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OD REDAKCIE / EDITORIAL

Prvá dekáda slovenskej bioetiky ¹

Milí priatelia,

v tomto jubilejnom roku si pripomenieme aj malé výročie bioetiky na Slovensku - prvú dekádu jej existencie a postupného budovania z naozaj skromných začiatkov. Veď po prevrate spôsobenom 'Nežnou revolúciou' stála nielen slovenská medicína a zdravotníctvo, ale celá krajina a 'všetok ľud' pred mnohostrannou transformáciou všetkých aspektov ekonomického, sociálneho aj kultúrneho života. Stará ideológia marxizmu - leninizmu zanechala za sebou intelektuálnu, ale aj morálnu spúšť; devastáciu, ktorej hĺbku a rozsah ukázali uplynulé roky a ešte stále ukazujú problémy, s ktorými zápasíme na všetkých úrovniach riadenia, moci, kultúrnej tvorby a dokonca i filozofickej a tvorivej umeleckej reflexie.

Reforma zdravotníckeho systému znamenala výzvu k obnove jeho morálnej integrity a reflexii 'starých' i celkom nových problémov, už v situácii narastajúceho pluralizmu politického, kultúrneho i „etického“. Situáciu od počiatku komplikuje nedostatok finančných zdrojov v období hlbokých transformačných zmien spoločnosti - a s tým súvisiace otázky o efektívnosti, efektívite, dostupnosti i racionalizácii zdravotnej starostlivosti. Etickým problémom, i mravným zápasom každodennej praxe zdravotníckych pracovníkov je nielen úsilie o zachovanie osobnej morálnej integrity v ťaživej situácii nedostatku prostriedkov pre vlastnú prácu a rastúcich tlakov zo strany pacientov a celej verejnosti, zdravotných poisťovní a nadriadených orgánov, ale najmä snaha o udržanie alebo zvýšenie úrovne poskytovanej starostlivosti. Demoralizujúce pôsobenie klientelizmu, podplácania osôb s rozhodovacími právomocami, nekalých metód ovplyvňovania preskripcie a kategorizácie liekov, neodborných, mocenských zásahov do riadenia zdravotníckych organizácií, ako aj mnoho zrejme neporiadku (z ktorého však očividne „niekto“ profituje) a diletantstva vedúceho k plytvaniu, akoby odsúvalo etiku a etické uvažovanie kdesi na okraj záujmu, do oblasti „pekných rečí“ a „zbožných prianí“, ktoré nemôžu nič podstatného ovplyvniť.

¹ English text see on p. 17.

(pokračovanie na s. 17)

Reklama

Advertisement

HOW THEN SHOULD WE DIE? California's „Death with Dignity“ Act

Robert W. Evans [1]

Veritas Institute, Auburn (California, USA)

Abstract

The cultural significance of recent changes in medicine and advances in biotechnology can hardly be overstated. Such have stirred fresh interest in the moral foundations of ethical decision-making and lively debate has ensued as well over the basis of human dignity. Largely divorced from the distinctive moral and ethical commitments that once informed and directed medical practice, modern secular notions of bioethics collapse frequently into human philosophical models of rights and justice. The project of Western medicine now continues within the cultural framework of a radical postmodern agenda that calls for the critical deconstruction and absolute relativizing of all knowledge, and the thorough secularization of the public square. Truth, once understood as a fixed expression of a fundamental reality, has been eschewed in favor of personal preference, subjective experience, private interpretation, and radical perspectivism. Perhaps the greatest challenge facing contemporary culture is that of arriving at a clear and convincing consensus on what constitutes moral surety as well as agreement on what knowledge can serve as an adequate foundation for living the moral life. Having abandoned the reality of divine involvement in the creation and sustenance of human life, contemporary culture now toys with what it means to be human without God. Increasingly popular is the view that whether one possesses dignity or not turns on the question of suffering. Under modern parlance it is simply undignified to suffer. Suffering, somehow, is believed to reduce a person to a state that is incompatible with dignity. Therefore, it should come as no surprise that one of the most pressing social issues today involves the effort to legalize physician-assisted suicide - a project based upon the view that people ought to „die with dignity.“

In California this view is embodied in Assembly Bill 1592, the „Death with Dignity Act.“ It is intended to establish California as the second state in the United States to legalize physician-assisted suicide. Patterned closely after Oregon's groundbreaking law, the California bill provides for a terminally ill patient to end his or her own life when certain conditions exist. The purpose of this paper is to review the historical development of California Assembly Bill 1592. An evaluation of both the content of this bill and the process by which it was introduced to the California State Assembly will be offered. The student of bioethics will here find that the usual arguments in support of physician-assisted suicide in the United States, as well as euthanasia in the Netherlands, have been employed in support of AB1592; namely, suffering and autonomy. Given the rather predictable pattern of argument advanced by advocates of physician-assisted suicide and euthanasia, this discussion will prove useful for those who wish to offer an informed and sensitive Christian response to similar legislative efforts in other states and countries.

Key words: physician - assisted suicide, euthanasia, California legislation, Christian perspective.

Introduction

The cultural significance of recent changes in medicine and advances in biotechnology can hardly be overstated. Such have stirred fresh interest in the moral foundations of ethical decision-making and lively debate has ensued as well over the basis of human dignity.

Largely divorced from the distinctive moral and ethical commitments that once informed and directed medical practice, modern secular notions of bioethics collapse frequently into human philosophical models of rights and justice. The project of Western medicine now continues within the cultural framework of a radical postmodern agenda that calls for the critical deconstruction and absolute relativizing of all knowledge, and the thorough secularization of the public square. [2] Truth, once understood as a fixed expression of a fundamental reality, has been eschewed in favor of personal preference, subjective experience, private interpretation, and radical perspectivism. Indeed, if there is but a single refrain that captures the prevailing postmodern sensibility it is the oftheard claim that there is no absolute truth.

Perhaps the greatest challenge facing contemporary culture is that of arriving at a clear and convincing consensus on what constitutes moral surety as well as agreement on what knowledge can serve as an adequate foundation for living the moral life. Our pervasive postmodern cultural drift has left us in a wake of moral and intellectual confusion and chaos. To be sure, ours is a culture that is at once both profoundly complex and ambiguous; a culture in which wholehearted tentativeness is extolled as a virtue. We are so steeped in the rhetoric of tolerance, relativism, and pluralism that we little recognize that morality, rights and justice require a transcendent referent.

Our generation is lost to the truth that human dignity is anchored by a shared conviction that all are made in the image of God. For this loss our culture is paying dearly, and with it goes the moral fabric and traditions of the public square and its institutions. And of this there may be no plainer example than the process of secularization occurring in medicine.

Having abandoned the reality of divine involvement in the creation and sustenance of human life, contemporary culture now toys with what it means to be human without God. Increasingly popular is the view that whether one possesses dignity or not turns on the question of suffering. Under modern parlance it is simply undignified to suffer. Suffering, somehow, is believed to reduce a person to a state that is incompatible with dignity. Therefore, it should come as no surprise that one of the most pressing social issues today involves the effort to legalize physician-assisted suicide-a project based upon the view that people ought to „die with dignity.“

In California this view is embodied in Assembly Bill 1592, the „Death with Dignity Act.“ Introduced by Assemblywoman Dion Aroner (D-Berkeley/Richmond) on February 26, 1999, Assembly Bill 1592 is intended to establish California as the second state in the nation to legalize physician-assisted suicide. [3] Patterned closely after Oregon's groundbreaking law, the California bill provides for a terminally ill patient to end his or her own life when certain conditions exist.

The purpose of this chapter is to review the historical development of California Assembly Bill 1592 (AB1592). An evaluation of both the content of this bill and the process by which it was introduced to the California State Assembly will be offered. The student of bioethics will here find that the usual arguments in support of physician-assisted suicide in the United States, as well as euthanasia in the Netherlands, have been employed in support of AB1592; namely, suffering and autonomy. [4] Given

the rather predictable pattern of argument advanced by advocates of physician-assisted suicide and euthanasia, this discussion will prove useful for those who are wish to offer an informed and sensitive Christian response to similar legislative efforts in other states and countries.

A Review of the Content of AB1592

The California „Death with Dignity Act“ authorizes an adult to make a request to end his or her life if: 1) the person meets certain qualifications, 2) the person is determined by his or her attending physician to be suffering from a terminal illness, and 3) the request for lethal assistance is made in conformity with certain procedural instructions. The bill states that the provisions of AB1592 are intended to establish the procedures by which a person may make a request to end „his or her life in a humane and dignified manner.“ [5]

The proposed law would provide immunity from civil liability, criminal prosecution, or professional disciplinary action to those participating in good faith compliance with the act. Furthermore, the bill states quite plainly that nothing in its provisions should be construed as permitting lethal injection, mercy killing, or active euthanasia. [6] Moreover, actions taken in accordance with the provisions of the bill would not be construed as constituting suicide or homicide. [7]

Among the general provisions of the bill are the qualifications that the patient must be an adult of 18 years or older; capable of making and communicating health care decisions to his or her health care providers; and that an „informed“ decision to end his or her life has been based upon an appreciation of the facts concerning medical diagnosis, prognosis, options, and risks and benefits of taking the prescribed medication. [8] The „qualified patient“ must also be a resident of California and suffering from a terminal illness. The bill defines „terminal illness“ as an incurable and irreversible disease that has been medically confirmed and will, within a reasonable degree of medical judgment, result in death within six months. [9]

The California bill also includes „safeguards“ that are designed to reduce the chances that the provisions of the law are misapplied, that patients have been assigned an incorrect diagnosis, or that a patient's request to end his or her life is as a result of an emotional or psychological problem. As such, before a patient may be considered as a candidate for physician-assisted suicide, a consulting physician must confirm the medical diagnosis and any symptoms suggestive of a psychological disturbance must be addressed. [10] Furthermore, requests for assistance in dying must be voluntarily expressed in writing and witnessed by at least two individuals, one of whom is a disinterested party to the estate of the patient and uninvolved in his or her care. [11]

In an effort to minimize the chances that a request for death is a consequence of an emotional problem, the attending or consulting physician who is of the opinion that the patient may be suffering from a psychological disturbance will make a referral for counseling. No medication intended to end life would be prescribed to the patient until the person conducting the counseling determines that the patient is not suffering from a psychological disorder, including depression. [12]

Finally, the bill proposes that in order to receive a lethal prescription, patients must make both an oral and a written request for assistance in dying. The verbal request must be reiterated to the attending physician no less than 15 days after making the initial oral request, and no less than 15 days must elapse between the initial oral request and the provision of a lethal prescription. Furthermore, no less than 48 hours must elapse between the patient's written request and the writing of the prescrip-

tion. The California bill states that a patient may rescind his or her request at any time and in any manner. [13]

A Review of the Process of AB1592

Reports of AB1592 had been splashed across the headlines of California newspapers when it was introduced before the state legislature in February 1999, and the story led the evening news on several local television stations. Reports of the bill's first hearing before the State Judiciary Committee, however, passed with little notice - the nation's attention had been diverted and its hearts were heavy. American society was drowning in a maudlin emotion of grief and shock.

At precisely the same hour that the „Death with Dignity Act“ was being heard in the judicial hallways of Sacramento, California, 2 youths brimming with rage and emptied of compassion were living out their twisted fantasies of fame and revenge by slaughtering innocent life in the school hallways of Littleton, Colorado. And only weeks before the California judiciary hearing, Jack Kevorkian had been convicted of murder for participating in the same conduct that assembly members were now being asked to view as compassionate and empowering.

In a deeply emotional and moving presentation, Assemblywoman Dion Aroner argued that the AB1592 „...is about compassion, but more than that, it is about choice. This is about how people spend the last days of their lives.“ [14] Perhaps there was a dry eye in the room when Ms. Aroner finished her presentation by telling the judiciary subcommittee a story describing the slow and agonizing death of a loved-one. Those in the packed auditorium were clearly moved. Even people who were in sharp disagreement with her proposed bill had a difficult time feeling anything but deep sympathy. Yet there was something more etched into the faces of those who filled the room - a vague sense of anxiety about what would happen if they were to find themselves similarly situated. Uncertainty, particularly when it involves death, tends to nourish fear.

The sympathy and fear that had lingered in the air following Ms. Aroner's presentation quickly evaporated and was replaced by joy and celebration when several opponents of the proposed legislation told their stories of loved-ones who experienced peace and triumph in the midst of pain and suffering. Suddenly, hope and optimism sparkled in eyes once heavy with gloom and despair only moments before. Such is the power of stories; such is the fickleness of the emotions they produce.

Several members of the judiciary committee had been absent during the hearing - occupied by competing legislative commitments. As such, those Assembly members in attendance during the morning hearing registered their votes and the bill was placed „on call“ until that afternoon when their missing colleagues could rejoin the committee. The partial vote was split and early indications suggested that the bill would not likely pass out of committee. During the recess that followed the first round of voting, various individuals and interested groups in the audience spilled into the hallways and outside onto the lawn to discuss the perceived leanings of those Assembly members who had not been present for the morning hearing.

Perhaps feeling assured that the bill would not secure the required number of votes necessary to pass, many in the morning audience left the state capitol and only a modest band of interested individuals followed the judiciary committee into their afternoon session. Conspicuously absent from the afternoon session were Assemblywoman Dion Aroner and Assemblywoman Audie Bock (Green Party-Oakland). Ms. Bock had been present for the morning hearing and had voted against the bill.

However, she was a newcomer to the Assembly and the hallways were buzzing with speculation that Ms. Aroner had taken Ms. Bock to some secluded area of the capitol and was trying to persuade Ms. Bock to change her vote.

Often overheard was the rumor that Ms. Aroner was using data from a recent Field Poll to convince Ms. Bock that fully 75% of Californians supported the right of an incurably ill patient to request and receive life-ending medications. On such a view, it was presumed that Ms. Aroner was arguing with the freshman legislator along the following lines:

1. legislators have an obligation to enact the collective will of the people;
2. the majority of Californians are in favor of physician-assisted suicide;
3. therefore, legislators must support AB1592.

Yet others remained fully convinced that the defeat of AB1592 was a foregone conclusion - a mere formality - and that there was little reason for concern.

In the late afternoon, judiciary committee chair, Sheila Kuehl (D-Santa Monica), called for the remaining votes on AB1592. At nearly the same time that the votes were being called, Ms. Aroner and Ms. Bock walked in through a side door and assumed their seats. The remaining Assembly members who were absent from the morning session registered their votes and the bill was defeated on an 8 - 7 margin. However, before the gavel could be brought down - signaling the end of AB1592 - Ms. Bock leaned forward, switched on her microphone, and advised Ms. Kuehl that she wished to change her earlier vote from „no“ to „yes.“ As such, the bill passed through the Assembly judiciary committee on an 8 - 7 vote and would move on to the appropriations committee.

The California Assembly Appropriations Committee has been regarded by many as merely a „rubber stamp stop“ for Assembly bills making their way along the judicial road to becoming law. As such, the assumption was that AB1592 would easily breeze through the appropriations hearing and that the next formidable battle would occur when the bill would pass from the appropriations committee to the full legislature. Accordingly, few attended the appropriations meeting.

On May 27, 1999, AB1592 was brought before the Assembly Appropriations Committee late in the evening. However in contrast to what many had suspected, the bill would not be „rubber stamped.“ Rather, Ms. Aroner would have to ask Assembly Speaker Antonio Villaraigosa (D-Los Angeles) to temporarily remove Assemblyman Herb Wesson (D-Culver City) late that evening and replace him with Assemblywoman Hannah-Beth Jackson (D-Santa Barbara). Ms. Jackson was a known supporter of AB1592 and would cast the deciding vote that allowed the bill to move out of the appropriations committee.

When interviewed about his late evening change in Assembly members for the vote on AB1592, the Assembly Speaker said that he had „made a commitment“ to Ms. Aroner to get the bill out of committee. [15] Mr. Wesson would later state that he did not mind being replaced because he would have voted against the bill and that his temporary removal from the committee „probably made my life easier.“[16]

As for Ms. Aroner, she proudly told reporters that she was very happy with the bill's progress through the legislature. „I think it's phenomenal. No one ever expected this to get out of its first committee,“ she said. [17] Nevertheless, Ms. Aroner announced the day following its approval by the appropriations committee that she would wait until the following year before attempting to present AB1592 before the entire state Assembly. „I don't have the votes. The Legislature's not where the public is, it's really clear,“ she said. [18] She added that she would take the following months to meet with her fellow legislators

in an effort to convince them of the bill's merits. [19] As of this writing, the expectation is that AB1592 will be brought before the entire Assembly in early 2000.

A Review of the Arguments in Favor of Physician-Assisted Suicide

Disillusionment over the American judicial process is soaring; one only need to consult election-day participation statistics and measures designed to capture public sentiment concerning our political processes to see that this is so. As if anyone needed additional reasons to become further disenchanted with government politics, the process by which AB1592 has advanced through the California Assembly strains credulity and inflicts further insult on a beleaguered culture that has lost its faith in those who don the mantle of authority in our society. While some proponents of the California „Death with Dignity Act“ stressed that the merits of physician-assisted suicide legislation could be discerned through rational discussion and debate, the manner by which California AB1592 has proceeded belies such an assertion. [20] Rather, the bill's „success“ thus far has been contrived - the product of backroom deal-making and late-night manipulation of Assembly committee composition. To state that the bill's progress has been „phenomenal“ and feign surprised delight concerning its approval in committee hearings is disingenuous at best.

When arguments in favor of AB1592 have been advanced, they assume the usual form. Autonomy (choice) and relief for those who suffer greatly (compassion) are common to all arguments advocating physician-assisted suicide and euthanasia. Commonly, choice and compassion are bundled together and presented as though they comprise a single argument in support of assisted death. [21] Constructed on such a view, Assemblywoman Aroner stated her argument as follows: „A mentally competent person suffering from a terminal illness who is in great pain should have the option of peacefully ending his or her own life.“ [22] Indeed, upon first blush, this appears as a singular reason for allowing physician-assisted suicide. Upon closer examination, however, one notes that this argument is actually comprised of two separate and distinct elements: autonomy and suffering.

The first element is autonomy - the mantra of the latter half of the 20th century. The word autonomy derives from two Greek words: *auto*, meaning „self,“ and *nomos*, meaning law. Strictly construed, the rule of autonomy maintains that each person is a lawgiver to himself or herself. Under such a view, each person has a right to self-determination in decision-making. One hears variations on the theme of autonomy every day: „This is my life and I can do with it as I please.“ „Who are you to tell me what I can or cannot do with my life?“ „Well, that may be true for you, but it's not true for me.“ With respect to the physician-assisted suicide debate, autonomy frequently involves the claim that people ought to be empowered to *choose* both the manner and time of their own death.

Meilaender offers an insightful critique of this assertion. He comments, „If self-determination [autonomy] is truly so significant that we have a right to help in ending our life, then how can we insist that such help can rightly be offered only to those who are suffering greatly?“ [23] The implications are straightforward. Surely those who do not suffer greatly likewise possess a right to self-determination. Why are we not constrained by the same logic to offer assistance to those seeking death and who are not suffering greatly?

During many years in practice as a clinical psychologist, this author counseled numerous people who were

experiencing serious emotional, financial, interpersonal, and mental conditions. Truly, their suffering was very real and deeply painful. Occasionally, the one receiving counsel would view his or her situation as hopeless and not perceive that there were viable options for extrication from seemingly unbearable circumstances. At such times, some would voice the intention of bringing life to an end. Depending upon certain clinical factors, mental health professionals are legally, ethically, and professionally bound to preserve the wellbeing and safety of the one making such a threat, including involuntary hospitalization, if necessary. But again, if these people are autonomous, don't they have a right to exercise self-determination?

The language of self-determination and autonomy is based upon the view that each one owns his or her life and may do with it as one pleases. Clearly, such a notion is hostile to any Christian understanding of human life. The testimony of the scriptures is consistent throughout - our lives are entrusted to us by the Creator. Life is not to be regarded as our own. The Apostle Paul brings this point home with some force when discussing the topic of sexual purity: Flee from sexual immorality. All other sins a man commits are outside his body, but he who sins sexually sins against his own body. Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? *You are not your own; you were bought at a price.* Therefore honor God with your body. [24] The Christian recognizes that he or she has been bought with a price, we are not our own!

The second element is suffering. As previously mentioned, contemporary culture has embraced the view that suffering is incompatible with human dignity - it is simply undignified to suffer. Hence, suffering must be either adequately controlled or fully eliminated from the human experience of death, and when this is not possible, death is believed preferable to suffering. One strongly suspects that advocates of physician-assisted suicide are confusing pain with suffering, for when asked to provide an example of uncontrolled suffering, advocates of physician-assisted suicide frequently describe a case involving unresolved physical pain.

Clinical vignettes involving „uncontrolled“ pain are proving exceedingly problematic for advocates of physician-assisted suicide. There is a growing consensus among medical professionals that all physical pain can be controlled. [25] Moreover, though stories about the failure of morphine to provide adequate pain relief abound, few advocates of physician-assisted suicide mention the medications Dilaudid (hydromorphone) or Levorphanol - each about five times more effective than morphine. Similarly, little is heard about the medication Fentanyl, a synthetic pain reliever that is about one hundred times more potent than morphine. [26]

If all pain can be controlled by the judicious and adequate administration of powerful pain-relieving medications, the advocate of physician-assisted suicide must alter the form of the argument. Perhaps for this reason, much of the rhetoric involved in more recent discussions of physician-assisted suicide has been marked by the substitution of the term „suffering“ for „pain.“ On such a view, it is argued that society has a moral obligation, based upon compassion, to either relieve or eliminate unbearable suffering.

However, does this change in focus and semantics resolve the problems created by previous arguments for physician-assisted suicide based upon the need to alleviate pain? Meilaender thinks not. He applies the same logic that he employed in his critique of autonomy to the question of suffering. He writes, „Similarly, if the suffering of others makes so powerful a claim upon us that we should kill them to bring it to an end, it is hard to believe that

we ought to restrict such merciful relief only to those who are self-determining, who are competent to request it.“ [27] Indeed, the experience of suffering is not restricted to those who are autonomous!

As in other legislative debates concerning the merits of physician-assisted suicide, some California supporters of AB1592 charged the Christian community with reacting to the sufferings of others with cool indifference, or worse, callous disregard. Surely God would not want those He supposedly loves to suffer - to allow human suffering to continue unchecked is incompatible with any coherent notion of a merciful and gracious God. Accordingly, it is argued, Christians should - among all people - favor safe and legal procedures that would allow a human being to escape the agonizing grip of unbearable suffering. How does the Christian respond?

Human suffering is neither enjoyable nor desirable - the scriptures never suggest otherwise. However, the Christian perspective recognizes that suffering may bring about qualities of character and positive benefits in a person's life not otherwise gained. The Apostle Paul writes that the Christian rejoices in sufferings because of the perseverance, character, and hope that is developed in the believer's life. [28] Elsewhere, Paul comments that the Christian's troubles result in an eternal glory and the infusion of Christ's power in the life of the believer. [29]

The Apostle Peter encourages his readers with the thought that suffering serves to refine one's faith and prove it genuine. In the process of endurance, the believer makes known the person of Christ, and praise, glory and honor result. [30] And the book of Job provides compelling evidence of how benefits were gained through the process of suffering. To be sure, the presence of suffering in the world comes as a result of the fall, but God can, and does, use suffering to work good into our lives.

Finally, the scriptures provide no indication that escape from suffering is necessarily God's will. It will be recalled that the Lord Jesus Christ, prior to His crucifixion, prayed three times that the cup of suffering He was about to endure be removed from Him if it were His Father's will. Thankfully for those who have claimed the grace and forgiveness from sin found only in Christ's shed blood, and who are now forever alive in Him, it was not! Can you imagine our lost and hopeless state if God's will is that suffering should always pass from those He loves? Indeed, it was on the basis of Christ's suffering that grace and forgiveness were extended to those who call upon His name and place their trust in Him.

Legislative „Safeguards“ in Physician-Assisted Suicide

For many, the central issues of concern with respect to physician-assisted suicide turn on the potential for tragic and irreversible consequences pursuant to its misapplication. More specifically, the public worries about the accuracy of medical diagnoses and the motives of financially-interested family members as well as cost-conscious hospitals and insurance carriers. The exquisite vulnerability of those who are disabled or elderly is frequently raised as a troubling issue, as is the mental status of patients requesting assistance with dying. Such concerns are not without merit given that similar problems have haunted the Dutch experience. In an effort to allay these fears, the California „Death with Dignity Act“ contains a number of „safeguards.“

First, AB1592 requires that the patient requesting physician-assisted suicide make a voluntary and informed decision based upon an understanding of his or her diagnosis, prognosis, and treatment options. The bill states

that the patient must be suffering from a terminal illness diagnosed by his or her attending physician and confirmed by a second consulting physician. This „safeguard“ is intended to protect against misdiagnosis and to ensure that, within a reasonable degree of medical judgment, the patient has no longer than six months to live.

On the surface, this „safeguard“ makes considerable sense. The public is now quite aware that autopsies revealed most of Jack Kervorkian's clients were not terminally ill and that some of his clients showed no anatomical evidence of physical disease. Accordingly, a second opinion regarding terminal illness seems imperative.

However, research indicates that medical prognostication is more art than science. In a one study, patients receiving a terminal diagnosis (i.e., death will likely occur within six months) were followed over the course of their care. Depending on the type of diagnosis assigned, some 20-35% of the patients studied were still alive after six months. Even more startling was the finding that between 12-20% of these „terminally ill“ patients were yet alive after one year! [31] These statistics did not change when a second opinion was obtained.

Within scientific disciplines, including the social sciences, such error rates are viewed as excessive. Generally, a 1-5% margin of uncontrolled variance is considered acceptable, in contrast to the 20-35% figure reported for medical prognostic accuracy involving terminal illness. In short, the medical profession is simply not able to reliably diagnose terminal illness within a reasonable degree of certainty.

Second, AB1592 allows attending or consulting physicians to refer a patient seeking assistance with dying to a mental health professional if, in the opinion of the physician, the patient may be suffering from an emotional or psychological problem that may interfere with his or her exercise of sound judgment. On the surface, this „safeguard,“ likewise, seems quite reasonable. However, a couple of points serve to illustrate the problems with this „safeguard.“

Research studies have consistently affirmed that most general practice physicians are unable to discern even the most common forms of psychiatric problems in medical and hospital patients. [32] In one study, fully 80% of general practice physicians were unable to identify the hallmark signs and symptoms of clinical depression. [33] Clearly, the ability of general practice physicians to detect the presence of possible emotional or psychological disturbance is wanting.

In some circles it has been suggested that the problem of unrecognized psychiatric disturbances among those seeking death is resolved by requiring all candidates for physician-assisted suicide to undergo a psychiatric or psychological evaluation. However, such a proposal does not settle the issue. The dying person is teeming with emotions. The one facing death struggles against an undercurrent of alternating disbelief and hope, itself superimposed against a backdrop of terror, rage, anguish and surrender. The psychological pendulum in the mind of the dying swings between the extremes of denial on the one end, and acceptance on the other. For days or even weeks, the dying person may relate to loved ones and medical staff a seemingly quiet and resigned acceptance of his or her own death. However, the pendulum frequently swings again and the dying person can express unrealistic thoughts about leaving the hospital or making plans for travel following discharge. [34]

The matrix of the mind is exceedingly complex-much more so when confronted with the prospect of impending death. Should a „decision“ for physician-assisted suicide be made while the dying person is in a mental state characterized by a temporary acquiescence to death's summons, such might merely reflect the patient's tran-

sient state of acceptance. And should the patient undergo a psychological evaluation during such times, the emotional turmoil churning under the surface of a reposeful air may escape notice.

Furthermore, what is to prevent a physician favoring physician-assisted suicide from making a referral to a psychiatrist or psychologist known by the physician to be similarly predisposed to a patient's right to choose? Such forms of professional alliance are common and should a referral occur under this scheme, the mental health evaluation may be conducted with a view toward political expediency, rather than in response to honest inquiry or medical necessity. Mental health workers frequently rely on primary care physicians for their referrals, and the politics involved in these relationships should not be ignored. The competition for mental health referrals is frequently quite keen and, as such, some are unwittingly (or otherwise) ensnared by a confirmatory bias - the tendency to provide the expected feedback in hopes of winning favor with the referring physician and encouraging future referrals.

Many physicians desire honest, straightforward, and competent information from their consultants - even if the consultant's opinions differ sharply from those of the referring physician. Unfortunately, this is not always the case and the consultant who disagrees with the referring physician's subjective clinical impressions may find his or her telephone referral line strangely quiet.

This problem is not merely theoretical. Frequently, physicians and attorneys will refer to psychologists and psychiatrists whom they believe will provide a desired opinion. These types of referrals regularly occur in civil, family and criminal law applications of behavioral medicine where a specific mental health professional is retained due to his or her reputation for being pro-defense or pro-plaintiff. [35] Referred to as „hired guns,“ these mental health professionals make their living by offering predictable and biased reports favorable to the cause of the one who has retained them. Clearly, mandating mental health evaluations for some or all candidates for physician-assisted suicide is not the „safeguard“ it purports to be.

This review suggests that the proposed „safeguards“ in AB1592 are unable to resolve the fears they seek to assuage. The medical profession has yet to develop prognostic capabilities that are sufficient for the purpose intended in the „Death with Dignity Act.“ And the difficulty experienced by most general-practice physicians in identifying patients suffering from emotional or psychological disturbances, coupled with the professional alliances and political climate in which referrals are frequently made, renders the mental health „safeguard“ problematic.

Toward a Christian Response

If the Christian community is to gain traction in resisting the intellectual and moral decline of our culture, we will need to become more thoughtful and perceptive of the postmodern worldview that surrounds us. Efforts to legalize physician-assisted suicide fail to acknowledge the biblical worldview concerning human dignity, suffering, death, and the afterlife. Furthermore, the scriptures consistently affirm that it is God, not man, who is in control of life and death. [36] The Christian worldview insists that this is not our life to do with as we please. [37] Rather, life is to be viewed as a gift that is received and lived moment by moment from the gracious hand of God. Such a view forbids any notion that we may take our own life, let alone the life of another.

Given postmodernism's misplaced emphasis on utilitarianism and autonomy, it should come as no surprise that much of the discussion concerning physician-assis-

ted suicide - along with the entire array of emerging bioethical tensions in our society - begin at the wrong end of the questions involved. For example, it has long remained a fixity within the Western Hippocratic medical tradition that the physician should, *Primum non nocere* - „First of all, do no harm.“ Cameron has described how American medicine has largely spurned this Hippocratic maxim over the past twenty-five years following the landmark January 1973 Supreme Court decision, *Roe v. Wade*. [39]

Today, our culture begins at the opposite end of the issue. As Assemblywoman Aroner stated in support of AB1592, „This measure is about compassion and choice.“ [40] In evidence of how far our culture has slipped in such a brief period of time, Brown invites us to consider the following: „Our late sensate society no longer even bothers to ask *whether* physicians have the right to kill certain patients but assumes that they do and argues only about how and when.“ [41]

In the thinking of many, the bioethical agenda in our society has allowed the proverbial camel to poke its nose under the tent. Several questions naturally follow from the discussions in California concerning AB1592: How much more ought we to allow? Will this lead to euthanasia? What affect would the Americans with Disabilities Act have upon this proposed bill which seeks to secure a right for some that would not be available to all?

For example, if a patient was unable to self-administer the lethal medication due to physical or mental incapacity, does not the ADA require that such individuals be afforded the same rights and privileges as everyone else in society? It would seem that the lethal dosage would need to be administered to physically and mentally disabled people by a second party. This would constitute euthanasia. And such would rapidly move us from „allowing death,“ to „causing death.“ This represents far more than a subtle shift in semantics-it represents a tremendous shift in culture. For once we become comfortable with the idea of „causing“ someone's death, where do we go from there?

John Brooke, president of Americans for Death with Dignity, has stated in substantial form that those of religious conviction do not have the right to thrust their morality through legislation action upon those who do not embrace the same beliefs. This argument is receiving increased play in discussions related to AB1592. But is it not true that *all* laws are a reflection of the moral consensus of the constituency that they govern? Indeed, laws are the embodiment of a culture's morality. The argument that one ought not, or cannot, legislate morality is absurd. All laws are moral laws. Laws instruct us concerning what one ought to do or ought not to do. Questions or issues that involve any semblance of *ought* are inherently moral. The question is not whether one has the right to introduce his or her morality into law, but rather, whose morals will the law reflect?

Furthermore, all questions of morality may be evaluated from either a secular or religious perspective. It is not at all clear why only religious perspectives should be barred from shaping the public square while secular views are touted as the „neutral“ or default setting to which our culture must dial its moral bearings and begin its discussions of contemporary issues. Why is it that only the religious paradigm must be held in contempt by our society and excluded from shaping the moral contours of legislative initiatives, including the California „Death with Dignity Act?“

As Cameron has ably demonstrated, Western medicine locates its roots in the Hippocratic Oath - one of the earliest documents adopted by the church with its original pagan content recast in light of first century Christian monotheism. [42] Medicine has been practiced since as

an inherently moral art grounded upon the ethical commitments that early Christian revelation affords. On such a view, it seems highly odd to suggest that those of religious faith should not bring their values and morals to bear on our society's decision whether or not to redirect the future of medicine and legalize physician-assisted suicide.

A far more appropriate question is to ask proponents of AB1592, and similar bills, to describe the values and morals that are so powerful as to justify tearing the practice of Western medicine from its historical Christian foundation. Arguably, medicine's Christian roots ought to be preserved and serve as the default setting that informs and directs its practice. Quite properly, it seems that the proponents of physician-assisted suicide ought to assume the burden of proof in their efforts to advance AB1592 given that their proposal signals a marked departure from medicine's historical foundations and is fully inconsistent with its moral character.

Finally, when did it become good medical practice to eliminate suffering by eliminating the sufferer? Brown rightly observes that Hippocrates never spoke of „ending suffering,“ rather, he spoke only of healing. [43] Brown adds, „If Hippocrates had been concerned primarily with ending suffering, he would have prescribed rather than prohibited deadly drugs. Instead, he made a categorical distinction between healing and killing, and while he acknowledged that healing is often impossible, he rigorously rejected killing.“ [44] Any notion of killing those who have entrusted their lives into the hands of the healer is unacceptable.

Conclusion

Contemporary culture stands in desperate need of hearing explicit instructions as to how to go about making moral choices, and the Christian church stands in desperate need of faithfully promoting a worldview that captures its convictions. In the bright glare of the post-modern mind, all traditions seem to fade away. But the world still seeks for that which will provide an adequate foundation for living the virtuous life.

Should our culture fail to hear and heed an informed and sensitive Christian response to its unbridled quest in reformulating the nature of humanity, the consequences might well prove devastating. Christians have much to do and the hour is late. As Colson has observed, „The truth is that Americans are losing their moral recognition of the universal dignity of human life.“ [45] California Assembly Bill 1592 is yet further evidence that this is true.

The church needs to cease from its blind insistence that the issues of bioethics are merely political, legislative or social in nature. Rather, we need to recognize that the issues of bioethics - including physician-assisted suicide - intersect with the very heart and message of the Christian faith. Indeed, the emerging bioethical tensions and agendas are insidiously redefining what it means to be human - a concept so fundamental to our theology. And if this is so, then the issues of bioethics may well represent the central cultural phenomenon that the Christian cannot afford to ignore.

The lyrics were penned over thirty years ago, but it is hard to imagine a more timely commentary on our contemporary cultural malaise:

*From the canyons of the mind,
We wander on and stumble blind,
Wade through the often tangled maze
Of starless nights and sunless days,
Hoping for some kind of clue-
A road to lead us to the truth.
But who will answer?*

*Is our hope in walnut shells
Worn 'round the neck with temple bells?
Or deep within some cloistered walls
Where hooded figures pray in shawls?
Or high above some dusty shelves,
Or in the stars,
Or in ourselves.
Who will answer?*

*If the soul is darkened
By a fear it cannot name,
If the mind is baffled
When the rules don't fit the game,
Who will answer?
Who will answer?
Who will answer? [46]*

The Christian church has been charged with a mandate to answer the call and to push back against a culture that is pushing very hard against it. The California experience with physician-assisted suicide will not likely be the final project for those who would seek to further secularize the public square and its institutions. The arguments and processes described in this chapter will likely be recapitulated in another place at another time.

If the church is to make a difference, she will need to be ready to rise up and speak. Indeed, the subject matter of bioethics is of compelling interest and the problems are certainly worthy of considered reflection. But more importantly, we need to be involved in making a difference because the moral aim of our Christian faith is so important to the quality of the society in which we live, and the eternal destiny of those with whom we share our lives.

Footnotes

[1] Robert W. Evans, Ph.D., Ph.D. is President of Veritas Ministries and Director of the Veritas Institute for the Study of Bioethics and Public Values in Auburn, California (near Sacramento). [2] For a collection of essays that serve as an able introduction to postmodernism, see David Dockery, ed., *The Challenge of Postmodernism: An Evangelical Engagement* (Grand Rapids, Mich.: Baker Books, 1995). The topic of postmodernism is considered in a more even and sustained manner in D.A. Carson, *The Gagging of God* (Grand Rapids, Mich.: Zondervan, 1996). [3] California Assembly Bill 1592, "The Death with Dignity Act," may be accessed online at www.leginfo.ca.gov. [4] To be sure, there are differences between the American and Dutch perspectives on what constitutes ethical end-of-life care. In the Netherlands, physicians may directly and intentionally end a dying patient's life if certain "safeguards" and requirements are met. Should government-approved procedures be followed and faithfully reported, Dutch physicians may be excused from criminal prosecution. Such activity constitutes euthanasia given that the physician administers the lethal medication to the patient. In the United States, physicians are not permitted to directly and intentionally end a patient's life. Rather, AB1592 and similar bills that have been introduced around the country, seek to legalize physician-assisted suicide. Under conditions of physician-assisted suicide, physicians are allowed to provide lethal medications to the patient. However in contrast to euthanasia, the patient must self-administer this prescription. Advocates of euthanasia in the Netherlands frequently charge that Americans do not understand the Dutch experience and that the arguments in favor of euthanasia in the Netherlands are wholly different than those advanced by Americans in support of physician-assisted suicide. However, the arguments for both euthanasia and physician-assisted suicide are the same; namely, autonomy and suffering. The difference lies in the Dutch emphasis upon the physician's *duty* to end suffering, whereas Americans tend to place greater emphasis upon the patient's *right* to choose the manner and time of his or her own death. For more on the Dutch experience, see David C. Thomasma, Thomasine Kimbrough-Kushner, Gerrit K. Kimsma, and Chris Ciesielski-Carlucci, ed. *Asking to Die: Inside the Dutch Debate About Euthanasia* (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1998). [5] California Legislature 1999-2000 Regular Session, Assembly Bill 1592 (February 26, 1999: 1). [6] *Ibid.*, 2. Mercy killing refers to the belief that human beings ought to be released from pain and suffering, and that there exists circumstances under which such release may only be attained through death. On such a view, the killing of a person is viewed as an act of mercy. Active euthanasia refers to the commission of an act by a second party that brings about the intentional death of another person. Active euthanasia is frequently accomplished through the administration of a lethal injection. [7] *Ibid.* [8] *Ibid.*, 3-4. [9] *Ibid.*, 4 [10] *Ibid.* [11] *Ibid.*, 4-5. [12] *Ibid.*, 6. [13] *Ibid.*, 7. [14] *The Sacramento Bee* (April 21, 1999: A1). [15] *The Sacramento Bee* (May 29, 1999: A3). [16] *Ibid.* [17] *Ibid.* [18] *Ibid.* [19] *Ibid.* [20] In introducing the "Death with Dignity Act," Assemblywoman Aroner said, "I think we're beginning the discussion [concerning the merits of physician-assisted suicide]." John Brooke, president of Americans for Death with

Dignity stated that physician-assisted suicide "is the wave of the future. Physician-assisted suicide is going to be more common." He added that it was time for California to resume debate over the idea of legalizing physician-assisted suicide. *The Oakland Tribune* (March 6, 1999: A12). [21] Gilbert Meilaender has made a similar observation and comments on this is his volume, *Bioethics: A Primer for Christians* (Grand Rapids, Mich.: Eerdmans Publishing, 1996), 62-62. [22] *The Oakland Tribune* (March 6, 1999: 1). [23] Meilaender, *Bioethics*, 63. [24] 1 Cor 6:18-20, NIV. Italics added. [25] For example see, Robert L. Sassone, *How to Protect Your Loved Ones From Pain* (Stafford, Virginia: American Life League, 1995), 11-12 [26] *Ibid.*, 5. [27] Meilaender, *Bioethics*, 63. [28] Rom 5:3-5. [29] 2 Cor 4:17, 12:10. [30] 1 Pet 1:6-9. [31] *The Boston Globe* (May 12, 1997, Sec. A, passim). [32] Reference forthcoming. [33] Reference forthcoming. [34] I wish to express my appreciation to Edwin Shneidman, PhD who, as my instructor in Clinical Thanatology while a student at UCLA, contributed greatly to my understanding of the inner world of the dying person. My discussion concerning the psychological dynamics of death bear his fingerprints. [35] See, Robert W. Evans, "The Use of 'Independent Medical Examinations' in Forensic Neuropsychology," *American Journal of Forensic Psychology* 4 (1992): 3-14. [36] For example, Job 14:5; Eccl 3:2; and, James 4:13-15. [37] Jer 10:23. [38] Ps 139:1-16 serves as a striking illustration of this truth. [39] See, Nigel M. deS. Cameron, *The New Medicine: Life and Death After Hippocrates* (Wheaton, Ill.: Crossway Books, 1992). [40] *The Oakland Tribune* (March 6, 1999: 1). The reader will notice that Assemblywoman Aroner here states the two central elements we have just considered in this chapter and common to all arguments for physician-assisted suicide and euthanasia; namely, compassion (suffering) and choice (autonomy). [41] Harold O.J. Brown, *The Sense Culture* (Dallas, Tex.: Word Publishing, 1996), 201. [42] Cameron, *The New Medicine*. [43] Brown, *The Sense Culture*, 201. [44] *Ibid.* [45] Chuck Colson, *Christianity Today Magazine* (November 16, 1998: 104). [46] L. El Aute and Sheila Aute, "Who Will Answer?," Ediciones Musicales, BMG, Ariola S.A., 1967.

Evans, R. W.: How Then Should We Die? - California's "Death With Dignity" Act. [Ako teda máme umrieť? Návrh zákona o „dôstojnej smrti“ v Kalifornii.] Medicínska etika & Bioetika [Medical Ethics & Bioethics], Vol. 7, 2000, No. 1 - 2, p. 3 - 9. Kultúrny význam nedávnych zmien v medicíne a pokroku v biotechnológii nemožno dostatočne doceniť. Vzbudili záujem o morálne základy etického rozhodovania a vyvolali živú debatu o podstate dôstojnosti človeka. Keďže sa zväčša opúšťajú presne definované morálne a etické záväzky, ktoré v minulosti informovali a usmerňovali medicínsku prax, moderné sekulárne pojmy bioetiky neraz degenerujú na úroveň púhych filozofických modelov práv a spravodlivosti. Projekt medicíny „západného“ typu pokračuje v medziach kultúrneho rámca radikálneho post-modernizmu a jeho agendy, pričom požaduje dekonštrukciu a absolútnu relativizáciu všetkého poznania a úplnú sekularizáciu verejného života. Pojem pravdy, ktorá sa v minulosti chápala ako vyjadrenie základnej reality, bol opustený v prospech osobnej preferencie, subjektívnej skúsenosti, súkromnej interpretácie a radikálneho perspektivizmu. Pravdepodobne najväčšou výzvou pre súčasnú kultúru je dosiahnutie jasného a presvedčivého konsenzu o tom, čo tvorí základ morálnej istoty a morálneho života. Nakoľko opustila presvedčenie o Božej účasti pri stvorení a udržiavaní ľudského života, súčasná kultúra sa pohráva s otázkou, čo to znamená byť človekom bez Boha. Stále populárnejším sa stáva presvedčenie, že to, či niekto vlastní ľudskú dôstojnosť alebo nie, sa láme na otázke utrpenia. Podľa súčasného názoru je jednoducho nedôstojné trpieť. Utrpenie, zdá sa, redukuje osobu do tej miery, ktorá je nekompatibilná s dôstojnosťou. Preto neprekvapuje, že jedným z najzdôrazňovanejších sociálnych problémov súčasnosti v rozvinutých krajinách je úsilie uzakoniť „lekárom asistovanú samovraždu“. Toto úsilie je založené na presvedčení, že ľudia musia „umierať dôstojne“. V Kalifornii sa tieto názory uplatnili v návrhu Zákona č. 1592 - Zákona o dôstojnej smrti [Death with Dignity Act]. Je zameraný na legalizáciu lekárom asistovanej samovraždy v Kalifornii ako v druhom štáte USA. Podobný prelomovému zákonu prijatému v štáte Oregon, spomínaný návrh zákona umožňuje terminálne chorému pacientovi ukončiť svoj život, pokiaľ sú splnené určité podmienky. Cieľom príspevku je analyzovať vývoj návrhu zákona č. 1952, a to jednak z hľadiska jeho vecného obsahu, ako aj spôsobu jeho predloženia v parlamente štátu Kalifornia [California State Assembly]. Záujemca o bioetiku nájde v článku rozbor zvyčajných argumentov podporujúcich lekárom asistovanú samovraždu v USA, ako aj eutanáziu v Holandsku - konkrétne: utrpenie a autonómiu. Vzhľadom na vcelku predvídateľný spôsob argumentácie zástancov lekárom asistovanej samovraždy a eutanázie, môžu byť úvahy uvedené v príspevku užitočné aj pre poznanie informovanej a citlivej argumentácie vychádzajúcej z kresťanských pozícií v odpovedi na podobné legislatívne iniciatívy v iných krajinách. *KLúčové slová:* lekárom asistovaná samovražda, eutanázia, legislatíva v štáte Kalifornia(USA), kresťanská perspektíva.

Address/Adresa: Robert W. Evans, Ph.D., Ph.D., Director, Veritas Institute for the Study of Bioethics and Public Values, Auburn, CA, USA.

NIEKOĽKO POHLADOV NA SÚČASNÚ SEVEROAMERICKÚ BIOETIKU

Postrehy a poznatky zo študijného pobytu v Spojených štátoch amerických

Jozef Glasa

Slovenská postgraduálna akadémia medicíny, Nadácia Ústav medicínskej etiky a bioetiky; Bratislava (Slovenská republika)

Abstrakt

Autor (ako štipendista Fulbrightovej nadácie) navštívil počas trojmesačného študijného pobytu v USA (január - apríl 2000) viaceré popredné centrá „severoamerickej“ bioetiky: Hastings Centrum (Garrison, N.Y.), Inštitút etiky J & R. Kennedyovcov a Centrum klinickej bioetiky (Georgetown University, Washington, D.C.), Centrum etiky zdravotníckej starostlivosti (St. Louis University, St. Louis, MO) a niekoľko ďalších. V článku, na podklade vlastných poznatkov a postrehov, podáva prehľadnú informáciu o jednotlivých navštívených centrách, ich programovom zameraní a spektre vykonávaných aktivít, vrátane periodickej publikačnej činnosti. V stručnosti glosuje aj aktuálny vývoj bioetiky na severoamerickom kontinente, a to najmä s ohľadom na jeho význam pre ovplyvnenie smerovania bioetiky v celosvetovom meradle. Zvláštnu pozornosť venuje bilaterálnym vzťahom a spolupráci slovenských bioetikov s jednotlivými autorom navštívenými centrami, doterajším povzbudivým výsledkom tejto spolupráce a jej ďalším možným perspektívam.

Kľúčové slová: bioetika v USA, centrá a inštitúcie, aktuálne etické problémy.

Úvod [1]

Bioetika (biomedicínska etika, „etika života“) - sa dnes najčastejšie definuje ako vedecká disciplína, ktorá študuje etické problémy spojené s činnosťou človeka (jednotlivca i ľudských spoločností) v oblasti medicíny, zdravotníctva a celej živej prírody. Ide najmä o nové etické otázky, ktoré prináša explozívny nárast vedeckých poznatkov a ich praktická aplikácia v mnohých oblastiach života, práce a životného prostredia súčasného človeka. Bioetika sa od svojho vzniku v 60-tych rokoch 20. storočia programovo usiluje o interdisciplinárny prístup: pri hľadaní odpovedí praktickej filozofie (etiky) na aktuálne otázky súčasného vývoja integruje poznatky medicínskych, prírodovedných a spoločenskovedných disciplín.

Súčasnú svetovú bioetiku zásadným spôsobom ovplyvnil jej vznik a vývoj v Spojených štátoch amerických (USA). V tejto krajine vznikli a rozvíjali sa prvé univerzitné i mimouniverzitné centrá a pracoviská tohto mimoriadne dynamického, i keď niekedy značne kontroverzného odboru. Od svojich počiatkov sa totiž bioetika nevyhýbala rôznym iniciatívam a reformným aktivitám, majúcim v USA neraz aj konkrétny legislatívny dopad. (Viaceri protagonisti - „klasici“ odboru ho dokonca ponímali aj ako hnutie svojho druhu, zamerané na reformu nielen medicíny, ale celej spoločnosti. Tu sa bioetika opakovane dostávala do nebezpečenstva, že bude zneužitá v argumentačnej výzbroji niektorých postmoderných „sociálnych inžinierov“.) „Export“ bioetiky *made in USA* takmer do celého súčasného kultúrneho sveta ovplyvnil a významným spôsobom ovplyvňuje nielen vývoj a morálny rozmer medicíny a iných vied o človeku a prírode, ale neobyčajne úspešným vstupom do mediálneho priestoru, ov-

plyvňovaním verejnej mienky a účasťou, či priamo iniciovaním legislatívnych zmien sa mimoriadnym spôsobom podieľa aj na ovplyvňovaní celej (post)modernej kultúry.

Autor, ako štipendista Fulbrightovej nadácie, mal počas študijného pobytu v USA (január - apríl 2000) možnosť pracovať v niekoľkých, v súčasnosti azda najvýznamnejších centrách „severoamerickej“ bioetiky. V tomto príspevku sa na podklade vlastných poznatkov a postrehov pokúsil podať základnú informáciu o jednotlivých navštívených centrách, ich programovom a názorovom zameraní, spektre vykonávaných aktivít, a v tomto pohľade v stručnosti glosovať aktuálny vývoj bioetiky na severoamerickom kontinente.

VÝZNAMNÉ CENTRÁ SEVEROAMERICKEJ BIOETIKY

Hastings Centrum, Garrison (N.Y.)

Patrí medzi najstaršie a najslávnejšie centrá bioetiky na svete. Je neštátnou - privátnou inštitúciou. Založili ho v roku 1969 spoločne filozof Daniel Callahan a psychiater Willard Gaylin v mestečku Hastings na rieke Hudson, po ktorom centrum 'zdedilo' názov. V roku 1987 sa Hastings Centrum (HC) na celé desaťročie presťahovalo do Briarcliff Manor, až sa v roku 1997 jeho sídlom stal Garrison, malá osada na brehu rieky Hudson, ležiaca naproti slávnej „West Point Military Academy“ (založenej prezidentom T. Jeffersonom v roku 1802), asi 80 míľ severo-západne od New Yorku. Rekonštruovaný objekt „Gordon House“ ponúka dostatok priestoru pre pracovne výskumných a administratívnych pracovníkov, veľkú knižnicu a konferenčnú halu, viaceré menšie zasadacie miestnosti, redakcie dvoch odborných časopisov, ba i samostatné ubytovanie pre 3 hosťujúcich vedeckých pracovníkov. Je umiestnený uprostred lesoparku na veľkom chránenom pozemku, spravovanom vplyvnou environmentalistickou organizáciou „Open Space Institute“.

HC sa „zaoberá základnými etickými problémami v oblasti zdravia, medicíny a životného prostredia, ktoré sa dotýkajú jednotlivcov, menších spoločností a ľudských spoločností.“ Medzinárodný tím HC pozostáva z menšej skupiny (asi 10 - 15 osôb) interných pracovníkov samotného centra („senior researchers“ - napr.: D. Callahan, B. Jennings, T. H. Murray, S. Doonolley, L. Knowles, a ďalší) a viac než 100 vedecko - výskumných a pedagogických pracovníkov („fellows“) z celého sveta, participujúcich na jednotlivých grantových výskumných projektoch. HC realizuje výskumné a edukačné projekty v oblasti teórie bioetiky, ale aj so zameraním na konkrétne otázky praktickej lokálnej, regionálnej, celoštátnej alebo globálnej politiky, najmä v oblasti medicíny, zdravotníctva a ochrany životného prostredia. Prehľad aktuálne riešených projektov spolu s podrobnejšími informáciami záujemca nájde na internetovej adrese: www.thehastingscenter.org. Typickou pracovnou metódou HC je široký interdisciplinárny prístup a záber pri riešení konkrétneho problému.

HC sa zásadne zaslúžilo o rozvoj bioetiky ako odboru, vypracovaní vysokoškolského kurikula bioetiky na vysokých školách v USA i vo svete. V svetonázorovej orientácii sa väčšina pracovníkov HC hlási k tradícii 'sekulárneho humanizmu'. Výsledky projektov interdisciplinárneho výskumu formovali odpovede na mnohé aktuálne otázky, ako ich prinášal prudký vývoj medicíny a prírodných vied v najširšom sociálnom, kultúrnom a politickom kontexte, naposledy s ohľadom na problematiku globalizácie. Odborníci HC sa podieľali na vypracovaní mnohých smerníc a odporúčaní pre riešenie etických problémov medicíny a zdravotníctva v USA, pracovali v poradných komisiách a pracovných skupinách prezidenta USA, ich stanoviská sú pravidelne žiadané americkým Kongresom a ministerstvami americkej vlády - a taktiež poprednými americkými médiami. HC venovalo zvláštnu pozornosť

problematike biomedicínskeho výskumu a etických komisií. Od roku 1979 publikuje odborný časopis „*IRB - A Review of Human Subjects Research*“.

Publikačná aktivita však HC zahŕňa predovšetkým vlastný časopis „*The Hastings Center Report*“ (viac než 11-tisíc abonentov; predstavuje prvý medzinárodný časopis venovaný etickým problémom medicíny, prírodných vied a profesionálnej etiky), monotematické suplementá k HC Reportu (prezentujúce výsledky najvýznamnejších výskumných projektov), súbory študijných materiálov, vlastné knihy a monografie, ako aj knižné publikácie pracovníkov Centra v iných vydavateľstvách.

HC má rozvinutý program zahraničných stykov a prijíma hosťujúcich výskumných pracovníkov ('visiting scholars'; a to aj z radov študentov). Zásluhou Prof. Daniela Callahana sa zvláštny zreteľ kladie na krajiny strednej a východnej Európy. V rámci tohto programu sťažovali v HC aj niekoľkí slovenskí odborníci. D. Callahan prednášal na „Medzinárodnom sympóziu medicínskej etiky“ v máji 1992 v Bratislave. V rokoch 1994 - 1997 sa slovenská pracovná skupina z Ústavu medicínskej etiky a bioetiky v Bratislave pod vedením autora tohto článku úspešne podieľala na medzinárodnom projekte „Goals of Medicine“ [2]. HC sponzorovalo viaceré medzinárodné konferencie v strednej Európe ('tradíciou' sa stali pražské 'West - East Bioethics Conferences') a prispelo k formovaniu skupiny odborníkov v oblasti bioetiky pracujúcich v týchto krajinách. (Z iniciatívy týchto odborníkov by sa mal spomínaný vývoj v auguste t.r. zavŕšiť založením „Stredo a východoeurópskej asociácie bioetiky“). HC má naďalej záujem na rozvíjaní spolupráce so slovenskými 'bioetikmi' a o ich účasť v konkrétnych projektoch Centra.

J. & R. Kennedy Inštitút Etiky, Univerzita Georgetown, Washington (D.C.)

Inštitút založili v roku 1971 na pôde jednej z najvýznamnejších univerzít USA - Georgetown University (GU), so zakladajúcim príspevkom Jozefa a Rose Kennedyovcov (rodičov prezidenta J. F. Kennedyho). Je výukovým a výskumným centrom, ktoré sa zaoberá etickým pohľadom na kľúčové problémy verejného záujmu (vrátane významných oblastí lokálnej, regionálnej, celoštátnej a globálnej politiky). Predstavuje najväčšiu skupinu univerzitných pracovníkov na svete, ktorá sa venuje výskumu a výuke biomedicínskej etiky a ďalších oblastí aplikovanej etiky.

Pracovníci Inštitútu zabezpečujú výuku študentov GU a študentov postgraduálneho štúdia (PhD.) vo filozofii, etike a bioetike (úzko spolupracujú s Katedrou filozofie GU, teológmi rôznych náboženských vyznaní v rozsiahlom učiteľskom zbore GU, ako aj s právnickou fakultou GU). Sú pozývaní ako experti v otázkach biomedicínskej etiky najvýznamnejšími štátnymi a vedeckými inštitúciami v USA a v zahraničí. Výskumný program Inštitútu je veľmi rozsiahly, odráža vedecké záujmy a profiláciu jeho pracovníkov, patriacich medzi popredné osobnosti svetovej bioetiky (napr. T. L. Beauchamp, R. R. Faden, LeRoy Walters, R. Kimura, E. D. Pellegrino, H. - M. Sass, R. M. Veatch a ďalší). Medzi priority výskumného záujmu patria: etické aspekty génovej terapie, autonómie, beneficencie, pluralizmu v medicínskej etike, informovaného súhlasu, smrti a umierania, nukleárných zbraní. Interdisciplinárne spektrum zahŕňa filozofiu, religionistiku, medicínu, právo, žurnalizmus, medzinárodnú politiku a podnikateľstvo. Inštitút usporadúva každoročne tradičný „intenzívny bioetický kurz“ (v roku 2000 sa bude konať už 26. ročník) a „bioetický kurz pre pokročilých“, s bohatou a špičkovou medzinárodnou účasťou. Medzinárodné programy Inštitútu sa aktuálne koncentrujú do dvoch oblastí: „*Ázijský bioetický program*“ poriada americko - japonské bio-

etické konferencie a organizuje medzikultúrny výskum (v spolupráci s japonskou 'Waseda University'); „*Európsky program v profesijnej etike*“: zahŕňa etické aspekty podnikateľstva, životného prostredia, zákonodarstva a najmä medicíny a zdravotníctva.

Inštitút zabezpečuje medzinárodnú bibliografickú a informačnú službu v oblasti bioetiky v rámci 3 veľkých projektov:

A) Bioethicsline[®]: ide o on-line databázu bioetickej literatúry z celého sveta (publikácie sú však prevažne v anglickom jazyku), excerpovanú tímom vysoko vzdelaných a skúsených pracovníkov, v roku 2000 sa má databáza stať priamou súčasťou on - line databázy Medline[®] (vedenej v 'National Library of Medicine'). V rámci bilaterálnej spolupráce a výmeny databáza Bioethicsline[®] od roku 1999 excerpuje aj časopis „*Medicínska etika & Biotika*“ (spätne aj všetky staršie ročníky od roku 1994) a všetky zaslané bioetické publikácie v anglickom jazyku vydané na Slovensku [3, 4].

B) National Information Resource on Ethics & Human Genetics: zabezpečuje referenčné bibliografické a informačné služby pre oblasť etických, legislatívnych a sociálnych dôsledkov genetického výskumu a jeho aplikácií.

C) National Reference Centre for Bioethics Literature (NRCBL): je najväčšou knižnicou odbornej literatúry v oblasti etiky zdravotnej starostlivosti a biomedicínskeho výskumu na svete. Jej súčasťou sú aj „*Kampelmanova zbierka judaistickej etiky*“ a „*Shriverova zbierka kresťanskej etiky*“.

Publikácie Inštitútu predstavujú svetovú špičku v oblasti bioetiky:

A. Kennedy Institute of Ethics Journal (KIEJ): štvrťročník venovaný problematike aplikovanej etiky, zvlášť bioetiky, prináša pôvodné práce, prehľadové články a bibliografické výbery na aktuálne témy „*Scope Notes*“.

B. Bibliography of Bioethics: každoročne vydávaná bibliografia (už viac než 25 rokov) obsahuje cca 3.600 nových citácií kníh, odborných článkov, súdnych rozhodnutí, vládných dokumentov a iných prác z oblasti bioetiky.

C. Bioethics Thesaurus: každoročne inovovaný index kľúčových slov pre databázu Bioethicsline[®].

D. Encyclopedia of Bioethics: (ed. W. Reich; vydavateľstvo MacMillan Simon & Schuster) najvýznamnejšie referenčné encyklopedické dielo v oblasti bioetiky. Druhé, prepracované vydanie vyšlo v roku 1995. Obsahuje 5 zväzkov (v súčasnosti je k dispozícii aj na CD).

E. New Titles in Bioethics: štvrťročne a každoročne publikovaný index nových titulov zaradených do knižnice NRCBL.

F. Scope Note Series: aktuálne bibliografické prehľady s krátkym úvodným komentárom, publikované v KIEJ i ako separátne výtlačky.

Úspešne začatá spolupráca s týmto významným bioetickým pracoviskom (vrátane už fungujúcej bibliografickej a informačnej služby) môže v budúcnosti prispieť k ďalšiemu rozvoju slovenskej bioetickej školy a jej primeranej medzinárodnej prezentácii.

Centrum klinickej bioetiky, Univerzita Georgetown, Washington (D.C.)

Centrum založili ako rozšírenie Kennedyho Inštitútu Etiky (KIE) na pôde Lekárskej fakulty (LF) GU v roku 1991. Zakladajúcou osobnosťou bol Prof. Edmund D. Pellegrino - lekár, bioetik, v minulosti riaditeľ KIE a dekan LF GU. Cieľom bolo priblížiť bioetické uvažovanie každodennej klinickej praxi veľkej univerzitnej nemocnice LF GU, zabezpečiť výuku biomedicínskej etiky ako „*klinickej etiky*“ pre študentov medicíny, ošetrovateľstva a ďalších odborov GU.

Väčšina stálych pracovníkov Centra - lekárov, vrátane Prof. E. D. Pellegrina, aktívne pracuje v rôznych medicínskych odboroch (najmä interna, chirurgia, gynekológia, rodinná a všeobecná medicína) alebo v ošetrovatelstve. Stály kontakt s praxou medicíny a ošetrovatelstva sa považuje za rozhodujúci pre kvalitu celého programu klinickej bioetiky. Plne kvalifikovaní klinickí pracovníci Centra absolvujú kompletne postgraduálne štúdium (PhD. program) vo filozofii alebo teológii. Sú členmi etických komisií univerzitnej nemocnice (pre výskum, ako aj „nemocničných“) a poskytujú 'etické konzultácie' pre zdravotníckych pracovníkov, pacientov i rodinných príslušníkov. Považujú sa za významnú súčasť komplexnej tímovej starostlivosti o pacienta.

Centrum úzko spolupracuje s KIE a ďalšími pracoviskami GU a vedie vlastné výskumné projekty v oblasti klinickej etiky. Má bohatú knižnú i časopiseckú publikačnú činnosť (vrátane príspevkov do časopisu *Journal of Clinical Ethics*) a pripravuje kvalitné učebné texty a výukové materiály pre študentov. Prijíma študentov postgraduálneho štúdia v zdravotníckej / klinickej etike, domácich aj zahraničných hosťujúcich výskumných pracovníkov (v rámci „(International) Visiting Scholar Program“). Konkrétna spolupráca so slovenskými odborníkmi by v budúcnosti mohla zahŕňať výmenu a konzultácie výukových materiálov a programov, empirický výskum v klinickej bioetike, ako aj výmenu a recenzie odborných publikácií v anglickom jazyku.

Centrum etiky zdravotnej starostlivosti, Univerzita St. Louis, St. Louis (MO)

Centrum bolo založené pred viac než 20 rokmi (1969). Je situované priamo v komplexe lekárskej fakulty a fakultnej nemocnice St. Louis University, čo umožňuje intenzívny kontakt a spoluprácu so špičkovými pracovníkmi klinickej medicíny a biomedicínskeho výskumu. Poslaním Centra je „akademický výskum, ktorý integruje a podporuje výuku a praktickú činnosť v oblasti zdravotníckej etiky. Jeho súčasťou je rozvoj kresťanskej (katolíckej) etickej tradície v interdisciplinárnom dialógu so súčasnou pluralistickou spoločnosťou.“

Zakladateľskými osobnosťami Centra sú profesori Kevin O'Rourke a Benedict Ashley, ktorých spoločná učebnica „*Health Care Ethics - Theological Analysis*“ (4. vydanie vyšlo v roku 1998) sa považuje za jeden z najlepších súčasných učebných textov vychádzajúcich z kresťanskej (katolíckej) etickej tradície. Centrum patrí k významným pracoviskám St. Louis University, čo sa odráža v jeho veľmi dobrom priestorovom, personálnom i technickom vybavení. Výnimočná akademická úroveň, dobrý manažment a široký záber aktivít podmieňujú vysokú úspešnosť Centra pri získavaní štátnych a súkromných grantov na realizáciu projektov výskumnej, pedagogickej a publikačnej činnosti.

Centrum zabezpečuje výuku medicínskej etiky, etiky zdravotníctva, etiky ošetrovatelstva a bioetiky pre študentov St. Louis University. Okrem toho má pozoruhodný PhD. program interdisciplinárneho postgraduálneho štúdia v zdravotníckej etike. (Je prístupný aj záujemcom zo zahraničia s možnosťou získania štipendia, trvanie - najmenej 2 roky). Centrum každoročne organizuje už tradičný „postgraduálny inštitút“ (kurz) v zdravotníckej etike (novšie je súčasťou „inštitútu“ aj 3-dňový blok venovaný „etike zdravotníckych organizácií“). Učiteľia a spolupracovníci Centra žijúci v St. Louis a jeho širšom okolí sa podieľajú na práci etických komisií univerzitnej nemocnice a mnohých ďalších zdravotníckych zariadení a organizácií v oblasti, spolupracujú s komisiami „Catholic Health Association“ (organizácia katolíckych nemocníc a zdravotníckych zariadení v USA, združuje poskytovateľov

cca 20% zdravotníckej starostlivosti v USA, sídlo asociácie je v St. Louis). Centrum vydáva vlastný časopis „*Health Care Ethics - USA*“ (štvrtročník, od roku 1993) a v 2 - 3 ročných intervaloch organizuje stretnutia zástupcov centier etiky zdravotníctva z celého sveta (slovenský delegát - Dr. J. R. Klepanec, sa zúčastnil na takomto stretnutí v roku 1994).

Vo výskumnej a publikačnej činnosti sa Centrum zameriava na 3 základné oblasti etiky zdravotníctva: **a)** teoretické základy (napr. princípy a normy zdravotníckej etiky), **b)** biomedicínsku etiku (aktuálne etické problémy medicíny a zdravotnej starostlivosti), **c)** etiku zdravotníckych organizácií (nemocníc, združení poskytovateľov zdravotnej starostlivosti, etc.). Vedenie Centra má dlhoročný záujem o európsku bioetiku. Počas pobytu autora sa dohodli konkrétne možnosti odbornej spolupráce so slovenskými bioetikmi.

Centrum pre otázky bioetiky a ľudskej dôstojnosti, Chicago - Bannockburn (IL)

Patrí medzi 'mladšie' bioetické centrá v USA. Je medzinárodnou, neštátnou, vedecko - výskumnou a výukovou organizáciou, zameranou na pomoc jednotlivcom, spoločnostiam a spoločnostiam v ich orientácii v teoretických i praktických otázkach súčasnej bioetiky. Medzi kľúčové oblasti záujmu Centra patria: etické aspekty génových manipulácií, akútnej medicíny, paliatívnej a terminálnej zdravotnej starostlivosti, eutanázia, asistované suicídium, technológie asistovanej reprodukcie človeka, alternatívna medicína a iné.

Centrum každoročne organizuje medzinárodnú konferenciu a medzinárodný postgraduálny kurz v bioetike. Vydáva kvalitný medzinárodný časopis „*Ethics & Medicine*“ (štvrtročník, or roku 1984) a informačný bulletin „*Dignity*“ (polročník, od roku 1995). Publikuje referátové materiály k spoločensky aktuálnym bioetickým problémom a vydáva celý rad knižných odborných publikácií v oblasti biomedicínskej etiky a zdravotníckej etiky. Pripravilo zaujímavé audio a video materiály k temer všetkým aktuálnym otázkam súčasnej bioetiky, vhodné na individuálne i skupinové štúdium (k dispozícii je zásielkový katalóg). Zaujímavou publikačnou sériou sú knižky vreckového formátu, určené pre širšiu verejnosť. Spolupracovníci Centra vyučujú na popredných univerzitách v USA a na Trinity International University v Bannockburn (IL), sídle Centra. Publikujú pravidelne v medzinárodných bioetických časopisoch, autorsky prispeli aj do „*Encyklopédie bioetiky*“. Kontakty a spolupráca so stredoeurópskymi a slovenskými bioetikmi sa datuje od medzinárodnej bioetickej konferencie v Budapešti (1994). Spočíva vo výmene odborných materiálov, literatúry a konzultačnej spolupráci. Riaditeľ centra - Prof. John Kilner, sa zúčastnil na medzinárodnej konferencii Ústavu medicínskej etiky a bioetiky „Health Care under Stress“ v Bratislave v roku 1995 (plánuje sa aktívna účasť Centra na bratislavskej bioetickej konferencii v roku 2001).

Inštitút Veritas pre štúdium bioetiky a spoločenských hodnôt, Auburn (CA)

Je neštátnym výskumným a výukovým centrom bioetiky. Programovo sa hlási ku kresťanskej (evanjelickej) etickej tradícii. Organizuje interdisciplinárne postgraduálne výukové kurzy v bioetike a poradenstve v otázkach etických problémov medicíny a zdravotnej starostlivosti pre zdravotníckych pracovníkov, ale aj pre teológov a pastoračných pracovníkov rôznych kresťanských denominácií. Vydáva vlastný informačný bulletin, audio-

kazety a textové výukové materiály. Inštitút rozvíja bohaté medzinárodné kontakty, predovšetkým s európskymi krajinami (vrátane strednej Európy), ale jeho aktivity sa v poslednom období rozšírili aj do Indie a Austrálie. Riaditeľ inštitútu - Prof. Dr. Robert W. Evans navštívil už viac ráz Slovensko, keď v rámci európskych prednáškových turné prednášal na viacerých slovenských vysokých školách a vedecko - výskumných, či pedagogických inštitúciách. Inštitút založil v roku 1999 zvláštne štipendium - „Veritas Institute Scholarship“, určené na podporu výskumnej práce študentov a postgraduálnych študentov vysokých škôl krajín strednej a východnej Európy v oblasti bioetiky.

Program v biomedicínskej etike, Univerzita Iowa, Iowa City (Iowa)

Program zabezpečuje predovšetkým výuku študentov medicíny, ošetrovateľstva a interdisciplinárnu výuku študentov iných odborov na Iowskej univerzite. Významným faktorom je existujúca spolupráca niektorých pracovísk univerzity s pracoviskami na Slovensku (najmä s Ústavom preventívnej a klinickej medicíny a Slovenskou postgraduálnou akadémiou medicíny v Bratislave), výmenné sťaže pracovníkov v rámci spoločných vedecko - výskumných projektov (najmä v rámci spoločného pracoviska „Institute of Rural and Environmental Health“) a postgraduálne štúdium perspektívnych vedeckých pracovníkov zo Slovenska na Iowa University. Spolupráca v oblasti bioetiky viedla dosiaľ k zorganizovaniu spoločnej konferencie so širšou medzinárodnou účasťou v Bratislave (ďalšia konferencia by sa mala uskutočniť koncom roku 2000 alebo v termíne jar - leto 2001) a k spracovaniu spoločného výskumného projektu (empirický výskum problematiky etických komisií). Eminentný záujem o ďalšiu spoluprácu i veľmi dobré finančne - logistické možnosti Iowa University ponúkajú sľubnú perspektívu pre ďalší rozvoj bilaterálnej spolupráce, s účasťou prípadne i ďalších slovenských pracovísk.

AKTUÁLNE PROBLÉMY BIOETIKY „MADE IN USA“

Bioetika v USA predstavuje v súčasnosti široko etablovanú vedeckú disciplínu, s nemalým odborným, inštitucionálnym (i finančným) potenciálom a nezanedbateľným spoločenským (a politickým) dopadom. Prakticky každá lekárska fakulta má program alebo centrum v biomedicínskej etike, navyiac v krajine funguje mnoho samostatných vedecko - výskumných alebo výukových centier medicínskej etiky/bioetiky. „Americký model bioetiky“, zväčša zhodný s tzv. **školskou bioetikou** (bioetika pestovaná na amerických univerzitách koncom 70-tych a v 80-tych rokoch 20. storočia; charakterizovaná používaním 4 bioetických princípov - benefienciencia, non-maleficiencia, autonómia, spravodlivosť = tzv. **principalizmus**), bol široko 'exportovaný' do univerzitných prostredí po celom svete (i keď najmä klasická európska filozofická škola naďalej pomerne úspešne odoláva silnejúcim amerikanizačným tlakom).

Významnou súčasťou americkej bioetiky je **klinická (bio)etika**. Mnohé nemocnice a iné zdravotnícke zariadenia zamestnávajú „klinických (bio)etikov“, ktorí majú špecifickú odbornú prípravu a poskytujú etické konzultácie zdravotníckym pracovníkom (najmä lekárom, resp. zdravotníckym pracovným tímom), ale aj pacientom a ich rodinným príslušníkom. Hlavnými problémami klinickej bioetiky sú „rozhodnutia na začiatku a na konci ľudského života“, otázka primeranosti diagnostiky a terapie, pokračovanie alebo ukončenie terapie, ktorá neprináša konkrétnemu pacientovi prospech (*angl. futile treatment*). Ďalej je to rozdielnosť názorov z etického hľadiska

diska na ďalší klinický postup u daného pacienta (medzi členmi ošetrojúceho tímu, medzi lekárom/lekármi a pacientom, resp. jeho rodinnými príslušníkmi), rozhodovanie o ďalšom postupe v prípade „nekompetentného pacienta“, detí a mladistvých, atď.

Mnohé z uvedených problémov podstatne vyplývajú z výraznej individualistickej orientácie americkej spoločnosti, keď sa zdôrazňuje najmä **rešpektovanie autonómie pacienta** (až po problém „medicínskeho závetu“ - *angl. „living will“*). Pravidlom je úplné informovanie pacienta o nepriaznivej prognóze a jeho aktívna účasť, pokiaľ je mentálne kompetentný, na rozhodovaní o ďalšom medicínskom postupe. Rozhodnutia kompetentného pacienta sa rešpektujú aj v prípade, ak sú proti všeobecne prijatému postupu 'v najlepšom záujme pacienta'. V prípade mentálne nekompetentného pacienta rozhoduje vopred určená osoba (*angl. surrogate decision - maker*), alebo rodinní príslušníci v spolupráci so zdravotníkmi (tu neraz prichádza ku konzultácii klinického (bio)etika alebo (nemocničnej) etickej komisie), alebo súd.

Výskumná práca i konkrétne závery a odporúčania bioetických grémii (rôznych komisií, 'konsenzných panelov' a pracovných skupín) sú poznačené situáciou výrazného **filozofického (etickeho) pluralizmu** a svetonázorovou prevahou '**sekulárneho humanizmu**' v odborných, vedeckých a univerzitných kruhoch (čo zďaleka neodráža situáciu v americkej spoločnosti, ktorá je vysoko religiózna - so značnou rozmanitosťou, pluralitou cirkví a náboženských spoločností, pri 'úplnej odluke cirkví od štátu'). Chýbanie spoločného mravného základu etického uvažovania (až do konca 60-tych rokov 20. storočia poskytovaného judeo-kresťanskou morálnou (eticou) tradíciou) v kruhoch severoamerickej „akademickej“ bioetiky neraz sťažuje až znemožňuje formuláciu rozhodnejšieho etického stanoviska. Pracovné skupiny sa preto neraz uspokojia s 'minimálnymi' etickými požiadavkami dosiahnutého **konsenzu** (*angl. „bottom line criteria“*), alebo skončia na pozíciách púheho '**legalizmu**' (eticke stanoviská diktované aktuálne platnými zákonnými normami).

Temer všadeprítomná '**postmodernistická' kríza** filozofického (vrátane etického) myslenia je o to závažnejšia, že etické problémy prinášané aktuálnym vývojom v medicínskych a prírodovedných disciplínach, ako aj prevratnými možnosťami nových biotechnológií, si neraz vyžadujú naliehavé a kompetentné riešenie. Zaujímavým javom v tejto súvislosti je obnovený záujem o **kresťanský orientovanú bioetiku**, ako aj o príspevok bioetiky rozvíjanej v duchu 'katolíckej tradície' morálnej teológie. Dôvodom je ich dlhá tradícia a veľmi dôkladná teoretická i „praktická“ prepracovanosť. V USA v tomto smere pôsobí aj pomerne silné postavenie zdravotníckych zariadení v správe katolíckej cirkvi na „trhu zdravotníckych služieb“ (až 20% všetkých ošetrovaných pacientov ročne). Tieto zariadenia navyše neraz pôsobia v najchudobnejších a zanedbávaných oblastiach a spoločenských. K tomu prispúva aj nemalý počet zdravotníckych zariadení, ktoré sú vo vlastníctve alebo v správe ostatných kresťanských cirkví.

Ďalšiu, veľmi významnú skupinu predstavujú zdravotnícke zariadenia vo vlastníctve početných židovských obcí (z ktorých sa zas tradične regrutuje značná časť odborne i 'mocensky' vplyvných amerických lekárov). Vplyv týchto lekárov (ale aj napr. psychológov a iných paramedicínskych odborníkov) na špičkovú univerzitnú severoamerickú medicínu je podstatný, čo pochopiteľne platí aj o samotnej bioetike, ako aj o aktuálnom legislatívnom a právnom prostredí fungovania severoamerického zdravotníctva. I keď vplyv náboženskej - **judaistickej tradície** nemožno ani v súčasnosti považovať za zanedbateľný (a autoritatívne stanoviská z týchto pozícií zaznievajú zreteľne ku všetkým aktuálne preraktovaným problémom bioetiky), väčšina 'akademických' autorov z tohoto ideo-

vého okruhu stojí skôr už na pozíciách 'sekulárneho humanizmu'.

Kľúčovým etickým i politickým problémom zdravotníctva v USA v najbližšej budúcnosti zostane zabezpečenie **prístupu k základnej zdravotnej starostlivosti** pre všetkých občanov krajiny (v súčasnosti je viac než 45 miliónov Američanov bez základného zdravotného poistenia a bez efektívneho prístupu k potrebnej zdravotnej starostlivosti). „Právo na zdravotnú starostlivosť“ však nateraz nefiguruje na zozname občianskych práv v USA. V tejto súvislosti ostane naďalej aktuálnou téma efektívnosti a hospodárnosti zdravotnej starostlivosti pre chudobnejšie vrstvy obyvateľstva (*angl. managed care*) a otázka individuálnych záujmov a práv pacienta, jeho dôvery resp. nedôvery voči zdravotníckym organizáciám a zdravotníckym pracovníkom.

Amerických 'univerzitných' bioetikov budú zaiste naďalej zamestnávať „**horúce témy**“ súčasnej americkej (i svetovej) medicíny a zdravotníctva. Patrí medzi ne napríklad výskum ľudských kmeňových buniek a jeho aplikácie, xenotransplantácie, klonovanie a génové manipulácie, génová terapia, atď. Po neočakávanom úmrtí pacienta v klinickej štúdií gérovej terapie sa všeobecne volá po sprísnení a sprehľadnení podmienok klinických štúdií v tejto oblasti a po zvýšenej ochrane výskumných subjektov - pacientov. Pozornosť vzbudzuje aj ďalší vývoj metód asistovanej reprodukcie človeka, problém „konfliktu záujmov“ lekárov - výskumných pracovníkov (ktorí v súčasnosti vlastnia patenty na výsledky biomedicínskeho výskumu, neraz i majetkové podiely (akcie) alebo vlastné biotechnologické firmy na komerčnú realizáciu svojich patentovaných výsledkov), výskum v rámci „Projektu ľudského genómu“ (charakterizovaného súperením „štátom financovaného programu“ (USA a Veľká Británia) a výskumu realizovaného v súkromnom sektore - ktorý sa však snaží o patentovú ochranu svojich výsledkov s cieľom ich komerčného využitia: nedávne vyhlásenie prezidenta B. Clintona a premiéra T. Blaira o sprístupnení výsledkov projektu širokej vedeckej spoločnosti na stránkach internetu vyvolalo značné zníženie ceny akcií týchto spoločností na burze). Aktuálnym problémom je aj otázka ochrany osobných zdravotných údajov pred zverejnením a zneužitím (napr. diskriminácia zo strany zamestnávateľov a zdravotných poisťovní) v situácii te-mer totálnej „komputerizácie“ medicíny a zdravotníctva (i celej severoamerickej spoločnosti).

Záver

Pre primerane kritického európskeho pozorovateľa bude „americká bioetika“ zaiste ešte dlho predstavovať stimulujúci, niekedy až bizarný obraz úsilia ľudského ducha zápasiaceho s odvekými i celkom futuristickými otázkami etiky ľudského života, jeho podstaty a zmyslu. V perspektíve nastupujúcej globalizácie si však európsky (i slovenský) bioetik môže všimnúť, že cez sklenenú stenu zmenšujúceho sa geografického a kultúrno-historického odstupu pozoruje svoje vlastné odborné a ľudské zápasy pred tvárou súčasnosti i večnosti... Vzhľadom na zrejmy „náskok“ severoamerickej vedeckej medicíny a prírodovedy, do istej miery reflektovaný na pôde bioetiky, súdnickej praxe i legislatívy (tu nemôžno zanedbať ani prínos mimovládnych organizácií a výskumu financovaného zo súkromných prostriedkov), je sledovanie vývoja v tomto kompetitívnom a rýchlo sa meniacom prostredí nielen nanajvýš zaujímavou záležitosťou, ale aj dobrou „prípravou“ na riešenie problémov, ktoré vývoj v kratšom alebo dlhšom časovom horizonte aj do nášho prostredia a našich podmienok zákonite prinesie.

References

- [1] Predchádzajúca, stručnejšia verzia materiálu bola publikovaná v časopise SLS Monitor: Glasa, J.: Významné centrá severoamerickej bioetiky, 2000 (v tlači). [2] D. Callahan, et al.: Goals of Medicine. Setting New Priorities. / Čile medicíny. Hľadání nových priorit Hastings Center Report, Suppl., 1997, S3 - 56. / Preklad v: Medicínska etika & Bioetika / Medical Ethics & Bioethics, 5, 1998. [3] Glasa, J. (Ed.): Contemporary Problems of Medical Ethics in Central Europe. Charis - IMEB, Bratislava, 1993. [4] Glasa, J., Klepanec, J. R. (Eds.): Health Care under Stress. Charis - IMEB Fdn., Bratislava, 1998. (Ďalšia literatúra u autora.)

J. Glasa: Niekoľko pohľadov na súčasnú severoamericú bioetiku. [Some Views on Contemporary North - American Bioethics.] ME & B, Vol. 7, 2000, No. 1 - 2, p. 10 - 14. Author (Fulbright Scholar 1999/2000) visited during his 3-month study stay in USA (January - April 2000) some of the leading centres of the „North - American bioethics“: The Hastings Center (Garri-son, N.Y.), J & R. Kennedy Institute of Ethics and Centre for Clinical Bioethics (Georgetown University, Washington, D.C.), Center for Health Care Ethics (St. Louis University, St. Louis, MO), and a couple of others. In the present essay, he gives an actual information about the bioethics centres visited, their programmes and scope of work, including regular publication activities. He comments briefly on the current trends of development of bioethics in USA, with regard to its influence in global perspective. Author pays a special attention to the bilateral contacts and collaboration of Slovak bioethicists with some US centres, as well as to the already existing encouraging results thereof, and outlines some current possibilities and perspectives for the future. *Key words:* bioethics in the USA, centres and institutions, current ethical problems.

Adresa/Address: MUDr. Jozef Glasa, CSc., SPAM, Limbová 12, 833 03 Bratislava, Slovenská republika.

INDIVIDUAL HEALTH: NEW DEFINITION AND ONTOLOGICAL BACKGROUND

Konstantin S. Khroutski

Institute of Medical Education, Yaroslav-the-Wise Novgorod State University, Novgorod the Great (Russia)

Abstract

Author argues in the paper, that contemporary philosophy and science do not consider individual health a major philosophical or scientific problem. He underlines, however, the actual importance of elaboration of a new philosophical underpinning of this important theoretical (and 'practical') notion. Author introduces an original framework of ontological assumptions, aimed to create a useful basis for the scientific comprehension and analysis of the phenomenon of individual health. His ontological system builds on the Russian cosmist philosophical tradition of pan-unity and active evolution. Working on this basis, a new definition of the individual health is proposed.

Key words: individual health, cosmism, active evolution, Russian philosophy

As a starting point of our reflections, it is important to note, that modern man - living in a contemporary civilised, democratic society - is frequently deprived of his/her right to get the necessary information regarding his/her individual health. Modern biomedicine individualizes, but sometimes 'depersonalizes' the man: it treats him/her as an abstract statistical unit. Although it admits the uniqueness of man's individual bio-organismic or psychosocial characteristics, it sees them exclusively as variab-

les within the common range of a given trait, i.e. as the biostatistical norm and its possible deviations. At the same time, contemporary philosophy and science do not consider individual health as a major philosophical or scientific problem. As a result, the man has to become ALREADY diseased (or found himself/herself in the surroundings of serious risk factors), to make the impressive power of modern biomedicine turn to help him/her. But it is nearly impossible at present, to attract existing enormous biomedical (as well as social and humanitarian) capacities to assist him/her in placing into work his/her individual 'factors of wellbeing', that would guarantee his/her health - the individual 'state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity' (following WHO's definition of health).

One of the origins of the on-going crisis of contemporary philosophy and science (which is reflected also in the problems of comprehension of the notion of individual health) may be seen in the fact, that modern biomedicine is strictly based on the pluralistic foundations. The current pluralistic development is 'natural' in the historical-cultural settings of the evolution of (post)modern Western civilisation, but it is not natural (and just un-natural) from the point of view of the natural sciences. As a matter of fact, at least since the year 1953, we know an absolutely incontestable fact of natural sciences - the evolutionary process of the life on the Earth is a single whole: the discovery of DNA by Watson and Crick, which proves the unity of all kinds of life on Earth, and the genetic transmission of certain somatic and even some psychological characteristics from parents to offspring by DNA molecules.

Next, the so-called 'paradox of creativity' should be considered: the contemporary man, being a creature of 'the Nature', actively creates and materialises the social and ecological forms of his/her existence on the planet Earth and actually steers the whole planetary life process. But, at the same time, no less than about 90% of all existing risk factors of 'modern' non-infectious diseases have a human ecological or social origin, thus, the one resulting from the man's 'creativity'. In other words, about 90% of all chronic diseases are anthropogenic. They actually stem from contemporary ontological, axiological, epistemological, and ethical incompetence and lack of wisdom of the (post)modern philosophy, science and man. At least, as far as bioethics is concerned, Prof. Edmund D. Pellegrino holds, that „the period of crisis“ has indeed come: existing ethical principles „ignore the person's character, life story, cultural background, and gender“; all that is determined by the „parlous state of contemporary philosophy and ethics and the strong current of nihilism and scepticism in both fields,, the later also expresses the denial of „arriving at any truth through philosophy and the relevance of any theory of reality“ [1].

Finally, one point seems to be clear: to cope with the crisis of modern biomedicine (also concerning the understanding of the notion of individual health), we obviously need to create a new framework of basic ontological assumptions, that should be well-founded for the deduction of valid theoretical proposals, reliable, in their turn, for the substantiation of rational comprehension and cognition of individual health.

Sir Alfred North Whitehead stated in his time: „Philosophy will not regain its proper status until the gradual elaboration of categorical schemes, definitely stated at each stage of progress, is recognised as its proper objective“ [2]. In our case, we find the philosophical foundations of the philosophical tradition of **Russian cosmism** to be the most suitable for our purposes. Relying on the work of the leading Russian personalities of philosophical cosmism (S. Semenova, 1993; A. Aleshin, 1995; O.

Shubaro, 1998; I. Kalchev, 1999; E. Gutov, 1996; and others) we list here ten most characteristic features of Russian cosmism:

- 1) Idea of *Pan-Unity (Total-Unity)* - the central idea of Russian cosmism;
- 2) Idea of *incompleteness of the evolution of world and man*;
- 3) Idea of *creative destination of man*;
- 4) Idea of *transformation of world as the meaning of human life*;
- 5) Idea of *responsibility of man for the fortune of universe*;
- 6) Idea of *active evolution*;
- 7) Comprehension of the *ascending character of evolution*;
- 8) Idea of the *synthesis of sciences*;
- 9) Epistemological opinion, that the *true knowledge is the result of empirical, rational and mystical (intuitive) cognition in their proper interconnection*;
- 10) Opinion, that all *human sufferings originate from an inappropriate cosmic position and activity of man*.

Philosophical cosmism (universalism) constituted the mainstream of Russian philosophy in the end of the 19th and beginning of the 20th century, having, at that time, favorable perspectives for its further evolution. However, since the 1917, the true Russian cosmism was not only badly repressed, even in a 'physical manner' ('gulags', executions, all kinds of ideological and physical terror), by the bolsheviks (in favor of the totalitarian promotion of *marxism - leninism*), but it was also almost completely deleted both from the Russian cultural sphere and from the Western and world attention.

Here, following the ideas of Russian philosophical cosmism and advancing our analysis, we develop our own 'cosmist' framework of basic ontological assumptions. We would like to stress here two points:

- a) an attribution of a new, cosmist meaning to the term 'subject',
- b) an introduction of two new philosophical categories: the *adaptational creativity* and the *creative creativity*.

Thus, our notion of 'subject' is the notion of the '*integrated functional subject*'. It means - from the cosmist point of view - every living organism on the Earth: molecule, cell, biological organism, biosphere, human being, family, community, social body, society, and, ultimately, the cosmic evolutionary process of Earth's life.

We introduce and discern two types of human creativity: the *adaptational creativity* and *creative creativity*.

Adaptational creativity (*micro-evolutionary, actual, constructive c.*). It largely conforms with *Carl Popper's evolutionary emergentism* - the constant production of novel tentative behavioral and cognitive patterns through actual problem solving in the present situation; here, man expeditiously uses the method of trial and error, as well as he/she effectively exploits the already existing (of Popper's 'world 3') scientific and cultural material; the means of positivism, rationalism, subjectivism, existentialism and phenomenology are equally relevant herein; man's adaptational creative activity ends ultimately in the attainment of the highest level of stability of his/her existence in the given environment.

Creative creativity (*macro-evolutionary, ascending, cosmist c.*). It is a creative activity personally gratifying man, aimed at the production of specific personal effects or results, directed to the fulfilment of the needs and attainment of man's wellbeing at a successively higher level (absent in the present reality), enabling the person's future integration and wellbeing. Creative activity is the manifestation of specific abilities of the person to realise his/her gratifying functional inclusion into the integrity of a new higher macro-level of man's wellbeing.

Henceforth, it is possible to present our main ontological assumptions. Their entire framework may be referred to as the **absolute cosmist wholism**.

It is based on the following constitutive principles:

1) Principle of the **universal functional integration** - 'all living is a whole - a functionally integrated subject'.

2) Principle of the **universal emergent evolutionism** - 'all living is a process': every subject (person) evolves simultaneously through an increasing capability of adaptation to the influences and requirements of an actual environment, as well as through his/her integration into the ascending (in complexity) levels of biological, regional or whole Earth's living ecological (social) integrity: of a molecule, organelle, cell, organ, bio-organism, eco-system (biocenosis, biosphere), human being, family, community, social body, society; the next integrity step inevitably will be the whole mankind.

3) Principle of the **particular role of the modern man in the Cosmic Evolutionary Process of Earth's Life (CEPEL)** - 'contemporary civilised man is a creator': the future wellbeing of the common CEPEL entirely depends on the man's deliberate cosmic creative activity.

4) Principle of the **evolutionary selection from above** - 'evolutionary selection from the future'. It is not exclusively the 'survival of the fittest' in the present environment, but, mainly, it is the realisation of subject's specific abilities and the compliance of the subject's (man's) gratifying personal activities (and the effects and results of these activities) with the needs of the coming, higher level of his/her integrated being. Thereby, the selection of a functionally suitable subject from the lower integrated level for the satisfaction of needs and requirements of the higher (above) organisational level of reality ("from the future", as "the higher organisational level (above)" is actually absent in the current existence of the person), e.g. of a child - into a school; of a schoolboy(girl) - into a university; of a student - into a vocational body; of a specialist - into the level of professional or societal management; etc.

5) Principle of the **unity of evolutionary levels** - 'of man's constant active creativity': at every period of man's postnatal life he/she is involved in the necessary micro-evolutionary processes at the current level of adaptation of his/her wellbeing - from 'infant forms up to mature form of stability' (metaphorically 'from an assistant to the professor'); and, at the same time, he/she ought to be - for the sake of his/her wellbeing and health - constantly integrated into the macro-process of his/her gratifying personal cosmist creativity: to produce the effects and gain the results of that activity and to make them available (and noticable for selection) for the higher integrated level of man's future existence (wellbeing).

6) Principle of **personal functional elitism**: the meaning of man's life is embedded in the successful ascendant evolution of man through all macro-levels of his/her being for the ultimate attainment, in the period of maturity, of specific (cosmist) personal macro-level of his/her being, to reach the man's personal specific (functional, of elite selection) contribution to the wellbeing of the whole CEPEL.

7) Together with the notions of biological and social evolution, the notion of the **personal cosmist evolution of the free civilised man** is characterized as the present-day forefront of the CEPEL. The further wellbeing of the CEPEL depends nowadays neither so much from the biological evolution (it reached its high point in the emergence of *Homo sapiens animalis*), nor from the social evolution (reaching its high point in the emergence of contemporary Western civilised society and *Homo sapiens sapiens*). Further continuation of the evolution is to-be-mission of a new evolutionary active subject - *Homo sapiens cosmicus*: the man, who is free from physical, biological, ecological and social harmful and oppressing

influences, and who is ready to realise his creative specific functional ability and contribute personally to the preservation and continuation of CEPEL.

The paragraphs given above were devoted to the brief description of the main framework of our ontological assumptions, deemed necessary for the comprehension of the phenomenon of individual health from the cosmist perspective.

We have elaborated - starting from the given set of assumptions - a philosophical system of deductive proposals and affirmations. However, its more detailed description would much exceed the space limit given to this paper (we would be happy to expose our deductions in future publications in *Medical Ethics & Bioethics*, or elsewhere, as well as to develop personal communication with the scholars interested in the subject).

To enable further discussion, we would like to introduce here a **new definition of the individual health**, based on our *cosmist dialectical* point of view: "The **individual health** refers to the successful unity of adaptational and creative processes of the human organism and personality."

In other words, individual health is the 'process of processes' ('ontogenesis of ontogeneses') of man's wellbeing. It comprises:

a) the man's successful ontogenetic macro-evolution (process of ascending integration of the whole man's being into the successively hierarchical levels (of ascending complexity) of man's specific (in given circumstances) integrated wellbeing); and, at the same time,

b) the regular and necessary man's micro-evolution (process of man's successful development and adaptation, from initial, elementary (infant) forms up to the mature 'homeostatic' forms and stages of man's integrated wellbeing on the given macro-evolutionary level).

In **conclusion**, we would like to observe, that our definition of individual health bears some similarity to the principles of Lennart Nordenfelt's conception of health, as expressed in his following statements: "a person's vital goals are states of affairs which are objectively related to his or her future happiness"; "expression of good health... must be founded on a concept of health, which refers to the uppermost level of organisation"; and "health is a predicate on the personal level" [3]. We also would like to refer to the position of WHO, calling to a "change of attitudes and organisation of health services, which refocuses on the total needs of the individual as a whole person" [4]. Thus, we believe, according to our cosmist position delineated in the paper, that personalism and holism are to become the essential approaches in developing strategies for ethically sound health promotion.

References

- [1] Pellegrino E. D.: The Metamorphosis of Medical Ethics: A 30-year Old Retrospective. *JAMA*, March 3, Vol. 269, 1993, No. 9, p. 1158 - 1162.
[2] Whitehead A. N.: Process and Reality: An Essay in Cosmology. The Macmillan Company, New York, 1967, 547 pages, p. 12. [3] Nordenfelt L.: Holism Reconsidered: A Reply to Taljedahl. *Scand. J. Soc. Med.*, Vol. 25, 1997, No. 4, p. 243 - 248. [4] The Ottawa Charter for Health Promotion. WHO Reg. Publ. Eur. Ser., Vol. 44, 1992, p. 1 - 7.

Khroutski, K. S.: Individual Health: New Definition and Ontological Background. [Individuálne zdravie: Nová definícia a jej ontologický základ.] *Medical Ethics & Bioethics (Bratislava)*, Vol. 7, 2000, No. 1 - 2, p. 14 - 17. Autor upozorňuje, že súčasná filozofia a veda nepovažujú otázku individuálneho zdravia za závažný filozofický alebo vedecký problém. Napriek tomu sa ukazuje naliehavá potreba vypracovať nové filozofické chápanie tohto významného teoretického (i 'praktického') pojmu. Autor uvádza vlastný systém ontologických predpokladov, zameraných na vytvorenie vhodného základu na pochopenie a

vedeckú analýzu fenoménu individuálneho zdravia. Jeho ontologický systém stavia na tradícii ruského filozofického kozmizmu, ktorej súčasťou sú pojmy ako vše-jednota a aktívna evolúcia. Vychádzajúc z uvedeného základu, autor navrhuje novú definíciu pojmu individuálne zdravie. **Kľúčové slová:** individuálne zdravie, kozmizmus, aktívna evolúcia, ruská filozofia.

Address for the correspondence: Dr. Konstantin S. Khroutski, Ph.D.; A/B 123, PO-25, Institute of Medical Education, Novgorod the Great, 173025 Russia.

(Od redakcie/Editorial - pokračovanie zo s. 1)

Táto situácia, trochu paradoxne, však neobyčajne zvýraznila potrebu nepokrytého etického zrkadla a ozajstného mravného úsilia a obrody v oblasti medicíny a zdravotníctva. Ukazuje sa stále jasnejšie, že bez konkrétnych skutkov konkrétnych ľudí, statočných, odvážnych a charakterovo pevných, to naozaj nepôjde...

Azda v tomto konkrétnom, až 'historickom' zápase možno vidieť i miesto a nezastupiteľné poslanie slovenskej bioetiky, alebo, ak chcete, postupne sa formujúcej 'slovenskej bioetickej školy'. Táto úloha je o to náročnejšia, že žijeme v období „bioetizácie“ súčasného kultúrneho i politického priestoru v medzinárodnom, ba globálnom meradle (napr. problémy klonovania, molekulárnej biológie a genetiky, ľudských práv v oblasti medicíny a zdravotnej starostlivosti, etc., sa denne dostávajú do centra pozornosti parlamentov, vlád, medzinárodných inštitúcií a organizácií - i všadeprítomných médií). Kritická a konštruktívna reflexia týchto etických problémov je nielen intelektuálnou povinnosťou voči našej odbornej i širšej verejnosti, ale aj nutnou podmienkou úspešného vstupu a fungovania Slovenska v politických, profesionálnych, odborných i kultúrnych štruktúrach zjednocujúcej sa Európy a sveta. Je tiež možnosťou priniesť vlastný, špecifický príspevok k tomu, aby sa tieto štruktúry a ich činnosť viac približovali ideálom pravdy, spravodlivosti a pravej humanity.

Náš časopis, milí priatelia, chce byť, spolu s vami, i v budúcom období aktívne a informované 'pri tom'.

Jozef Glasa
vedúci redaktor

The First Decade of Slovak Bioethics ¹

Dear friends,

in this Jubilee Year 2000, we remember also a small jubilee of bioethics in Slovakia - the first decade of its existence and development, that has started from very modest beginnings. After the 'Velvet Revolution' of 1989, the Slovak medicine and health care, together with the whole society and people of Slovakia were facing a major, multifaceted transformation of nearly all aspects of economical, social and cultural life. The 'late' ideology of marxism - leninism left behind disastrous intellectual, but also moral ruins; devastation, the depth and extent of which became only partially visible during the previous 10 years, while it is still being shown in various problems we struggle with at different levels of management, power, cultural creativity, and even a philosophical and creative artistic reflection.

The reform of the health care system posed a challenge to the restoration of its moral integrity and reflection on the 'old' and brand new problems. This was to

take place in the situation of a growing political, cultural and „ethical“ pluralism. Since the very beginning, the situation has been complicated by the scarcity of financial resources, due to the difficult economical situation in the period of deep transformation changes. Therefore, the questions of efficacy and effectiveness, accessibility and rationing of the health care were dominating the 'practical' discussions and public debates. The preservation of personal moral integrity in the situation of scarcity of necessary resources and increasing pressures from patients, general public, health insurance companies and health administrations, surely is both an ethical problem and an issue of personal moral struggle, that is being faced nowadays by many Slovak health care professionals. Even a more difficult struggle accompanies the efforts of health care workers to maintain, or even improve the quality of the care provided. Demoralisation effects of 'clientelism', widespread 'tipping' of decision-makers, morally unacceptable methods of influencing doctors' prescribing and ministerial reimbursement categorisation of drugs, un-professional, top-down influence on the management of health care organisations, as well as a lot of obvious organisational and systemic mess (profitable for certain interest groups or concrete persons) and a lot of 'dilettantism' leading to serious mistakes and considerable wastes, they all seemingly shift ethics, ethical reflection and decision-making outside the margins of common interest, to the sphere of mere 'nice words' and 'beautiful wishes', with no impact upon the reality of everyday's life.

This situation, however, shows even more clearly the necessity of an undistorted ethical mirror, and a real moral effort and revival in both the field of medicine and health care. Yes, it becomes more visible (though not more appreciated), that there is no possibility for a change to better without concrete moral deeds of concrete, morally sane people.

It might be expected, that in this concrete, 'historical' struggle, the Slovak bioethics, or, if you want - the gradually growing Slovak bioethics school, finds its proper place and an irreplaceable destiny. The tasks faced by the Slovak bioethicists today are even more demanding, as we live in the period of „bioethisation“ of the overall cultural and political space in the national, international, or even global arena (e.g. the problems of human cloning, molecular biology and genetics, human rights in medicine and health care, etc., being in the centre of attention of the parliaments, governments, international institutions and organisations - and the media). Critical and constructive reflection of the ethical problems should be seen not only as an intellectual duty towards our professional and general public, but also as a '*conditio sine qua non*' for a successful entering and 'functioning' of Slovakia in the political, professional, scientific and cultural structures of Europe and the World. At the same time, it provides for a challenging opportunity to bring in our own, specific contribution, to bring these international structures and their work nearer to the ideals of truth, justice and genuine humanity.

Our journal, dear friends, is eager „to be in“, together with all of you, as an active and well-informed participant.

Jozef Glasa
Editor

¹ Editorial - English translation of the Slovak text from p. 1, 17.

EUROPEAN PARLIAMENT RESOLUTION ON HUMAN CLONING

The European Parliament,

- having regard to the proposal by the United Kingdom Government to permit medical research using embryos created by cell nuclear replacement (so-called „therapeutic cloning“),

- having regard to its resolutions of 16 March 1989 on the ethical and legal problems of genetic engineering (1) and on artificial insemination „in vivo“ and „in vitro“ (2), of 28 October 1993 on the cloning of the human embryo (3), of 12 March 1997 on cloning (4), of 15 January 1998 on human cloning (5), and of 30 March 2000 (6),

- having regard to the Council of Europe's Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine - the Convention on human rights and bio-medicine - and its own resolution of 20 September 1996 on this subject (7), and the additional protocol which forbids the cloning of human beings,

- having regard to Recommendation 1046 of the Parliamentary Assembly of the Council of Europe on the use of human embryos,

- having regard to the Community's Fifth Framework Research Programme and specific programmes thereunder,

- having regard to Directive 98/44/EC of the European Parliament and of the Council of 6 July 1998 on the legal protection of biotechnological inventions (8),

A. whereas human dignity and the consequent value of each human being are the main aims of Member States, as stated in many modern constitutions,

B. whereas the undoubted need for medical research resulting from advances in knowledge of human genetics must be balanced against strict ethical and social constraints,

C. whereas there are other ways than embryonic cloning of curing serious illnesses, such as those that involve taking stem cells from adults or from the umbilical cords of new-born babies, and other external causes of disease which require research,

D. whereas the Fifth Framework programme and Council Decision 1999/167/EC of 25 January 1999 adopting a specific programme for research, technological development and demonstration on quality of life and management of living resources (1998 to 2002) state „In the same way, no research activity understood in the sense of the term „cloning“, with the aim of replacing a germ or embryo cell nucleus with that of the cell of any individual, a cell from an embryo or a cell coming from a later stage of development to the human embryo, will be supported“,

E. whereas therefore there is a prohibition on the use of Community funds, either directly or indirectly, for any such research,

F. whereas aforementioned Directive 98/44/EC states that there is a consensus within the Community that interventions in the human germ line and the cloning of human beings offends against ordre public and morality,

G. whereas an attempt is being made to use linguistic sleight of hand to erode the moral significance of human cloning,

H. whereas there is no difference between cloning for therapeutic purposes and cloning for the purposes of reproduction, and whereas any relaxation of the present ban will lead to pressure for further developments in embryo production and usage,

I. whereas Parliament defines human cloning as the creation of human embryos having the same genetic make-up as another human being, dead or alive, at any stage of their development, without any possible distinction as regards the method used,

J. whereas the proposals of the United Kingdom Government require the assent of the Members of both Houses of the United Kingdom Parliament, who are to be permitted a free vote of conscience on the issue,

1. Believes that human rights and respect for human dignity and human life must be the constant aim of political legislative activity;

2. Considers that „therapeutic cloning“, which involves the creation of human embryos solely for research purposes, poses a profound ethical dilemma, irreversibly crosses a boundary in research norms and is contrary to public policy as adopted by the European Union;

3. Calls the UK Government to review its position on human embryo cloning and calls on its honourable colleagues, the Members of the United Kingdom Parliament, to exercise their votes of conscience and reject the proposal to permit research using embryos created by cell nuclear transfer when it is laid before them;

4. Repeats its call to each Member State to enact binding legislation prohibiting all research into any kind of human cloning within its territory and providing for criminal penalties for any breach;

5. Urges maximum political, legislative, scientific and economic efforts to be aimed at therapies that use stem cells taken from adult subjects;

6. Reaffirms its support for biotechnological scientific research in medicine, provided that is balanced against strict ethical and social constraints;

7. Renews its call for human artificial insemination techniques that do not produce an excess number of embryos in order to avoid generating superfluous embryos;

8. Calls on the appropriate national and Community authorities to ensure that the ban on patenting or cloning human beings is reaffirmed and to adopt rules to this end;

9. Calls on the Commission to guarantee full respect for the terms of the Fifth Framework Programme and all specific programmes thereunder, and points out that the best way to implement this decision is to ensure that no research institution that is in any way involved in the cloning of human embryos gets money from the EU budget for any of their work;

10. Repeats its insistence that there should be a universal and specific ban at the level of the United Nations on the cloning of human beings at all stages of formation and development;

11. Considers that any temporary committee set up by this Parliament to examine the ethical and legal issues raised by new developments in human genetics should take as a starting point the views already expressed in resolutions of this House. The committee should examine questions for which Parliament has not yet expressed a clear position. Its powers, composition and term of office shall be defined on a proposal from the Conference of Presidents, without any limitation of the powers of the permanent committee responsible for matters relating to the monitoring and the application of Community law on these issues;

12. Instructs its President to forward this resolution to the Commission, the Council, the governments of the Member States, the Members of the UK Parliament, and the Secretary-General of the United Nations.

Notes

(1) OJ C 96, 17.4.1989, p. 165. (2) OJ C 96, 17.4.1989, p. 171. (3) OJ C 315, 22.11.1993, p. 224. (4) OJ C 115, 14.4.1997, p. 92. (5) OJ C 34, 2.2.1998, p. 164. (6) Texts Adopted, Item 9. (7) OJ C 320, 20.9.1996, p. 268. (8) OJ L 213, 30.7.1998, p. 13.

REFLECTIONS ON THE UNITED STATES NATIONAL INSTITUTES OF HEALTH DRAFT GUIDELINES FOR RESEARCH INVOLVING HUMAN PLURIPOTENT STEM CELLS – THEOLOGICAL PERSPECTIVE

James J. Sotis

Trinity Graduate School, Deerfield, IL (USA)

Abstract

Since the human embryonic stem cell research involves destruction of human embryos and, therefore, hinges on the fundamental question of the status of the embryo, it is essential to examine this status carefully in order to establish fitting guidelines for research. The US National Institutes of Health has proposed its own guidelines on the matter recently (1999). The document, rooted in current pluralistic perspectives in moral philosophy (or bioethics), is criticised in this paper as morally inadequate. The argumentation of the criticism stems from the theological perspective on human personhood, which focuses on a continuity of personal identity from embryos to adult human beings. An additional concern for the author is the moral complicity in which the research dependent upon the destruction of human embryonic life is sanctioned.

Key words: human embryonic stem cells, research, NIH guidelines, criticism, theological perspective, human personhood

Introduction

Since two US research teams independently isolated and cultured human embryonic stem cells in November 1998, much focus has been given to the promising medical benefits of stem cell research. Due to the potential of such research, the US National Institutes of Health [1] has proposed guidelines for research on human embryonic stem cells, whose derivation from human embryos, however, is dependent upon the destruction of the embryo. [2] Although the debate continues as to the legality of human embryo research, the US Department of Health and Human Services (DHHS) has attempted to interpret the current law in such a manner which would allow them to federally fund stem cell research. The NIH's approach, although commendable in its desire to aid in the advancement of medicine, is morally problematic as outlined in the drafted guidelines for research involving human pluripotent stem cells.

Philosophical/Ethical Underpinnings of NIH Proposed Guidelines

Since stem cell research involves the destruction of human embryos and, therefore, hinges on the fundamental question of the status of the embryo, it is essential to examine this status carefully in order to establish fitting guidelines for research. The DHHS recognized that fact back in 1994 when the Human Embryo Research Panel convened and decided that an appropriate approach to

the issue of personhood is one that is pluralistic in its orientation. A pluralistic approach rejects a simple single criterion approach, basing personhood solely on factors such as the capacity to experience pain, the beginning of brain activity, or some degree of cognitive development. The NIH affirms that an appropriate regard for the status of the human embryo encompasses a multiplicity of factors such as genetic uniqueness, potentiality for development of sentience, brain function, and a degree of relational presence. Although the panel decided that a single criteria approach was insufficient in establishing personhood, they concluded that the „developing presence [of these qualities] in an entity increases its moral status until, at some point, full and equal protectability is required.“ [3] Therefore, the panel recommended that research be limited to the window of opportunity prior to the fourteenth day of development post-conception, at which time significant differentiation takes place marked by the development of the primitive streak. A principle of respect was thereby initiated for the embryo, which, although it provides protection, requires different considerations and entails different obligations at different developmental stages. [4, 5, 6]

Therefore, with differing degrees of protection and obligation, seemingly justifiable research is not ruled out. Currently, the DHHS is prohibited by the US Congressional appropriations law to fund „the creation of a human embryo or embryos for research purposes; or research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death...“ [7] However, the DHHS sought legal counsel and determined that the current restriction does not pertain to the use of human pluripotent stem cells, for such cells are not embryos. [8] Thus, federal funding of the use of stem cells in research (whether obtained from an human embryo or human fetal tissue) is not regarded by the DHHS to be illegal within their interpretation of the current statute, but only funding for the *derivation* of stem cells from a human embryo is regarded as such. Therefore, as long as the derivation of these stem cells (and hence the destruction of the embryo) does not receive federal funds, the DHHS believes it is morally and legally permissible to fund research that utilizes such derived stem cells. The NIH has proposed, therefore, these strict guidelines for the oversight and direction of this research arguing that it will provide what is lacking if funding for this research were only accessible from the private sector. [9]

Theological Response to Personhood

As previously articulated, stem cell research hinges on the fundamental question concerning the status of the human embryo. If one accepts the pluralistic approach, as the NIH proposes, then one is hard pressed to define at which point the developing fetus has full and equal protection as a person within the greater human community. The NIH's own statement suggests that it occurs at some point, yet they do not fully elaborate on their perspective. [10] This begs numerous questions, „At what point along the developmental trajectory does the embryo become a person requiring this kind of protection? At implantation? At fourteen days? At twelve weeks? At twenty-four weeks? At birth? At some developmental age when it gains full cognitive awareness of its existence?“ From a pluralistic perspective, it is seemingly impossible to come to a definitive conclusion regarding this decisive point. Thus, the indeterminate nature of this approach contributes to its moral inadequacy.

A theological perspective on personhood, on the other hand, focuses on a continuity of personal identity

from embryos to adult human beings. [11] The view of personhood from Scripture is based on the fundamental belief that God has created human beings in His image. [12] Based on and flowing from God's definitive work of creation is the regard for all human life as sacred. [13] Thus, the theological perspective is neither dependent on the developmental stage of an embryo nor on its ability or capacity to perform certain functions. It centers on the ontological status of humans as divine image-bearers.

One biblical passage often cited in reference to the issue of personhood is the 139th chapter of the book of Psalms. King David reverently and conclusively writes from a perspective that strongly reinforces the biblical view of personal continuity. He addresses the issue of God's omniscience in regard to his present life (v.1-6), the possibly hypothetical implications of future choices to elude that knowledge (v.7-12) and the complex formation of the psalmist within his mother's womb (v.13-16). God is described as one whose vast and intimate knowledge of our lives extends throughout the continuum of life, from unformed substance to adulthood. Rae and Cox address the use of the term „unformed substance“ by citing its translation by the primary lexicon for the Old Testament as „embryo“. [14] However, one may still maintain that the passage is indecisive as to which definitive point along the development of the embryo the psalmist is referring. Even so, one need only look to another of the Psalmist's writings to grasp his understanding of personhood. In the 51st psalm, he laments not only his sins as an adult but also his inclination to sin from the very time of his conception. [15] Thus, the psalmist clearly points out that there is continuity of personal identity from the earliest stage of gestational development to the most developed stage of adulthood. He signifies that the human person to whom he refers as being woven together in the womb is the same person who now praises his Creator. [16]

Therefore, a view of personhood, which encompasses a continuity of personal identity, has significant implications for human stem cell research. Since personhood is established as early as conception, an embryo at each of its developmental stages has the right to full and equal protection. It not only has the right to respect, but also to life and, subsequently, to protection from harm. Thus, research, which requires the destruction of the human embryo, is morally problematic and is not justified regardless of the potential medical benefit. The utilitarian spirit of the age has already produced numerous scientific tragedies in the name of medical advancement at the cost of hundreds and thousands of human lives. [17] Human embryonic stem cell research is, therefore, both theologically and ethically proscribed.

Moral Complicity

Alexander Capron, in an article in the Hastings Center Report, traces the current history of the increasing controversy surrounding human stem cell research. [18] He cites the two independent laboratories which successfully isolated and cultured human stem cells, one removing the cells from the inner mass of blastocysts from excess embryos donated by IVF clinics, and the other obtaining the cells from the primordial germ line of aborted fetuses. The distinction between these two cell sources has been made in that US law currently allows for federal funds to be used for human fetal tissue research. However, as was alluded to previously, the current law also forbids any federally funded research in which human embryos would necessarily die. In January 1999, the NIH sought legal counsel and was advised that since the human embryonic pluripotent stem cells do not have the totipotency of earlier cells, these extracted

stem cells do not carry the potential to develop into full human beings and, therefore, are not embryos. Thus, the NIH believes that it will still be within the confines of the law by funding research on such cells.

Capron further explains that this legal circumlocution is rather puzzling. The government seemingly has found a way to allow for federal funding of research on human stem cells but it will not allow funding for the creation of the means by which those cells are obtained for that research. Capron likens the NIH to the shoemaker who surprisingly finds finished shoes each morning. Yet, as he suggests, would they be naive enough to think that tiny little helpers make the stem cells in the night? [19] His point is compelling regarding the seeming naiveté that the NIH is promoting in welcoming a circumvention which fails to recognize what the law may have intended in the first place. What did the US Congress mean when they passed the law emphatically stating that it was illegal for human embryos to be killed in order to perform experimental procedures? Was their intention to guard against the creation of embryos for research purposes but to implicitly permit the destruction and discarding of those entities they sought to protect through their law as long as federal funds were not used in the process? It is highly unlikely that this is the case.

One apparent observation is that, in terms of the law, the NIH's desired proposals to federally fund stem cell research result in the very act of moral complicity. A brief explanation of moral complicity is necessary for our discussion: „Complicity rests on the premise that someone whom the law interchangeably calls an accessory, accomplice, aider and abettor, secondary party, or to whom I refer as a helper in his principal's offense is derivatively, not vicariously, liable for that offense. The difference between derivative and vicarious liability is that, unlike vicarious liability, derivative liability is based on the defendant's own actions, not merely on his relationship with someone else. Derivative liability and therefore punishment is shared equally among principals and helpers. Proof of the helper's derivative liability is heavily mediated by the conduct and attitude of the principal. If the principal commits a crime, then equal credit goes to the helper as well, provided that the crime which occurs is one the helper knew about and whose success the helper intended when he provided his assistance.“ [20]

Though the argument can be made that it is not forbidden by law for private funds to be used to support human stem cell research and precursory removal of stem cells from either embryos or fetuses, it is nearsighted in its approach. The real issue then becomes one of moral complicity rather than legal liability. If the US Congress believes the federal funding of the destruction of human embryos is illegal (albeit fully human or not, they inarguably constitute human life), there must be just moral cause for their position rather than a simple pragmatic reason. Therefore, couched in Yeager's legal terms, it is apparent that the created demand for human embryonic stem cells results in the NIH being derivatively liable for the destruction of human embryos.

One appropriate theological response draws our attention to the wisdom literature of the biblical book of Proverbs. The author's imperatives are morally relevant for our current dilemma: „Rescue those being led away to death; hold back those staggering toward slaughter. If you say, 'But we knew nothing about this,' does not he who weighs the heart perceive it? Does not he who guards your life know it? Will he not repay each person according to what he has done?“

[21] A few observations regarding this text will aid in our understanding. First, it appears from the author's perspective that there is a certain group who is being helplessly led away to death and destruction. The author is seemingly one step ahead of us when he sets before us our own justifying response, „But we didn't know that they were being led away!“ He further elaborates that there is One who weighs (or as the Hebrew implies „judges justly“) the hearts of men and is familiar with their unspoken motives. What is more, as much as Yeager's language illustrates the legal injustice of complicity, the proverbial author states that there are moral and possibly spiritual consequences for such actions. It is clear that, whether through self-perpetuated denial or active indirect demand, one is derivatively liable if one is morally complicit. Therefore, according to proverbial wisdom, the befitting response to the current bioethical situation is two-fold: 1) to engage in active „rescue“ of such embryos which are being led away to destruction by promoting such legislation that will stop the use of embryos in research and 2) to engage in long range policy formation that will promote alternative forms of substantially beneficial research on alternative sources of stem cells (e.g. adult and animal stem cells) in order that treatments and cures might be developed. [22]

Conclusion

The NIH's proposed guidelines assume a position on the status of the human embryo that is morally inadequate. A pluralistic approach allows for such justifiable experimentation in which human embryos are destroyed in the name of potential medical benefit. A theological perspective of personhood focuses on the continuity of personal identity, thus, indicting any such research that destroys the life of a human embryo. Furthermore, an additional concern is the moral complicity in which the NIH is engaging by sanctioning research dependent upon the destruction of human embryonic life. It is, therefore, my strongest opinion that the NIH should not fund human pluripotent stem cell research for the aforementioned reasons.

Endnotes

[1] Department of Health and Human Services, Draft National Institutes of Health Guidelines Involving Human Pluripotent Stem Cells, <http://www.nih.gov/news/stemcell/draftguidelines.htm>, 12/1/99, p.1. [2] The Center for Bioethics and Human Dignity's statement On Human Embryos and Stem Cell Research: An Appeal for Legality and Ethically Responsible Science and Public Policy. [3] Scott B. Rae, Paul M. Cox, and the Center for Bioethics and Human Dignity, *Bioethics: A Christian Approach in a Pluralistic Age* (Grand Rapids: Eerdmans, 1999), p.173. Rae and Cox gathered their information regarding the NIH approach from the National Institutes of Health Human Embryo Research Panel, Report of the Human Embryo Research Panel (Washington, DC: National Institutes of Health, 27 September 1994). These criteria are also affirmed by the ethics advisory board of Geron Corporation (one of the research groups responsible for establishing a cell line). [4] Rae and Cox, p.173. [5] Geron Ethics Advisory Board, „Research with Human Embryonic Stem Cells: Ethical Considerations,“ *Hastings Center Report*, 29, No. 2 (1999), p.32. [6] The US National Bioethics Advisory Commission also has adopted a principle of respect regarding the human embryo in their report on human stem cell research in which they articulate that the human embryo and fetus alike „deserve respect as forms of human life“. Although their position is equally as problematic, a formal critique of their report is outside the bounds of this article. For their report and recommendations on human stem cell research, see National Bioethics Advisory Commission, *Ethical Issues in Human Stem Cell Research: Volume I, Report and Recommendations of the National Bioethics Advisory Commission*, (Rockville, Maryland: NBAC, September 1999). [7] United States Public Law 105-277, section 511, 112 STAT. 2681-386. [8] NIH Draft Guidelines, p.2. [9] *Ibid.*, p.2. [10] Rae and Cox, p.173. Rae and Cox states that the NIH leaves this point unspecified in the report. [11] Rae and Cox, p.162. [12] Genesis 1:26-7; 9:6. All biblical scriptures are taken from the Holy Bible, New International Version, (International Bible

Society, 1973). [13] Exodus 20:13; Deuteronomy 5:17. [14] Rae and Cox, p.133. [15] Psalm 51:4,5. Rae and Cox elaborate more on this specific text in their fourth chapter. [16] Rae and Cox, p.133. [17] The Center for Bioethics and Human Dignity's statement On Human Embryos and Stem Cell Research: An Appeal for Legality and Ethically Responsible Science and Public Policy. [18] Alexander Morgan Capron, „Good Intentions,“ *Hastings Center Report*, 29, No. 2 (1999): p.26-7. [19] Capron, p.27. [20] Daniel Yeager, „Helping, Doing, and the Grammar of Complicity,“ *Criminal Justice Ethics*, 15 (Winter/Spring 1996): p.25-35. [21] Proverbs 24:11,12. [22] The potential medical benefit of such research is contested by the National Bioethics Advisory Commission in their report on human stem cell research.

J. J. Sotis: Reflections on the United States National Institutes of Health Draft Guidelines for Research Involving Human Pluripotent Stem Cells - Theological perspective. [Úvahy o US NIH Návrhu smerníc pre výskum ľudských pluripotentných kmeňových buniek.] *Medicínska etika & Bioetika [Medical Ethics & Bioethics]*, Vol. 7, 2000, No. 1 - 2, p. 19 - 21. Nakoľko výskum ľudských embryonálnych kmeňových buniek zahŕňa deštrukciu ľudských embryí, a preto sa dotýka závažnej otázky morálneho statusu ľudského zárodka, je nevyhnutné starostlivo skúmať a definovať tento status, aby bolo možné vytvoriť náležité smernice pre tento výskum. Americký Národný ústav zdravia (NIH) nedávno publikoval návrh vlastných etických smerníc (v roku 1999). Dokument, ktorý vychádza z aktuálneho pluralizmu v súčasnej morálnej filozofii (či bioetike), sa v práci kritizuje ako morálne neadekvátny. Argumentácia autora vychádza najmä z teologického chápania ľudskej osoby a zameriava sa na kontinuitu osobnej identity človeka, počnúc ľudským zárodkom až do dospelosti. Autor si všíma aj jav „morálneho spolupáchateľstva“, keď štátna inštitúcia (NIH) podporuje výskum, založený na deštrukcii ľudského embryonálneho života. *Kľúčové slová:* ľudské embryonálne kmeňové bunky, výskum, smernice NIH (USA), kritika, teologická perspektíva, ľudská osoba.

Address for correspondence: James J. Sotis, MA Cand., Trinity Graduate School, D-931, 2065 Half Day Road, Deerfield, IL 60015, USA.

O KNIHÁCH / BOOK REVIEWS

MORÁLNE OTÁZKY PSYCHOLÓGIE

Personalistický príspevok k vybraným problémom [Moral Issues in Psychology. Personalist Contributions to Selected Problems] Edited by James M. DuBois, University Press of America, Inc., Lanham, New York, London, 1997, 176 strán, ISBN 0-7618-0543-5

Súčasná psychológia predstavuje veľmi široké pole výskumu a praxe v zdravotníctve, poradenstve a sociálnych službách, personalistike, manažmente, politike atď. Kdekoľvek sa však prejavuje jej pôsobenie, vždy sa dotýka človeka. Ak chce však dobre plniť rozličné špeciálne ciele, zvlášť vo svojej službe človeku, nemôže sa vyhnúť konfrontácii s určitými morálnymi otázkami a ich riešením. Predkladaná publikácia *Morálne otázky psychológie*, je jedinečným príkladom takejto konštruktívnej konfrontácie. Vznikla ako zborník prednášok 2. výročnej konferencie Inštitútu personalistickej psychológie (Institute for Personalist Psychology, Univerzita Dallas (TX), október 1995). Okrem vyžiadovaných referátov obsahuje aj spracovaný záznam diskusného fóra konferencie. Jednotlivé príspevky formulujú a skúmajú viaceré kľúčové morálne otázky zaujímavé pre psychológov, psychiatrov, či pracovníkov v poradenstve.

Publikácia je rozdelená do 3 častí: 1. Základné otázky psychológie morálky a morálnej výchovy [Fundamental issues in moral psychology and education], 2. Zaobchá-

dzanie s nenávisťou a bolesťou [Dealing with hatred and pain]. 3. Morálka a výzva naturalizmu [Morality and the challenge of naturalism].

Prvá časť začína príspevkom Marvina W. Berkowitza „Dokonalá morálna osoba: Anatómia a formácia“ [The complete moral person: Anatomy and formation]. Upozorňuje, že súčasné prístupy k modernej morálnej výchove sú príliš polarizované a vzájomne súperia. Pritom je tu naopak potrebná integrácia, a to predovšetkým kognitívne-vývinových prístupov a prístupov zameraných na formovanie charakteru. Táto vyžaduje základný model, ktorý by definoval morálnu osobu - potrebuje „morálnu anatómiu.“ Morálna anatómia, ktorú ponúka a podrobne rozoberá Berkowitz, je jedným z najúplnejších modelov, ktoré sú v psychológii k dispozícii a zahŕňa nasledovné komponenty: 1) morálne správanie, 2) morálny charakter, 3) morálne hodnoty, 4) morálny úsudok, 5) morálne cítenie a 6) morálnu identitu. K základným morálnym komponentom patria aj meta-morálne charakteristiky osoby - ako je sebadisciplína a empatia. Ako také nie sú súčasťou morálnej anatómie, ale významne morálny život osoby podporujú. V ďalšej časti si autor kladie otázku, aký by bol najlepší výchovný spôsob pri formovaní plne morálnej osoby. V logickej nadväznosti na rozoberané morálne charakteristiky osoby sa pokúša ukázať rodičom a pedagógom, ako by mali postupovať pri tejto formácii. Záverečný rozbor morálneho vývinu je inšpiráciou rovnako pre výchovu i teóriu. Snaží sa prekonať existujúce rozpory jednotlivých teórií a výchovných prístupov v záujme uznania toho, čo je v jednotlivých modeloch hodnotné.

Josef Seifert („Morálne dobro a duševné zdravie“ [Moral goodness and mental health]) na základe krátkeho rozboru základných pojmov, vrátane definície zdravia WHO rozoberá vzájomné vzťahy medzi morálnym dobrom a duševným zdravím a morálnym zlom a duševnou chorobou. Podľa neho nie je duševná choroba žiadnou morálnou chybou, tak ako ani duševné zdravie nie je nijakou čnosťou. Uznáva ďalej, že istá úroveň duševného zdravia je pre morálku potrebná. Vzťah medzi morálnym dobrom a duševným zdravím však v tomto bode nekončí. Zdôrazňuje, že duševné zdravie vyžaduje schopnosť rozlišovať medzi dobrom a zlom, a tiež že morálne zlo môže prispievať k deštrukcii racionality, ktorá je základným elementom duševného zdravia.

Druhá časť publikácie sa venuje niektorým konkrétnym problémom, ktoré prináša klinická prax. Paul C. Vitz a Philip Mango („Nenávisť a odpustenie: hlavné dilemy sekulárnej psychológie“ [Hatred and forgiveness: Major moral dilemmas in secular psychology]) sa venujú rozboru problému nenávisťi a odpustenia. Nenávisť (príčom rozlišujú medzi hnevom a nenávisťou) má znaky obranného mechanizmu, ale je aj udržiavaná vôľou. Služí človeku ako ochrana pred bolesťou, ale za príliš vysokú cenu. Nenávisť oberá človeka o pokoj a radosť. Odpustenie predstavuje uzdravujúci akt a primeranú odpoveď na nenávisť. Predstavuje proces, ktorý zahŕňa štádiá podobné štádiám zármutku, ktoré rozpracováva Kubler-Rossová. Každé štádium má svoje vlastné požiadavky, vrátane stálej tendencie k falošnému, pseudo-odpusteniu, ktoré môže nadobúdať rozličné podoby (narcistickej kondenzácie, poretia, rekatívneho výtvaru, prepracovania, neurotickej závislosti, symbiózy, manipulatívneho používania moci).

Robert Kugelmann („Byť zodpovedný za bolesť: rozpory v ovládaní bolesti“ [Becoming responsible for pain: Contradictions in pain management]) si všimá konflikt medzi slobodou a determinizmom na príklade moderných programov ovládania chronickej bolesti (inšpirované holistickým hnutím v sedemdesiatych rokoch, zdôrazňujúcim zmenu v životnom štýle pacientov).

Tretia časť publikácie prináša tri príspevky, v ktorých

sa konfrontuje psychológia s výzvou naturalizmu (názor, že všetkému okolo nás je možné porozumieť pomocou prírodných zákonov). Pre naturalizmus je typické, že vidí zmysel morálneho kódexu jednoducho v zachovaní existencie prírody, alebo možnosti sprítomnenia jej rozličných potenciálov, vrátane tých potenciálov, ktoré majú svoj základ v inštinktoch. Obsahuje dve debaty: 1. diskusiu medzi Howardom H. Kendlerom a Johnom F. Crossom („Môže psychológia objaviť morálne normy?“ [Can psychology discover moral norms?]) a 2. Richardom W. Crossom a Johnom R. Whitom („Psychológia a filozofia: styčné body a body divergencie“ [Psychology and philosophy: Points of contact and divergence]).

Publikáciu uzatvára skvelý príspevok Jeffrey Satinovera - „Gnostické jadro Jungovej psychológie: Radiačný efekt na morálny poriadok“ [The gnostic core of Jungian psychology: Radiating effects on the moral order] analyzujúci etické aspekty jungiánskej psychológie. V prílohe knihy je uvedený materiál zhrňujúci filozofické princípy personalistickej psychológie.

Zborník je vítaným príspevkom pre bližšie poznanie modernej, personalistickej orientovanej psychológie. Je poučným i intelektuálne stimulujúcim čítaním. Odporúčame záujemcom o hlbšiu analýzu etických problémov súčasnej psychológie, tak z pohľadu filozofickej, resp. antropologickej teórie, ako aj z aspektu praktickej klinickej, resp. terapeutickéj a poradenskej praxe.

PhDr. Mária Glasová, PhD.
Katedra psychológie a patopsychológie
PDF UK Bratislava

ZDRAVÁ RODINA - ZÁKLAD DEMOKRATICKEHO ŠTÁTU V EURÓPE 2000

T. Lenczová (Ed.), Slovenská spoločnosť pre rodinu a zodpovedné rodičovstvo, Bratislava, 2000, pb, 148 strán.

„Zdravá rodina, zdravá najmä vo svojich vzťahoch a hodnotách, má integrujúci vplyv na osobnosť mladého človeka i na stabilitu osobnosti dospelých. Je najúčinnnejšou prevenciou rôznych nezdravých javov v spoločnosti (drogovej závislosti, predčasného a neviazaného sexuálneho správania, prejavov násillia, vandalstva, atď.).“ Na druhej strane, ak je rodina problémová, rozvrátená, chýbajúce pozitívne pôsobenie na formovanie osobnosti človeka a jeho život nedokážu nahradiť ani škola, cirkvi, štátne, súkromné alebo verejno-prospešné organizácie a iniciatívy. Náhradné výchovné zariadenia, policajné, alebo iné represívne opatrenia sú drahé a pomerne málo účinné. Ekonomické náklady na riešenie prejavov spoločenskej patológie a ich dôsledkov z roka na rok i na Slovensku rastú. Prevenciou je posilňovanie a podpora rodín vhodnými opatreniami štátnej rodinnej politiky, ako aj vytváraním pre rodinu priaznivej spoločenskej klímy.

Zdravá rodina nie je hotový stav, ale neustály proces. „Každá reálna rodina je ovplyvňovaná prostredím, v ktorom vzniká a funguje, hodnotami i hmotnými podmienkami, spoločenskou klímou, individuálnou a verejnou akceptáciou a podporou rodinných hodnôt. Je ovplyvňovaná prostredím širšej rodiny, legislatívou a opatreniami rodinnej a sociálnej politiky štátu, neformálnymi vzťahmi vzájomnej medzirodinnej svojpomoci i inštitucionálnou podporou zo strany štátu, cirkví a samosprávnych orgánov. Výsledkom procesu aktívnej i pasívnej komunikácie rodín s prostredím a zachovávaním vlastných hodnôt a životného štýlu je úroveň vzťahov, spôsobov uspokojovania potrieb a aktívne napĺňanie rodinných funkcií v každej konkrétnej rodine.“

Spomenuté problémy a súvislosti boli predmetom rovnomennej konferencie, konanej 19. mája 2000 v Bra-

tlavce. Jej výsledkom je referovaná kniha. Predstavuje veľmi cenný súbor odborných príspevkov a materiálov, redigovaný vedeckou tajomníčkou a hlavnou organizátorkou konferencie. Hlavným vydavateľom publikácie, ktorá vyšla s podporou Ministerstva práce, sociálnych vecí a rodiny Slovenskej republiky a v spolupráci s Výskumným ústavom práce, sociálnych vecí a rodiny v Bratislave, je Slovenská spoločnosť pre rodinu a zodpovedné rodičovstvo. Veľkým kladom publikácie je jej vysoká aktuálnosť.

Kniha je rozdelená do piatich tematických celkov.

Prvá časť predstavuje pohľad odborníkov na rodinu ako prirodzenú inštitúciu ľudských dejín, ktorá ani na prahu 3. tisícročia nestratila na svojej oprávnenosti a aktuálnosti: istoty zdravej rodiny, ako základná podmienka úspešnej výchovy mladej generácie (M. Potočárová); pohľad mladých dospelých na generáciu svojich rodičov (M. Košč); konfrontácia ideálu a reality s ohľadom na psychologické a sociálne aspekty na prelome storočí, a súčasné trendy vývoja rodinnej problematiky vo svete i na Slovensku (M. Glasová); postavenie dieťaťa (M. Mojžesová), matky (M. Černáková), muža a ženy v rodine z pohľadu delby domácich povinností (Z. Vránová).

Skúsenosti mimovládnych organizácií pracujúcich v prospech rodiny sú náplňou druhej časti publikácie: rodina a škola (C. Danišová); pomoc deťom z patologických rodín, deťom týraným, zanedbávaným a zneužívaným (E. Kúdelková, I. Hukelová); deťom so zdravotnými problémami (A. Chrebetová); výuka prirodzených metód plánovania rodičovstva (J. Predáč); pomoc pri rozbehu malého rodinného podnikania (S. Porubánová). Poznatky štátnych organizácií pracujúcich v prospech rodiny (III. časť) reprezentuje príspevok o rodine z hľadiska poradensko - psychologických služieb na Slovensku (J. Kusá). Táto časť obsahuje aj krátku úvahu o rodine z pera Chiary Lubich, zakladateľky hnutia Focolare.

Vo štvrtnej časti knihy sa rozoberajú rôzne aspekty pozície rodiny na Slovensku a v rámci rodinnej politiky: v európskom kontexte (M. Wingen, Nemecko); v politike OSN (M. Freiová, Česká republika); v oblasti výskumu (R. Bednárík); účinnosti rodinnej politiky (K. Pastor); spolupráce rodiny a samosprávy (M. Demeterová); rodinnej legislatívy v Slovenskej republike (J. Mikloško st.; K. Tuhárska).

Piata časť publikácie obsahuje informácie o realizácii rodinnej politiky na Slovensku z hľadiska príslušných ministerstiev: Ministerstvo práce, sociálnych vecí a rodiny (M. Škodová); Ministerstvo výstavby a regionálneho rozvoja SR - rodinná politika v oblasti bytovej výstavby (J. Horský); Ministerstvo školstva - Konceptia výchovy k manželstvu a rodičovstvu na základných a stredných školách; Ministerstvo hospodárstva - Analytický materiál Národnej agentúry pre podporu malého a stredného podnikania; Ministerstvo spravodlivosti - informácia o legislatívnych zámeroch pripravovaných v gescii ministerstva.

V poslednej kapitole publikácie sa nachádzajú zhrnutie diskusie a závery konferencie (11 bodov), ako aj známa Charta práv rodiny (Rím, 1983).

Kniha predstavuje cenný pohľad na problematiku rodiny na Slovensku, pričom sa nevyhýba ani európskym, resp. globálnym porovnaniam. Obsahuje mnoho užitočných, aktuálnych informácií a podnetov nielen pre odborných pracovníkov v oblasti podpory rodiny a rodinnej politiky, ale aj pre všetkých, ktorých zaujíma vec zdravej, stabilnej rodiny na Slovensku. Sympatickým prvkom je široké spektrum zahrnutých pohľadov a dialogický charakter publikácie.

MUDr. Jozef Glasa, CSc.
odborný asistent SPAM

VYBRANÉ KAPITOLY Z VÝCHOVY K MANŽELSTVU A RODIČOVSTVU J. Glasa, I. Podmanický, ÚMC, Bratislava, 1999, pb.

Metodickú príručku spracovali v šťastnej kombinácii vysokoškolský pedagóg v oblasti etickej výchovy a lekár, známy odborník na otázky medicínskej etiky a bioetiky. Má slúžiť učiteľom na osobnostné formovanie detí a mládeže pre ich životné roly v manželstve a rodine a pod týmto zorným uhlom pre zdravé začlenenie sexuality do ich vlastného osobnostného rozvoja. Učiteľia etickej výchovy, ako koordinátori výchovy k manželstvu a rodičovstvu na školách, a učiteľia náboženskej výchovy a ostatných relevantných predmetov majú za úlohu odovzdávať vecné znalosti a zážitkovo sprostredkované poznatky na troch stupňoch školského vzdelávania i mimo školy. Prezentovaný celostný prístup k príprave na manželstvo a rodičovstvo je na Slovensku výsledkom niekoľko rokov trvajúceho dialógu medzi rozdielnymi prístupmi k odovzdávaniu poznatkov o vzniku a ochrane ľudského života a o vzťahoch muža a ženy deťom a mládeži na školách:

a) V náboženskej výchove sa táto úloha vníma ako výchova k predmanželskej čistote a zodpovednej láske, ako súčasť výchovy osobnosti. Jej hlavným priestorom je rodina a potom predmanželská príprava vo farnostiach. Okrem toho pôsobia mnohé mládežnícke skupiny a spoločnosti, rehoľné spoločnosti a mimovládne organizácie (Donum vitae - Teen Star, Hnutie kresťanských rodín, ai.), ktoré vychovávajú mládež v tomto duchu. Od roku 1996 sú tieto otázky súčasťou osnov náboženskej výchovy na základných a stredných školách.

b) V etickej výchove, zavedenej od septembra 1993 ako povinne voliteľný predmet s alternatívou náboženská výchova, sa používa pojem výchova k sexuálnemu zdraviu a rodinnému životu. Podľa definície SZO z roku 1974 „sexuálne zdravie predstavuje taký súhrn telesných, citových, rozumových a spoločenských stránok človeka ako sexuálnej bytosti, ktorý obohacuje osobnosť, zlepšuje jej vzťahy k ľuďom a rozvíja schopnosť lásky“. Etická výchova chápe výchovu k sexuálnemu zdraviu ako celostnú pedagogicko-psychologickú a medicínsku úlohu, zameranú na harmonický rozvoj osobnosti mladých ľudí a na začlenenie sexuality do ich osobnostného rozvoja.

c) Slovenská spoločnosť pre plánované rodičovstvo po zasadaní Svetovej federácie pre plánované rodičovstvo (IPPF) v Szegede v roku 1992 naliehavo žiadala MZ SR a MŠ SR, aby sa na školách SR vyučovala sexuálna výchova. Jej podstatným 'posolstvom' je realizácia tzv. „sexuálnych práv“ jednotlivca, vrátane práva na intimitu sexuálneho života a používania antikoncepcie bez vedomia rodičov pre deti a mládež, informácie o tzv. „bezpečnejšom“ sexe. Ústrednou témou sú informácie o antikoncepčných prostriedkoch a o ich používaní, zdôvodňované obavou z nárastu predčasných neželaných tehotenstiev adolescentov.

Pri tvorbe *Koncepcie výchovy k manželstvu a rodičovstvu* na pôde Ministerstva školstva SR, schválenej vládou SR v júni 1996, sa reflektovali všetky tieto prístupy.

Cieľom metodickej príručky podľa autorov je „poskytnúť námety a podnety na zamyslenie, v optimálnom prípade i na prehodnotenie vlastných postojov a názorov“ (s. 79), poskytnúť základné penzum informácií, praktických zásad a skúseností z výchovy k manželstvu a rodičovstvu (ďalej VMR) pre pedagogickú prax učiteľov.

Kniha pozostáva zo 6 kapitol a viacerých príloh. Prvá kapitola poskytuje prehľadnú informáciu o cieľoch, zásadách a princípoch koncepcie VMR, ktorá je východiskom pre jej realizáciu. Druhá až piata kapitola podávajú to základné penzum informácií pre pedagogických pracovníkov, aby - hoci v rôznych predmetoch - mohli zachovať osobnostnotvornú líniu VMR. V tejto kapitole autori

vychádzajú z charakteristiky osobnosti človeka a jej rôznych rozmerov, schopností a podmienok jej rozvoja. Dôraz sa kladie najmä na obsah pojmov sloboda, zodpovednosť a na osobitosti rol ženy a muža.

Tretia, ťažisková kapitola, hovorí o vývoji, formách a základných zložkách ľudskej sexuality a o rizikových faktoroch, ktoré ovplyvňujú zdravý sexuálny vývoj. Štvrtá kapitola hovorí o hodnote manželstva ako trvalého vzťahu a o podmienkach, ako možno túto hodnotu takto prežívať, napriek odlišnému obrazu vzťahu muža a ženy v masmédiách a ukazovateľom rastúcej rozvodovosti a klesajúcej sobášnosti. V kapitole o rodičovstve a rodinnom prostredí sa hovorí o osobnostnej príprave na rodičovstvo, o podstate a realizácii zodpovedného rodičovstva a o spôsoboch regulácie počatí.

Pre 2.-5. kapitolu je spoločný tento postup: od teoretických a vecných poznatkov ku aktivitám, ktoré majú dať žiakom a študentom predkladanú látku „osobne zažiť“ a učiť sa ju reflektovať. Každá téma, i čiastková téma je uvedená vhodným citátom, ktorý svojou pôsobivosťou môže „senzibilizovať“ poslucháčov. Tieto kapitoly obsahujú spolu 33 aktivít a na ďalšie aktivity z dostupných metodických príručiek etickej výchovy sa odvolávajú. Pred každou vecne ucelenou skupinou aktivít je uvedený ešte krátky a výstižný metodický úvod. V nich uvedené dispozície niekedy kladú na pedagógov dosť náročné nároky. Obsahujú aj odkazy na hlavné témy etickej výchovy, ktoré v tej - ktorej vecnej oblasti je vhodné využívať pre celostný efekt preberaných tém na rozvoj osobnosti mladých ľudí. Každá aktivita je označená vekovou kategóriou, pre ktorú je určená. Spolu s odkazmi na odporúčanú literatúru tak tvorí táto metodická príručka ucelený metodický materiál.

Na záver zhrniem hlavné pozitíva a niektoré mínusy tejto cennej metodické príručky.

Pozitíva: zacielenie na celostný rozvoj osobnosti mladých ľudí, na ich výchovu k slobodne zvolenej zodpovednosti, dôraz na všeľudské hodnoty, otvorenosť a pravdivosť hodnotenia súčasných socio-kultúrnych trendov týkajúcich sa ľudskej sexuality, veľký priestor pre diskusiu, podnetnosť pre hľadanie vlastných názorov a postojov, pre vlastné uvažovanie, citlivosť voči omylom a zraneniam mladých ľudí.

Pravdepodobne pre ohraničený rozsah príručky sa občas vyskytli skratkové vyjadrenia, kde stručnosť bola na úkor úplnosti informácie (napr. s. 16, s. 45 - 4a/ a s. 53 kde sa zdôvodňuje, prečo sexualita má optimálne prostredie v manželstve, alebo s. 69 o názoroch katolíckej cirkvi na antikoncepciu).

Kniha je pozitívnym prínosom pre realizáciu VMR.

Ing. Terézia Lenczová, CSc.
SSRaZR, Bratislava

Jozef Glasa, M.D., PhD.
SPAM, Bratislava

LIFE AND DEATH IN HEALTHCARE ETHICS. A Short Introduction.

H. Watt, Routledge, London - New York, 2000, pb.

The small, pocket format of this concise, thoughtful and well accessible guide to some of the most important, dilemmatic moral issues in modern health care, should not misguide the potential reader. The book is excellent, readable, clearly - written, well - edited. Should be „a must read“ item for a health professional, student of medicine or nursing, but also for a lay person encountering any of these „hot“ moral issues in his or her personal or family life.

Dr. Helen Watt, research fellow at the Linacre Centre for Healthcare Ethics in London, is not unfamiliar (to say the least!) to the Slovak, or even East European bioethics audience: she took part several times (as an invited lecturer) in the international bioethics summer courses - conferences organized by the Institute of Medical Ethics and Bioethics in Bratislava. A small part of the material of the book appeared already in the Institute started journal *Medical Ethics & Bioethics* and in the publication *Health Care under Stress* (Ed. by J. Glasa and J. R. Klepanec; Bratislava, 1998).

The moral issues considered include: euthanasia and withdrawal of treatment, the persistent vegetative state (PVS), abortion, in vitro fertilization (IVF) and cloning, life - saving treatment of pregnant women. Each topic allows Dr. Watt to go masterly through difficult definitions, explanations of notions, terms and principles, illuminate difficulties and peculiarities of health care decision - making, and illustrate the dilemmas with short case presentations. The book seeks to offer 'a way of reason' for the reader in taking a personal position with regard to the concrete moral problem. The approach of the author is a personalistic one: it links morality to human fulfilment (meant as the enjoyment of 'basic human goods' as life, knowledge and friendship). This approach gives a central place to human intentions in evaluating means for promoting human well-being. It lays stress on the impact of choices on the moral agent him- or herself (on the kind of people we make ourselves to be by choosing what we do). This is for Dr. Watt (and for many others) more to morality than the mere achievement of 'good results'. This is a refreshing, bright perspective in the current foggy atmosphere of a pluralistic utilitarian despotism and personal pessimism.

Medicínska etika & bioetika - Medical Ethics & Bioethics, založený ako časopis Ústavu medicínskej etiky a bioetiky v Bratislave, spoločného pracoviska Lekárskej fakulty Univerzity Komenského a Inštitútu pre ďalšie vzdelávanie zdravotníckych pracovníkov v Bratislave. Je určený pracovníkom etických komisií v Slovenskej republike, ako aj najširšej medicínskej a zdravotníckej verejnosti. Má tiež za cieľ napomáhať medzinárodnú výmenu informácií na poli medicínskej etiky a bioetiky. Prináša informácie o aktuálnych podujatiach a udalostiach v oblasti medicínskej etiky a bioetiky, pôvodné práce, prehľady, reprinty legislatívnych materiálov a smerníc pre oblasť bioetiky, listy redakcii a recenzie. Príspevky a materiály uverejňuje v slovenskom alebo anglickom jazyku. Vybrané materiály vychádzajú dvojjazyčne. Vedecké práce publikované v časopise musia zodpovedať obvyklým medzinárodným kritériám (pozri Pokyny prispievateľom - ME&B 2/94, s. 10).

Medicínska etika & bioetika - Medical Ethics & Bioethics, founded as the journal of the Institute of Medical Ethics & Bioethics (Bratislava), a joint facility of the Medical Faculty of the Comenius University and the Postgraduate Medical Institute in Bratislava (Slovak Republic). It aims to serve the informational and educational needs of the members of ethics committees in the Slovak Republic and the broadest medical and health audience. It aims to enhance the international exchange of information in the field of medical ethics and bioethics. The information published comprises news, original papers, review articles, reprints of national and international regulatory materials, letters, reviews. Contributions and materials are published in Slovak or English. Chosen materials are published in both languages. Scientific papers published in ME&B must respect the usual international standards (see Instructions for authors - ME&B 2/1994, p. 10, and some later issues).

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