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OD REDAKCIE / EDITORIAL

Vážení priatelia,*) *Bratislava, Leto 1996*

keď dnes, na seminároch nášho ústavu pre študentov Lekárskej fakulty UK v Bratislave, predstupujem pred nové a nové skupiny mladých adeptov a adeptiek lekárskeho povolania, čítam im neraz na tvárach rozpačitú otázku - "A načo vôbec ešte dnes máme hovoriť o etike? Nemali by sme sa radšej venovať 'odborným' predmetom?" ("Čo nevidíte, ako to všetko okolo nás, ba i v samej medicíne beží? Aký význam tu má ešte akési 'filozofovanie'? My chceme mať v živote predovšetkým úspech!") Ozaj, má to vôbec ešte nejaký zmysel? Nie je to len obyčajná strata času, energie a prostriedkov? Našich, fakulty - i tých študentov a študentiek? Ponúkajú sa rôzne odpovede i rôzne dôvody. Priestor tohto úvodníka nedovoľuje ani ich strohé vymenovanie...

Predsa však - jedným z najpraktickejších 'dôvodov' sa mi zdá tento: medicínska etika je i o tom, akým lekárom v skutočnosti chcem byť. Nemyslím teraz, pravdaže, len na rýdzo odbornú, či skôr 'technickú' alebo 'technologickú' stránku veci. Mám na mysli skôr porozumenie tomu, čo znamená prijať a vykonávať lekárstvo ako svoje životné povolanie. Čo to znamená, ak chcete, byť prijatý do 'lekárskeho stavu' [1]. Nie je to, ako všetci vieme, len obliekanie 'bieleho plášťa', nosenie fonendoskopu, neurologického kladivka, ORL-zrkadielka, alebo iných vonkajších 'znakov profesie'; tým menej je to arogantné uplatňovanie moci nad životmi a zdravím pacientov, či formálnej autority voči spolupracovníkom a spolupracovníčkam stojacim na nižších stupienkoch hierarchie zdravotníckej starostlivosti. Ide tu - ako nás už po stáročia upozorňuje medicínska etika - predovšetkým o celoživotnú, namáhavú službu človeku. Neraz v situáciách, kedy sa bojuje o to najvzácnejšie - o zdravie, alebo o život. Lekárske povolanie znamená tiež mimoriadnu, v podstate kontinuálnu osobnú zodpovednosť. Vieme, že lekár len ťažko odkladá svoje 'lekárstvo' s bielym plášťom, ktorý zanecháva v ordinácii alebo na oddelení...

Myslím, že ozajstné naplnenie lekárskeho poslania nie je možné bez skutočnej a hlbokej úcty, ba lásky ku každému človeku, najmä k tomu, ktorý potrebuje našu konkrétnu pomoc a starostlivosť. Nejde to bez úprimného rešpektovania jeho osobnej dôstojnosti a integrity - fyzickej, psychickej i duchovnej. Bez prijatia každého pacienta ako ľudskej osoby, v nárokoch i právach rovnej nám samým, našim príbuzným, či známym. Náš pacient je 'náš blížny' [2]. Práve ten doráňaný, špinavý, bezvládny, ubolený a opustený človek na rôznych cestách svojho života prepadnutý chorobou, nešťastím, či inými 'zbojníkmi'. Veľkosť, hĺbka i utrpenie lekárskeho povolania možno spočíva práve v tom, aby sme sa celý život o tento postoj znova a znova pokúšali: skrášňovať a humanizovať tú konkrétnu tvár dnešnej medicíny, ktorá je privrátená k našim pacientom. Alternatívou, ako sa zdá, je medicína strojov, technológií a bezcitných 'nadľudí', či cynických robotov. Myslím, že takéto prijatie lekárskeho povolania, či stavu je i jadrom pravej lekárskej kolegiality, lekárskeho povedomia a zdravého sebavedomia.

Naši študenti, aspoň vo svojom individuálnom prípade, si dnes ešte viac-menej môžu vybrať. Najmä v tom, akú medicínu chcú vlastne vo svojom lekárskom živote robiť: akými lekármi, lekárkami sa chcú stať. Ktoré vzory, ktoré modely lekárskeho povolania chcú osobne, vo svojej praxi uplatňovať. A preto je možno dobre, že medici majú aspoň tých pár seminárov medicínskej etiky. Našou úlohou, ako učiteľov, musí byť, aby sa táto vzácna príležitosť nepremárnila. Veď po promócií, v tvrdej dennej praxi, 'situácií' a 'podmienkach', bude na uvažovanie a orientáciu čoraz menej času. Či nie?

Jozef Glasa

[1] *Ženevská deklarácia Svetovej asociácie lekárov.* [2] *Podobenstvo o Milosrdnom Samaritánovi, Evanjelium podľa Lukáša, hl. 10, 29 - 37.* **English translation - see p. 15.*

SOME REMARKS ON IMMORALITY OF EUTHANASIA

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Abstract

The term euthanasia is used in the paper in agreement with the Dutch model, and its main principles (i. e. euthanasia is an act, euthanasia is defined as voluntary, euthanasia is defined as intentionally taking the life) are discussed. It is demonstrated, that the slippery slope in the Netherlands is a reality, and it is pointed out that it will be extremely urgent to prepare restraints and prohibitions against such activities in other countries: they should be the safety rails surrounding the abyss.

Key words: active euthanasia, slippery slope, medical ethics

"In the Netherlands the Public Prosecutions Department must be notified of every unnatural death, regardless of whether it was the result of a murder, a traffic accident or the termination of life by a doctor. There is a separate statutory notification procedure, which entered into force on June l994, for the termination of life by a doctor. The notification procedure is based on a list of criteria which serve as guidelines for assessing the thouroughness and caution exercised by a doctor who has terminated the life of a patient whose suffering was unbearable and for whom there was no prospect of improvement. Using these criteria, the doctor drafts a report which must be verified by the municipal pathologist. The public prosecutor also assesses whether the doctor can invoke *force majeure* [1]."

Brief, compendious and concise abstract of the fact, that active euthanasia is somehow protected by law. The criteria for lawful euthanasia are [2]:

l. The request must come only from the patient and must be entirely free and voluntary.

2. The patient' s request must be well considered, durable and persistent.

3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.

4. Euthanasia must be a last resort. Other alternatives to alleviate the patient' s situation must have been considered and found wanting.

5. Euthanasia must be performed by a physician.

6. The physician must consult with an independent physician colleague who has experience in this field . We can continue by enumerating other activities in this field - which demonstrate that attention given to this area is steadily mounting. Many authors hold up the Dutch model for physician asisted death as an example of a progressive system which might be implemented elsewhere. The fact, that a bill to legalise voluntary euthanasia in Australia's Northern Territory was passed by a majority on May l995, may serve as an example [3].

I will confine myself to the point of view of medical ethics (or bioethics, if you want). First of all - with respect to the widespread confusion about the term euthanasia - it is necessary to define it. In my paper I will use this term in agreement with the Dutch model - as intentionally taking the life of a person upon his or her explicit request by someone other than the person concerned.

This definition implies three important points: l.Euthanasia is an act, it is defined as doing something (usually giving a drug) and it is not defined as refraining from action (i.e. stopping a treatment). 2. Euthanasia is defined as voluntary. 3. Euthanasia is defined as intentionally taking the life (with the sole intention of) [4]. This definition excludes some acts which happen in medical practice and which are perfectly legal: e.g. withdrawing or withholding of the life-sustaining treatment because that treatment itself is too burdensome for the patient or because that treatment is medically futile. This definition excludes also the administration of a treatment with the purpose of relieving the symptoms of illness in the foreknowledge that this may or will hasten death. This attitude must be, naturally, in agreement with the principle of double effect [5]. (The definition, on the other hand, does not include the case when the life-sustaining treatment is withdrawn or witheld with an intention to hasten the patient's death - the act termed formerly 'passive euthanasia', with the same moral significance as an active form, but this distinction will not be a matter of my interest in this paper.)

l. Euthanasia is an act

In this place it is necessary to remind of what The Oath of Hippocrates says: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect" [6]. I am very well aware of the present discussions - especially in USA - concerning the question "why reasonable people would not accept the Hippocratic principle?" [7]. - Because the Hippocratic ethics gives a remarkable authority to the physician to use his judgement to decide what will be beneficial for the patient. We are modern people living in the 20th century and our autonomy is such a great value, that we ourselves can decide what is beneficial for us!

On the other hand, many authors wrote persuasively about the ominous implications in current revisions and, in effect, rejections of the Hippocratic Oath (e.g. Leon Kass of the University of Chicago [cit. 8], who also proved, that there is no firm philosofical or legal argument for a "right to die" [9]). They pointed out, that an extraordinary value-system of a great moral power was hidden in this Oath. They argued like this [10]: "While there has certainly been - and still is - a tradition of paternalism in medical practice, in which treatment decisions are taken by physicians and other health care workers without adequate consultation with the patient, this is to be distinguished from Hippocratic 'paternalism', in which the basic moral framework of medical practice is accepted by the physician (not in fact devised by him: he is committed to it by the Oath) and which determines the limits of his patient care.... The abandonment of the idea of medicine as constituted by distinct moral commitments gives place, on the one hand, to notions of patient autonomy" - to which we turn below - "and, on the other, to a reduction of medicine to the clinical and other skills of the physician... The shift from covenant to contract is evident."

2. Euthanasia is defined as voluntary

Here is the place to discuss the patient's autonomy: "Autonomy is the capacity for giving direction to our lives through the choices we make. Why should we value this capacity? Because it is through our choices that we can come to flourish as human beings... It is plain to common sense, that many human choices are self-destructive. A choice which has no other justification than that it is

MY choice - it is what I want to do - has as such no claim in our respect" [11]. But even if some decision for self-destruction seems to be reasonable, the pressures operating in the typical case might be thought to preclude any possibility of a decision sufficiently free and sufficiently informed [10].

Consider a candidate for the "voluntary" euthanasia. By definition according to different proposals, e.g. that of the Dutch model, the candidate must be sick, typically terminally ill, with a poor prognosis and much discomfort, which usually include depression, a sense of worthlessness, anxiety about family commitments, etc., etc. Almost all of these patients are incapacitated, hospitalized, frightened by strange and impersonal routines, fearful, and suffering mentally and physically. I think - having extensive experience at the bedside of severely ill patients, including the cancer patients - that they are far from excercising a free power of choice, even in more elementary matters, than that dealing with the termination of their lives. If we add to this situation a law permitting euthanasia and a medical community practising it, the disaster can be completed. I think that taking into account - as a chief argument for euthanasia - the 'voluntariness', as a manifestation of the patient's autonomy, makes here the sad, but real form of ethical parody.

Moreover, it should be evident, that a doctor probably will not acceede to a patient's request to be killed, if he thinks the patient still has prospects of a worthwhile life [11]. The judgement, that the patient does not have a worthwhile life, plays the fundamental role in argumentation justifying euthanasia. Euthanasiast killing rests for its justification precisely on denying the position, that human beings possess in themselves worth and dignity. How is it possible, that physicians think this way? In the Universal Declaration of Human Rights it is clearly defined, that the dignity of the sick remains intact and whole, whatever their suffering, their level of consciousness or defects that may affect them [12].

3. Euthanasia is defined as intentionally taking the life

The intention to kill is approved in the above mentioned definition. I will not argue by the usual argument of our culture, and our judeo-christian tradition - the sanctity, dignity and inviolability of each human life. I will confine myself only to the slippery slope argument, which is, first of all, the slope in thinking.

It is the simple observation of a 'common sense', that one thing is connected with the other, and one thing frequently leads to the other. If we give ouselves permission to do one thing, we are inescapably inviting the question about permission to do the next thing. Once a person or society starts down a certain path, gravity will pull them further along it. If we allow physicians to end the lives of the imminently dying at their request, it won't stop there. We will be drawn further down the path to include other categories of individuals - e.g. terminal, but not yet dying patients, incurable but nonterminal patients, handicapped newborns, the senile, the mentally handicapped, and so on. This mentality is very logic: If it makes sense to relieve a short period of suffering for the dying patient, wouldn't it make even more sense to relieve a longer span of suffering for the non-dying but terminal or incurable? And why have we to stop here? What about those who are no longer able to make decisions for themselves, but have not made provisions in advance? Shouldn't they also have the opportunity to have their pain and suffering relieved? The doctrine of "substituted judgement" or, in certain sense - the doctrine of the "best interest of the patient" could be applied here. And if it is applicable to adults, why not also to the handicapped newborns and to terminally ill children? Or why not to mentally ill - to relieve their mental anguish? These examples clearly demonstrate that one step onto the slope of active voluntary euthanasia might lead to a slide down the slope even to the point of legitimizing nonvoluntary euthanasia, or even involuntary euthanasia, ending a person's life against his or her will [13].

The Dutch model demonstrates, that the slippery slope is a reality [2, 14]. In the well-known study dealing with the inquiry of the Remmelink commission published in the Lancet [15], it was documented that 0,8% of all deaths in the Netherlands in 1990, approximatly 1000 cases, were due to the life terminating acts without explicit and persistent request. From these data it was quite evident that physicians did not adhere to the criteria specifying all the prerequisite conditions under which physician assisted death might be permissible. "When the decision was not discussed with the patients, almost all of them were incompetent [15]". Physicians were not, and in many cases are not, prosecuted - although euthanasia is still and probably will remain the subject of the criminal law. Assisted death has also become tolerated, or accepted in these conditions.

Newer reports (after the year 1994 [14]) clearly acknowledge, that non- and even involuntary euthanasia is no more a sporadic event, but a justified, frequent part of the medical practice in Holland. The situation makes it evident that initial legal or medical parameters do not necessarily determine the end-results. The only recent difference is, that these terminations of lives - e.g. those of the newborns or comatose patients - have been excluded from the category of euthanasia (this term - as I mentioned in the beginning of this paper - was left only for the voluntary forms). Nevertheless, new Act extends the notification procedure to these cases, because "these patients might be the subjects... even to decisions, which guide the process of death by pharmacological means [4]", and physicians - though formally found guilty - are discharged from prosecution [14].

"In view of many, any suggestion that there may be analogies between the way the Nazis were and the way we are, between what they did and what we are doing and proposing to do is simply intolerable. The very suspicion of such similarities is too painful to bear [8]". Nevertheless, I think that in this place, it is necessary to remind the Nazi Euthanasia Program and the slippery slope of that time. Some authors (e.g. R. J. Neuhaus) are convinced, that there are close similarities between 'what they did then and what we are doing now'. They too asked and answered the question - who shall live and who shall die, and who belongs to the community entitled to our protection. Then and now, the subject at hand is killing [8]. The genocide of six millions of Jews was somehow unleashed by the morphine overdose given to the first handicaped child, and by the notion that the life of this child was a life not worthy to be lived (lebensunwertes Leben).

It would be useful to quote here the evaluation of the slippery slope of medical science under Nazi dictatorship by Dr. Leo Alexander, Boston neurologist and psychiatrist, who served as a consultant to the Secretary of War and to the Chief of the Counsel for War Crimes at the Doctors' Trial at Nuremberg: "Whatever proportions these crimes finally assumed, it became evident to all who investigated them, that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unpro-

ductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. But it is important to realize, that the infinitely small wedged-in level from which this entire trend of mind received its impetus was the attitute toward the nonrehabilitable sick. It is, therefore, this subtle shift in emphasis of the physicians' attitude, that one must thoroughly investigate. It is a recent significant trend in medicine... to regard prevention as more important than cure. Observation and recognition of early signs and symptoms have become the basis for prevention of further advance of disease [16]".

It is useful to remind here, that the way to the crimes against humanity is always prepared by peculiar ways of thinking about humanity. It is evident to all, but perforemd as a willfully blind action, that lives once thought to be undeniably human are now thrown into question.

In our country (Czech Republic) the Code of Ethics for Physicians clearly emphasizes: "Euthanasia and assisted suicide are not allowed." At present, discussions concerning euthanasia are not in the centre of attention of the general public. I feel that they might only mirror the trend towards copying all "progressive and modern thoughts" coming from the 'West'. On the other hand, I believe, that it is urgent to prepare restraints and prohibitions concerning euthanasia - also in the field of the law. We should "place fences around the law", as a rabbinical dictum says. In this case this means, that broken fences can be repaired and new fences can be erected. They should be safety rails surrounding the abyss. The signposts of Hippocrates and that of Nuremberg trial should be retrieved and refurbished [8, 17]. On the other hand "When the fences and the safety rails have been removed, when the signposts have been changed or taken down, what reason is there to believe that people in our time will not do what was done then [8]?"

I think that it is possible and appropriate to finish these remarks with the words of John Donne: "...any man's death diminishes me, because I am involved in Mankind; and therefore never send to know for whom the bell tolls; it tolls for thee" (E. Hemingway).

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Munzarová, M.: Some remarks on immorality of euthanasia, **ME&B, 3, 1996, No. 2, p. 2-4.** Termín eutanázia sa v príspevku používa v zmysle holandského modelu. Autorka diskutuje kľúčové princípy tohto pojmu (t.j. eutanázia je čin (skutok), eutanázia sa definuje ako dobrovoľná, eutanázia sa definuje ako úmyselné zbavenie života). Poukazuje na fakt, že klzká plocha v Holandsku je skutočnosťou. Zdôrazňuje naliehavú potrebu prípravy reštrinkcií a zákazov proti podobným praktikám v iných krajinách: mali by sa stať 'bezpečnostným zábradlím' ohradzujúcim priepasť. *Kľúčové slová: aktívna eutanázia, šikmá plocha, medicínska etika.*

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RETROSPEKTÍVA

RETROSPECTIVE

Medzinárodné sympózium o medicínskej etike/International Symposium on Medical Ethics, Bratislava, 29. - 30. 5. 1992 *

V máji 1992 sa uskutočnilo v Bratislave v priestoroch Kongresového centra "Istropolis" významné podujatie s medzinárodnou účasťou - Medzinárodné sympózium o medicínskej etike/International Symposium on Medical Ethics. Organizátorom sympózia, ktoré sa konalo pri príležitosti Svetového Pro-Life kongresu (World Pro-Life Congress, Bratislava, May 28 - 31, 1992), bol Ústav medicínskej etiky a bioetiky IVZ a LFUK v Bratislave. Sympózium prinieslo rad zaujímavých pohľadov na viaceré konkrétne etické problémy súčasnej medicíny a zdravotníckej starostlivosti, mnohé v podaní významných osobností slovenskej a českej medicíny a bioetiky, i viacerých hostí zo zahraničia. Nakoľko sa z finančných a technických dôvodov nepodarilo vydať súhrnnú publikáciu materiálov sympózia, rozhodla sa redakcia uverejňovať postupne dostupné texty príspevkov podujatia vo zvláštnej rubrike (počnúc ME&B č. 3/1995). Veríme, že týmto spôsobom aspoň čiastočne splatíme dlh voči autorom prednášok a aktívnym účastníkom sympózia, ako aj voči našej lekárskej a zdravotníckej verejnosti.

** Engl.: The International Symposium on Medical Ethics (May 29 - 30, 1992) was held at the Bratislava Congress Centre "Istropolis" on the occasion of the World Pro-Life Congress, Bratislava 1992 (May 28 - 31, 1992). The organizer of the Symposium was The Institute of Medical Ethics & Bioethics of the Postgraduate Medical School and the Medical Faculty of Comenius University, Bratislava. The papers presented at the Symposium brought in a number of interesting views on many aspects of important ethical problems of contemporary medicine and health care. Several outstanding personalities of Slovak and Czech medicine and bioethics, as well as distinguished guests from abroad lectured in the Symposium, attended by about 500 participants. We continue in publishing of the available texts of papers presented at the Symposium in this heading of our journal (started since ME&B 3/1995).*

SCIENTIFIC HEALTH CARE IN A CHRISTIAN PERSPECTIVE

Four Ethical Limits on Medical Practice

Benedict M. Ashley

The medical profession acknowledges its ethical obligations, but it tends to think that these obligations are determined exclusively by the recognized goal of the profession, namely to use the resources of science to improve the health of the patient. Any attempt to introduce other standards of conduct into medicine appears to many physicians to be an unwarranted intrusion by those who lack professional medical competence. Consequently, considerable resentment is felt when the Church, as in its recent document on human reproduction, seems to impose limits on medical research and practice. [1] What competence does the Church have in scientific medical matters?

The answer is of course, "None at all." Nevertheless, the Church no more intends to intrude on medical expertise as such, than do the financial and political institutions which restrict the actual practice of medicine and medical research by far more powerful pressures than the Church can apply. The Church speaks up on medical questions only when she perceives that an issue involves the rights of the human persons who are the subject of medical practice and the correlative responsibilities of medical providers to these subjects. In all societies human rihgts are violated, and it has always bee the recognized duty of the Christian Church and indeed of all religious bodies to act as advocates for the victims of such violations, especially when they are powerless. The "preferential option for the poor" of Magisterial documents, [2] regards not just poverty in the narrow sense, but every form of human rights violation.

This is not to imply that the medical profession is often guilty of conscious injustices to patients, but only that it like other professions, (and I by no means exempt the clergy from this same accusation) sometimes, under the immense pressures of its services to humanity, becomes blinded to abuses incidental to its great services. Thus it is in terms of justice and respect for human rights, [3] that I want to explain the few, but sometimes very irritating, ethical restraints which the Church has urged on the medical profession. I say "urged" because the Church, unlike finance and politics, has no power, except that of persuasion, to restrain medicine. She speaks only to the conscience of physicians, confident that by their commitment to so noble profession, they are men and women of good will.

As I understand the teaching of the Church, it proposes only four major limits to medical research and practice which are in fact part of the tradition of the medical profession itself, so that when the Church proposes them it is only reminding physicians of their own commitment, classically expressed in the Hippocratean oath. These principles are not inventions of the Roman curia, as some have snidely claimed, but are derived very directly from the teaching and example of Jesus Christ. They simply formulate that respect for the human person, or human dignity, which is basic to all the learned professions in the service of humanity.

The **first of these principles** is respect for human life and was formulated in the Ten Commandments as "Thou shalt not kill" which the biblical context itself shows is to be understood as "Thou shalt not kill the innocent", thus not applying to the unjust aggressor in the act of aggression or as punishment of serious crime. Jesus' own advocacy of non-violence, even against enemies, is so well known that this point requires no elaboration here. [4] It is sufficient to point out that recent developments which have pressured physicians whose commitment is to save life into becoming executioners radically undercuts the whole tradition and meaning of the profession. Will physicians become like those lawyers who use their knowledge of the law to break it? [5] The direct killing of human life by abortion or euthanasia cannot be excused on the grounds that it is the pregnant patient who choses to kill her child or the suffering patient who wants to die. In such cases the physician always and in all circumstances in morally obliged to refuse any cooperation in such direct attacks on human life. [6] Human life is not a human creation, but is a gift of God given in stewardship to be used well, not to be rejected.

A **second principle** is that the primary responsibility for one's own body is one's own, consequently no medical procedure may be applied to anyone without their free and informed consent, or if they are incompetent to make such a decision, that of their proper guardian acting for their benefit. [7] Again, this principle is exemplified in a wider sense by Jesus when he respected the consciences of his followers, asking of them only their own voluntary commitment. [8] This principle in fact liberates the physician from the obligation to decide for the patient whose exact circumstances and disposition it is very difficult for him to know. The physician's obligation is to truthfully inform the patient or guardian of his diagnosis and recommendations for treatment, its risks and benefits, not to decide for the patient whether in fact the recommendation is to be followed. Of course, as already mentioned, physicians ought not to cooperate in decision made by their patients which the physicians themselves believes to be either medically or ethically unsound.

The **third principle** is really a corollary of the second: the physician ought not to insist on procedures which the patient (or when the patient is incompetent the guardian) judges to be "extraordinary means," i.e., to promise only a minimal benefit or at least one which does not compensate for the burdens of such treatment to the patient and to those who will have to provide this care. [9] It is sometimes seen that physicians, either from a laudable commitment to do all their art can provide, or from a reluctance to admit the limits of their art, of from hesitation to make a difficult decision, or perhaps because of fears of litigation, have a tendency to propose procedures whose benefit is dubious or whose burden is excessive, even against the will of the patient or the guardians. The Christian attitude, expressed by Jesus in his own submission to death, is that bodily life is not the ultimate value but is relative to spiritual goals. [10]

The **fourth principle** concerns what is the most ethically controversial field of medicine that of sexuality and reproduction. Before trying to formulate this principle, it is important to focus these controversial questions on the essential point. [11] The Church's concerns about sexuality are primarily not, as many suppose, that it fears the earthly pleasures which sex can provide as dangerous rivals to the the heavenly joys which religion promises. No, the Church's primary concern as regards sexuality is a concern for justice, and above all justice to the child.

The wide adoption of contraception (against the solemn warnings of the Church as to its intrinsic moral deformity in the face of dissent of not a few moral theologians) has separated sexual activity from its relation to procreation. As a result many Catholics no longer perceive the fact that the ultimate moral significance of sex cannot be understood unless we focus our attention on how each form of sexual activity affects children. Hence, I would like to illustrate the way in which the Christian moral perspective affects medical practice from the field

of pediatric medicine, at the same time noting that the same four basic principles apply to all medical fields.

Limits on Pediatric Medicine

Every child from the first moment of its existence is a human person with human rihgts. [12] The first of these rights obviously is to be born and that is why abortion is a grave injustice to the child that cannot be excused by some lesser advantage to the mother. But the child also has a right to be born within marriage, because only in such a stable environment can it have its full chance to develop physically and psychologically. It is unique to the human species that the male is bound to the female by the possibility of intercourse throughout the entire year, and this biological bond it perfected by the deep psychological bond of complementarity and intimate personal communication that makes possible a union of true love. This bond of love between the spouses is the best guarantee of the child's security and when it is broken, as we see so often today in divorces, the child suffers a very real deprivation. Such an unlucky child is truly handicapped, truly disabled in a way that is very difficult to remedy.

Not only does the child have a right to be born and to be born legitimate, but it has a right to be born to its biological parents. The adpoted child is still a handicapped child, although its adoptive parents may do much to remedy its loss of biological parents. Yet these adoptive parents, for all their loving care, cannot restore to the adopted child what children normally enjoy, the security and sense of identity which comes from knowing they are bound to their parents not merely by the subjective ties of love, as wonderful as these, are but by the objective basis of love in flesh and blood. Human experience throughout history and the accounts we frequently read in the newspapers of adopted children searching to find their biological parents are proof that this human longing is profoundly a part of our nature. [13] Hence, artificial reproduction by heterologous insemination from a donor other than the husband produces a child who lacks this biological link to its adoptive father. [14] When this insemination takes place in a surrogate mother, this bond to parents is still further weakened, since now the child is clearly the fruit of adultery. [15]

What then are we to think of artificial homologous insemination with the semen of the husband, or of in vitro fertilization where the child is no longer the result of intercourse at all, but is the product of a technician who combines ova surgically removed from the mother with the father's semen — semen in both cases usually obtained by masturbation? [16] Undoubtedly the result of such techniques is still the production of a healthy child, genetically linked to a couple who would otherwise have to adopt. Yet this child too is a handicapped child, because it lacks that ultimate objective link to the parents which the normal child has, namely, that it is fruit of the very act of love which binds the parents to each other. A child has the right not only to be born, to be born legitimate, to be raised by its natural parents, but also to be the co-creation with God of the their act of sexual love.

This point seems to many absurdly subtle. After all, they say, does it make that much difference to the child? Perhaps the child will never know that it was produced in a test tube. Perhaps if it does know it will accept the fact that its parents wanted it so badly that they were willing to resort to high-tech procedures to beget it. No doubt such acceptance will in fact not prove especially difficult for many children, just as being adopted is usually accepted simply as a fact of one's life. Certainly it is better to live and to live in a loving family as a wanted child, that not to exist at all. Compared with this joy, the exact mode of one's coming into existence seems not of much importance. But to admit all this is not to admit that such children are not handicapped in a very fundamental way. They lack something to which they have a natural right.

This point becomes more telling when we stop to think of the social consequences of the gradual acceptance of artificial insemination and in vitro fertilization as a regular procedure. It is a psychological fact that even now many children fear that maybe they are really adopted children and not the biological children of their parents, with a consequent anxiety that they may ultimately be rejected by these "parents." [17] What will the situation be when all children begin to question whether perhaps their "real parent" was a nameless technician who concocted them in a laboratory? Today in developed countries where the environment has become highly artificial, the sense of the natural foundations of the family are already much weakened. [18] In the United States the single-parent family is becoming a wide-spread phenomenon, and children are more and more raised in "day-care centers" with parents absent. Children deprived of the natural bonding that results from the intimate love expressed in intercourse that is the source of their very existence and identity are handicapped children, victims of a grave injustice.

But you may say, "But without these techniques this child would never have existed at all. How can there be an injustice to a child who does not yet exist?" I will answer that most physicians would agree that when a couple decides to beget a child with a serious genetic disease, they are responsible for its existence as seriously defective child, and they probably should refrain from satisfying their own desire for a child, although unquestionably once such a child is conceived it has the right to be born and cared for. Similarly, an in vitro child once conceived has a right to be implanted in a mother, to be born, and to be cared for, but the parents who gave the ovum and sperm from which they were constructed by a technician bear a responsibility for bringing this child deprived of a normal origin into existence. The child is no longer viewed as a unique gift, but is reduced "to an object of scientific technology."[19]

The Church's conception of human sexuality emphasizes "the language of the body." The Instruction on Respect for Human Life follows the Church's understanding of sexuality as a natural sacrament, a sign of a spiritual love. Hence married couples express their unifying love not merely by spiritual but by bodily acts, because human beings are both body and soul and their mutual gift of self is bodily and spiritual. Their cooperation with God in the creation of a new human being who is also both body and spirit is therefore a truly sacred act, of a higher order than that of human technology which may assist it but cannot substitute for it. [20]

Both the test-tube baby and the seriously defective child may well say, "I thank my "parents" for having me produced, but it was an injustice to me to come in the world deprived of what other children enjoy." Moreover, when such deprivations are the result of merely natural or accidental causes beyond human control, we must accept them as part of our destiny, but when they are the result of human deliberation and choice we can rightly blame them on their perpetrators.

Further reflection shows that the other aspects of the Church's teaching on sexuality which seem over restrictive to many today, stem first of all from this same concern for the rights of the child. Contraception does not guarantee that a couple engaging in extra-marital intercourse will absolutely avoid pregnancy. No form of contraception now known, except sterilization, is free from a serious risk of pregnancy, as is evident from the very

high rates of abortion, chiefly among the unmarried, in many countries where contraceptive methods are widely distributed and accepted. [21] To engage in even one act of intercourse involves a very real risk that a child may result, and this child will suffer the injustice of illegitimacy. If the relationship is adulterous there is the further injustice of the grave injury to the marriage bond and to children already begotten in this bond. Thus the Church rejects extra-marital sex not only because it is an irresponsible indulgence, but because the more such relationships are countenanced in a society the more the security of children within stable families is imperiled. The injustice done to children by divorce is perhaps even more serious. [22]

The same reasoning applies to homosexual activity, today so widely condoned, to other forms of sexual indulgence separated from any relationship to procreation, and even to masturbation. [23] Such activities, which seem to affect no one but those who freely engage in them, in fact create in the culture an attitude to human sexuality which undermines the security of the family and hence of the child. Persons enslaved to such practices are incapable of forming that kind of stable marriage which children need for their own growth, and the result is that they themselves may grow up without clear heterosexual sexual identity and motivation. The Church should defend the human rights of homosexuals and other sexual deviants, but it cannot accept their claims that their condition is simply a normal variant nor that their indulgence of their abnormal inclinations is morally justified. It is a false compassion to help a disabled person deny their disablement, and true and loving care to enable them to acknowledge their defects realistically and to learn to live with dignity and wirtue in spite of them. Thus the whole Christian view of sexual ethics centers in the rights of the child. This is why, I believe, that while Jesus did not preach about sexual morality often, and only to correct the defects of the Mosaic Law with respect to divorce and to insist on purity of heart as well as of action, yet he often dwelt on the dignity of the child, of the "little ones." When his disciples tried to dismiss children lest they get in the way of the Master's preaching and healing, Jesus rebuked them and called the children to himself, blessed them, and said "Of such is the kingdom of God." [24] He also warned that anyone who corrupted the innocence of children deserved to have a mill-stone hung aroung his neck and to be cast into the sea. [25] Any service done to a child, Jesus said, was a service to Himself. Those who sincerely feel this Christ-like concern for children will come to see, I believe, the wisdom of what the Church has always taught and teaches today about sexual morality, even if it is a "hard saying."

One of the saddest blots on the record of human history has been the neglect of children. [26] When we think that in many countries in the past half of all human beings died in infancy, and this situation in many places today still prevails, and we realize that most of this results from poverty, we cannot doubt that human greed is a major factor in their deaths. Again the history of abortion, of infanticide, of child abandonment, of child prostitution, of the neglect of education, of polygamy, illegitimacy, venereal disease and drug addiction transmitted to children is appalling. Even in wealthy, aristocratic, and royal families throughout history there is a scandalous pattern of leaving children to the care of servants, sending them away to school to get rid of them, and neglecting their moral training. In many ways today the situation is not much better.

This is why the role of the pediatrician in society is of immense importance. Modern medicine makes it possible to remedy many of the ills and defects which in former times had no answer. Anyone who has visited a modern hospital for children is deeply moved by the wonderful and truly loving care that suffering children receive there, and the profound understanding of the needs of the child which so enriches the Church's own experience as advocate of children's rights.

In the United States today there is tremendous concern for the abused child and stringent laws about reporting such abuse to public officials. Although Americans are so sensitive to what they regard as public intereference in the bed-room and so jealous of the "right of privacy" which the Supreme Court has discovered as an implication of our Constitution and its Bill of Rights, yet few question the duty of the government to breach the privacy of the home to salvage the abused child or the battered wife. It is an anomaly therefore that the Supreme Court continues to declare that a woman's "right of privacy" permits her to destroy the child which in a few months or even days will be so rigorously protected from abuse. In the long run the facts of medicine will expose this contradiction for what it is. We must come to recognize that sexual activity by its very nature has a social dimension because of its relation to the welfare of children and cannot ever be simply a private matter.

The Positive Guidance of the Church

Yet again some engaged in research may well, say, "These restrictions which the Church puts on the development of new techniques stand in the way of the scientific research necessary to find ways to overcome genetic defects and in many other ways to promote the health of children. Is not the Church therefore hypocritical in claiming to be the advocate of the rights of the child?"

The Church does not oppose, but strongly urges scientific research on genetic and developmental problems and the devising of better techniques to regulate procreation and overcome infertility, and to promote child health. [27] It prays for the success of such endeavours and encourages young people to enter into the scientific and medical education for this motive. The Church originated the hospital and it has encouraged religious commitment of sisters, brothers, and priests to hospital ministry. [28]

Nevertheless, the Church has to insist on the ethical principles which somewhat limit medical research and practice in order to be the advocate of the rights of the child and of adults. This does not set the Church in opposition to the medical professions since both Church and profession ultimately aim at the welfare of human beings. Rather it places the Church in a position of dialogue. The Church does not impose these principles but simply brings them to the attention of the medical profession, confident that fair-minded discussion will permit the truth to prevail.

Difficulties arise chiefly in the case of Catholic healthcare facilities sponsored by the Church. When a hospital takes the name of "Catholic" and especially when it is controlled by a religious order, it publicly professes to those who seek its services that it shares in the Church's advocacy of human rights, and it ask for financial support on that basis. Consequently, if it were to permit this institution to cooperate in medical procedures which in the Church's judgment violate human rights, it would become a responsible party to making false claims to the public.

Today, Catholic hospitals are often staffed by many physicians and nurses who are not professing Catholics, or who are Catholics alienated from the teaching authority of the Church. Moreover, many of their patients are not Catholics or are alienated Catholics. Finally, Catholic hospitals commonly are beneficiares of public funds re-

ceived from a secular, pluralistic state and would have great difficulty continuing their services without these funds. They seem, therefore, obligated to provide the public with all the medical procedures which are usual in non-Catholic institutions. This situation raises both the ethical problems of cooperation in activities which have both good and bad effects and of respect for the consciences of those with whom one does not agree. [28]

As regards conscience, it should be clear that a Catholic healthcare institution can never in any circumstances do or formally cooperate in doing anything which the Church has authoritatively declared to be immoral. While it is certainly true that the pastors of the Church, even the Supreme Pontiff may on occasion err in their teaching, short of the solemn definitions of the universal episcopate or the Pope which bear the mark of infallibility, their guidance because of its authoritative character is the only safe guide for an instituion that by its name claims the support of the Church. [29] Individual Catholic professionals in their own personal decisions, apart from institutional policy, must of course ultimately act according to their own well-informed conscience, but it is difficult to see how in matters of ethics such a professional can honestly suppose that his own moral judgment is more reliable than that of the Church, even when he sees that the bishops are in fact mistaken with regard to some of the medical data. Of what service is a physician to a patient, if the patient ignores the physician's advise and follows his own untrained understanding of medical matters? Of what service then is the Church to physicians, if they ignore her teaching and follow their own, usually untrained, understanding of ethics in ethical matters?

On this score a good deal of confusion has arisen in recent years because a good many prominent theologians have dissented from the Church's teachings, especially on questions involving sex and reproduction. [30] Consequently some physicians have the impression that the existence of such dissent permits Catholics freely to select the theological opinion which seems most plausible or even most convenient and act on it, and for physicians to cooperate in the implementation of these preferences. Instead they should be aware that Vatican II sought to give great freedom (sometimes today seriously abused) to theologians to debate issues to promote the advancement of the discipline of theology.

Consequently, views are frequently put forth in a hypothetical manner for critical discussion among theologians, without any guarantee that these views will eventually prove sound. Indeed the odds are that most will prove unsound, just as most experimental drugs prove useless. Consequently, the views of theologians never have and never will be a sound basis for moral action until they have been approved by the pastors of the Church who alone have authority from their office to guide Christian consciences.

Physicians, therefore, should draw their ultimate practical guidance not from the writings of theologians, however distinguished, especially as often badly reported in the public media, but from the authentic declarations of the Church. I assure you that today these declarations when they touch on medical issues are not made without careful consultation with the medical profession.

The more difficult question is how to respect the consciences of those with whom we necessarily cooperate. How do Catholic physician counsel patients whose moral convictions are different from their own? Can physicians accept the decision of such patients and act on them simply as agents of their clients? What if the patient insists and threatens to seek counsel from another physician? The answer to such questions must certainly be that although Catholic physicians must be respectful of the subjective conscience of their patients and not pressure them to act contrary to their consciences, for the same reason they must respect their own Catholic consciences and refuse to cooperate in what they believe to be objectively wrong. When a third party is involved as in abortion, or in the possible transmitting of a venereal disease, the physician should do what he can to protect the third party.

What if the Catholic health-care institution or the individual Catholic physician or nurse in involved in a cooperative endeavor with non-Catholic institutions or professionals, or is receiving government funding, and thus becomes involved in actions that are forbidden by Catholic teaching? We have here the very delicate prudential question of what is technically called “formal and material cooperation.” [29] The Catholic Church has never taken the purist stand tha it is wrong to cooperate in any activity with others if this cooperation involves even indirect support of some morally reprehensible actions. If we were to take that stand, we would have to withdraw from the world to which Jesus send us to minister. He did not hesitate, in spite of the criticism of the Pharisees, to dine with sinners, even when his presence seemed to give some support to their sinful ways of life.

It is always wrong to cooperate formally with actions which are intrinsically evil either by actually sharing in their execution, or approving, or advising them. The physician who will not perform an abortion but refers a patient to an abortionist cooperates formally and shares in the crime of abortion. On the other hand a physician who works in a hospital where along with many legitimate services some abortions are performed, but does not perform them himself nor approve them, cooperates only materially, i.e. indirectly, in that although his own work is good it helps maintain the hospital and thus indirectly makes possible the abortions. To decide whether such indirect or material abortion is ethical, the physician must weigh the consequences of his continuing to work there or of withdrawing. If by withdrawing he can stop the abortions or bring about some other very good result, he should leave. But if his withdrawal will have little effect in preventing the evil, and will make it difficult for him to continue his own good services, it would be better for him to stay. Thus what needs to be considered is how immediate is his cooperation in the evil, the more immediate the greater must be the good accomplished or the evil prvented by his cooperation to justify this cooperation.

In the case of a Catholic institution entering into some cooperative agreement with another, such questions must be thoroughly worked out and formalized in the written agreement before the cooperation is begun, as well as being subject to future revision based on experience. In the case of state funding and regulation, Catholic institutions in extreme cases must refuse such funding unless proper respect for conscience is shown by the government, even if this means closing the institution.

In such situations there may be a possibility of purely material cooperation, since it is possible that the evil of eliminating Catholic institutions and the witness they give to human rights in medicine may outweigh the evils involved in this cooperation. Yet it should be remember even in such cases that material cooperation may sometimes have such an appearance of hypocrisy that the scandal given may weigh the scale against cooperation. The early martyrs refused even a pinch of incense to the idol of the Emperor.

A final doubt is raised by the fear of many in medical research that the Church's concern for human rights, as laudable as it may be, will become a serious obstacle to advancement of the very knowledge that will enable medicine in the future better to serve the child and give it

its rights. Why disaprove, for example, the use of fetuses in research that have been obtained by abortion if this would not prevent their abortion, but would put them to some use that would help other children? Why completely forbid in vitro fertilization when this technique is so useful in learning how to remedy genetic diseases? Why forbid obtaining semen by masturbation, when this makes infertility testing and the discovery of remedies for it more effective?

Over all this hangs the shadow of historic incidents such as the Church's opposition to the dissection of corpses, or to Galileo's discoveries with the telescope! [30] More accurate history demostrates that such incidents have been relatively rare and can hardly count among the more serious impediments to scientific advance such as the failure of governments to support basic research except for military purposes. Yet it should by granted in honesty that ethical considerations may close off some attractive research modes. Who does not grant today that we cannot simply use human beings like we do guinea pigs? Or that researchers must be content to experiment on animals before they use new drugs or new kinds of surgery on humans, although direct experiments on humans would be more revealing? The ingenuity of scientists has always found ways to explore nature inspite of such necessary restrictions, and indeed it is likely that the very challenge of these restraints has spurred research. [31] What the Church insists on is simply that the fetus ought to be treated as a human subject, not as subhuman. We would not use human persons marked by a Hitler for genocide for experimental purposes on the excuse they are going to die anyway. Nor, less we seem to be partners in this crime, would we use their corpses. Why then should we experiment on fetuses created in the laboratory to be studied and then destroyed, or on ones obtained from and abortionist? Therefore, the Catholic Church as the community of which Jesus Christ, the healer, is head, speaking through its pastors who have received their commission of guidance from Him, blesses research scientists, physicians, and nurses, in their self-sacrificing work for humanity, laying no burden or restriction on them except to remind them that all human beings, including children, and the unborn, are created in God's image and should come into the world in families that exemplify God's love and through the very act of love by which this mutual covenant of love is firmly established, and should leave this world consoled by the Church's sacraments, neither unwisely retained in life by some useless medical tour de force, nor rejecting the gift of life by so-called "mercy killing." The medical profession has won the great honor in which it is still held by this reverence for the dignity of human person even when obscured by the extremes of suffering, and it will retain that honor only when it retains that reverence, today already somewhat tarnished by too many compromises with practices utterly contrary to human dignity.

History demonstrates that the rights of truth, including scientific truth itself, depend on our respect for human dignity. [32] Science is a human activity and achievement, one of the noblest of human activities and achievements, and it cannot flourish except in a society that appreciates and defends the great human values. When human life loses its sacredness, brute power rules the world and science becomes just another instrument of enslavement rather than a search for truth. Therefore, the healthcare profession, if it is to be loyal to its own dedication to science in the service of human health, must defend human rights, even at the inconvenience of certain reasonable restrictions on its own options. In fact such restraints do not inhibit scientific progress but rather guide it into more productive channels.

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2. SCDF, Instruction on Christian Freedom and Liberation, n. 68, translated in Origins 15 (April 16, 1986) 714-728 speaks of the poor as "the object of a love and preference".

3. Theses de la comission theologique international: La dignite et les droits de la personne humaine, Documentation Catholique 82 (1985): 383-391.

4. See Raymond Regamey, O.P., Non-Violence and the Christian Conscience (New York: Herder and Herder, 1966) for the necessary distinctions.

5. See Leon Kass, M.D., "Neither for Love nor Money: Why Doctors Must Not Kill" in The Human Life Review 15 (Fall, 1989) 93-115.

6. SCDF, Declaration on Procured Abortion, 1974, translated in Osservatore Romano, English ed., Dec. 5, 1974 and Declaration on Euthanasia, May 5, 1980, translated in Austin Flannery, O.P., ed., Vatican Council II: More Postconciliar Documents, vol. 2 (Northport, NY: Costello Publishing Co., 1982), p. 510-517.

7. On informed consent see Benedict M. Ashley and Kevin D. O'Rourke, Healthcare Ethics: A Theological Analysis, 3rd ed. (St. Louis, MO: Catholic Health Association of the United States, 1989), p. 68-70, 203-204 and Edmund Pelligrino, M.D., "The Moral Foundations for Valid Consent," Proceedings of the Third National Conference on Human Values and Cancer (Washington, DC: American Cancer Society, 1981).

8. John 6:60-69.

9. "It is also permissable to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected or a desire not to impose excessive expense on the family or the community." Declaration on Euthanasia (note 6 above); cf. Ashley-O'Rourke, (note 7 above) p. 380-384.

10. "Normally [when prolonging life is in question] one is held to use only ordinary means—according to the circumstances of persons, places, times, and cultures—that is to say, means that do not involve any grave burdens for oneself or for another. A more strict obligation would be too burdensome for most people and would render the attainment of higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends." Pius XII, "Prolongation of Life", Nov. 24, 1957, translated in Gary Atkinson, ed., Issues in Ethical Decision Making (St. Louis, MO: Pope John XXIII Medical-Moral Research and Education Center, 1976).

11. The most important magisterial documents are: Pope Paul VI, Humanae Vitae: Encyclical Letter on the Regulation of Births, 1968 (Washington, DC: United States Catholic Conference); SCDF, Declaration on Certain Problems of Sexual Ethics, Dec. 29, 1975, translated in Flannery (note 6 above), p. 486-499; and DV.

12. The Church's position on human rights from conception does not depend on the question of the time of ensoulment (cf. Declaration on Procured Abortion, note 6 above), since even if it were uncertain that the conceptus is already a human person, the benefit of the doubt must be in its favor. But as a matter of fact present scientific evidence removes reasonable doubt on this score (cf. Instruction on Respect for Human Life, note 11 above). Efforts to show that the conceptus is not an individuated organism until approximately the time of implantation in the uterus on the ground that during this phase of development twinning or fusion of twins can still take place (e.g. Norman M. Ford, When Did I Begin?, Cambridge: Cambridge University Press, 1988) do not sufficiently taken into account the evidence that in mammals the genome is in control of development of the embyro (or pre-embryo as some term it) from the first cell division and that in the morula and blastula phases, although the blastomeres remain totipotential and if separated can develop into complete new organisms by a kind of natural "cloning" as seems to happem with identical twins, etc., yet they already exhibit a tight compaction and interrelation as well as an organic polarity that indicates they are not simply a loose assemblage of cells, but a true unified organism. Cf. Scott F. Gilbert, Developmental Biology (Sunderland, MA: Sinauer Associaties, Inc. 1985), p. 74-109.

13. See Jan De Hartog, Adopted Children (Adams Publishers Inc.: 1987); Erica Haimes and Noel Timms, Adoption, Identity, and Social Policy: The Search for Distant Relatives (New York: Gower publishing Co, 1985); Arthur D. Sorsky, et al. Adoption Triangle Doubleday, 1984); Jeanne Du Praw, Adoption: The Facts, Feelings, and Issues of Double Heritage (New York: Messner, 1987) for current information on this problem.

14. "Recourse to the gametes of a third person, in order to have sperm or ovum available, constitutes a violation of the reciprocal commitment of the spouses... Moreoever, this form of generation violates the rig-

hts of the child; it deprives him of this filial relationship with his parental orginis and can hinder the maturing of his personal identity.", DV II, A, 2.

15. "Surrogate motherhood represents an objective failure to meet the obligations of material love, of conujugal fidelity, and of responsible motherhood; it offends the dignity and the right of the child to be conceived, to be carried in the womb, to be brought into the world and to be brought up by his own parents; it sets up to the detriment of families a division between the physical, psychological, and moral elements which constitute those families." DV II A,3.

16. See Ashley-O'Rourke (note 7 above), p. 280-283. The magisterial objection to artificial insemination by the husband (AIH) does not rest primarily on the fact that the process usually involves self-stimulation to obtain the semen (although that too is probably illicit) but on the separation of reproduction from the marital act.

17. See note 13 for bibliography.

18. See excerpts from The Family: Preserving America's Future, by the Working Group on the Family, a White House task force, in The Human Life Review 13 (Winter, 1986) 105-116.

19. DV, II, B, 4, c.

20. "Fertilization achieved outside" the body "remains by this very fact deprived of the meanings and the values which are expressed in the language of the body and in the union of human persons." DV, II, B, 4, 6. The concept of "the nuptial meaning of the body" as expressing the need of human persons to make a total gift of themselves to others, sexually or in other modes of self-giving, has been remarkably developed by John Paul II in his Reflections on "Humanae Vitae" (Boston: St. Paul Editions, 1984) p. 29-34 and Original Unity of Man and Woman (Boston: 1981).

21. See Stan E. Weed, "Curbing Births, Not Pregnancies", Wall Street Journal, Oct. 14, 1986. According to the World Almanac there were 1, 300,760 legal abortions performed in the United States in 1981. This figure has remained stable to date. For the stand of the Magisterium on contraceptive sterilization see Doctrinal Congregational Statement on Sterilization, March 19, 1975, in Commentary of National Conference of Catholic Bishops (Washington, DC: United States Catholic Conference, 1978).

22. See Zoe L. Frost, "Children in a Changing Society, " Childhood Education, March/April, 1988, p. 244 ff.

23. SCDF, Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons, translated in The Vatican and Homosexuality: Reactions to the Letter, ed. by Jeannine Gramick ad Pat Furey (New York City: Crossroad, 1988) with my contribution, "Compassion and Sexual Orientation," p. 105-111. Most of the other contributors (except Archbishop John R. Quinn, p. 20-27) are hostile to the Letter. See also John Harvey, The Homosexual Person: New Thinking in Pastoral Care (San Fancisco: Ignatius Press, 1987).

24. Matthew 19: 13-15. For concise explanations of the Christian understanding of human sexuality see Ronald Lawler, Joseph Boyle, Jr., and William E. May, Catholic Sexual Ethics (Huntington, IND: Our Sunday Visitor Press, 1985) and Paul M. Quay, The Christian Meaning of Human Sexuality (Evanston: Credo House, 1985).

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26. See Philippe Aries, Centuries of Childhood (London, 1982). For a contrary view see Thomas Fleming, "Affection and Responsibility in the Family in Classical Greece," The Journal of Family and Culture 1 (1985) 43-56.

27. "Basic scientific research and applied research constitute a significant expression of this dominion of man over creation. Science and technology are valuable rsources for man when placed at his service and when they promote his integral development for the benefit of all." SCDF, DV, Introduction.

28. On the history of the hospital see William A. Glaser, Social Settings and Medical Organization (New York: Atherton, 1970).

28. See Ashley-O'Rourke, p. 188-90, 30. See Archbishop Daniel Pilarcsyk: "Dissent in the 31. Church," Origi 1986) 175-178.

29. Ibid.

30. See Bernard Vinaty et al., Galilei: 350 ans d'histoire, ed. by Paul Poupard with a declaration of John Paul II (Tournai, Belgium: Desclee International, 1983).

31. Who denies that research on living adults must be restricted by ethical considerations and animals used instead, although this makes research somewhat more difficult?

32. See Robert Jay Lifton, The nazi Doctors: Medical Killing and the Psychology of Genocide (New York: Basic Books, 1986).

N.B. Paper submitted by the author in May 1992 to the International Symposium on Medical Ethics, Bratislava, Slovakia, 29. - 30. 5. 1992.

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HOMO PATIENS: ÉTOS LEKÁRSKEHO POVOLANIA A ETICKÁ VÝZVA SÚČASNOSTI

Peter Korený

Lekár je vo svojej klinickej praxi konfrontovaný s otázkami, ktoré ďaleko presahujú horizont vlastnej odbornomedicínskej starostlivosti. V poslednej inštancii sú to otázky patriace do metaklinickej oblasti, t.j. do oblasti špecificky humánnych fenoménov, ktoré sú neprístupné klinickému mysleniu a ktoré sa skrývajú za klinickým obrazom ochorenia. Špecificky humánne fenomény vytvárajú vo svojom súhrne existenciálnu a duchovnú dimenziu trpiaceho človeka.

Vstupujeme tu práve do tej oblasti, kde sa pred nami vynára "homo patiens" ako bytostne slobodný a zodpovedný subjekt, ktorý sa vzťahuje k svetu hodnôt a v konkrétnych situáciach realizuje rôzne potencie životného zmyslu.

V popredí záujmu je tu pacient s jeho "poslednými" otázkami a špecificky ľudskými témami: naplnenosť a prázdnota ľudského života, zmysel života dramaticky obmedzovaného chorobou, zmeny hodnôt a hodnotenia u pacientov, existenciálna dynamika ako napätie medzi aktuálnym a potenciálnym bytím človeka, sebaprojektovanie do budúcnosti a sebatranscendencia. Ďalej sú to otázky zmyslu utrpenia a smrti, viny a pocitu viny, zúfalstva a nádeje. Sotva možno hovoriť o humanizácii modernej zdravotníckej starostlivosti a nebrať pritom do úvahy túto oblasť špecificky humánnych fenoménov, resp. zotrvávať len na úrovni zohľadňovania psychologických a sociologických aspektov chorého človeka. Nevšímavosť, resp. jednoducho nevidenie tejto osobitej roviny existencie pacienta sa v podstate rovná tomu, že ho ako ľudskú bytosť neberieme vážne.

Existencia tohto metaklinického priestoru nie je akademickou otázkou alebo čírou teoretickou konštrukciou. Sú to predovšetkým sami pacienti, ktorí nás konfrontujú s týmto okruhom otázok. Svedčia o tom pozorovania pacientov, ktorí sami a s veľkou naliehavosťou kladú otázky o zmysle života a hodnotách. Ba čo viac, tieto kritické otázky sa pre nich niekedy stávajú jedinými významnými otázkami. Upnutie sa k hodnotám, ktoré môžu naplniť zmyslom život napadnutý chorobou, pôsobí aj ako základný (ak nie rozhodujúci) motív a hlbší dôvod ďalšej existencie chorého človeka. Význam tohto motivačného faktora vzrastá osobitne v prípade ťažko chorých a umierajúcich pacientov.

V metaklinickom priestore jednak niečo **odkrývame** a **zviditeľňujeme** a jednak na niečo **apelujeme** (1). Pri tomto apele by som sa chcel teraz trochu zastaviť.

V pozadí manifestovaného správania sa niektorých onkologických pacientov, ktorí sa nesnažia nijako vzdorovať svojmu (biologickému) osudu, sa v niektorých prípadoch akiste skrýva to, že celé svoje Ja bezozvyšku stotožňujú so svojou chorobou a nechávajú sa ňou celí infiltrovať. Svojmu postihnutiu sami prepožičiavajú zmysel niečoho, čo má nad nimi fatálnu moc, ktorá ich celých ovláda a formuje ich ďalšiu existenciu. (Toto " prepožičanie zmyslu" je však vždy aktom slobodného rozhodnutia pacienta.) Pacienti povyšujú chorobu na "ne-moc" a sami seba degradujú na jej pasívny a poddajný prívesok. Nedokážu k nej zaujať osobný postoj ako k niečomu, čo v istom zmysle predstavuje len ich **parciálny problém,** ktorým sa ani zďaleka nevyčerpáva celá ich osobnosť. Sami tak zavrhujú svoju osobnosť, presnejšie povedané zavrhujú to, čím sú v existenciálnej a duchovnej dimenzii svojho bytia. Zavrhujú svoju osobnosť, ktorá je (prinajmenšom potenciálne) vždy niečím **podstatne iným** a niečím **viac,** než akákoľvek ťažká situácia, v ktorej sa ocitajú. Týmto "viac" sa stávajú v chápajúcom prisvojení si vlas-

tného utrpenia vo vzťahu k možnostiam svojej individuálnej existencie, vo vzťahu k zvažovaniu možností realizovať za danej situácie (so všetkými jej somatickými a psychickými obmedzeniami) hodnoty a naplniť zmyslom svoj život zasiahnutý chorobou.

Najdôležitejšie je pomôcť týmto pacientom obnoviť kontakt so samými sebou, so svojim Ja. Ide o to, aby sa naučili rozlišovať medzi tým, čo naozaj nemôžu ovplyvniť a za čo nemôžu, a tým, čo je v ich moci. Inými slovami, ide o to, priviesť pacientov k vedomiu svojej bytostnej slobody a zodpovednosti za to, čo zo svojho života napadnutého chorobou sami urobia.

Aby sme si túto problematiku ešte viac priblížili, uvediem príklad iného (a v istom ohľade priamo protikladného) osobného postoja k chorobe. Tento postoj si dovolím ilustrovať na jednom životnom príbehu, ktorý popisujú B. Blažek a J. Olmrová vo svojej knihe "Krása a bolesť". Žena, vo veku 65 rokov, bola vo svojom živote už osemnásťkrát hospitalizovaná. Okrem odoperovania mandlí a žlčníka a dvoch operácií spojených so zranením, všetky ostatné hospitalizácie súviseli so srdcom. Vo veku 35 rokov jej bola diagnostikovaná srdcová chyba a podstúpila operáciu. Operácia zverejnila postihnutie a tým zaistila určité nevyhnutné práva z neho vyplývajúce. Táto znížená latka vo fyzickej sfére viedla ku zvýšenej duchovnej aktivite. Budúca pedagogička si najprv dokončila okupáciou prerušenú strednú školu a potom absolvovala pedagogickú fakultu: "Hneď vzápätí po tej operácii, akonáhle som bola z rekonvalescencie trochu vonku, chopila som sa všetkých možností, aby som všetky duševné i telesné sily vydala a rozvíjala...". Táto žena nebojuje s chorobu ani priamym útokom - že by ju premáhala ešte väčším vypätím - ani obchvatom - pokusmi nájsť toho pravého lekára. Šetrí silami i zdravím, aby mohla čo najviac vykonať. Srdcová operácia v nej nedokázala vyvolať sebamenší záchvev. Veď táto žena neprijala predstavu, že bez tohto postihmutia by jej život mohol prebiehať nejako inak: sú väčšie sily v nej i mimo nej, ktoré určujú chod jej života (2). Celým svojím životom preukázala, že človek ako potenciálna existencia je niečím nepomerne viac než osudové danosti a obmedzenia jeho života, ktoré zmeniť nie je v jeho moci.

Praktický význam vyčlenenia existenciálnej a duchovnej dimenzie pacienta vidím predovšetkým v tom, že je východiskom pre odokrývanie a prebúdzanie špecificky ľudských potencií v pacientovi, ktoré je možné rozohrať a postaviť proti biologickým, psychologickým a sociálnym danostiam a ohraničeniam jeho života. Ak sa na pacienta začneme pozerať touto optikou, nejaví sa nám viac ako akýsi monolitný útvar, ktorý je celý difúzne kontaminovaný, ovládaný a determinovaný svojou chorobou (3). Naopak, ukazuje sa v živom dynamickom rozpätí existencie a faktického bytia, duchovného a biopsychofyzického, osudovo daného a formovaného (stvárňovaného), pacientom naozaj neovplyvniteľného a pacientom (do istej miery) ovládateľného.

Na autobiografiách trpiacich ľudí a na umeleckých zobrazeniach utrpenia sa stále znova presviedčame, že chorý človek zmysluplne začleňuje postihutie do svojej individuálnej biografie. Podobne aj v horizonte našej bežnej skúsenosti sa "choroba" a s ňou späté utrpenie objavuje v kontexte celku ľudskej existencie a za chorobou vždy vidíme chorého človeka. Nadväzujúc na to by sme mohli dospieť k vytvoreniu syntetického portrétu "homo patiens" ako človeka, ktorý transponuje fakt utrpenia na špecificky humánnu rovinu a tým ho zľudšťuje. Mimochodom, tu si hneď môžeme povšimnúť hlbokú asymetriu vo vzťahu lekára a pacienta. Zatiaľ, čo homo patiens transponuje fakt choroby na existenciálnu rovinu, u lekára vidíme skôr tendenciu transponovať ľudskú problematiku spojenú s chorobou na odborne-vecnú rovinu, kde sa cíti byť istejší a kde má prevahu nad pacientom. Pri vytváraní obrazu "homo patiens" je predovšetkým dôležité postihnúť trpiaceho človeka v rôznych kvalitatívne špecifických rovinách, ktoré sú vzájomne neredukovateľné. Vo vnútorne diferencovanom zobrazení trpiaceho človeka treba okrem takpovediac klasického prihliadania na psychologické a sociologické aspekty, vystihnúť aj jeho existenciálnu dimenziu, ktorou človek práve presahuje aj svoju bio-psycho-sociálnu ohraničenosť. O praktickej dôležitosti takéhoto multidimenzionálneho nazerania na trpiaceho človeka, sme sa mohli presvedčiť na vyššie uvedených protikladných postojoch k utrpeniu.

Pozoruhodný ľudský výkon, ktorý nám predvádza trpiaci človek, predstavuje určitú výzvu súčasnej dobe, vyznačujúcej sa hedonistickým únikom od bytostnej zodpovednosti človeka za život a povrchným, na obdiv vystavovaným optimizmom, ktorý glorifikuje tzv. radostné stránky života a odstraňuje z neho utrpenie a stálu prítomnosť smrti. Avšak tou mierou ako sa civilizácia snaží odstraňovať zo života utrpenie a prítomnosť smrti a vytvárať prostredníctvom tzv. priemyslu zábavy stále nové a nové zdroje radostí a zmyslových rozkoší, vystavuje človeka čoraz hlbšiemu utrpeniu zasahujúcemu duchovné jadro osobnosti.

Problémy, ktoré sme tu načrtli, sú filozofickej povahy. Nejde pritom o umelé vnášanie filozofickej problematiky do medicíny, ale skôr by sme sa mali usilovať nadviazať na prakticky žitú filozofiu človeka v núdzi (teda pacienta) a človeka pomáhajúceho v núdzi (teda lekára). Navyše je to podľa K. Jaspersa práve naša doba, ktorá tlačí lekára (a hlavne psychiatra) do roly, ktorá bola predtým výsadou kňazov a filozofov.

Na záver celej tejto úvahy by bolo možné pokúsiť sa explicitne formulovať, v čom spočíva hlboký filozofický étos lekárskeho povolania. Zdá sa mi, že vzhľadom na to, o čom sme tu hovorili, nič nie je výstižnejšie ako nasledujúci Goetheho výrok: "Ak budeme brať ľudí takých, akými sú, potom ich robíme horšími, ak ich ale budeme brať takých, akými by sa mali stať, potom z nich robíme to, čím môžu byť".

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MEDICÍNSKA ETIKA A SEXUÁLNA VÝCHOVA

Ladislav Lencz

Každý psychológ vie, že vedieť, čo je správne, ešte zďaleka neznamená robiť to, čo je správne, preto medicínska etika musí vyústiť v účinný výchovný program, založený na hlbokej znalosti vývinovej a sociálnej psychológie. To sa týka najmä etiky sexuálneho správania.

Projekt realizovaný v populácii 6000 rodičov a adolescentov zo 4 oblastí USA potvrdil skutočnosť, ktorú mnohí z nás poznajú z vlastných pozorovaní, t.j. že pre sexuálne správanie sú rozhodujúce vzťahy v rodine, v ktorej dieťa vyrastá. Ak sa dieťa cíti rodičmi prijaté, milované a oceňované, ak komunikácia medzi rodičmi a deťmi je intenzívna a dobrá, celoživotné monogamné manželstvo získa v hodnotovom systéme dieťaťa popredné miesto. Takéto

dieťa netrpí citovou depriváciou a zpravidla nemá potrebu púšťať sa do predčasných citových a erotických dobrodružstiev. Ak tieto podmienky nie sú splnené, mladý človek hľadá kompenzáciu za citovú depriváciu v predčasnej erotike. Pri rozkolísanej psychike detí vyrastajúcich bez lásky prvé dobrodružstvo sa končí spravidla frustráciou, čo neraz vedie k uzavretiu sa do seba, strachu zo sexu alebo naopak, k promiskuite.

Ak teda sexuálna výchova (výchova k životu v rodine) má byť účinná, nesmie sa obmedziť len na 'technické' poučenie, ale musí zohľadniť spomínané skutočnosti.

Existuje pomerne málo výskumov, ktoré by sa venovali psychickým aspektom sexuálneho správania a ešte menej projektov, ktoré by ich zabudovali do účinného programu. Veľmi zaujímavým prínosom v tomto smere je projekt nadácie Americké rodiny "Význam plodnosti pre rodinu", podporovaný americkým ministerstvom zdravotníctva, ktorý dôsledne uplatňuje aspekty psychológie osobnosti, vývinovej a sociálnej psychológie.

Projekt vychádza zo skutočnosti, že pre sexuálne správanie má rozhodujúci význam skúsenosť lásky a také správanie rodičov, ktoré rozvíjajú sebaoceňovanie (self-esteem), komunikačné schopnosti a sebaovládanie dieťaťa. Pomáha rodičom osvojiť si výchovné metódy, ktoré podporujú tieto dôležité skúsenosti a postoje u dieťaťa. Podrobnosti sú opísané v knihe Mercedes A. Wilson - Láska a rodina.

Trojročná aplikácia projektu v kontrolovaných podmienkach sledovania priniesla pozoruhodný úspech. V 'experimentálnej' skupine 6000 osôb sa vyskytli iba 3 otehotnenia adolescentiek na 1000 mladých, kdežto americký priemer je 111 otehotnení na 1000 mladých.

K tomuto výsledku treba poznamenať, že podľa môjho názoru nepotvrdzuje dostatočne účinnosť metódy, pretože už dobrovoľná účasť v experimente tohto druhu svedčí o relatívne dobrej atmosfére v zúčastnených rodinách. Preto nevieme, či dobrý výsledok (28-násobný pokles otehotnení adolescentiek) je spôsobený prevažne metódou, alebo skôr dôsledkom už existujúcej dobrej atmosféry v rodine. Z hľadiska zámeru, ktorý sleduje tento príspevok, je však táto úvaha irelevantná. Rozhodne potvrdzuje aspoň to, čo tento príspevok chce dokázať a na čom je založená naša koncepcia: pozitívnu koreláciu medzi dobrou rodinnou atmosférou a žiadúcim sexuálnym správaním.

Veľkým prínosom projektu je, že pomáha často bezradným rodičom, aby vedeli svojim dospievajúcim deťom nielen prikazovať a zakazovať, ale aj účinne pomáhať. Na druhej strane zameranie na rodičov je jeho podstatnou slabosťou: pomerne veľká časť súčasných rodín je nefunkčná, chýba záujem a často aj elementárne predpoklady zúčastniť sa podobného projektu.

Nemáme prístup k rodičom, zato však všetky deti máme v škole. Ak sa podarí vybudovať pravé a láskyplné spoločenstvo, v ktorom sú vzťahy podobné vzťahom v dobrej rodine, skúsenosť lásky, prijatia, oceňovania a zmysluplnej komunikácie v rodine - môžu aspoň do istej miery priblížiť deťom chýbajúcu lásku v rodine.

Na tejto 'filozofii' je založený náš projekt školskej výchovy nazvaný "Etická výchova". Funguje už dva roky na 20 školách a od septembra 1991 na ďalších asi 300 školách na Slovensku. Na štatistickom vyhodnotení účinnosti projektu sa pracuje, kvalitatívne hodnotenie (výpovede učiteľov) hovoria o tom, že správanie menších detí za rok, správanie stredoškolákov behom dvoch rokov sa výrazne zmení. Deti sú otvorenejšie, naučia sa riešiť konflikty neagresívne, napríklad vzájomným vysvetlením, naučia sa akceptovať aj menej príťažlivé deti. Zaznamenali sa výrazné úspechy aj u problémových detí. Sexuálna výchova je plánovaná až v treťom alebo štvrtom roku, pretože napred treba položiť dobré základy úcty k sebe a úcty k druhým, empatie, asertivity, prosociálneho správania, rozvíjať komunikačné zručnosti, atď.. K projektu patria aj rôzne techniky a spôsoby, ako zapojiť do výchovného procesu aj rodičov - doterajšie skúsenosti sú pozitívne. Stručný opis projektu a jeho doterajších výsledkov bol uverejnený v Učiteľských novinách č. 30/1991.

Osobitne chcem vyzdvihnúť dôležitosť sebaoceňovania a komunikácie pre sexuálne správanie. Nízke sebahodnotenie vedie k sebapoškodzujúcemu správaniu a rôznym výstrelkom, včítane sexuálnych. Pri nedostatku schopnosti komunikovať ostáva len jediná možnosť, ako vyplniť spolu strávené hodiny: erotické a sexuálne hry. Dnes mnohí považujú petting a dotykové hry za prostriedok, ktorý umožní oddialiť prvý genitálny styk: myslím, že oveľa lepšie je naučiť deti zmysluplne komunikovať. Dobrá komunikácia môže dať prvým láskam obsah a chrániť pred úskaliami nezrelého sexu.

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LÉKAŘSKÁ STÁVKA

Anna Váchová

Za jakých okolností - a zdali vůbec - mohou lékaři stávkovat? Někteří z nás myslí, že nikdy, ale jiní mají za to, že absolutní zákaz by koneckonců znemožnil snahy lékařů dovést své požadavky do konce, znemožnil by použít v krajních okolnostech krajního prostředku. Jádro problému je totiž v tom, že je to pacient, ne zaměstnavatel, kdo je poškozován, když lékaři stávkují, a lékaři to jsou, kteří se ukáží jako bezcitní a neodpovědní. Proto podmínky, že kterých by měla být vyhlášena stávka - tento původní dělnický způsob nátlaku na zaměstnavatele - musejí být zvažovány velmi opatrně.

Není pochyb o tom, že společnost, která je výhradním a bezkonkurenčním zaměstnavatelem zdravotnických pacovníků a současně majitelem finančních zdrojů, se začne dříve nebo později vzdávat kvality zdravotní péče vo prospěch zadržování financií. V této situaci je pak zásadní, při jakém stupni finančního diskomfortu se začne projevovat zhoršení péče o nemocné, a který okamžik tohoto úpadku pocítí zdravotníci jako limitní, a zvolí stávku jako způsob krajní výstrahy. Všichni jsou potom vystaveni závažnému etickému problému, když se rozhodnou stávkovat, že postupy proti zaměstnavateli mohou skončit poškozením pacientů. Musí řešit dilema, zda jsou povinni pracovat dál a napomáhat implicitně deterioraci zdravotní péče nebo stávkovat a ohrozit některé pacienty možnými nevýhodami. Volba stávky v oblasti léčebné péče se nám tedy jeví jako poněkud omezená.

1. Domníváme se, že by lékař neměl stávkovat jen pro svůj vlastní prospěch. Hippokratova přísaha, kterou by měli lékaři respektovat, klade dobro pacienta nad jeho vlastní a poskytování pomoci, dokonce v nepohodlí a nebezpečí, považuje za povinnost. Jestliže se očekává, že lékaři budou pracovat např. v době epidemií, může se také předpokládat, že musí být schopni akceptovat také i jiné potíže, vyskytující se ve zdravotnické profesi. Tento problém však není jednoduchý. Zoufalé situace volají po dramatických a neobvyklých řešeních, ale i postupné zhoršování kvality života lékařů v důsledku špatných ekonomických a jiných podmínek, zasluhuje řešení.

Pro lékaře není možné odvádět práci dobré úrovně, když jejich vlastní problémy a potíže pramení ze špatných duševních a materiálních podmínek. Peníze samozřejmě hrají roli: v důsledku stresu a nepravidelnosti práce si zdravotníci mnoho služeb musejí nechat udělat. Lékař, jehož práce vyžaduje plnění závazků stojících nad obdobnými v jiných profesích, je oprávněn k jistému fi-

nančnímu kompenzování. Zůstává nicméně pochybným, jestli toto oprávnění samo může ospravedlnit stávku.

Řešení finančních požadavků zdravotníků vyžaduje porozumění na obou stranách. I když zdravotnické organizace mají za povinnost poskytovat pacientům tu nejlepší možnou péči, nemůže se od nich čekat, že budou vycházet vstříc požadavkům na zvýšení platů v každém případě. Nicméně se ani nedá očekávat, že zaměstnanci, i když si své povolání sami zvolili, zůstanou ve vykořisťovaném a nestimulujícím postavení. Do středu zornosti by se současně mělo dostat také omezené a eticky nezdravé myšlení manažerů, které ve svých důsledcích vede ke konfrontacím.

2. Pracovní podmínky lékařů jsou odlišné od jiných profesí. Je běžné, že se požaduje od mladého chirurga, aby byl přítomen u velkých nebo neobvyklých chirurgických výkonů i po své pracovní době. Je pravdou, že rozpis práce ho k tomu nezavazuje, ale k erudici to potřebuje. Tak mnohdy denně poskytuje služby navíc. Pro starší kolegy, zastávající bezpečné vyšší postavení, je lehké shlížet na mladé kolegy s despektem, odmítají-li pracovat v podmínkách, ktoré by měly být sociálním i kulturním pokrokem již překonány. Mnozí ze starších lékařů se vypracovali v době, kdy se do rodičovských úvazků uvázaly ženy a podřídily své vlastní potřeby potřebám manželů - lékařů, pro něž potřeby pacientů nemohly být nikdy sekundární ve srovnaní s jejích rolí otců a manželů. Mnoho se však změnilo. Ne vždycky se může očekávat, že život lékaře bude podřízen jen jeho medicínské podobě. Není divu, že mnoho mladých lidí pociťuje tento požadavek jako nepřijatelný. Moudří starší kolegové by je měli pochopit a neodsuzovat je pro radikalitu a revolučnost, která plyne z jejich nezralosti. Mladí kolegové totiž přicházejí do arény klinické praxe skutečně nepřipravení ve všem, kromě - v nejlepším případe - teoretických znalostí. Na druhé straně by mladí lékaři měli vědět, že mezi medicínským egoismem a čistým soupeřením vede jen úzká hranice, a angažovanost v práci by měla stát na prvním místě jejich snažení.

3. Vyhlášení stávky ve zdravotnických zařízeních by mělo být vždycky záležitostí svědomí. Nestávkující by neměli být ostrakizováni, protože se tak rozhodli pro dobro pacientů spíše než z jiných nižších motivů. Jestliže ti, kteří pracují na novorozeneckých odděleních, JIP, chirurgové na sále nebo pohotovostní tým odmítají stávku, potom jejich stanovisko musí být akceptováno.

Úvaha o závažnosti důsledků, které hrozí podmínkám a kvalitě léčebné péče, a o riziku pro pacienty, vyplývajícím ze zamýšlené akce, není nikdy přímočará, a někteří lékaři budou trvale dávat přednost bezprostřednímu zájumu pacientů. Neměli by být skandalizováni, protože mají na své straně mnoho kladných motivací.

Společnost skutečně investuje mnoho do studujících lekařství, aby je vybavila dovednostmi nezbytnými pro práci na vysoké úrovni. Tato investice je nejen finanční, ale i praktická: studentům je umožněno učit se na pacientech, což s sebou nese újmu přinajmenším na pacientovu soukromí, vyloučíme-li možnost újmy somatické. Skutečnost, že lékařova erudice vyrůstá vlastně v podmínkách poskytovaných dobrovolně společností je faktem, kterého by si lékaři měli být vědomi, a neměli by se považovat za nezávislé dodavatele určitého zboží nebo dovedností. Neměli by být v pokušení držet společnost "v šachu" jako jiné skupiny zaměstnanců.

Lékařské stávky nejsou obdobné jako jiné stávky, protože se od lékařů očekává, že postaví blaho pacientů nad své vlastní zájmy. Tento etický postoj však činí lékaře, zdravotní sestry, klinické psychology, lékařské techniky a farmaceuty v jejich sporech se zaměstnavatelem zranitelnými. Ideálem by bylo, kdyby manažeri zdravotnictví pracovali v těsné vazbě se zdravotníky a obě skupiny by zároveň neslevovaly z vysoké etické úrovně práce. Zdá se však, že současné řídící orgány zatím nedospěly k této kvalitě. To má za následek, že lékaři stojí tváří v tvář reálné a těžké volbě mezi požadavky, kladenými na ně zaměstnavatelem, a kvalitou jejich práce. Neexistuje žádná absolutní volba. V řešení těchto dilemat lékaři musejí sami pečlivě rozhodovat mezi vzájemně disparátními hodnotami, které jsou s těmito dilematy spojené.

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PROBLÉMY S POJMOM HUMANIZÁCIE PSYCHIATRIE

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Snahy humanizovať psychiatriu nie sú nové. Vyvíjajú sa storočia. Samozrejme, ich obsah sa menil. Najprv išlo o boj s neľudskosťou v prístupoch k duševne chorým, o snahy humanizovať podmienky duševne chorých v ústavoch. Dnes ide takisto o kritiku starostlivosti o duševne chorých, ale niekedy aj o kritiku psychiatrie ako takej, jej teórie a liečby a tiež o legislatívne otázky.

Osud duševne chorých v dávnej, ale ani nie tak dávnej minulosti bol veľmi ťažký. V 15. i 16. storočí sa používali klietky bláznov. Procesy s bosorkami sa nie vzácne týkali aj duševne chorých. Chorí boli v kláštoroch, ale až do 19. storočia aj vo väzniciach. Zachovali sa pramene, podľa ktorých ľutovali väzňov, že musia byť s duševne chorými, nie duševne chorých, že sú umiestnení s kriminálnikmi.

V 19. storočí predpisy hovorili o starostlivosti o duševne chorých a chudobných, o povinnosti postarať sa o nich. Upravovali však hlavne to, že obec sa musí postarať o svojich chorých a obec musí hradiť trovy, ak sú v nemocnici. Chorí boli umiestňovaní v nemocniciach hlavne preto a vtedy, keď bolo treba chrániť verejnosť, izolovať ich, alebo boli v takom zlom stave, že sa nevedeli o seba postarať.

Boj proti zlým podmienkam v ústavoch bol ťažký. Presadzovať, že chorí nemajú byť prikovaní reťazami, že sa majú lepšie stravovať, že s nimi treba ľudsky zaobchádzať, sa darilo len veľmi pomaly. Neboli k dispozícii účinné liečebné prostriedky, tie prišli až v 2. polovici nášho storočia. Aj keď boli chorí už predtým umiestňovaní v nemocniciach, alebo ústavoch a podmienky už boli omnoho lepšie, nemohlo byť ešte všetko v poriadku. Chýbal aj kvalifikovaný personál. Psychiatria vždy dostávala menej finančnej podpory a kvalitná starostlivosť je drahá. Nemá zmysel zatajovať, že ešte aj prvé roky po vojne na psychiatrických oddeleniach niekedy pracovali tí, ktorí sa neosvedčili na iných oddeleniach a boli tam preraďovaní z trestu. Teda nie so záujmom o prácu s duševne chorými, ale doplňovali chýbajúci personál. Hlavne však - a to treba zdôrazniť - až objavenie moderných liečebných prostriedkov, psychofarmák, umožnilo ísť ďalej. Až vtedy bolo možné zrušiť dozorcov, zvieracie kazajky, bez obáv dať pacientom normálny príbor na jedenie, zmeniť ťažké dubové lavice, ktoré sa nedajú zdvihnúť, za obyčajné - esteticky lepšie vyhovujúce stoličky, umožniť pacientom robiť ručné práce, strihanie nožnicami, prácu s ihlami a podobne.

Život na psychiatrických oddeleniach je dnes celkom iný vďaka moderným liekom. Navyše sa podstatne skrátila doba liečby, teda pobytu na oddelení. Chorí sa aj po viacerých atakoch choroby vracajú pomerne rýchlo domov, ale aj do práce. Aj verejnosť ich dnes prijíma iným spôsobom, kultúrnejšie, ľudskejšie. Zaujímavé je, že práve v tejto situácii začínala ostrá vlna kritiky psychiatrie.

Ak by išlo len o kritiku starostlivosti v slabšie vybavených ústavoch, nebolo by možné mať námietky. Naopak, taká kritika zo strany verejnosti by bola vítaná. Donútila by úrady lepšie finančne dotovať psychiatriu. Vlna kritiky psychiatrie, ktorá prepukla v 60-tych rokoch a zasiahla západnú Európu, sa týkala podstaty psychiatrickej teórie. Presadzoval sa až taký krajný názor, že psychické choroby sú výmyslom psychiatrov a psychiatri poškodzujú svojich pacientov. Poškodzujú ich tým, že im podávajú škodlivé lieky, a tým, že ich deklarujú za pacientov a teda označia ich za chorých, čím ich sociálne poškodia.

Táto extrémna podoba antipsychiatrie, ktorú presadzovali politizujúce spolky študentov, básnici, filozofi, spolky bývalých pacientov, sa zakladala na vedecky nepodloženej predstave, že nie mozog je chorý, ale spoločnosť a niekto sa správa odchýlne preto, že spoločnosť je zlá, chorá a tú treba zmeniť, nie liečiť chorobu mozgu. Antipsychiatrické hnutie spôsobovalo oficiálnej psychiatrii na západe veľké starosti. V niektorých krajinách rušili psychiatrické lôžkové oddelenia, z ktorých časť dnes už znovu existuje. Nikto teraz nevie povedať, koľko životov stála aktivita antipsychiatrov.

Chorobná podstata duševných chorôb je dokázaná. Nie psychiater, ale prejavy choroby poškodzujú pacienta sociálne. Včasná liečba nielen rýchlo zmierni prejavy choroby, utrpenie pacienta, ale chráni ho pred zrakom verejnosti. Ľahšie sa po liečení vracia domov a do práce ten, o ktorom síce vedeli, že sa lieči, ale nevideli ho v jeho chorobe. Chorý, ktorý nie je včas liečený v nemocnici, zničí si svoje postavenie v práci, minie majetok, odcudzí sa susedom, okrem toho hrozia ďalšie riziká, nehoda, samovražda.

Druhá stránka kritiky sa týka legislatívy. Proti obave zo zneužitia psychiatrie nemožno mať námietky. Spoločnosť skutočne musí mať kontrolu nad tým, ako sa z titulu duševnej choroby obmedzuje osobná sloboda. Ide však zase o to, aby duševne chorí nedoplácali na extrémne tendencie. Napríklad, diskutovalo sa o práve duševne chorých na samovraždu. Extrémny charakter malo rozhodnutie jedného amerického súdu o práve na duševnú chorobu, duševný rozvrat. Samozrejme, vyvolalo to odmietavú reakciu zo strany odborníkov.

V každom štáte je súčasná legislatíva v niečom odlišná. K zjednoteniu vedú dokumenty medzinárodného významu, konkrétne Luxorská deklarácia ľudských práv duševne chorých a ďalšie. Všeobecná spokojnosť nie je doteraz. Napríklad americkí psychiatri poukazujú na to, že na obrovskom množstve bezdomovcov participujú duševne chorí, ktorí nie sú liečení a právo obmedzuje možnosť liečiť ich, pokiaľ sa nestanú zjavne nebezpečnými.

K nám sa vlna antipsychiatrie v 60-tych rokoch cez železnú oponu nedostala. V určitej forme však prišla teraz. Dočítame sa v novinách, že psychiatri sú zlí ľudia, že psychiatri neoprávnene "kŕmia" pacientov liekmi a podobne. Aká je dnes situácia u nás po legislatívnej stránke. Doteraz o nútenej liečbe rozhodovali národné výbory, od začiatku roka 1992 súdy. Psychiatri vítajú kontrolu, oponentúru, vítajú, že o zodpovednosť v takej vážnej veci, akou je liečba bez súhlasu pacienta, sa delia s niekým kompetentným. Predsa je však niekoľko stránok, o ktorých, ako sa zdá, je užitočné diskutovať.

1. Pacienta, ktorého psychiatrické zariadenie zahlási súdu, že bol prijatý bez súhlasu, príde vyšetriť sudca. Hovorí s pacientom, pýta sa ho na podrobnosti, na to, čo psychiatri považujú za jeho bludy a halucinácie. Nakoniec súhlasí s psychiatrami, že prijatie bolo potrebné a vydá o tom rozhodnutie. Jestvovala by aj iná realizácia zákona. Napríklad v Rakúsku sudca tiež kontroluje prijatie, ale má k tomu úradného lekára. Máme detailne dokumentované, koľkých pacientov sme po rozhovore so sudcami museli medikamentózne upokojovať. Je to trauma pre pacienta, u ktorého si sudca overuje, či naozaj hovoril o prenasledovaní a podobne. Len lekár vie hovoriť s pacientom tak, aby ho nepoškodil.

2. Podľa platného občianskeho zákona sudca skúma, či zdravotný stav pacienta je skutočne tak narušený, že hrozí konkrétne ohrozenie jeho samého, alebo okolia. Ojedinele sa už stalo, že sudca akceptoval duševnú chorobu, ale nezistil z choroby vyplývajúce bezprostredné riziká. Napríklad pacientka 5 dní nejedla, a to sudca nepovažoval za vážne. Bolo to v tých dňoch, keď pán Mareček hladoval už asi 40 dní, a preto sa to zdalo málo poškodzujúce.

V tom smere sa nám javí návrh zákona o zdraví pripravovaný v SR vyhovujúcejší než federálny občiansky zákon a zodpovedá aj zákonom iných zemí. Totiž zisťuje sa aj to, že ak by sa pacient neliečil, zhorší sa jeho zdravotný stav.

Veľmi vážnou vecou je odstavec príslušného paragrafu Obč. zákona, ale aj pripravovaného zákona SR, podľa ktorého do príchodu sudcu - a sudca musí prísť do 7 dní - sa nemá začať liečba, môžu sa robiť len najnutnejšie opatrenia.

Odhliadnuc od toho, že nejestvuje možnosť ohraničiť najnutnejšie opatrenia, ak sú medicínske, od začatia liečby, hrozí tu návrat ku zvieracím kazajkám, ak by psychiatri tento pokyn zobrali doslovne. Objavil sa dodatočne aj výklad, dôvod tohto opatrenia. Tvrdí sa, že psychiatrické liečebné prostriedky narušujú organizmus, a ak by sa použili pred príchodom sudcu, ten by nevedel odlíšiť, či príznaky u pacienta pochádzajú z choroby, alebo boli zapríčinené liekmi.

Takéto zdôvodnenie bolo pre psychiatrov prekvapením. Je to laická predstava, ktorá sa rozširovala na západe pred štvrťstoročím. Vedecká psychiatria túto tézu nepripúšťa. To, že sa dostala do výkladovej časti návrhu zákona, svedčí len o tom, že zmeny sa nerobili v spolupráci s odborníkmi.

3. Do 3 mesiacov od prijatia do nemocnice pacient obdrží uznesenie, z ktorého sa dozvie, že jeho prípad bude riešiť súd a bude preto vyšetrený súdnym znalcom psychiatrom. Za 3 mesiace je veľká časť pacientov už doma. Vyrovnávajú sa s tým, že boli na psychiatrii. Naraz dostanú takéto uznesenie súdu. Aj v tomto bode by bolo potrebné hľadať iný spôsob, aby aj obsah listiny ľudských práv, ale aj skutočný záujem pacienta bol chránený.

Psychiatri dávajú na rôznch fórach podnety v tomto smere. Ide o to, aby neboli v konflikte právo občana na slobodu a povinnosť lekára liečiť chorých. Súlad sa dá dosiahnuť, ale len vtedy, keď sa problémy riešia bez emócií, bez iných tendencií a hlavne kvalifikovane.

Súhrn

Autori sa zamýšľajú nad históriou starostlivosti o psychicky chorých a nad vývojom postojov spoločnosti k psychicky chorým a k psychiatrii. Postoje spoločnosti, s ktorými súvisí aj prijímanie zákonných opatrení upravujúcich právnu stránku starostlivosti o psychicky chorých, odrážajú úroveň porozumenia podstaty psychických chorôb v laickej verejnosti. Cieľom práce je poukázať na etické problémy, s ktorými sú psychiatri konfrontovaní pri svojej práci.

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Dear friends, *Bratislava, Summer 1996*

when meeting today new groups of young candidates of medical profession, I often read an untold question from their faces: "Why should we today still speak about ethics? Why don't we pay our attention solely to the 'practical disciplines'?" ("Don't you see how the life runs nowadays, as well as the medicine itself? What's the reason for any 'making the philosophy' in such a situation? We do want from our lives the success in the first place!") Honestly, does it really make sense? Isn't it just a wastage of time, energy, and resources? Those of ourselves, the University - and also of our students? There might be many answers and reasons affirming the need in question. The space allowed for this editorial is too small to accommodate even the sole listing of them.

It seems to me one of the most 'practical' affirmations might be the following one: medical ethics is concerned also with the question on what kind of a physician do I really want to be, or become. I do not think here, of course, about a purely 'scientific', 'technical', or 'technological' site of contemporary medical profession. Rather I mean the understanding of what does it mean to accept and practicise medicine as the life-long profession. What does it mean, if you want, 'to be addmitted to the medical profession'1. It is not, as we all do know, just to wear the 'white coat', stethoscope, neurologist's hammer, or other external signs of the profession. Neither it is an arrogant exercising of power upon the health and lives of our patients, nor that of the formal authority upon our collaborators in the health care team. Rather, I believe, it is in the first place the very specific kind of a whole-life service to the people, to the men and women, as well as it is an extraordinary, and continuous responsibility. A complete fulfillment of this mission seems nearly impossible without a sincere and deep respect, I would better say 'love', to every man or woman that happens to become our patient. Impossible, without sincere respect of his or her dignity and integrity - physical, psychological, and spiritual. Impossible, without respecting him or her as a human person in the full sense of the word, equal in the rights and claims with ourselves, our relatives, or friends. Our patient is our 'neighbour'2. The one, that is injurried, ugly, helpless, in pain, abandoned; the man or woman at the different ways of his or her life attacked by an illness, disease, accident, disaster, or by other 'robbers'. The glory, the depth, and suffering of our profession, may be, dwells in this: trying once again throughout our lives to comply with this attitude; trying to make the face of contemporary medicine - the one that is faced by our patients - more humane and nice. The alternative, as it seems nowadays, is becoming the medicine of machines, technologies, instruments; practicised by some kind of 'supermen' without empathy, or by cynic robots. I believe, the more positive approach, i. e. taking the medical profession as a kind of mission in the 'service to humanity'1, composes the heart of a true collegiality of medical professionals; the self-understanding, pride, and healthy self-esteem of the medical profession.

Our students, at least as individuals, can make some choices at the time 'when they are addmitted to the medical profession'1. Namely, they can choose for themselves, what kind of a medicine will they like to perform in their future professional lives: what kind of a doctor will they like to become. Which examples, which models will they follow. Thatswhy, perhaps, it is good, that our students of medicine attend at least these few seminars on medical ethics. Our task, as teachers, is to use this time properly: this chance must not be lost. After the graduation from the University, in the busy everyday's practice, in pushing 'situations', and complicated 'conditions', there will still be less time for ethical reasoning and orientation. Or not?

(Text from the page 1.) ***Jozef Glasa***

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