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OD REDAKCIE / EDITORIAL

Milí priatelia,*⁾

Bratislava, Marec 1998

prihovám sa Vám na začiatku piateho ročníka *Medicínskej etiky a bioetiky*. Toto skromné jubileum dáva príležitosť obzrieť sa dozadu na dosiaľ vydané stránky, ale aj možnosť uvažovať o ďalšom smerovaní časopisu - a pre redakciu: formulovať si nové ciele, či predsavzatia.

Uplynulé roky existencie časopisu odzrkadľovali vývoj medicínskej etiky a bioetiky na Slovensku ako nového interdisciplinárneho odboru, ponúkajúceho nielen filozofickú reflexiu morálnej stránky vývinu súčasnej medicíny a zdravotníctva, ale aj odbornú podporu a pomoc pri neľahkom osobnom rozhodovaní v aktuálnych morálnych dilemách každodennej lekárskej i ošetrovateľskej praxe. Zvláštnu pozornosť bolo a bude potrebné venovať novým etickým problémom, ktoré súvisia s prebiehajúcou transformáciou slovenského zdravotníctva.

Po prvých mesiacoch a rokoch nadšenia a "inštitucionalizácii" odboru vznikom Ústavu medicínskej etiky a bioetiky, spoločného pracoviska Lekárskej fakulty UK a Inštitútu pre ďalšie vzdelávanie zdravotníckych pracovníkov v Bratislave, nastalo obdobie postupného budovania odboru, výchovy nových pedagogických pracovníkov, vzniku etických komisií, rozvíjania medzinárodných kontaktov a spolupráce, vzrastajúcej publikačnej činnosti i postupného vzniku prvých slovenských učebných textov medicínskej a ošetrovateľskej etiky. Popri postupnej profilácii a profesionalizácii nových pracovníkov by však doterajší vývoj i ďalší rozvoj odboru bol nemysliteľný bez množstva nehonorovanej, dobrovoľnej práce kruhu nadšených spolupracovníkov a sympatizantov z celého Slovenska, ba i zo zahraničia. To platí ešte viac pre vznik a vydávanie *Medicínskej etiky a bioetiky*. I keď neisté finančné podmienky a niektoré technické a organizačné problémy spôsobili značné nepravidelnosti vo vychádzaní časopisu, na prahu tohto nového ročníka dúfame, že sa predsa len už blýska na lepšie časy.

Mnoho bude, pravdaže, závisieť aj od Vás, milí čitatelia a čitateľky. Ide o to, aby časopis bol pre Vás zaujímavým a podnetným čítaním, zdrojom užitočných informácií - ale i priestorom na kladenie otázok a spoločné premýšľanie o komplikovaných, ale súčasne i veľmi "praktických" problémoch súčasnej medicíny a zdravotníctva. Potešíme sa Vaším podnetom, pripomienkam, konštruktívnej kritike, ale najmä Vaším originálnym príspevkom vo forme článkov do niektorej z rubriík časopisu. Príjemné čítanie a uvažovanie, priatelia!

*English translation - p. 6.

MUDr. Jozef Glasa

Reklama

Advertisement

ONCOLOGY AND ETHICS

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Abstract

The paper address some moral issues involved in the study and treatment of malignant tumours. It considers especially two inter-related concerns: truth-telling and clinical experimentation. Author argues in the paper that truth-telling to patients and to their relatives is an essential requirement of human dignity. It is necessary for social cohesion and for the proper functioning of health-care systems at the service of the human person in sickness and in need. It is not just an abstract ideal: it has to do with fundamental issues of justice and charity. It involves the most basic respect for fundamental human rights in regard to the weakest and the most vulnerable in society. In the case of clinical experimentation the strict inter-relationship between truth, justice and human rights resurfaces. Above all, when the medical and moral implications of dealing with people afflicted with potentially lethal tumours are considered, it can be seen that compromises with truth entail compromises with people's lives and rights. The importance of truth-telling in charity and compassion and of respect for truth at every level in bioethics is much greater than may be imagined at first sight. Without it, ethics and morality are rendered vacuous and health care personnel and patients alike suffer.

Key words: oncology, ethics, truth-telling, clinical trials

Aims of this Paper

This paper seeks to address some key moral issues involved in the study and treatment of tumours. As other contributions tackle terminal care, this features here only in passing.

It is intended to consider two inter-related concerns: truth-telling and clinical experimentation. The fundamental bioethical issues at stake are sharply focused when potentially lethal pathologies, as in oncology, are involved. The prevalence and danger of tumours make the moral questions more urgent and more delicate.

The Obligation to Tell the Truth

Many people still recognise the obligation to tell the truth at least in most circumstances. More may acknowledge it by the experience of contrast, of themselves being told deliberate untruths. Judaeo-Christian tradition reveres truth. Fidelity implies whole-hearted sincerity and truth (Hos. 2:18-22) to avoid 'killing' a member of the covenant people by being a 'lying witness' against him (1). Truth is linked to life, justice, the protection of the weak (Dt. 19: 16-21). Jesus was utterly true to His Father and to His mission before religious and political leaders. He corrected his disciples rather than seek mere popularity. He could have avoided death by denying His claims, but He did not do so. Giving His life for the truth, His resurrection revealed the full truth that our life here is but life "in its earthly phase" (2), a preparation to live eternally in Him. Christ's call for sincerity and truth, to say 'yes' if we mean 'yes', 'no' if we mean 'no', led to the early Christian concern for absolute truthfulness (Mt. 5:33-37; 2 Cor. 17:17) (3).

The virtue of truthfulness is radically at odds with lying for convenience, with the duplicity often displayed through the media. It is a virtue not peculiar to religious faith. Collaboration requires trust; the denial of truth brings suffering and further injustice. As with all basic human rights, the right to truth is not conferred by contract or by government; it stems precisely from our being human, from our inherent dignity as persons (4). Building life upon lies of racial or class superiority has provoked systematic manipulation and degradation. It should make us wary of denying truth to the weakest, to those least able to fend for themselves, such as the sick, dying, dependent and anxious.

Such a commitment to truth does not mean that all the truth known must be revealed to all who ask on every occasion. Moral theological casuistry has justified evasion, mental reservation, etc. (5), but deliberately stating what is known to be false (6), lying, is more difficult. The Catechism specifies lying as "to speak or act against the truth in order to lead into error someone *who has the right to know the truth*"; it does not say that telling a direct lie is ever morally right, but only that the gravity of the wrong can vary (6).

Whatever the complexities of truth-telling under threat or fear, the conflict situations in medical ethics in which it arises, are of a different sort. What is said to patients and what is decided about them may have serious consequences for their survival, but there is no equivalent of blackmail (7). This is not to underestimate the gravity of truth-telling in oncology. From the suspicion of a pathology to the X-rays, biopsies and other tests prior to diagnosis, to the prognosis and management of a malignant tumour there are many consultations involving numerous personnel as well as family and friends. At all points telling the truth or deceiving patients and/or others seems to be at stake.

Presuppositions and Truth-Telling

A person's anthropological presuppositions will affect his response to this multiplicity of exchanges. If the actual possession of reason determines human rights, the unborn child, neo-nate, severely mentally handicapped, senile and comatose either have never truly been human persons or have ceased to be such: they "can no longer possess themselves and can therefore come into the possession and authority of others" (8). Such a re-definition of who belongs to the truly human community would have profound implications for informed consent and for clinical experimentation. It would also mean the strong could manipulate the weak at will, which would certainly damage those with tumours. Those in the terminal stages of illness might be re-classified as non-persons had they not had the foresight to make provisions in an earlier lucid stage. Should patients not be informed in advance that they risked being thus re-classified? It is morally objectionable to assume, otherwise, that they had tacitly approved their re-classification as non-persons.

This anthropology compromises theories of autonomy and beneficence. While our autonomy or freedom is "an exceptional sign of the image of God" (9) in us, a concept of autonomy which does, not acknowledge our dependence on one another or on God is exaggerated. There is a risk too of acting out of caprice or of 'inventing' what is morally right. Where objective human goods and exceptionless moral norms protecting basic rights are thus restricted, talk of beneficence is ambiguous. Relativism in morality results: discrepancies in treatment for similar conditions would increase, the non-rational and not-yet-rational could be treated as mere objects. Interventions which do not respect the totality and functional integrity of each person would be possible; limbs, tissues

and organs could be harvested at will, and the basic equality of all people would be at risk.

Finally, in our scientific and technological age, there is a real danger of a patient with a tumour being treated more as a problem than as a person (having rather than being). A cursory and perfunctory approach, insufficiently alert to what the patient has understood or feels, results. Where the Christian perspective that the body is part of who the person is and not a thing the person has is lost, the danger of looking no further than at what is wanted, what is technically possible, is great. In such a reductive anthropology the properly moral perspective is lost (10). Truth-telling to patients and to families will never be adequate in this case. Where, too, lying has become habitual in a culture, masking the truth from patients is more likely.

A major presupposition for us, then, is that the patient's dignity requires that he/she be treated as a partner in treatment as far as possible, a duty seeming to derive from human nature itself in that the person is a subject or end and not an object or means (11). Dialogue with health-care personnel is critical if there is to be this active respect for the patient. This will also carry benefits in terms of the patient's peace of mind and of his enhanced capacity to collaborate with the treatment adopted.

The Communication of Truth to Patients and Relatives

The following two instances of truthful communication come from my pastoral experience. Prior to histological confirmation, trained personnel recognised malignancy from X-rays; their comments were overheard by the patient's wife. Again, an old lady with stomach cancer, living alone, was asked by a community nurse: 'You do know you're dying, don't you?' Due care was lacking.

The communication of verified malignancy should be made by a consultant in the field. A friend present, confident despite shock to ask questions, can help obviate misunderstanding. Careful, sympathetic presentation of options is needed. Complications may make emergency surgery inappropriate (metastases, pulmonary incapacity) or it may be ineffective, but aggravate the spread of disease.

Forecasts may be unreliable (in 1996 a cancer patient told 5 years earlier he had 2-3 years to live sued doctors for emotional and financial damage, since he had given up work), but honesty about the prognosis can affect the patient's decision. Unpredictability suggests: 'It is impossible to say for sure, but I have known patients who have lived...' as an appropriate form of communication, honest but not exceeding what can rightly be said.

The success of therapy is also unsure. Stating what it is *hoped* may be achieved is truthful, but it opens the way to later revision. Notice of noxious effects of radio/chemo-therapy should go along with checks on family support and provision of specialist care to facilitate continuing with many normal activities. The right to stop burdensome or useless treatment should also be mentioned. Instead of giving brute information, dialogue and respect are offered, active support and tangible care provided. Care and truth require special checking (the right file) where news is bad, where unsuccessful therapy entails disappointment, even despair. Truth-telling in justice and charity weighs heavily where doctors judge the patient cannot support knowledge of a lethal cancer. Asked if there is any hope, it would be right to say there was some hope and to indicate what it was *hoped* could be done. The truth can and should be communicated by indicating the tentative nature of therapy: 'I suggest we try ...' 'This should shrink the tumour, but I can't guarantee that it won't grow again'. What is said is true, but not unrealistic. A basis of trust, facilitating further communication of the truth in stages, is built up (12).

Where death is imminent, patients often know what well-meaning relatives seek to conceal. A lady whose relatives wished her not to know she was dying said to me in their presence: 'Father, I know I'm dying and I want you to anoint me'. Christians see death not as annihilation in the manner of reductive anthropologies, but as the gateway to eternity. In the sacraments the dying person can entrust himself freely and unreservedly in faith to Christ; to die in Christ is not to die alone, but to die in Him who is the Lord of all life, the conqueror of death (13).

Where a competent person does not wish to know his situation, his wish should in principle be respected, not for the sake of an exaggerated autonomy, but to allow him to do what may be unwise. Some who say this in fact want to know how they are faring when very ill; people also change their minds. This highlights one problem with powers of attorney and living wills. The wishes of one who is incapacitated should be respected, provided they do not seek what is immoral, but one who was incompetent as a minor who is now a 'great minor' able to understand and give a view should decide himself (14). To reduce the risk of patients merely pleasing doctors upon whom they are dependent, their understanding of alternatives with their risks and benefits should be checked through simple questions (15). Truth is not compromised, but its effective and respectful communication is enhanced. Moreover, in the context of terminal illness, truthfulness and honesty on the part of all about what is done and why it is deliberately done make all the difference between morally upright care and treatment and the intrinsic moral evil of all euthanasia.

Clinical Experimentation

A particular case of truth-telling and free, informed consent concerns investigations of drugs which may give better performance or which may open up new avenues for the treatment of disease, not least of tumours, a recognised necessity for medical progress (16). For experimentation to pass from laboratory and animal testing to humans, truth requires a clear scientific basis and a precise objective, morality further requires that protecting animals from cruelty and misuse should not expose humans to greater risks (17).

The moral demands of clinical experimentation on human subjects further entail that risks be stated and not be excessive, trials be conducted by competent, specialist personnel, free, informed and revocable consent be obtained, and an independent ethical committee monitor the trial, ordering its cessation, if need be, on moral grounds (18). Whereas phase I trials investigate toxicity to determine the maximum tolerable dosage of a drug and phase II assess the percentage response of a pathology (in this case the delay in metastatic disease and/or the rate of shrinkage of a tumour), phase III compare a new drug with standard treatments of some kind (19). Here the use of pharmacologically inactive treatments (placebos), perhaps psychologically beneficial, allegedly permits a scientifically more reliable comparison (20).

There may be two or three 'arms' to a randomised, clinical trial, perhaps with a placebo or standard therapy for the pathology. Such trials may involve patients not knowing to which 'arm' they have been assigned (single blind) or, to reduce the danger of subjective bias, neither patients nor doctors knowing (double blind). Here informed consent can be difficult to obtain. Patients may be told of one 'arm' only and be asked to consent to that, left unaware that they are participating in a clinical trial precisely because it is realistically anticipated that, were they to be so informed, consent would be lacking.

The scientific necessity for placebos may be questioned when standard therapy can provide a point of com-

parison. With lethal pathologies, leaving some patients with no active treatment is especially problematic; the validity of any informed consent could be questioned. Not only may a 50% or 33% chance of therapy seem to 'pressurise' consent, but the more basic moral duty to care for our bodily health means that informed consent cannot be validly given to what is immoral on our own behalf or as proxy for others (21).

A further point about instituting a clinical trial relates to women of a fertile age. Powerful chemo-therapeutic agents might harm a foetus or damage fertility. The general exclusion of such women from these trials could hardly be extended to those with incurable cancer, who should be eligible if given training in natural family planning, the reason for seeking to avoid a pregnancy at present being perfectly upright (22). In a contraceptive culture, this is rare; women of a fertile age are required to be taking contraceptives before being admitted to such trials. Leaving aside the scientific validity of natural methods of birth regulation, this constitutes a violation of the rights of such women who cannot in conscience use contraceptives.

When we consider the actual course of clinical trials, a safety monitoring committee should keep the process under review and call a halt where people seem to be damaged. However, such a committee is not a full ethics committee; it will not usually have been consulted about the protocol, but only monitors on the basis of what is given to it. In multi-centre trials, especially of an international nature, its role can be very important. Foreseen side-effects should be known to patients to avoid unnecessary distress. A three-arm trial with an oral, low and high intravenous dose of a drug will probably see those randomised to the oral arm being treated more readily, since hospital beds will not be needed, while greater care will be available to the hospitalised. Staff in each centre need to become used to operating with a new drug. Serious adverse events have to be assessed to see how far they are due to underlying disease progression, the intravenous line or the new drug as such. Ethical evaluation is thus complex.

Morality and statistical concerns may conflict. Statisticians need to be able to express themselves in terms accessible to intelligent laymen. Where one arm seems to have more deaths or serious adverse events, statisticians may wish to keep the trial going until the point of statistical significance and are likely to argue that such a conclusion is not proven, but only plausible. Though truth is more than statistics, scientific truth of value to others needs to be based on statistically verified results. Where recruitment has been limited (due to a very aggressive drug) but one centre shows many recruits, a short-circuiting of informed consent is to be suspected. A safety committee should arrange a visit and an analysis to protect the rights of vulnerable patients. Standardised forms of written consent, available to the committee, seem essential. The committee has the task of assessing whether or not the consent given by patients and doctors at the start of a trial can perdure.

At the end of a trial the moral questions do not disappear. Should patients randomised to one arm continue to receive treatment now judged inferior because distress at learning that their treatment had been ineffective or was second-best would do more harm? With terminally ill cancer patients, the wish to avoid such distress is especially understandable, but deliberately giving inferior treatment seems unjustifiable. Where no great difference is established between treatments, those randomised but not yet receiving treatment should not be given a new drug.

A final consideration has to do with communicating the results of the trial truthfully. If a three-arm trial was designed to show that a high dose of a drug was most

effective against a lethal cancer, but the results showed that dose as the least successful, should not this information be published as a contribution to medical knowledge? Where commercial interests are involved, as often happens when pharmaceutical companies invest vast sums of money in trials of enormous potential value to cancer sufferers, the pressure not to publish is great. Or publication may mask the full truth, as would be the case if it were said that the results of a comparison of three regimens were whatever they were. The most honest and most truly scientific presentation would specify what was sought and what was found, but perhaps commercial reputations and interest in the next, perhaps more successful, venture might militate against this.

Conclusion

It has been shown in this paper that truth-telling to patients and to relatives is an essential requirement of human dignity. It is necessary for social cohesion and for the proper functioning of our health-care systems at the service of the human person in sickness and in need. It is not just an abstract ideal. It has to do with fundamental issues of justice and charity. It involves the most basic respect for fundamental human rights in regard to the weakest and the most vulnerable in society, including those who do not yet have the use of reason or who have lost it. A Christian society and a truly humane society will acknowledge and respect this claim.

In the case of clinical experimentation the strict inter-relationship between truth, justice and human rights resurfaces. Above all, when the medical and moral implications of dealing with people afflicted with potentially lethal tumours are considered, it can be seen that compromises with truth entail compromises with people's lives and rights.

To sum up, the importance of truth-telling in charity and compassion and of respect for truth at every level in bioethics is much greater than may be imagined at first sight. Without it, ethics and morality are rendered vacuous and health care personnel and patients alike suffer.

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considerazioni etico-deontologiche, in Spagnolo e Sgreccia, op. cit., 91-94 at 91. (21) Pius XII, Allocation to the first International Congress on Histopathology, 14th September, 1952, In: Verspiieren, op. cit., 219-29 et 222-23. Rights over our bodies are not absolute; we are stewards, not owners in their regard. (22) Spagnolo A.G.: Comitato etico dell'Università Cattolica: Raccomandazioni riguardo alla inclusione delle donne in et fertile nei protocolli di sperimentazione clinica, Medicina e morale, 1996, 141-43; Paul VI, Humanae vitae, 25th July, 1968, Acta apostolicae sedis, 60 (1968), 481-503, n. 10.

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Bratislava, March, 1998

Dear friends,

I let myself to approach you at the beginning of the fifth year of *Medical Ethics & Bioethics (ME&B)*. This modest anniversary allows to look backwards to the pages already published, as well as it calls to think about the future; on how the journal should proceed further, perhaps, to the third Millennium... This could also be the time for the editorial team to formulate new goals and intentions.

Previous years of *ME&B* has reflected the development of medical ethics and bioethics in Slovakia as a new, interdisciplinary specialty; aiming to offer both the philosophical reflection on moral aspects of contemporary medicine and health care, and also some "professional" support and/or help by the difficult personal decision-making in moral dilemmas of everyday's medical and nursing practice. A special attention has been (and should be) paid to the ethical problems of the ongoing transformation process of the Slovak health care system.

The first months and years of exciting enthusiasm, and the "institutionalization" of the discipline via founding of the Institute of Medical Ethics and Bioethics (as a joined institute of the Postgraduate Medical School and of the Faculty of Medicine, Comenius University; Bratislava), were followed by its continuous development, marked, among others, by the education of new teachers, appearance and work of ethics committees, development of international contacts and collaboration, increasing publication activities, elaboration of the educational texts and materials on medical and nursing ethics in Slovak language, numerous meetings, courses, conferences, lectures, workshops..., appearances in the media (radio, TV, press). Besides the gradual professionalization and profiliation of new workers in the field, the previous and future developments would be impossible without the great amount of voluntary, unpaid work of the growing circle of enthusiastic collaborators and sympatisants from different parts of Slovakia, and from abroad. Their invaluable contribution should be highly appreciated.

This is also true for the founding and publishing of *ME&B*. Though the difficult financial and organisational conditions have caused considerable irregularities in publishing of the journal, it is hoped at the beginning of this volume, that a decisive improvement is to be achieved this year.

We believe, a great deal of "the future" will depend upon you, myladies and gentlemen, our dear readers! Our aim is to make, together with your contribution(s), the journal an interesting and stimulative reading, a resource of valuable informations in the field, but also, and not for the least, a familiar, open space for posing questions and for shared thinking about the complicated, but, at the same time, also very "practical" ethical problems of contemporary medicine and health care.

We would appreciate very much receiving your suggestions, remarks, and constructive criticism, but, even more, your submitted papers and letters for any of *ME&B*'s headings. Comfortable reading, and nice thinking, dear friends!

Jozef Glasa, M.D., Ph.D.
Editor

* English translation of the Slovak text from the p. 1.

SOCIAL AND DEMOGRAPHIC DETERMINANTS OF ABORTION

(40-years' Experience in Slovakia)

Karol Pastor

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Abstract

Various factors which may influence the level of abortion rate are discussed in the paper. Theoretical considerations are illustrated by the statistics data of the Slovak Republic. Most of the conclusions reached, according to the author's opinion, may be valid for other populations as well. It is shown, that the most important determinants of the abortion rate are: political regime, 'population climate', legislative and economic conditions, contraception use, religiosity and public opinion. Contraception use itself accelerates the diffusion in the population of the new non-restrictive patterns of sexual behaviour. Therefore, in general, it does not reduce the abortion rate. The 'demand' for abortion is shifted to the contraception use (or to the alternative fertility control methods) only when the "relative price" of abortion increases. Pro-life activities and religiosity increase the "moral cost" of abortion and in this way they work as an important stabilizing factor.

Key words: demography, abortion rate, legislative conditions, 'population climate', contraception, sexual behaviour.

A Brief Historical Survey

It is a well-known fact, that the modern history of induced abortion started in the Soviet Union in 1920, where it was legalized soon after the Bolsheviks' revolution. This had been portrayed as one of the "achievement of socialism", which should have served to the 'emancipation of women', ensuring the right of the woman to decide about her maternity. The other reason given was the aim to prevent criminal, 'unsafe' abortions. The legalization of abortion was interpreted as a sign of progress, set deliberately into a contradictory relationship to the "obsolete" religious doctrines.

For these reasons, soon after the World War II, the countries which had fallen under the Soviet dominance adopted a similar abortion legislation. Since 1956-1957 abortion acts have been approved in China, Poland, Hungary, Bulgaria, Romania and former Czechoslovakia. Just a little bit later such laws were enforced in other 'communist' countries, with exception of Albania and North Korea. In the meantime these acts were modified in one or another way (towards more 'liberal' or to a more restrictive ones; for details see [2]). In Czechoslovakia, a new, quite permissive abortion law was approved in 1986.

In most countries of the West induced abortions were prohibited due to their judeo-christian moral, as well as legal traditions up to the 1970-ies. Later on, the more or less restrictive abortion legislation has been passed almost in all countries of Europe and worldwide. At present, induced abortion is still not allowed in Ireland.

Factors Associated with Evolution of Abortion Rates

The aim of this contribution was to study, mostly from the demographical and statistical point of view, various factors, that, according to our opinion, have an impact on

the evolution of the induced abortion rates nowadays and in the recent past; especially in the 'countries in transition' from the former totalitarian, centralistic towards a more democratical political and economical systems. The possible impact of the following factors was studied: the political regime, legislation, 'population climate', contraception, public opinion, religiosity and life-style.

Our theoretical considerations, presented in the paper, are illustrated by using the statistical data of the Slovak Republic (SR) (routinely collected and published by the Statistical Bureau of SR and the Institute for the Health Information and Statistics in Bratislava). These are believed to be reasonably complete and reliable. The main evolution trends are presented in the figures attached to the text. Where available, the data from other countries were taken into account as well (cf. [1], [4], [9]).

1. Political Regime

A remarkable feature of all the world abortion surveys until the early 1990-ies was, that the top places belonged for long to the communist or to the former communist countries. Regardless of the possible doubt about the reliability of some data, the abortion rate could be seen as a demographical index, which was able to distinguish quite well the developed West from the 'communist' East in that period of time. According to the data given in [9], for example, in the "top group" there were 28 such countries, followed by USA, Singapore, Sweden, etc. Only Poland and Azerbaijan were out of the line, while data for North Korea and Albania were not given. Slovakia with its 37.8 abortions per 1.000 women aged 15-44 (1991) was placed near the end of this "top group".

We think, the first reason for this was the time priority of the communist regimes in the legalization process of abortion. The next one might be seen in a tolerant attitude of the communist state towards abortion, which roots in the core of the marxist ideology. The ideology of "historical" materialism and collectivism had established an overall attitude, according to which the state was put into the position to be able to manipulate considerably the lives of its citizens. The value of life of an individual was not considered a real obstacle in this respect.

The totalitarian state, at the same time, claimed for itself and applied in practice a strong ideological monopoly. Thus, when e.g. the legalization of induced abortion had been presented as an "achievement of socialism", it was not possible to criticize it openly. Therefore, under the communist regime, the pro-life activities (similarly to all independent initiatives) were regarded as the ones going against the state, and therefore oppressed or punished.

Thus, the political regime seems to be among the main determinants of the abortion rate. If this assumption is true, then after certain political changes the abortion rate should change accordingly. This has, in fact, happen in many of the former 'communist' countries. For this reason, it is methodologically incorrect to compare with respect to the abortion rate the states belonging to different political blocs, as well as to simply compare (without an appropriate interpretation) the situation in any state before and after a profound political change. In Slovakia, the breaking year is 1990. So, the years 1958 - 1989 form a closed period which is appropriate for particular study.

2. Legislation

Within the periods of relative political stability, the most significant changes in abortion rates occurred as a result of modifications in legislation. A good example for it are Hungary (1956 liberalization, 1974 restriction), Romania (1957, 1966, 1972 and 1990), Poland (1956,

1990), or Slovakia and the Czech Republic (1957, 1986 further liberalization).

After each liberalization the number of abortions rapidly grew up. Only a small part of them could be explained as a legalization of former illegal ones. Undoubtedly, when restriction occurs, the demand for illegal abortions is higher, however, by analogy with the economic theory, the total demand for induced abortions is less. On the other hand, the increase in number of induced abortions after liberalization can be used as an upper limit for estimation of criminal abortions in the past. For this reasons, the estimates for number of criminal induced abortions in the first half of XX-th century in Slovakia (30.000 or more yearly, see e.g. [3]) published by some demographers are for sure highly over-estimated. Similarly, also others estimates of criminal abortions seems to be over-estimated, perhaps deliberately (to support more liberal laws).

Each legal restriction lowers the total number of induced abortions (legal and illegal), because it increases "costs" of abortion and changes reproductive behaviour. Legal restriction also increases the "moral costs" of abortion (and reversely, the liberalization decreases them), particularly when another moral authority absents. Namely in these conditions law 'substitutes' ethics.

An example illustrating such a 'psychological' effect of legislative changes is the one of Slovakia in Autumn 1986, when a more liberal abortion law has been approved. Although it has come into force since January 1987, people adjusted their behaviour according it immediately and the number of abortions increased in one fourth three months earlier [5].

3. 'Population Climate'

One of the most important determinants of abortion rate is the population climate. Induced abortions have served from the very beginning as a drastic tool for fertility control. Abortion laws in the eastern Europe were approved when the post-war population boom was culminating. It was the time when demand for more effective population control arose.

As can be seen from the demographic development in Slovakia, periods with the pro-population orientation (1950s, 1970s) have alternated with the opposite ones. It is interesting that in the periods with higher birth rates there were more registered pregnancies and less induced abortions. As it is shown in [5], both abortions and contraception were used for birth control, even in the fixed proportion. The above mentioned fact implies that pro-population measures lower the abortion rate, but it does not work reversely: anti-abortion campaign does not cause an increase in natality (however, this is usually not its purpose). So, hypothetical "unwanted children" problem is not a regular 'consequence' of anti-abortion measures when these are introduced successfully (The Ceausescu's sudden restrictions introduced in Romania in 1966 are, of course, a different story...).

A sudden deterioration of living conditions works as an anti-population measure, it increases the abortion rate. For example, the prices of consumer goods in Czecho-Slovakia were liberalized in January 1991 and started to grow rapidly. This was associated with an immediate increase of the abortion rate. In February, when the growth of prices had been stopped, the abortion rate returned to the previous level. Within one state the local population climate may differ, e.g. (as this is a case in Slovakia at present) in accordance with the access to flats. In the cities and immigration regions a demand for flats highly exceeds supply, which may also contribute to the higher abortion rates in these areas. On the other hand, the unemployment rate in Slovakia seemingly does not increase abortion rate considerably.

4. Contraception

It is supposed 'traditionally' (by its proponents and supporters), that contraception in general lessens abortion rates. The Slovak experience during the years 1958 - 1989 seems to contradict this presupposition (Fig. 1). In this period, the contraception use in women (hormonal, intrauterine or other medically prescribed contraception) was growing steadily, but abortion rate did grow too (with an exception of the pro-population measures period of the early 1970s). As mentioned above, an increment of both (contraception and abortion) got a fixed proportion for 15 years: for each 7 women who newly started the use of modern contraception 1 new abortion occurred. In other words, contraception and abortion are not substitute but complementary 'goods' [3].

This 'paradox' can only partially be explained by the 'failures' of contraception. A more important fact, observed during this period, seems to be the development of two parallel trends: 1) a general fertility decline and 2) spread of a non-restrictive sexual behaviour. Both contraception and abortion appear to give backing to these developments [8]. The proportion of contraception and abortion 'use' is given also by their "relative prices" and by the prevailing views, values and customs of the society.

The relative price contraception vs. abortion can be changed - e.g. by legislative means (restriction or liberalization of abortion laws; in 1987 the change of law in favour of abortion); by financial means (establishing or increasing the fee for abortion performance; Czech Republic 1992, Slovakia 1995); or by the changes of the public opinion (e.g. change of the moral evaluation of abortion as a result of successful pro-life or pro-choice campaigns).

We believe the same is true also for other countries.

Contraception and abortion are used for the same purposes and in the same way. However, their proportion may differ from country to country according to the local conditions, traditions, religiosity, etc.

5. Public Opinion, Religiosity, Life-Style

Religiosity as a factor of public opinion belongs to the main determinants influencing the induced abortion rate. For example, in Slovakia, the abortion rate varies very much in different regions of the country (the highest level is five times greater than the lowest one). The variability of abortion rate is well associated with the level of religiosity (the correlation coefficient is about -0.8). In more religious districts, there is a lower contraception use, but not a higher rate of pregnancies [6].

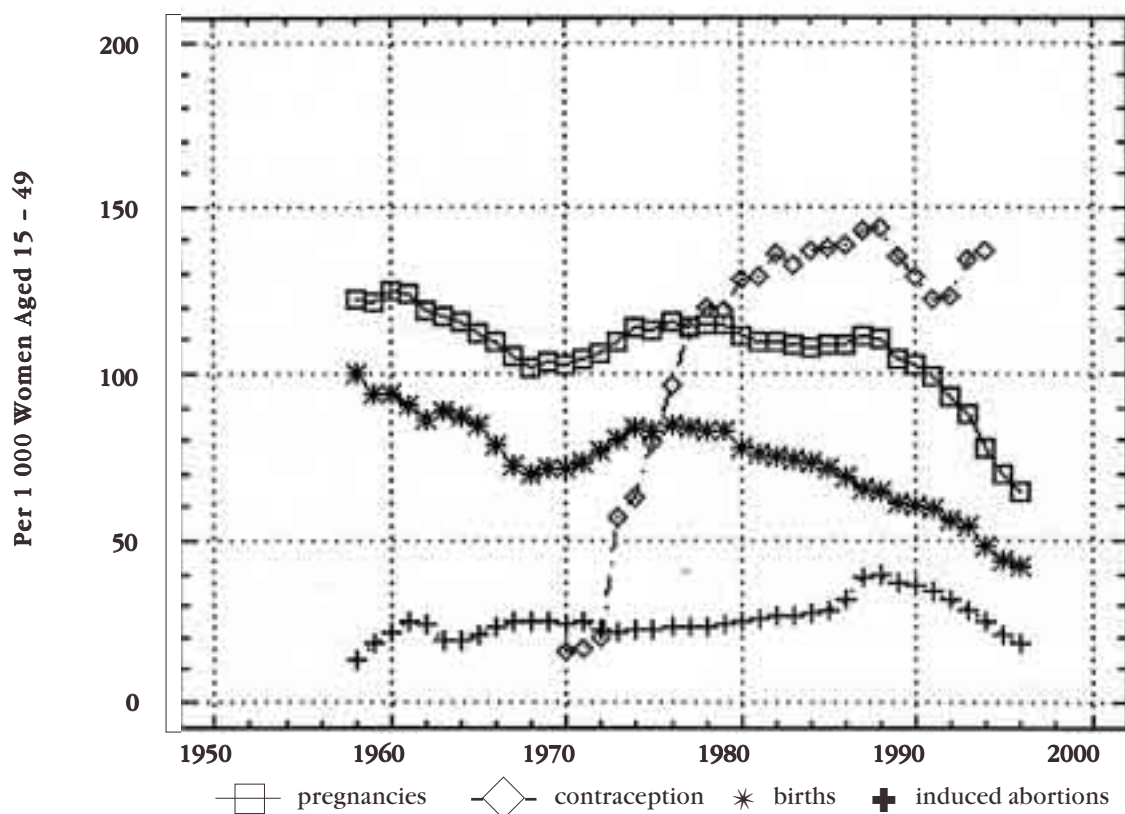
Similar association can be observed also in the Czech Republic and in other countries of the former 'Eastern Block'. Where the religiosity is lower, there the abortion rate is more sensitively influenced by other factors.

The above mentioned facts suggest that the number of pregnancies occurred can effectively be influenced also by other means, instead of the contraception alone.

In general, sexually non-restrictive and restrictive methods of fertility regulation can be distinguished. Induced abortion and contraception belong to the former group, while natural family planning methods to the later one. What will prevail in the society and in what proportion, this depends on many factors including the traditions, innovations and ideational determinants of the society. A considerable move towards the non-restrictive sexual behaviour has taken place in the developed countries of the 'West' since the 'Sexual Revolution' of 1960s.

Factors, that support the non-restrictive (promiscuous) sexual behaviour and corresponding life-style (including e.g. pornography, drugs; but also contraception up to the certain limit) may lead, as has been shown above, to the higher abortion rates. On the other hand, the pro-life movement and similar activities may influence the public opinion and contribute this way significantly to the decline of the abortion rates (by increasing the social and moral 'cost' of abortion). This is seemingly one of the major reasons of the break in the development of abortion ra-

Figure 1: Terminated Pregnancies and contraception, Slovakia, years 1958 - 1996



tes in the East European countries after the fall of communist ideological monopoly.

6. Recent developments

Finally, it remains to comment briefly on the latest developments of abortion rates in Slovakia and other countries of the former 'communist block'. After the changes in 1989, together with the political-economical model of the West, these countries are taking over also the model of demographic behaviour. So in 1990s, we can observe a gradual approximation of their demographical indices to those of the rest of Europe. As a positive phenomenon, that has occurred in the majority of East European countries, the recent significant move down of abortion rates towards the values typical for the Western European countries has been observed. The fall of the ideological monopoly might be listed among the main causes of these changes.

In Slovakia, for example, abortion has become an important topic in public discussion and in media since 1990. Pro-life groups have been allowed to work openly. The authority of churches has risen (also in connection with the visits of pope John Paul II to Slovakia (1990, 1995)). Slovak Government and Parliament have dealt with a proposal of the law on "respect of human life within the medicine and health care" in 1992. Although the legislative process was interrupted because of the elections and has not continued after it, the accompanying discussion has had a significant impact on the public opinion in the country. While in the neighbouring Czech Republic a similar discussion led to an introduction of the fee for the abortion performance (1992), in Slovakia this happened three years later (1995). In the same time, a wide supply of modern contraceptives has revealed on the market. The decline in both abortion and birth rates and (since 1992) an increase in contraception use were observed.

These developments have accelerated the start of the second demographic transition in Slovakia (and in most other East European countries), with all arriving problems, that are connected with it. But this problem is going far beyond the framework of this paper.

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DOKUMENTY/DOCUMENTS

At its annual meeting in Hamburg, Germany, at the end of last year the World Medical Association adopted several declarations and other statements, two of which are reprinted here.

DECLARATION OF HAMBURG

Declaration of Hamburg concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment

Adopted by the 49th World Medical Assembly, Hamburg, Germany, November 1997.

Preamble

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

2. Primary among these declarations are the World Medical Association's *International Code of Medical Ethics*, *Declaration of Geneva*, *Declaration of Tokyo*, and *Resolution on Physician Participation in Capital Punishment*; the Standing Committee of European Doctors' *Statement of Madrid*; the *Nordic Resolution Concerning Physician Involvement in Capital Punishment*; and the World Psychiatric Association's *Declaration of Hawaii*.

3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

Resolution

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:

(i) to encourage doctors to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;

(ii) to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and

(iii) to extend its support and to encourage other international organisations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

(i) to protest internationally against any involvement

of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment;

(ii) to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;

(iii) to publicise information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and,

(iv) to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Statement.

DECLARATION WITH GUIDELINES FOR CONTINUOUS QUALITY IMPROVEMENT IN HEALTH CARE

Adopted by the 49th World Medical Assembly, Hamburg, Germany, November 1997.

Preamble

1. The purpose of health care is to prevent, to diagnose or to treat illness and to maintain and to promote the health of the population. The goal of quality review in health care is continuous improvement of the quality of services provided for patients and the population, and of the ways and means of producing these services.

2. The obligation continuously to improve one's professional ability and to evaluate the methods used is included in the ethical codes of physicians. According to them a physician has to maintain and increase his/her knowledge and skills. He/she shall recommend only examinations and treatments that are known to be effective and appropriate according to the state of medical art.

Purpose of the guidelines

3. Physicians and health care institutions have a moral obligation to strive for continuous improvement of services. The purpose of these guidelines is to strengthen this pursuit by means of quality review practices and to create ethical grounds for such review practices, like clinical peer review.

Application of the guidelines

4. Ethical guidelines for continuous quality improvement concern all physicians, institutions providing health care services for patients, and producers of review services.

Obligation for quality review

5. All physicians, other health care professionals (including health administrators) and institutions have to aspire to improvement of their work. Active participation by everyone in clinical audit and in quality review initiatives should be encouraged. Quality review evaluations can be used for independent external audit, and with the aim of accreditation.

Standards for good quality work

6. Those involved in work with patients need to specify the standards necessary for good quality work and for the evaluation of the quality of the work. The resources and skill mix of staff within health care establishments should be adequate to attain the required standards of good quality work.

7. Patient data, whether recorded on paper or on computer, has to be written and preserved with care, taking into consideration the obligations for confidentiality. Procedures, decisions and other matters connected with patients need to be recorded in a form which will allow information for measuring specific standards to be available when needed.

8. Health care professionals should have adequate opportunities to maintain and develop their knowledge and skills. Recommendations and clinical guidelines should be easily available for those requiring them. Health care institutions need to create quality systems for their own use and to ensure that instructions concerning such systems are followed.

Recognition of quality review

9. All physicians should continuously evaluate the quality of their work and their level of ability by self-review methods.

10. The quality of health care can be assessed by both internal and external methods. The agencies for both processes have to be widely approved, and the methods used must be generally accepted and based on research or sufficient knowledge.

11. Internal clinical peer review, observation of examination and of treatment methods, comparison with others, observation of the organisation's ability to act and monitoring of the feedback from patients have to be continuous activities undertaken by every service provider.

12. External quality review initiatives, such as external peer review and audit, should be carried out with a frequency corresponding to the evolution of the field and always when there is special reason for it.

Confidentiality of patients' records

13. Patient records can be used in quality review. Patients should be made aware of the use of their records in quality review. Their medical records should be kept confidential and anonymised and should not be accessible to inappropriate persons. All reports, photographs, videos and comparative data have to be presented in such a form that the patients involved in a review cannot be identified.

Confidentiality of peer review

14. A precondition for successful peer review is the freedom of institutions and physicians to agree to be reviewed and their commitment to review. It is recommended that informed voluntary consent be obtained from those to be reviewed.

15. The results of a review belong to those subscribing to it. The results can be used for comparisons and general purposes only with the approval of the subscriber and those involved in the review, unless national legislation provides otherwise.

16. A provider of services can inform his/her customers about the results of quality review and use them in marketing his/her services, provided this is allowed by the law.

17. Review of the work of an individual physician is the responsibility of the physician him/herself and

his/her superior physician. Information regarding an individual physician should not be published without consent of the physician concerned.

18. An external review shall not reveal to others the results of the review, or other information obtained during the review, without the written permission of the subscriber of the review.

Ethics committees

19. Generally approved ethical principles of health care and national codes of medical ethics have to be followed in quality review.

20. If doubts are raised about ethical issues in a review project they should be referred to an ethics committee. However, in general, the routine submission of review projects for approval by ethics committees is not necessary.

Competence of the reviewer

21. The reviewer has to be experienced in the field that the review concerns and competent in quality development techniques and in clinical audit methods. When medical care is reviewed, the reviewer must be a physician. The reviewer has to be accepted by those to be reviewed, whenever possible.

Impartiality of the review

22. The chosen reviewer must be as impartial and as independent as possible. He/she has to be well acquainted with the activities of those to be reviewed. The reviewer has to be objective in his/her report. His/her conclusions should be based on a critical evaluation of observations and facts. The reviewer must not allow commercial or competitive matters to influence the content of his/her statement.

Review and supervision by authorities

23. Quality review of health care and continuous quality improvement of services is a part of the activity of every physician and institution. The supervision of professional activities made by health care authorities is a distinct activity and should be kept separate from health care review. The results of a review of physicians can be used for the purposes of supervising authorities only by a separate mutual agreement between the health care authorities and the physicians concerned, unless national legislation provides otherwise.

Plánované akcie / Forthcoming Events (Europe)

- Women's Health Issues, February 18 - 22, 1998, Rome.
- Ethics and palliative care, April 2 - 4, 1998, Nijmegen, The Netherlands.
- Children and Mental Health - The Moral Considerations, April 29, 1998, London.
- Informed consent in research and clinical practice, May 15, 1998, London.
- Teaching and Communication Skills for Clinicians, July 1 - 4, 1998, London.

KRÁTKE PRÍSPEVKY

SHORT PAPERS

BIOETIKA BUDÚCNOSTI: HOBBY ALEBO POVINNOSŤ?

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Abstrakt

Bioetika vznikla domýšľaním etických dôsledkov nových, prevratných objavov v medicíne a biológii v ich komplexných interdisciplinárnych súvislostiach. Staré i 'nové' problémy, ktoré nastoľuje a pokúša sa riešiť, patria k najzaujímavejším filozofickým i 'praktickým' otázkam súčasnosti. Lekár tretieho tisícročia bude vo svojej každodennej praxi často konfrontovaný s etickými aspektami svojej činnosti. Odborná erudícia v tejto oblasti - z hľadiska individuálneho pacienta i spoločnosti - bude patriť k významnej zložke jeho profesionality (povinnosť). Vývoj medicínskych a biologických vied však bude prinášať nové - náročné i zaujímavé etické otázky, smerujúce k lepšiemu pochopeniu existenciálnych problémov moderného človeka, prehĺbeniu jeho porozumenia sebe samému i okolitému životu a svetu. Sledovanie tohto vývoja môže byť významným osobným a osobnostným obohatením lekára (hobby).

Kľúčové slová: bioetika, výuka, lekárska prax, osobnosť lekára

1. Bioetika je dieťaťom poslednej tretiny dvadsiateho storočia. Vznikla domýšľaním etických dôsledkov nových, prevratných objavov v medicíne a biológii v ich komplexných interdisciplinárnych súvislostiach (1). Popri postupujúcej špecializácii a 'atomizácii' prírodných aj spoločenských vied priniesla snahu o integrujúci, hodnotovo orientovaný pohľad do budúcnosti života prírody i ľudskej civilizácie. Napriek tomu je oblasť bioetiky v súčasnosti skôr poľom konfrontácie širokého spektra názorov existujúcich v súčasných pluralitných spoločnostiach, tak v rozvinutých krajinách západnej Európy a Severnej Ameriky (2, 3, 4), ako aj v štátoch, kde prebieha zložitý proces transformačných zmien po páde "železnej opony" (5, 6).

2. 'Staré' i 'nové' problémy, ktoré bioetika nastoľuje a pokúša sa riešiť, patria k najzaujímavejším filozofickým i 'praktickým' otázkam súčasnosti (Tab. 1) (7). Rezonujú v širokom priestore médií masovej komunikácie, v umení - komerčnom i "ozajstnom", zamestnávajú parlamenty, vlády, ministerstvá, medzinárodné inštitúcie vedy i moci (napr. Rada Európy, Európsky parlament, prezident USA), no týkajú sa aj rodín a jednotlivcov, pokolení súčasných, i tých, ktoré sa ešte len počnú a narodí. Mnohé sa s naliehavosťou konkretizujú v úvahách a náročných rozhodnutiach lekára na ambulancii alebo pri lôžku pacienta.

Lekár tretieho tisícročia bude vo svojej každodennej praxi veľmi často konfrontovaný s etickými aspektami svojej činnosti. Bude pracovať obklopený a prostredníctvom stále dokonalejšej techniky, ktorá znásobí jeho možnosti účinne zasiahnuť do chorobných i fyziologických procesov ľudského organizmu, ako aj dôsledky týchto zásahov sledovať a vyhodnocovať. Môže však súčasne prehľbiť aj roztvárajúcu sa priepasť oddelenia lekára od pacienta na úrovni jednoduchšej i hlbšej komunikácie, ako aj na rovne osobného, ľudského vzťahu.

Pri svojich rozhodnutiach bude lekár stále viac musieť

brať do úvahy stanoviská pacienta, jeho hodnotový systém a preferencie, etické a svetonázorové aspekty, prístupovať k pacientovi a jeho blízkym ako k partnerom v dialógu. Na druhej strane bude naďalej rásť úloha lekára v rozhodovaní o indikácii alebo ne/kontra/indikovaní náročnej a drahej diagnostiky a liečby. Bude jazýčkom na váhach medzi viac alebo menej oprávnenými požiadavkami pacienta, jeho rodinných príslušníkov, známych - a možnosťami a záujmom spoločnosti poskytovať finančné prostriedky a ďalšie zdroje pre oblasť zdravotnej starostlivosti. Rozhodovanie lekára si teda bude vyžadovať nielen "technicko-technologické" medicínske vedomosti, ale aj náležitú prípravu v oblasti profesionálneho hodnotenia a zvažovania etických aspektov a dôsledkov prijímaných medicínskych rozhodnutí. Úlohou lekára bude postupovať vždy v najlepšom záujme pacienta, s prihliadnutím na oprávnené limity a záujmy spoločnosti (8). Odborná erudícia lekára v tejto oblasti bude patriť k významnej zložke jeho profesionality (povinnosť).

3. Vývoj medicínskych a biologických vied však bude zaiste prinášať nové - náročné i zaujímavé etické otázky, smerujúce k lepšiemu pochopeniu existenciálnych problémov moderného človeka, prehĺbeniu jeho porozumenia seba samému i okolitému životu a svetu. Využitie poznatkov a nových technologických možností, najmä z oblasti molekulárnej biológie a genetiky, bude naďalej problematizovať základné vžitie pojmy, mravné normy a etické princípy globálnej ľudskej civilizácie, najmä tie, ktoré vychádzajú z jej tradičných judeo-kresťanských koreňov (Ľudská osoba, individualita a integrita, rodina a manželstvo, otcovstvo a materstvo, ľudské práva, ...). Súčasná kríza európskeho i svetového myslenia a kultúry - niekedy označovaná pojmom *postmodernizmus* - môže naznačovať i niektoré nebezpečenstvá a zápasy 'kultúry života' a 'kultúry smrti' v budúcom tisícročí, ktoré sa v nezanedbateľnej miere odohrajú práve na poli bioetiky (9). Sledovanie tohto vývoja môže byť významným osobným a osobnostným obohatením lekára (hobby). Demokracia budúcnosti, ak sa nemá stať skrytou formou ideologickej - a v istom stupni svojho vývoja dokonca biologickej, skupinovej totality, bude vyžadovať ľudí - občanov, ktorí budú schopní samostatne kriticky myslieť a rozhodovať sa, ako aj prijímať a niesť osobnú zodpovednosť. Vzhľadom na úzku spätosť medicíny s kultúrou danej spoločnosti možno právom očakávať, že jej úloha i z tohto hľadiska nebude zanedbateľná. Poznanie a presadzovanie kľúčových priorít v oblasti medicíny a zdravotníckych systémov tretieho tisícročia (10) sa bude odvíjať od pochopenia a definovania základnej antropologickej paradigmy - od porozumenia podstate, poslaniu a zmyslu človeka a jeho života na Modrej planéte Zem - a ďalej.

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Abstract

Glasa, J.: Bioethics of the Future: Hobby or Obligation? Medical Ethics & Bioethics (Bratislava), Vol. 5, 1998, No. 1, p. 11-12. Bioethics originated as a reflection of the ethical aspects of new discoveries in medicine and biology in their interdisciplinary inter-connections. The 'old' and 'new' problems it articulates and tries to find solutions for belong to the most interesting philosophical and 'practical' issues of a professional as well as of general interest. A physician of the Third Millennium will be frequently confronted in his or her everyday's practice with numerous ethical aspects of his or her work. Professional knowledge in this area - from the point of view of an individual patient as well as from that of the society - will constitute an important part of his or her professionalism ('obligation'). The development of medical and biological sciences will bring with new and interesting ethical questions, many of those oriented towards better understanding of the 'existential' problems of modern man, the understanding of himself (herself), his (her) surrounding life and world. Follow-up of these developments could make a positive contribution towards the intellectual growth of the physician as a personality ('hobby'). **Key words:** bioethics, practice of medicine, personality of the physician.

Tabuľka 1: "Horúce témy" bioetiky

biomedicínsky výskum s účasťou ľudských subjektov,
ukončenie alebo nezačatie niektorých druhov reanimačnej liečby u kriticky chorých pacientov,
eutanázia, umelý potrat,
sterilizácia mentálne handikapovaných osôb,
kontrola pôrodnosti, antikoncepcia,
umelá inseminácia, oplodnenie v skúmavke,
náhradné materstvo,
transplantácia orgánov a tkanív, xeno-transplantácia,
implantácia umelých orgánov,
definícia smrti, dlhodobé bezvedomie, perzistujúci vegetatívny stav,
psychochirurgické, psychofarmakologické a behaviorálne prístupy na ovládanie ľudského správania,
technológia rekombinantnej DNA,
genetické inžinierstvo,
génová terapia, genetický skrining a poradenstvo,
AIDS, prenatálna diagnostika, eugenika,
spravodlivé rozdeľovanie obmedzených prostriedkov,
ochrana životného prostredia a biodiverzity,... (atď.)

(Súhrn prednášky na konferencii "Výuka medicíny v 3. tisícročí", LFUK, Bratislava, sept. 1997.)

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NEMOCNICA SV. LADISLAVA V BRATISLAVE A JEJ OSUDY V PRIEBEHU STÁROČÍ

Karol Bošmanský

Starostlivosť o chorých, chudobných a starých bola v staroveku celkom neznáma vec. S rozvojom kresťanstva sa začala postupne systematicky organizovať starostlivosť o starých, chorých a chudobných občanov. Prvé nemocnice sa začali budovať čiastočne súkromne, ale poväčšine boli založené a vedené rôznymi rehoľnými komunitami. Útulky pre opateru chorých a starých ľudí dostali často meno podľa Lazára z evanjelia.

Cirkev sa ujímala zakladania mestských nemocníc a zverovala ich do správy kláštorom. Takto roku 651 vznikla v Paríži dodnes slávna nemocnica Hôtel de Dieu. Neskoršie vznikla aj nemocnica sv. Bartolomeja v Londýne.

Kráľ Ladislav (1040-1095) s najväčšou pravdepodobnosťou povolal do Bratislavy členov rádu sv. Antona, ktorí sa menovali antoniti. Rád založil francúzsky šľachtic Gaston de Dauphine a jeho syn Querin. Členovia rádu sa postupne usadili po celej Európe a venovali sa charitatívnej službe a zakladaniu nemocníc. Roku 1777 sa rád zjednotil s Maltézskeým rádom, ktorý taktiež vykonával službu chorým.

Roku 1095 členovia rádu sv. Antona založili v Bratislave nemocnicu, ktorú po svätorečení kráľa Ladislava roku 1192 z úcty k bývalému dobrodincovi zasvätili spolu s novovybudovanou kaplnkou sv. Ladislavovi. Takto sa stal sv. Ladislav patrónom prvej nemocnice a neskoršie postaveného kostola v Bratislave.

O osude novozaloženej nemocnice - špitáli v 12. a 13. storočí vieme pomerne málo. Je však temer isté, že nemocnica vykonávala svoju požehnanú činnosť.

V čase križiackych výprav križiacke vojsko táborilo aj v Bratislave. V tom čase slúžila nemocnica ako lazaret pre chorých vojakov. Je prirodzené, že nemocnica bratstva sv. Antona v Bratislave počas križiackych výprav dosiahla svoj najväčší rozkvet.

Tatársky vpád priniesol veľké nešťastie celej zemi. Roku 1241 zapálil chán Batu nemocnicu. Postupne boli zničené všetky objekty, ktoré sa nachádzali za mestskými hradbami. Hrad a vlastné mesto Bratislava, ktoré boli chránené hradbami, postavili sa na odpor vpádu Tatárov.

V priebehu krátkeho času obnovili členovia rádu sv. Antona vypálenú nemocnicu pravdepodobne s podporou mesta, ako sa spomína v zakladajúcej listine Gerharda z Tombres.

Ďalší veľký úder zažila nemocnica a jej obyvatelia v čase, keď kráľ Otakár II. (1278) rozširoval územie svojho kráľovstva smerom na východ. Vnikol roku 1271 do Uhorska a dočasne obsadil jeho veľkú časť. Nemocnica sa musela opäť reštaurovať, čo sa zvládlo veľmi rýchlo.

Roku 1309 nastal medzi členmi rádu sv. Antona v Bratislave a mestskou radou určitý spor kvôli majetku nemocnice. Po rokovaniach a uzavretí zmluvy prešla nemocnica rádu sv. Antona do čiastočného vlastníctva mesta, ktoré opakovane prispelo materiálne na jeho výstavbu a rád si ponechal duchovný dozor nad nemocnicou. Aj po uzavretí zmluvy roku 1309 spravovali antoniti nemocnicu až do konca 14. storočia.

Roku 1397 prešla nemocnica do úplného vlastníctva mesta Bratislavy. Členovia rádu sv. Antona mali už len podradné práva. Na základe zmluvnej listiny Gerharda z Tombres, generálneho predstaveného rádu antonitov, dostala sa nemocnica so všetkými právami, movitým i nemovitým ma-

jetkom s konečnou platnosťou do vlastníctva mesta Bratislavy. Členovia rádu sv. Antona odišli z nemocnice a venovali sa rozjímavému životu. Mesto prevzalo nemocnicu do svojej správy a dosadilo za správcu nemocnice Mikuláša Lachhtla. Za správcov nemocnice sa nemohli menovať chudobní mestskí úradníci. Táto hodnosť bola skôr čestným úradom (nobile officium) ako zamestnaním. Za správcov sa volili poväčšine bohatí občania, ktorí nemocnicu materiálne podporovali. Napr. správca nemocnice Bartolomej Scharrach bol vlastníkom viacerých vinohradov, sudcom mesta a neskoršie aj mešťanomom. Nemocnicu všemožne podporoval. Ďalší správca Albert Gailsam kúpil vinohrad a odkázal ho nemocnici.

Na začiatku 15. storočia zažila nemocnica a jej obyvatelia ťažký úder. Nastalo tak vpádom husitov roku 1428, ktorí nemocnicu vypálili. V priebehu krátkeho času sa nemocnica opravila a pod správou kráľovského slobodného mesta Bratislavy bola nemocnica opäť vo veľkom rozkve. Patrili jej okrem nemocností, ktoré postupne dostala, aj peniaze v hotovosti. Svedčí o tom účtovnícka kniha, ktorá je uložená v mestskom archíve.

V tomto období pred rokom 1529 kráľovské mesto vlastnilo iba jednu nemocnicu, ktorá bola založená rádom sv. Antona. Nachádzala sa v okolí dnešnej Špitálskej ulice. Ulica s najväčšou pravdepodobnosťou dostala meno od tejto nemocnice. Špitálska ulica pozostávala pôvodne z dvoch častí: špitálskej a reichardskošpitálskej časti (dnešná Rajska ulica).

Historik Ortway uvádza, že nemocnica sv. Ladislava až do roku 1529 stála na mieste dnešného katolíckeho ústavu starostlivosti o občanov ako jediná nemocnica v Bratislave.

Viac ako 100 rokov bola nemocnica sv. Ladislava majetkom mesta a po celú dobu blahodárne pôsobila. Neočakávane roku 1529 utrpela ťažkú ranu. Stalo sa to vtedy, keď sa Suliman II. vzdal obliehania Viedne a viedol svoju osmanskú armádu cez Bratislavu späť do Turecka. Keďže sa nemohol zmocniť pevného postavenia na hradbách Bratislavy, zničil všetky budovy mimo mestských hradieb. Tak zničil kostol sv. Michala a Laurencia ako aj nemocnicu sv. Ladislava. Tieto tragické udalosti sú veľmi zaujímavé a podrobne opísané v správe kráľovského mesta Bratislavy, ktorá bola adresovaná majestátu kráľa Ferdinanda I. Úbohí obyvatelia špitálu zostali bez prístrešia a ochrany a boli vystavení svojmu nepriateľnému osudu. Magistrát mesta sa cítil byť zviazaný vo svojom svedomí voči obyvateľom nemocnice. Preto im krátkodobou poskytol ubytovanie a opateru v tom čase neobývanom kláriskom ženskom kláštore, kým sa neobnoví nemocnica sv. Ladislava. Roku 1543 bola opäť postavená nemocnica na mieste, kde stojí dodnes. Jej obyvatelia sa nastahovali opäť do obnovených priestorov špitálu sv. Ladislava.

V druhej polovici 16. a v prvej polovici 17. storočia prebiehal život v nemocnici nerušené. Nemocnica opäť získala materiálnu pomoc a morálne úspechy. Nový ťažký úder postihol nemocnicu, keď Turci za vlády Leopolda I. vtrhli do našej zeme a zničili ju ohňom a mečom. V tom čase rakúsky vojvodca Montecucoli opevnil hradby mesta a nechal všetky domy mimo hradieb zrúcať, aby nepriateľ nenašiel miesto, z ktorého by mohol útočiť. A tak roku 1672 padli za obeť na základe Montecucoliho plánu kostol i nemocnica sv. Ladislava, keďže stáli vedľa seba. Po ich zničení za veľmi krátky čas boli znova vybudované. Roku 1683 zaplavili hordy Thökölyho krajinu a ich pričinením ležala nemocnica opäť v troskách. Kolégium dómskej bratislavskej kapituly a magistrát mesta sa veľmi pričínili o to, aby sa nemocnica s kostolom čím skôr vybuďovala. Barón Horváth-Kuffenitz vybuďoval roku 1689 kostol i nemocnicu na vlastné trovy, ako to už raz urobil pred 17 rokmi. Kostol a nemocnica sv. Ladislava slúžili až do roku 1830 (obr.1).

Skoro 150 rokov slúžila nemocnica i kostol svojmu poslaniu. Stavba však postupne chátrala. Kostol a nemocničné budovy sa postupne ocitli pod úrovňou ulice. V dôsledku prenikania vlhkosti boli múry nemocnice i kostolíka zatuchnuté. Kostol pokrytý šindelovou strechou bol vážne poškodený. Mnohí vyslovili obavu, že sa kostol môže kedykoľvek zrútiť. Miestnosti nemocnice boli v dezolátnom stave. Preto kostol a nemocnica boli úradne zatvorené. Obyvatelia nemocnice sa odsťahovali do miestneho lazaretu.

Mesto nebolo ochotné prispieť svojou pomocou, keďže nemocnica bola katolíckym inštitútom. Preto sa stavby kostola a nemocnice sv. Ladislava ujali katolícki občania. Mestský registrátor Bernhard Betsera založil katolícky spolok starostlivosti o občanov a spolu s administrátorom kostola a nemocnice Karolom Uhlom položili základ na vybudovanie dnešného inštitútu. Dňa 10. marca 1830 pod záštitou magistrátneho radcu Františka Namera konalo sa prvé zasadanie novozaloženého stavebného spolku, kedy sa rozhodlo o osude katolíckej obecnej nemocnice spolu s jej kostolom. Staviteľ Ignác Feigler vypracoval plány na stavbu nemocnice a kostola. Odstránili sa ruiny bývalého kostola a nemocnice. Najprv sa začalo so stavbou kostola, nakoľko bol v strede plánovanej stavby. Do základného kameňa sa vložili vtedajšie

Obr. 1. Katolícky mestský špitál sv. Ladislava s kostolom pred rokom 1830



berné mince a zoznam ďalších vecí vrátane zakladajúcej listiny v latinskej reči, ktorú vyhotovil Karol Uhl, duchovný predstavený kostola a nemocnice sv. Ladislava. Po položení základného kameňa pokračovala stavba veľmi rýchlo. Po niekoľkých mesiacoch boli hlavné práce na ústave starostlivosti sv. Ladislava spolu s kostolom v štádiu ukončovania (obr. 2). Na fasáde celého komplexu nad vchodom do kostola je nápis: Dei Gloriam Et Calamitatis Civis Praesidio Municipis Urbis. P. P. MDCCCXXX. (K Božej sláve a k ochrane trápením sužovaných občanov. Občania mesta. Zriadené 1830.) Treba poznamenať, že stavba nemocnice s kostolom sv. Ladislava v tejto podobe a len s malými úpravami pretrváva až do dnešných čias.

Keď sa stavba ukončila, nasťahovali sa pacienti do novostavby nemocnice, ktorá i naďalej zostala pod správou mesta Bratislavy a pod dohľadom slávneho mestského magistrátu. Nemocnica bola spravovaná Katolíckym spolkom starostlivosti o občanov, ktorý mal za členov 30 bohatých a poctivých občanov mesta Bratislavy. Spolok mal svoju pečať, uprostred pečate sa nachádza postava sv. Ladislava s latinským nápisom: Pečať katolíckej mestskej nemocnice sv. Ladislava v Bratislave 1840.

Do novej nemocnice sa nasťahovalo 26 pacientov. V krátkom čase stúpol ich počet na 42.

Roku 1897 si členovia Katolíckeho spolku starostlivosti o občanov v Bratislave pripomenuli 500-výročie udalosti, keď roku 1397 Pavol Domicellus a Ladislav de nuova Domo previedli nemocnicu sv. Ladislava do vlastníctva mesta Bratislavy. Členovia Spolku vypracovali stanovky a dali nemocnici názov: Základina katolíckej občianskej opatrovne sv. Ladislava v Bratislave. Cieľom Katolíckeho spolku starostlivosti o občanov, ktorý nemocnicu viedol, bolo zabezpečiť po každej stránke starým a chorým občanom posledné roky svojho života.

Po roku 1918 sa už Katolícka občianska opatrovňa nepovažovala za spolok, ale za dobročinnú základňu pre chudobných. V druhej polovici 20. storočia slúžila budova ako internát, nakoľko v Bratislave už bolo viacero nemocníc, útlukov a vybuďovali sa domy dôchodcov.

Z historického náčrtu dejín prvej bratislavskej nemocnice vyplýva, že bola založená členmi rádu sv. Antona roku 1095. Členov rádu - antonitov do Bratislavy povolal kráľ Ladislav. V priebehu času bola nemocnica niekoľkokrát zničená. Až do 17. storočia bola jedinou nemocnicou - špitálom, chudobincom a lazaretom v Bratislave. Až roku 1672 sa vybuďo-

vala nemocnica milosrdných bratov. Jej kapacita bola 62 postelí. Ďalšou nemocnicou bola nemocnica sv. Alžbety, ktorá bola vybudovaná roku 1738. Jej kapacita bola 22 postelí a mala len interné oddelenie, na ktoré sa prijímali výlučne ženy. Nemocnica evanjelickej cirkvi bola vybudovaná na začiatku 19. storočia, roku 1807. Mala kapacitu 20 postelí. V rokoch 1857-1864 bola vybudovaná fakultná nemocnica na Mickiewiczovej ulici. Potom sa postupne v Bratislave budovali ďalšie nemocnice, ako ich poznáme.

Z historického hľadiska dnes môžeme tvrdiť, že v civilizovanom svete je len veľmi málo takých ústavov, aký mali občania kráľovského mesta Bratislavy ako bola nemocnica sv. Ladislava. Špitál sv. Ladislava pripomína v niektorých fázach existenciu zariadenia, ktorému dnes hovoríme hospic. V písomníctve nachádzame nasledovné údaje: "So všetkou pietou vstupujeme na miesto skutočnej posvätej humanity. Vyčerpaný pútnik, ktorý prekročí bránu tohoto ústavu zúctoval s radosťami a starosťami života. Netuži viac po pozemskom šťastí. Má iba jediné želanie: koniec života prežiť v nerušenom pokoji. To, čo mu raz život sľuboval, na to celkom zabudol, celkom to stratil ako dieťa spomienky. Jedine viera v Boha, nádej na stretnutie s Ním v nebi a láska k blížnemu mu zostali. Dobrí a šľachetní ľudia sa postarali o skromné potreby jeho staroby, skrášlili jeho útulok a tak dopadajú zlaté lúče lásky k blížnemu hrejivo na unavenú hlavu starca."

Keď si pripomenieme, čo chorému garantuje hospic, vidíme, že v tomto ústave sa rešpektovala jeho ľudská dôstojnosť a že v posledných dňoch života netrpel chorý a starý človek osamelosťou.

Pri príležitosti oslavy 500-ročného jubilea špitálu roku 1897, kedy prešiel ústav definitívne do vlastníctva slobodného kráľovského mesta Bratislavy, napísal lekár špitálu sv. Ladislava Dr. Štefan Vámosy (1862-1932), rodák z Tomášikova, absolvent viedenskej lekárskej fakulty: "Útulok bratislavského katolíckeho spolku pre starostlivosť o občanov je azylom stratených, ale obnovuje znova nájdene šťastie, miesto

Obr. 2. Katolícky mestský špitál sv. Ladislava spolu s kostolom po roku 1832 a teraz



pokoja a ochrannú strechu pre tých, ktorí v dôsledku ťažkých úderov v boji o prežitie boli zlomení a zbavení pozemského dobra. Dráma života, ktorá veľakrát končí katastrofou, nachádza tu priaznivé východisko."

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Profesor Badalík, zakladateľ Školy verejného zdravotníctva v Bratislave - šesťdesiatnikom

Prof. MUDr. Ladislav Badalík, DrSc., sa narodil na Slovensku v obci Jacovce neďaleko Topoľčian. Je absolventom Lekárskej fakulty Karlovej univerzity v Prahe. Už od počiatku svojej vedeckej a pedagogickej práce venoval zvláštnu pozornosť problematike verejného zdravotníctva a epidemiológie.

V roku 1986 sa stal riadnym profesorom epidemiológie. Zaoberal sa najmä epidemiológiou tuberkulózy a respiračných chorôb. Pred 25-mi rokmi sa zaslúžil o zriadenie Oddelenia klinickej epidemiológie a štatistiky v Národnom ústave tuberkulózy a pľúcnych chorôb. Pracoval tu na viacerých medzinárodných výskumných projektoch, vedených v spolupráci so Svetovou zdravotníckou organizáciou (SZO) a Britskou lekárskou radou. Najvýznamnejšie vedecké výsledky prof. Badalíka sa týkali najmä nasledovných oblastí: prognózovanie výskytu tuberkulózy; epidemiologické štúdie o sarkoidóze, chronickej bronchitíde, karcinóme pľúc; kontrolované klinické a profylaktické sledovania; surveillance tuberkulózy ako zoonózy a ďalších. Jeho závažný vedecký prínos ocenila aj Medzinárodná únia boja proti tuberkulóze so sídlom v Paríži. Prijala ho najprv za korešpondujúceho, neskôr za svojho riadneho člena. Prof. Badalík mnoho rokov pracoval v epidemiologickej komisii tejto významnej medzinárodnej organizácie.

Počas pôsobenia na Inštitúte pre ďalšie vzdelávanie pracovníkov v zdravotníctve vybudoval Katedru medicínskej pedagogiky. Toto pracovisko čoskoro dosiahlo medzinárodnú akceptáciu a významne sa podieľalo na medzinárodných aktivitách v rámci SZO, kde prof. Badalík pôsobil opakovane ako odborný konzultant. Pracoval i v Regionálnej úradovni SZO na Filipínach, ako expert SZO pri budovaní škôl verejného zdravotníctva. Zúčastňoval sa opakovane, ako člen československej (neskôr slovenskej) delegácie, na Valnom zhromaždení SZO v Ženeve a na Regionálnom zhromaždení SZO v Kodani. V roku 1991 bol menovaný za prvého riaditeľa novozaloženej Školy verejného zdravotníctva (ŠVZ) v Bratislave. Škola sa stala riadnym členom medzinárodnej Asociácie škôl verejného zdravotníctva (ASPHER). Rozvíja významné výukové, výskumné a publikačné aktivity v oblasti verejného zdravotníctva a zdravotníckeho manažmentu.

Profesor Badalík publikoval viac ako 250 vedecko - odborných článkov, predniesol veľké množstvo prednášok na domáciach i zahraničných vedeckých fórach. Je členom redakčných rád viacerých lekárskejších časopisov. Od roku 1992 je členom Kráľovskej spoločnosti pre zdravotníctvo v Londýne (FRSH). Je prezidentom Slovenskej spoločnosti pre vzdelávanie lekárov a členom Slovenskej delegácie v Stálej komisii európskych lekárov pri EU. Od založenia Ústavu medicínskej etiky a bioetiky v Bratislave patrí prof. Badalík k jeho priaznivcom a podporovateľom spolupráce ústavu a ŠVZ v oblasti výuky i v niektorých medzinárodných aktivitách.

Pri príležitosti významného životného jubilea prajeme prof. Badalíkovi dobré zdravie, mnoho tvorivých síl a spokojnosť v pracovnom, osobnom i rodinnom živote.

Ad multos felices annos!

MUDr. Jozef Glasa, CSc.

Professor Badalík, founder of the School of Public Health in Bratislava - sexagenarian

Professor Ladislav BADALÍK, M.D., DSc., was born in Slovakia in Jacovce near Topoľčany. He graduated from Medical Faculty of Charles University in Prague. Since the very beginnings of his scientific and



paedagogical career he focused his attention to the issues of public health and epidemiology.

In the field of epidemiology, prof. Badalík achieved the highest degree of professional specialization, and acquired the scientific and academic distinctions. In 1986 he became professor of epidemiology. He dealt mainly with the epidemiology of tuberculosis and respiratory diseases. 25 years ago he established the Department of Clinical Epidemiology and Statistics

in the National Institute of Tuberculosis and Pulmonary Diseases where he worked on several well-known studies conducted in collaboration with the World Health Organization and with British Medical Research Council. Beside this there is a lot of items that made Professor Badalík well-known, e.g. prognosing of TB occurrence, epidemiology of chronic bronchitis, chest carcinoma, controlled clinical trials, controlled prophylactic trials, surveillance of TB as zoonosis, etc. The contribution of Professor Badalík was honoured also by the International Union against Tuberculosis (Paris) by appointing him to the corresponding, and later on to the full membership (He contributed a lot to the work of its Committee for Epidemiology).

At the Postgraduate Medical School in Bratislava he founded the Department of Medical Education, which soon has become internationally accepted and entrusted by WHO with more and more demanding tasks. Professor Badalík served repeatedly as a short-term WHO consultant. He worked in Regional Office of WHO at Philippines with the task to advise in founding the Schools of Public Health. He was nominated many times a member of Czechoslovak (later on Slovak) delegation to the General Assembly of WHO in Geneva and to the Regional Assembly of WHO in Copenhagen.

In 1991 he was appointed to the position of director of the first, newly established School of Public Health in Slovakia (seated in Bratislava). The School is a member of the Association of Schools of Public Health in Europe (ASPHER).

Professor Badalík published more than 250 articles, he is a member of editorial boards of several medical journals.

From 1992 he is Fellow of the Royal Society of Health in London (F.R.S.H.). He is President of the Slovak Delegation to the Standing Committee of European Doctors.

We wish prof. Badalík good health, the joy and happiness in personal - family life, and many fruitful moments and projects within his professional and scientific mission.

Ad multos felices annos!

Jozef Glasa, M.D., Ph.D.

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