

Above all, the best interests of the child

Ten years in the life of the Warsaw Hospice for Children

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Before I refer to the activities of the Warsaw Hospice for Children on this its tenth anniversary, I would like to share with you some reflections directly connected with care of the child in general, and of the dying child and his family in particular.

We are a society which ill-treats its children in that, despite all the campaigns, programs and efforts which have been produced on the subject of child care, we still think that if we do not correct and chastise our children they will have difficulty to achieve and succeed in the future. We have forgotten that repression is not education, a smack is not a correction, and that each child is individual and worthy with his own characteristics which should be respected, guided and valued.

Throughout time children have always been an easy target for adult aggression. We can say that the ill-treatment of children has its deepest roots in the history of mankind. For centuries, aggression towards children has been justified in various ways; they have been sacrificed to appease the gods, or to improve the species, or as a way of imposing discipline. In our history we find myths, legends and literary narratives describing the ill-treatment and extermination of children.

In mythology, Saturn devours his sons and Medea kills her two children in order to take revenge on Jason. In the Bible Abraham was on the point of sacrificing his son Isaac, and Herod ordered the slaughter of innocents. Four hundred years before Christ, Aristotle said: 'A child or a slave are a possession, and nothing that is done with or to a possession is unjust'. In our own times, doctors still regard their patients as possessions, referring to them as "my

patient". In the 4th century A.D., in ancient Greece, children were sacrificed, while in Jericho children were built into the foundations of ramparts, walls, buildings and bridges, supposedly to strengthen them. Infanticide was also a way of getting rid of children with physical defects.

During the Nazi era the Polish suffered the greatest atrocities perpetrated against their children. We must not forget, in our more recent history, that in late 1942 and 1943 the SS carried out massive expulsions uprooting 110,000 Poles from 300 villages in the Zamosc-Lublin region. Families were torn apart as able-bodied teens and adults were taken for forced labor and elderly, young, and disabled persons were moved to other localities. Tens of thousands were also imprisoned in the Auschwitz or Majdanek concentration camps. Throughout the Zamosc expulsions the Germans seized many children from their parents, to be racially screened for possible adoption by German parents. As many as 4,454 children chosen for Germanisation were given German names, forbidden to speak Polish, and re-educated in SS or other Nazi institutions, where many died of hunger or disease. Few ever saw their parents again. Many more children were rejected as unsuitable for Germanisation after failing to measure up to the racial scientists' criteria for establishing "Aryan" ancestry; they were sent to children's homes or killed, some of them at Auschwitz by the administration of phenol injections. An estimated total of 50,000 children were kidnapped in Poland, the majority taken from orphanages and foster homes in the annexed lands. Infants born to Polish women deported to Germany as farm and factory laborers were also usually taken from the mothers and subjected to Germanisation. (If an examination of the father and mother suggested that a "racially valuable" child might not result from the union, abortion was compulsory.)

There are many more examples which show in similar ways how children have been and still are victims of abuse by adults, who use them as a cheap work force, as child soldiers in war, and as lethal instruments for terrorism all over the world. I do not wish to suggest that every adult ill-treats children, but I want to draw attention to the way in which, in certain circumstances, and terminal illness is one such circumstance, the darkest and most destructive part of the parents and health care teams personality is activated by the situation. Let us remember the findings of Sigmund Freud, which reveal man as a being with instinctive destructive drives, which are balanced by love – Thanatos and Eros. However, this is a delicate balance which, when altered or interrupted, releases the most destructive forces which affect very directly the most vulnerable individuals – children and adolescents. Before the imminent death of a child the parents and the family in general experience a feeling of catastrophe, and all catastrophes produce feelings of fear, pain and resentment at being victims of a situation which is neither expected nor wanted. Feelings of grief and guilt rise up in the parents and the medical team treating the child, thinking that they have done something wrong, and at the same time they experience feelings that everything possible must be done, every last effort made to save the child, even though they know that the process is irreversible. Rather than defending the interests of the child, a personal battle begins, a blind defiance in the face of death.

The parents begin to experience strong feelings of resentment towards their child, with the awareness that the personal projection which they thought they would achieve through their descendants is being cut short; the feeling of guilt generates a violence which manifests itself among the family members and very often towards the child himself. Among the medical staff guilt is manifested in the sense of failure, the feeling that a battle has been lost, and the terminal illness of the child forces us to confront our own vulnerability and that of our own children. It makes us feel that at any

moment we or our children could also become ill and die. The feelings of the child or of the family are no longer taken into account, because they have lost sight of the central objective: that of caring for and accompanying the child in his final illness, and this objective is substituted with absurd iatrogenic actions, which feed a perverse process of frustration among the team, and unnecessary suffering in the patient and his family. There is no respite in this insane battle in which the doctor, who has in effect lost his way, will use the word "persuasion" when he wants to make the family his allies, when in reality that word masks the cruelest manipulation: that of the feelings of a family who is about to lose a child. The actions which are generated in this struggle, even when the scientific evidence shows that the illness is terminal, become ferocious, and unconscious drives begin to be activated in each adult involved. Generally we are not conscious of these feelings, and in the complicated psychic framework this lack of awareness brings into play mechanisms which present themselves as a desire to carry on doing things but which in practice invade, perturb and harm the dying child. This is a defense mechanism which the medical team uses in order to reduce at any cost the anguish generated by the proximity to the process of dying and death, especially when they have no knowledge of any methodology and techniques to deal with the situation.

What happens then?

Both the family and the health care team devote themselves frantically to searching for every possible remedy: the parents seek out specialists who might save their child, while the doctors defying the evidence before them, strengthen the mechanism of denial which drives them to present the fantasy of a cure when a cure is impossible. Thus, they will not hesitate to try new experimental treatments, despite the fact that they may have serious side effects for the dying patient. They suggest mutilating surgery which, far from saving the child simply prolongs his suffering, often for months. These interventions only serve to cause more pain and suffering to the child, and indeed increase his loneliness and isolation, depriving him of the ability to live out the last days of his life with dignity and with the feeling of being accompanied on this journey. This scenario can only be described as ill-treatment. Communication with the family becomes increasingly more complicated. Evasive language, and the hidden presence in such language of lies and deceit, even though

the intention might be to soften the situation, serves only to cause confusion, distrust, and greater pain. The doctor, the pediatrician, whose good intentions and feelings are not in doubt, but whose specific training to deal with these situations is questionable, will turn his work into a personal quest, with the impossible goal of always wanting to achieve a cure. We should remember the phrase made popular by Bérard and Gubler more than one hundred years ago 'The true role of the doctor is to cure occasionally, to give relief often, and to comfort always'. Comfort is expressed in the quality of the accompanying, in the manner in which he is at the side of the child who is going to die.

In an official document from the Holy seat in July 1981, John Paul II said, with specific reference to certain ethical questions relating to seriously ill and dying patients: 'Life on earth is a fundamental gift but is not absolute. Therefore, the limits of our obligation to maintain life in any one person should be an individual matter. The decisive ethical criterion for the individuation of those limits is founded on the distinction between proportionate measures, which must never be denied, in order not to anticipate and cause death, and disproportionate measures which can justifiably be renounced in order not to descend into therapeutic obstinacy'. But to accept the renouncement, which is a form of knowing when to stop, a level of awareness is required which most medical teams do not have. Without this realization and awareness about what is happening in each person's feelings, it is impossible to try to transform invasive action into an action of accompanying. Overcome by a state of massive denial, the team inadvertently sets in motion iatrogenic interventions; this attitude feeds their obstinacy and weakens their capacity to know when to stop. This professional obstinacy, as it is called, is a form of ill-treatment, it constitutes abuse of the child and of his right to live out the last stages of his life in peace.

However, I also want to state very firmly that not all members of medical teams become abusers. For abuse or ill-treatment to take place there must be determining factors in the personalities

of the team members, and a correspondence in the particular profile of the patient and his family. I refer here to professionals with low self-esteem, those who are depressed or have a tendency towards depression, neurotics, those with anxiety problems, alcoholics, and those tending to be impulsive in character and with a low tolerance of frustration. These types have a poor perception and understanding of the affective needs of children, and a profound lack of knowledge of how the psyche of children functions according to their age and the different stages of development. On the other hand, abuse happens in families where couples are very young, living on very little money, with unemployment and inadequate living conditions. As for the child, some determining factors for abuse or ill-treatment are the presentation of a prolonged or terminal illness, hyper-activity, situations where the control of symptoms is difficult to manage, and in general terms, the fact of being an unwanted child.

The trigger for unconscious aggression in the health care team is fundamentally its feeling of failure, and its lack of knowledge about how to manage the situation of dealing with the fact that the illness is terminal, particularly when the ethical parameters which the members know, have not integrated to form a part of their personality and are therefore not applied, but exist only as theoretical statements which can easily be forgotten.

Why do these behaviors occur?

How can we explain this phenomenon of abuse?

From the basis of psychoanalysis I will attempt to offer some explanations.

Although infancy and childhood have been studied from the pedagogical and psychological aspects, such intensive work has not been carried out on the dynamic of infancy as an object of historical appraisal in its actual or "real life" conditions. The absence of a full history of infancy is due in part to the incapability on the part of the adult of seeing the child in a historical perspective. Only when children acquire autonomy do they belong to the world of adults, and only when they gain access to this world do they begin to form a part of history; consequently, by denying infancy with all its characteristics, the child's history did not exist either. The more one goes back in time, the lower the level of pediatric skills is and the more exposed children are to violent death, being abandoned, beating, manipulation and sexual abuse.

Greek and Roman worlds regarded the life of the child as something of worth, regarding children as interesting and of value, this perception of infancy and childhood would change and, throughout the early Middle Ages and for many centuries after, would discard that appreciation of children with their intrinsic values which was evident in the Roman Empire. It seems that at the beginning of the Middle Ages the child was regarded only as a small version of a man, not yet grown, but who would soon become complete. It was a period of brief transition, and in that difficult environment of war, the weakness symbolized by the child was not seen as something desirable. Consequently, infancy and childhood remained in the shadows for a long time. As Philippe Ariès states 'There was a time when historians tended to believe that the sensitivity towards infancy had never changed, that it was a permanent element of human nature, or that it went back to the XVIII century, to the Age of Enlightenment. Today we know that its gestation has been long and gradual, that it emerged slowly in the second part of the Middle Ages, from the XII-XIII Centuries, and that it has asserted itself since the XIV Century with a movement which has progressed constantly'. For Ariès the process of transformation of the modern concept of infancy and childhood is closely related to the category of feeling that is, the social recognition of the existence of feelings, one the fundamental condition in this process.

In the traditional old western society the child's image was poorly represented, and even less so the adolescent. The duration of childhood was reduced to the period of greatest fragility when the young was not viable alone; as soon as he was able to develop physically he would soon mix with adults, sharing their work and play. The baby then became a young man, without going through the stages of youth, which probably existed before the Middle Ages and which have become essential today in developed societies. The transmission of values and knowledge, and in general the socialisation of the child, were not guaranteed by the family nor controlled

by it. The child was then separated from his parents, and for many centuries his education was a work of apprenticeship, thanks to the cohabitation of the child or youth with adults. From this stems the belief held by many even today that a child is simply a small version of an adult.

The presence of the child in the family and in society was so brief and insignificant that there was insufficient time or opportunity for the recollection to become fixed in people's memory and sensitivity. There was only a superficial awareness towards the child, reserved for the earliest years when he was regarded as something pleasing. People amused themselves with him as they might a small pet animal. If the child were to die then, as frequently happened, there might be some who grieved, but as a general rule the matter was not considered to be very important: another child would replace him. The child remained an anonymous being.

Let us not deceive ourselves, for we have not progressed as much as we might like to think and hope. Many of us have retained this outdated attitude and today some, thinking that they are using a good technique for comforting and accompanying, will say to a bereaved mother: 'never mind, you are still young and can have another child'.

With regard to the organization of the family, in ancient times the fundamental duty and purpose of the family unit was the conservation of wealth and property, the practice of a common trade and mutual help day by day in a world in which a man, and even more so a woman, could not survive alone, and then in cases of crisis, the protection of honor and of life. The family did not have an affective function, which did not mean however that love was always absent. In our world today there are still many cultures which live according to these values, and others like those who suffer in refugee camps as a result of being displaced by war have been forced to live in this way.

At the end of the XVII Century customs underwent a considerable transformation in a profound and definitive way. Schooling became the substitute for apprenticeship as a means of education, which meant that the cohabitation of the child with adults ceased, as did, as a consequence, learning about life by direct contact with them. Despite a great deal of reluctance and reticence, the child was separated from the adults and kept apart. So began the so-called "preparation for life" constituted by the process of education and

schooling. The family became a place of necessary affection between couples and between parents and children, which it was not before. This affection is manifested principally through the importance given to education from that time onwards. A completely new feeling emerged: parents took an interest in their children's studies and followed them with a dedication entirely belonging to the XIX and XX Centuries, and unknown before then.

Religious orders such as the Jesuits became teaching orders, and their teachings were no longer directed towards adults, like the preachers in the Middle Ages, but were essentially reserved for children and young people. They taught parents that they were charged with, and responsible before God for the body and soul of their children. This belief, which is very strong in our culture, when exacerbated by the presence of a terminal illness, makes it extremely difficult for parents to value and respect the autonomy of their children even when they, by reason of their age and state of perfect mental health are able to make their own decisions. 'You will do as I say because this is why we are your parents'.

The Victorian idea of the role of children in society is also still very firmly entrenched in pediatricians: 'children are to be seen not heard'. How many pediatricians still, when there is a child in the consulting room who is perfectly capable of expressing himself verbally and explaining what is happening to him, ignore that child and address the mother with the question 'what is wrong with your child?'. They see the child but they are not listening to him.

You will be wondering what my presentation so far has to do with the Warsaw Hospice for Children.

I felt it necessary to begin with this introduction as a prelude to talking about this particular Hospice, which today celebrates ten years of existence, and whose main concern is to defend and protect the best interests of the child. The Hospice staff therefore concentrate their efforts on avoiding the ill-treatment and abuse which is still suffered today by children with terminal

illness all over the world. I will not discuss the history of its origins and development here, as this has already been done by previous speakers. However, I would like to mention some aspects which I believe make this Hospice rather different and special.

I am privileged to have been connected with this project from its beginning; I have seen it grow and develop like a child, progressing from its first sounds and uncertain steps to a steadier walk, as intellect, emotional richness and creativity grew and flourished.

Generally speaking, all children's hospices, whether in their residential programs or home services, share the same principles: to care for the dying child from the physical and psychological point of view, and to support the family at this very difficult time. In practice, each hospice operates in a different way and although the ultimate objective is the same, the methodology, the ethics, the organization and projects differ considerably. Some hospices place their emphasis on pastoral care, with a marked religious influence; some tend to favor more the management of physical symptoms than emotional ones. Others still use formulae which have been phased out over time and which should be reviewed. Other hospices attach great importance to academic aspects, publications, journals or research. Some hospices feature programs which are as ephemeral as the lives of their patients. Again, some remain caught up in a bureaucratic tangle, or have expanded so much that the quality of their service is much reduced. What makes each hospice different in the way it operates is directly related to the personality, capacity for leadership, personal efforts and the scientific, ethical and spiritual ideas and convictions of its mentor. We cannot therefore speak about the Warsaw Hospice for Children without speaking of Tomasz Dangel. While writing this I have made a conscious effort to see Tomasz as objectively as possible, as far as my friendship, affection and profound respect for him will allow me to.

Our first meeting was in 1991 near Konin, at a workshop which I lead by invitation of someone whom we all know well as a pioneer in palliative care in Poland, and with whom I have the pleasure of sharing this occasion today. I refer to Professor Jacek Luczak. I remember at that workshop, among the other participants there was a very serious individual, tall, smartly dressed in a suit and tie, with a moustache which added even more severity to his face. His posture when standing was very stiff, and he introduced himself as an

anesthetist from Warsaw who worked with terminally ill children. At that moment I had the feeling that I had seen this before in other parts of the world, and, in my experience, the combination of anesthesia and pediatric palliative care had not proved so far to be a very good experience for the dying child. This person had good scientific training, an enormous capacity for work, (which I must say he still has, despite the blow of reaching his half century, which always sounds longer than 50 years). However, apart from this academic and scientific training and his good intentions, he had at that time, absolutely no knowledge whatsoever of topics or subjects relating to children's emotions, and to their spiritual and affective needs, and above all this ignorance extended into his own personal sphere, as Tomasz's self-knowledge was minimal. He subjected me to all kinds of questions, remaining immutable in the face of any indications that I pointed out to him about serious methodological errors with regard to communication with patients. His attitude was defensive, hostile and defiant. His expression conveyed anger, and he questioned everything that I said. I still remember the exhaustion and irritation that this first encounter caused me, and all that I hoped at that time was never to see such an unpleasant individual again.

We met again the following year; and I awaited with trepidation the moment when he would join in the discussion. However, I felt that something was changing behind this still rigid and distant facade. I could not be sure whether it was a real change of attitude or a forced stance. By 1994, the time of our next meeting at one of my workshops, I literally saw "another person". I even wondered whether it was I who was getting used to this person and whether the supposed changes were a product of my wishful thinking. Fortunately there was sufficient evidence to be sure that something very important was being released in Tomasz; a vital energy which until now had not found its true path seemed to be starting to flow. His profound religious convictions were not an

obstacle to his apprenticeship because they were rooted in faith and not in fanaticism or a closed ideology. His spirituality blossomed and, alongside it the freedom to choose a path, without restrictions, blame or guilt. A few years passed during which our contact was minimal. I heard about Tomasz and his Hospice through other people until 1999, when we met again, and we began from that point to share not only common professional interests but a profound affective communication which has proved very valuable for me. We have forged, recapturing my Polish origins, a link and a bond based on the three pillars which sustain our personal and professional lives: Love, Honesty and Trust.

I have learnt a great deal from Tomasz and although he may not be aware of it, he has helped me to strengthen my hope and to trust even more, in the capacity which some people have to revive and redirect their affective life, to change, learn new things, challenge old ideas and beliefs, and not to remain trapped inside sterile, politically correct postures. These personal changes in Tomasz, leading to greater self-awareness and which always require great effort to achieve, have been the model for the spirit and ethics of the Warsaw Hospice for Children.

Hospice care is the essence of pediatric palliative care. In my view I see the activity of the Hospice as something which is constantly changing, always being prepared for the unexpected, the surprising, for sadness, but also for what is luminous, bright, joyous, for such is the human condition, and especially that of children, who are capable of displaying humor and smiling even in the most dramatic situation.

If we imagine the work of the Hospice as that of a group of people dedicated to accompanying dying children and their families to help them to pass through the last stage of life as well and as positively as possible, we could imagine their work as if it were a "road movie" in which two or more characters set out on a journey whose main purpose is to take things as they come, to enjoy every day, and to be open to new experiences. In this type of film the characters appear to be aimless, but this is not really the case. In reality this is a journey on which losers can recover their hope and their dignity – even though it may be only at the last moment. On this imaginary journey, as I see it, the characters know that at any moment the road might come to a sudden end at the edge of a dangerous precipice, but they also know that

the journey is worth undertaking, not because they already know the final destination but because they are enjoying it to the utmost.

We already know the person, now let us look at his work as the founder of the Warsaw Hospice for Children.

Tomasz Dangel's most important contribution is his global vision of a European movement of pediatric palliative care to develop harmoniously, to join forces instead of wasting time and energy on internal arguments or power struggles. His skill lies in having known how to create an institution with soul, and with clear objectives and projects, with a way of working in which there is a balance between the advances of science and the art of communicating and knowing how to be with those who are about to die. His concern for the emotional well being of the children and their families has as much importance as the management of physical symptoms.

The true impact of the Warsaw Hospice for Children not only in Europe (Slovakia, Hungary, Byelorussia, England, etc.) lies in the effort it puts into education, and the teaching programs offered so that each one of us has the opportunity to improve awareness of ourselves and acquire new techniques to avoid the suffering of children. These ideas which have gained strength in the Warsaw Hospice have gone beyond the frontiers of Europe through the work of its founder, and I know that they constitute an essential work of reference in Argentina and other South American countries.

The Warsaw Hospice for Children and all its staff know that a pragmatic approach to life and health, regarding both as purely material things, stripped of their spiritual dimension and of their ethical value, is not good for anyone who is working with dying children.

Although medicine is considered a natural science, fundamentally it embodies a great deal of moral and spiritual science, because what it seeks is to bring about the well being of man, that is to say, it is humanitarian.

It is our understanding (and I say "our" because I feel a part of the place and activities of this Institution which today celebrates 10 years of existence) that life and well-being are moral values.

If we accept life and well-being as ethical values, all we professionals working in health care would be obliged to recognize them as such, since they would have an imposing force, a moral imperative.

Although we value the importance of theoretical conceptualizations and the use of language, we do not like the moral postures which remain in the sphere of politics or what is merely empty talk. We understand that moral values alone are not sufficient for us to achieve ethical behavior. Upon this solid substratum we also have to place standards or rules which we also have to keep in mind. With a firm system of values and principles it will be easier for our actions to be good ones, provided that our subjective moral conscience identifies with it completely. If this correspondence does not exist we immediately become frauds and charlatans.

We are conscious of the fact that to carry forward the ideas of this Hospice means that we will always have to accept defiance and challenge, and that we will have to have the energy to swim somewhat against the current. We are also aware that the road is long and hard, and that because of its nature there is no final and definitive goal. We know that medical ethics is a process which has spread over many centuries, and, given that national morals are a changing element, traditional medical ethics, from which we try to distance ourselves, have been so influenced by Greek philosophy, Roman law and the Jewish Christian religion, that they have been and still are characteristically naturalist, paternalist, dogmatic and authoritarian.

With the promulgation of human rights, which have been completed and perfected throughout two long centuries, a new ethos has emerged of Anglo-Saxon bent, which unlike the traditional is secular and democratic, liberal and pluralist. The medical ethic which we want for our children and their families is one which is supported by three fundamental pillars: Autonomy, Non-harming – doing-good, and Justice. The patient is guided by autonomy, the health care team by doing good, and society is guided by justice. Autonomy must be expressed in the instruction which symbolizes the moral and legal right of the patient to make his own decisions, to be heard always, even the smallest patient, even though they might not be in a position to take measures which are beyond their understanding because of their young age. These decisions must be made with complete freedom, without restrictions or coercion,

however well meaning the intentions of the doctor or the team. As regards justice, this must be understood within the framework of well being as the fair distribution of the scant possessions and wealth of a community, that is to say, distributive justice. With respect to the principle of non-harming – doing good we consider it to be the essence of the act of caring, retaining in all its meaning that of the Code of Hammurabi in antiquity, the Hippocratic Oath or the Invocation of Maimonides, that is to say that the patient must suffer no harm but only good. We understand by good of course what the patient considers to be beneficial to him and not the imposition of our opinion. Good can never go hand-in-hand with the desire to end life, but we all know that if the patient is well attended without pain, and feels that he is accompanied and loved, the problem which arises when he asks for his life to be ended is rare. The medical act, for it to be genuine and not just an artificial, empty posture, and for it to be truly ethical, must be inspired by virtue, or even better, virtues. Without these it is not possible to understand the function and authority of moral rules and principles.

Some virtues are part of the psychic and emotional endowment which make up each individual's character, while others are acquired and can therefore be developed with apprenticeship. The system of medical ethics does not happen intuitively, it has to be taught. This is one of the principles that the Warsaw Hospice for Children sustains with conviction. Experience has shown us that good intentions which everyone undoubtedly has are very important in this work with children, but achieving a solid moral foundation requires a wide knowledge of the standards of objective morality and subjective morality, well exercised in the daily process of ethical reflection.

Beyond the idealistic and utopian idea that a professional can possess all the virtues: faith, hope, charity, caring, prudence, strength, temperance, fairness, love, honesty..., we believe that the most important virtue in someone who works with terminally ill children, in those who genuinely defend their interests, must be that of being

humanitarian, because this virtue implicitly embraces all the others.

People who work in this Hospice are asked to make the constant effort required by trying to stay in touch with another person's suffering, and knowing how to put themselves in the place of that person. If this is achieved then compassion and understanding will flow, which bring the carer and the patient together and allows the creation of a constructive dialogue. Compassion is a feeling which stems from the unconscious, autonomously, and at a distance from the standards of objective reality. In my understanding, this ethical position, as I have presented it, together with the permanent safeguard of the dignity of the patient, means that this, our Hospice, sees its future over the next few years, as a defiance which is well worth accepting and sustaining. We believe firmly in the power of education as a means of transformation, a vehicle which will allow us to create an education which is not purely an expounding of doctrine, is not based just on lectures, conferences, and reference books, but which is an active, living apprenticeship, which increases and improves our knowledge of ourselves and consequently achieves a greater understanding of our work with children.

What I have learned in the years during which I have been connected with the Warsaw Hospice for Children, is to accept that our life is largely uncertain in terms of the grand scheme of things of which we are ignorant, and cannot manipulate as we wish. We begin to exercise our freedom when we cease our resistance to life, when we accept that what is happening is in some way, for some reason necessary, even though we are incapable of understanding it. If we trust in the justice of the laws of the universe, in cosmic energy, or in divine justice, we will not need to judge, or to plan punishment and revenge. If we believe that we are part of a greater organization we will not need to control our existence and it will be our dignity which will show us the path to follow.

What makes this Hospice special and vibrant is that each of its members must understand in their heart and not just intellectually, that to tolerate differences not only complements and helps the suffering child and his family, but means accepting another into one's own being and discovering the miracle of creation through him.

All that really matters is to learn how to discover beneath the many layers of prejudice what is our true essence, and to live the

experience responsibly through our actions. To love and to love oneself means caring for and caring for oneself and respecting oneself as a manifestation of nature, or of divine creation in a process of evolution towards more perfect forms of existence.

Only from a discovery of the world with all its experiences will we be able to put ourselves in another's place, and this is the basis of the reciprocity which enables us to accept and welcome others and to learn from them. From this vital perspective we will defend the interests of the child.

On that imaginary journey which I described earlier, this creative road movie which is the path of the Warsaw Hospice for Children, given the choice I would have no hesitation in choosing Tomasz Dangel as my traveling companion.