategies presented in this paper are offered from the optic of a clinician who has for many years worked at the bedside of the sick, the dying, and the unloved and those who care for them.

As nurses committed to the Catholic health care ministry, we are the privileged inheritors of a centuries-old moral tradition which has proclaimed its historic commitment to the dignity and freedom of every person since the time Christ walked among lepers and the despised of his own time. The work of the initial and continuing formation of our colleagues in caring aimed at reaffirming their own human dignity and freedom, and that of those entrusted to their care, enhancing a healing relationship with the sick while working for positive change in health care systems, must engage a new prophetic if these efforts are to bear fruit and be sustained. This work is centered in the Church's teaching mission and the New Evangelization, not simply to teach but to proclaim Jesus Christ by one's words and actions, that is, to make oneself an instrument of his presence and action in the world.³ We as Catholic nurses and others of good will who collaborate in the Church's healing ministry are authentic ministers of the Gospel.⁴

The Catholic health care ministry is often

3 Congregation for the Doctrine of the Faith. *Doctrinal Note on Some Aspects of Evangelization*

(December 3, 2007)

4 U.S. Conference of Catholic Bishops, *Co-Workers in the Vineyard of the Lord* (Washington: U.S.

Conference of Catholic Bishops, 2005).

the only one, but the authentic voice speaking on behalf of the unborn, the sick, the dying, the abandoned, and those who care for them. It is a privileged ministry that is perpetually joined with the Church especially as it accomplishes its Christian vocation and its mission in responding to all persons who are unwanted and unloved, those brothers and sisters of ours who live in families, in communities and in societies and under oppressive situations that crucify humanity, in its flesh and in its unity.⁵

As a model of Christ's life and messenger of his words, we as nurses have been gifted

and commissioned to embrace the promise to care that is an authentic encounter with Jesus Christ. The care of the sick, the highest form of the *Imitatio Dei*, when viewed in partnership with Jesus, the author of all life, is a very special privilege in the stewardship of creation because it cares for the human person, the summit of God's creative act: nurturing the life that is in them, easing the pain that diminishes them, and accompanying them in their ultimate journey.⁶

Through the powers entrusted to each of us, let this noble work of reforming America's health care system begin. The question "who do we really care about" must include:

individuals, broken families, all social and ethnic communities

the woman who is homeless, unwanted and unloved;

the student who is dying from AIDS

young parents who must decide whether to

5 T. Radcliffe, *Sing a New Song: The Christian Vocation* (Springfield, IL: Templegate Publishers, 1999):242

6 I. Perkins, *The Physician in the Moment of Grace*, *Ethics & Medics* 33.9 (September 2008): 1-3.

carry their unborn child to full term or have an abortion;

the children of our streets;

immigrants and the undocumented

exploited persons and victims of human trafficking;

health care administrators and legislators who fail to be responsive to the poor;

the prisoner filled with rage who is difficult to love

- the family caring for a parent with Alzheimer’s dementia who seek relief from a mind entombed, and
- our clinical colleagues who have lost the gifts of the healer;

As privileged caregivers let us continue this ministry of healing and hope so together we can engage our society and its diverse cultures and evangelize them. In the words of Pope Benedict XVI let us work together with all persons of good will to become “prophets of this new age, messengers of His love, drawing all people to the Father and building a future of hope for all humanity”⁷ where human dignity, freedom and human flourishing will be assured, affirmed and protected.

Our mission of compassion, and caring is clear: caring for one another is an obligation to be embraced, never a problem to be endured. Through our caring with compassion in the context of the Christian community we bring the healing ministry of Jesus Christ to one another. The ministry of healing is a prophetic witness and an authenticating sign of what we proclaim by word of mouth.

As Catholic nurses and as members of the Christian community, we as healers have the power to embrace and overcome any obstacles to the fulfillment of

7 Pope Benedict XVI, *Young People Build a Future of Hope for All Humanity* Closing Homily, World Youth Day, July 20, 2008 (Rome, Italy: Vatican city: Libreria Editrice Vaticana: http://www/Vatican.va/holy_father/benedict_xvi/homilies/documents/hf_ben_xvi_hom_2008).

this most noble Promise. The late Joseph Cardinal Bernardin, in his pastoral letter on health care, *A Sign of Hope*, wrote:

We are called, indeed empowered, to comfort others in the midst of their suffering by giving them reason to hope. We are called to help them experience God’s enduring love for them. This is what makes Christian healthcare truly distinctive. We are to do for one another what Jesus did: comfort others by inspiring in them hope and confidence in life. As God’s ongoing, creative activity in the world and the love of Christ make it possible for us to continue to life despite the chaos of illness, so too our work in the world must also give hope to those for whom we care. Our distinctive vocation in Christian healthcare is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give to those who are ill, through our care, a reason to hope.⁸

The care of the sick and those who care for them, entering the heart of Jesus’ special that is in our patients, easing the pain that diminishes them, and accompanying them on in their ultimate journey.⁹

May God protect each of us in every caring moment as we embrace His sick and fulfill our promise to preach God’s love, to care for the sick with compassion, and to bring hope and healing to those we love and those whom we have promised to care. Lets us embrace a new paradigm of nursing care that consists of human dignity, compassion, vulnerability, presence and human flourishing and apply it in transforming health care through the power of Catholic Nursing.

In this privileged experience of human caring entrusted to us, remember:

- in the quiet time of your life contemplate what God wants for you, your colleagues and your patients;

8 ⁸ Bernardin, J. (1995). *A sign of hope*. St. Louis: The Catholic Health Association of the United States

9 ⁹ Casey, J. (1991). *Food for the journey: Theological foundations of Catholic health care*. St. Louis: The Catholic Health Association of the United States.

- take time to listen to the sick – only they can tell you of their experience of being ill, of their hopes and dreams forgone;
- take time to care for one another with the same passion you care for the sick;
- share your narratives of care with other clinicians;
- do not assume that you can or must respond alone to the complex needs of others – on one expects this of you;
- have the moral courage and fortitude to bear the sufferings of others and to accept their stigmata in their journey toward Calvary;
- above all things remain faithful to your promise to care and to heal even in spite of the forces that would have you do otherwise;
- establish supportive partnerships with other clinicians;
- even if you are alone do not be afraid to defend your position in defense of human dignity and the freedom of conscience and your commitment to professional practice;
- advocate for yourself, your colleagues and your patients;
- remain vigilant in protecting the moral center of the healing relationship;
- create care environments that promote human dignity and flourishing;

As you view this presentation, Listen To Me ¹⁰ reflect on your many encounters with colleagues,

10 Perkins, I (2009). *Listen To Me An Invitation To Care and To Heal (PowerPoint Presentation)*

patients and families. Recall these caring moments:¹¹

- I will hold your hand;
- I will dry your tears;
- I will stay with you until your fears subside;
- Never will you be alone against the night;
- Gently, ever so carefully, I will walk the sacred journey with you;

Through your experiences of pain, of hope and of healing I will be with you, to bear your burdens, to ease your troubled heart.

11 Landry, C. (1999). *This Sacred Journey in Gentle Sounds 4 (CD)*. Portland, Oregon: OCP Publications



World Health Organisation

Mrs Isabelle Wilson, CICIAMS Representative to the World Health Organisation (WHO), attended the 66th World Health Assembly from 20th to 24th May 2013 and the 134th Executive Board Meeting from 20th to 25th January 2014.

Report from 66th World Health Assembly

The first day was largely taken up by the electing of the chairpersons of the various committees and of the plenary sessions, and the address of the Director General, Dr Margaret Chan. Dr Chan recalled 10 years ago the Assembly met under a cloud of anxiety due to the outbreak of Severe Acute Respiratory Syndrome (SARS). International Health Regulations were extensively revised which gave the world a greatly strengthened legal instrument for detecting and responding to public health emergencies including those caused by new diseases.

Two new diseases were identified:

Human infections with a novel corona virus, from the same family as SARS, were first detected in the Eastern Mediterranean Region. Forty one cases were identified of which there had been 20 deaths. Although small in number human to human transmission has occurred and health care workers have been infected.

China reported the first ever human infections with the H7N9 avian influenza virus. More than 100 cases were confirmed in the first three weeks. Numbers dropped dramatically due to the closure of live bird markets. China responded quickly collecting and communicating a wealth of information and collaborated quickly with the WHO. Human to human transmission is negligible at present.

It was stressed that a high level of vigilance is essential to alert people to the threat from emerging and epidemic prone diseases

The Director General emphasised that investing in the health of the people is a smart strategy for poverty alleviation. This calls for inclusion of non communicable diseases and for continued efforts to reach the health related Millennium Development Goals. Dr Chan assured everyone that the effort to reach these goals had been accelerated in the previous 1,000 days especially in the health of women and children.

An integrated action plan for the prevention and control of diarrhoea and pneumonia was released by WHO and UNICEF in April 2013. The plan focuses on 15 highly effective interventions, each one saving the lives of and revolutionizing child survival. The newest vaccines and best antibiotics are included as well as time tested basics like breast feeding, good nutrition in the first 100 days, soap, water disinfection, sanitation and the trio of oral re- hydration, salts and zinc, and ingenious efforts by front line worker to reach the most at risk poor and hungry children.

Over nine million people living with HIV/AIDS in low and middle income countries are seeing their lives prolonged with improved antiretroviral therapy with prices dropped dramatically and regimens became safer.

The efforts to stimulate the development of new medical products are critically important for every country. For tuberculosis and malaria recent progress is encouraging but threatened by the spread of resistance to mainstay medicines. Few replacements are in the pipeline and medicine is progressing towards a post antibiotics era when common infections will kill once more.

Not one single country has managed to turn around the obesity epidemic in all age groups. Prevention must be the corner stone of the global response as the Political Declaration of the High Level Meeting of General Assembly on the Prevention of Non Communicable Diseases clearly states.

We are living in deeply troubled times of financial instability, food shortages, political insecurity, changing climates, times of armed conflict, hostile threats among nations, acts of terrorism and mass violence, and violence against women and chil-

dren. Insecurity and conflict endanger the health of large populations.

A focus on universal health coverage continues with the strong emphasis on equity and social justice, and everyone must be committed to this goal.

There was long debate on WHO reform which will continue for a long time. Mrs Wilson attended sessions on:

Preparedness - surveillance and response:

Implementation of the International Health Regulations (2005)

Pandemic influenza preparedness, sharing of influenza viruses and access

to vaccines and other benefits

Smallpox eradication- destruction of variola virus stocks – worldwide eradication.

Poliomyelitis and the intensification of the global eradication initiative.

Hepatitis

Antimicrobial drug resistance as described by the Director General.

Mrs Wilson attended a side event “Securing the Future- Saving the lives of women and children”. A question was asked – why focus on women and children?

287, 000 women die due to complications of pregnancy and childbirth each year

2.7 million still births yearly

6.7 million children die before their 5th birthday

3 million babies die in their first month of life

2 million infants die between 1-12 months

Graphs were shown on trends in maternal mortality and causes of maternal deaths and trends in under 5 years of age and neonatal mortality. Also shown was the UN Commission on Life Saving commodities for women and children, human resources – a critical component of commodities provision and also connecting different work streams.

Mrs Wilson met with Ms Annette Mwansa

Nkowane, Health Policy and Services Department and discussed CICIAMS collaboration document with her. Mrs Wilson also met with Monsignor Robert Vitillo, delegate for the Holy See and an expert on HIV/AIDS

Report from 134th Executive Board Meeting

The first morning was as usual taken up with the election of the chairpersons of the various committees and the report of the Director General. There were a record number of participants which proved to Dr Chan the high level of interest in Global Health.

The Director General said that her report would be brief due to the number of items on the agenda (N=67) and 17 resolutions which had to be debated and put forward to the World Health Assembly. Dr Chan stated a lean, effective and flexible WHO must be strategic and highly selective in the work it undertakes. An outstanding performance in a limited number of high impact areas rather than a full menu approach that dilutes our energy and resources is necessary. Everyone is aware that some new challenges, especially those driven by the globalisation of unhealthy life styles, can only be addressed through collaboration with multiple sectors including some industries. The G8 Summit in 2013 on dementia made it clear that some major and costly health problems have virtually no effective interventions for their prevention, early detection or cure. The Director General stated that only 81 Member States regularly submit usable death data with only 34 submitting data of high quality.

The world again faces simultaneous humanitarian crises. There are 4 at present – The Syrian Arab Republic, South Sudan, The Central African Republic and the Philippines, which are testing the WHO's emergency performance in a highly visible way.

Dr Chan asked for continued vigilance as WHO continues to monitor sporadic cases of MERS corona virus, H7N9 and other influenza viruses including north America's first case of H5N1 reported in January 2014.

The Director General illustrated outstanding performance in high quality areas. WHO pre-qualified more than 400 medical products – 62 during the past year. 97% of the global vaccine supply is quality assured. Worldwide, 65% of babies are immunised using WHO pre-qualified vaccines.

Having life saving interventions available in health facilities will not reduce maternal mortality in the absence of overall improvements in the quality of maternal care and emergency services. Focus must be placed on improving quality of care.

Dr Chan announced that in December 2013 the WHO certification commission declared four African countries free of guinea worm disease, one of them being Nigeria who previously reported 650,000 cases each year. The Nigerian President committed to do the same for polio. Surveillance for cases and investigation of rumours were done hand in hand with polio immunisation teams.

Mrs Wilson attended sessions on:

Communicable Diseases which discussed and debated one global strategy and targets for Tuberculosis prevention, care and control after 2015, also the global vaccine plan as referred to in Dr Chan's Address. Much emphasis was put on migration, the treatment of HIV/AIDS, and the need to reduce poverty and poor nutrition.

Non Communicable Diseases:

The follow up to the Political Declaration of the High Level Meeting of the General Assembly on the prevention and control of non communicable diseases.

Maternal infant and young child nutrition and obesity in children under 5 years was discussed at length and the 28 European Member States requested that the Director General to complete the work on the development of recommendations for Member States to ensure appropriate marketing of complimentary foods.

Breast feeding should of course always be en-

couraged for the first 6 months of life and beyond.

Promoting health through the life course:

Monitoring the achievement of the health related Millennium Development Goals

Health in the post 2015 United Nations development agenda.

Multi-sectoral action for a life course approach to healthy ageing with much emphasis on life expectancy

Addressing the global challenge of violence in particular against women and children.

The progress in the cessation of female genital mutilation and very early marriage.

Youth and health risks with emphasis on education and awareness of sexually transmitted diseases, drug and alcohol abuse and tobacco related diseases.

Reproductive health – strategy to accelerate progress towards the achievement of international health related development goals and targets.

Mrs Wilson also attended two side events, one in which the emphasis was on the inclusion of young people in decision making and the second was *Securing the Future – saving the lives of women and children*. Both of these sessions were very lively with many young people giving their views on both subjects which is good for the future of WHO.

Contact was made with Monsignor Robert Vitillo, the delegate of the Holy See and an expert on HIV/AIDS.

Unfortunately, Mrs Wilson was unable to contact Ms Annette Mwansa Nkowane, the WHO focal person for nursing and midwifery, as she was not in her office for the week of the meeting.