Thomas Percival (1740-1804)

Born in Warrington in 1740, the son of a local merchant, Thomas Percival chose to follow the profession of his grandfather and uncles - that of a physician. Both of his parents died when he was a very young boy, and he was raised by a sister. He was educated at Warrington Grammar School and at War-wington Academy. Later he followed by studying Medicine at Edinburgh University, where he came into contact with several Scottish intellectuals, including David Hume.

On graduation, Percival returned to Warrington, where he married and established a medical practice, though in 1767 he moved the practice to Manchester. He was a prolific author, and apart from several childrens' stories, he published two volumes of essays: “Essays, Medical and Experimental” in 1767, and “Essays, Medical, Philosophical and Experimental” in 1773 - both books found popular praise from the critics. In 1770, concerned by the high rate of mortality in Manchester, he began to study death records in an attempt to discover the causes.

He isolated several now self-evident causes - poverty, malnourishment and lack of public hygiene. He made specific proposals for the more detailed and accurate keeping of official death records. His work caused him to develop a great deal of sympathy for the poor of Manchester. He was also involved in reforms aimed at correcting the worst effects of poverty - these included reforming the conditions of work in factories.

Percival was instrumental in 1781 in setting up the Manchester Literary and Philosophical Society, which he started in his own home. It grew so large that another meeting place had soon to be found. Percival was President of the Society for the most part of his life.

In 1803, Percival published a document on medical ethics; this laid down strict rules of conduct for medical practitioners. His Code was the basis of the “Code of Ethics of the American Medical Association” drawn up in 1849. A man of great charisma, Percival numbered Voltaire and Diderot amongst his friends. Thomas Percival died in 1804.

A monument to his memory stands in Warrington Parish Church, and an inscribed tablet can be found in the rooms of the Literary & Philosophical Society in Manchester.
WHY IS THE ETHICS OF EUTHANASIA WRONG?

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Introduction

The culture of death embodies a total misunderstanding of the nature of the human person, a denial of the innate dignity of persons. The denial of this truth causes a crisis in ethics. Sometimes there are very good reasons why we have the right even the obligation to allow the dying to die their own death. But there is a world of difference between allowing or permitting death and deliberately setting out to bring death about. So it is very important to show the real nature of euthanasia in order to avoid confusing terminology.

We will try to show why euthanasia is wrong by showing, first, how seriously false its anthropology is; second, how its consequentialist/proportionalist methodology is simply unworkable; and third, later on we will show the consequences that follow from accepting the presuppositions of pro-euthanasia leaders (developing the "slippery slope" argument).

I. False Anthropology

The defence of euthanasia presupposes that there is such a thing as a life not worth living and that it is morally right to bring death about if this is necessary to protect the higher good of human dignity. For proponents of euthanasia, human bodily life is of itself not an intrinsic good of the person but merely an instrumental good for the person, i.e., the consciously experiencing subject. The ethics of euthanasia holds that all human lives are not of equal value but only lives of a certain "quality." It is "maintained that a human being must possess a number of presently exercisable capacities in order to be counted as a person. Somebody lacking those abilities also lacks the rights which properly belong to persons — including the 'right to life.'" (1) Moreover, they are defending a person's right "to determine the manner of their dying, since persons are entitled to dignity, and certain conditions of dying are incompatible with dignity and worth, and that lives lived under certain conditions are lives which cannot be respected, are lives which lack dignity." (2)

For proponents of euthanasia, it seems crucial that one should be able to judge certain human beings' lack of dignity and worth. For them, to kill these people is to do them a benefit: "it is to terminate pathetic existences; it is to relieve the patient's prospective quality of life was too poor, as the basis for a decision to move someone from existence to non-existence in this world." (5)

We have to say that on the one hand we reject those 'quality of life' judgements which are intended to identify death itself as a good to be pursued, but on the other hand we do not deny that judgements which can (but need not) be called 'quality of life' judgements do enter into the process of medical decision making. In the latter case, the doctor makes some sort of comparison between the benefits and the risks and burdens for the patient that will or may accrue from the specific treatment under consideration. And this comparison is inevitably made against the background of the patient's present and likely condition and prognosis. It focuses, and must be kept focused, on the advantages and disadvantages of specific possible treatments, given their effects, side effects, and outcome. But it does not inquire about the worthwhileness of the patient's being alive at all. (7)

We will try to show why euthanasia is wrong by showing, first, how seriously false its anthropology is; second, how its consequentialist/proportionalist methodology is simply unworkable; and third, later on we will show the consequences that follow from accepting the presuppositions of pro-euthanasia leaders (developing the "slippery slope" argument).

A Working Party Report makes a distinction in the decision resulting from the non-euthanasiast and euthanasiast practical reflection: "The decision resulting from the non-euthanasiast practical reflection may be that no possible specific treatment is now, for this patient, worthwhile. And that decision may be arrived at in the knowledge that untreated, the patient will probably die somewhat earlier than he would if treated. And indeed that consequence of the decision may be accepted without regret, and with the feeling, expressed or unexpressed, that death will bring relief to that patient. Still, such a decision can be perfectly reasonable and morally proper. But it would be euthanasiast, and so morally improper, if it used the judgement that death would bring relief, or that the patient's life was no longer worth living, or that the patient's prospective quality of life was too poor, as the basis for a decision to regard death as the objective, or an objective, of the treatments to be decided on." (8)
The other big problem of the ethics of euthanasia is in a false understanding of the human person. As May says: “For them, man is not an indissoluble union of body and soul; he is the Cartesian ghost in a machine, for they regard man’s humanity as exhausted by his consciousness and rationality, and his body and biological life as a subpersonal, subhuman component, part of a ‘world of nature’ over which the rational and conscious agent has complete dominion.” (9) We see that this view of man is incompatible with the biblical and Christian understanding of the human person.

Here it is worthwhile to take a deeper look at dualism and what influence it makes to morality. According to Christian faith and sound philosophy, human beings are animals, but they are animals who are radically different in kind from other kinds of animals. They are different because they can do things that other animals cannot do at all, i.e., speak in propositional sentences, judge the truth or falsity of propositions, and make free choices. And in order to account for their capacity to do these things, it is absolutely necessary to infer that there is present, within the entitative or ontological make-up of the human animal something utterly lacking in the entitative make-up of other animals, i.e., a spiritual or nonmaterial principle – the soul. They are, in other words, persons.

But human persons, insofar as they are in truth animals, are not spirit persons. Rather, they are body persons, sexually differentiated into male and female. When God created man, he did not create a conscious animal, but a self-aware and capable of relating to other selves, to whom he then gave a “body structure.” Rather, when God created man to his own image, “male and female he created them.” (10) He created man as living flesh, and when his only-begotten Son became man in order to show the depths of the Father’s love for this special creature, he became flesh. (11)

We are not selves having and using bodies. According to Grisez, we are bodies – we are rational, sentient, organic bodies, and “the fact remains that the human person is a certain, special kind of body.” But dualistic theory “would frankly state that a person owns and uses a body, but that a person is not a body.” (12)

Moreover, he says: “In the light of the teaching of faith that the human person becomes by adoption a member of the divine family (cf. Rom. 8:14-17) and a participant in divinity (cf. II Pet. 1:4), we also can conclude that the organic life and the biological process of the human body belong to divine life. Moreover, ‘belong to’ here means inclusion, not merely possession. Human biological processes are not possessions and instruments of the person. And as dogma of the Assumption makes clear, the person as body is destined for heavenly glory.” (13)

According to St. Thomas Aquinas, the human person is a unity and the body is the person who is to be saved. Grisez criticises this understanding of the human goods only in the sum total of their concrete instances.” (17) By this he means that proportionalists focus attention on the actual realisation of these goods in definite states of affairs. They look upon them as goals to be achieved. Grisez criticises this understanding of the human goods because it fails to appreciate the truth that “all of the basic human goods have a certain reality – they determine persons existentially – simply in being chosen.” (18)

This understanding, in other words, fails to take seriously the self-determining character of free choice. According to May, “a proportionate reason or good is needed to justify doing deeds that effect evil, but the proportionate good that serves as the end to be achieved does not suffice to render deeds good and right” and “if we take the significance of our deeds seriously, as revelatory of our being and as shaping our identity, we must conclude that if we directly or indirectly do evil, such as

II. False Methods of Moral Judgement

The proponents of euthanasia give a very false dualistic anthropology using the consequentialist/proportionalist method. We call this ethics “consequentialism” because it focuses upon states of affairs consequent upon choices and their execution. This theory is also called “proportionalism” because what is the most central to it is its appeal to the proportion of good and bad as a basis for moral judgement. (16) The proponents of this method of moral judgement use a comparative evaluation of the benefits (goods or values) and harms (bads or disvalues) promised by the various alternatives of choice. According to them, one ought to choose the possibility, which offers the best proportion of good to bad.

Grisez notes that “the human goods (and bads) whose proportions are to be compared exist for proportionalists only in the sum total of their concrete instances.” (17) This understanding, in other words, fails to take seriously the self-determining character of free choice. According to May, “a proportionate reason or good is needed to justify doing deeds that effect evil, but the proportionate good that serves as the end to be achieved does not suffice to render deeds good and right” and “if we take the significance of our deeds seriously, as revelatory of our being and as shaping our identity, we must conclude that if we directly or indirectly do evil, such as
death, we show that we are willing to take on as part of our moral identity the identity of evildoers, for evil is what we want if it is an evil that cannot be intended." (19) In the case of euthanasia, no redescription ("showing compassion," "preserving human dignity," etc.) can conceal the reality of killing because this evil (death) is brought about directly intended or willed.

For they deny moral absolutes, some acts which are intrinsically evil; in some moral dilemmas they accept these acts which are normally prohibited as morally acceptable in the presence of a proportionate good. (20) But how can a moral theory, which claims to be a coherent one, condone the doing of evil to achieve good? Moreover, "judging the moral character of an action principially on the basis of hoped-for results is, at best, ambiguous and, at worst, an exercise in futility," and our daily human experience "proves how difficult it is to accurately predict the results or consequences that will flow from our actions, especially in the context of moral dilemma situations." (21)

What are these conditions? The first is "that a moral judgement is to be made, which means both that a choice must be made and a morally wrong option could be chosen." The second is "that the option which promises the definitely superior proportion of good to bad be knowable." (22)

That the theory is absurd and incoherent Grisez shows by proving that two conditions to be met which proportionality requires are simply not compatible. What are these conditions? The first is "that a moral judgement is to be made, which means both that a choice must be made and a morally wrong option could be chosen." The second is "that the option which promises the definitely superior proportion of good to bad be knowable." (22)

Grisez puts it this way: "If the first condition is met and the morally wrong option could be chosen, then its morally acceptable alternative must be known. Otherwise one could not choose wrongly, for one chooses wrong when there is no morally acceptable alternative would disappear, and they would no longer remain as alternatives.

III. Slippery Slope Argument

In order to show the danger, which follows from the theories carried out by proponents of euthanasia, here it is worthwhile to examine a principal argument used years ago against euthanasia. This argument has different metaphorical expressions, namely, "thin edge of the wedge," "the first step on the slippery slope," "the foot in the door," "the camel's nose under the tent." This argument forces us to consider whether unacceptable harms may result from attractive and apparently innocent first steps. It means that legitimisation of some forms of action will lead to other acts or practices that are morally objectionable. (24) The first step down the "slippery slope" is the hardest, but it will find itself moving so quickly that it will be very difficult to stop or turn back.

In other words, the "slippery slope" affects us in subtle increments, which in themselves seem not only harmful but also as helpful individual steps. Yet once we take the first step, we may be half way down the slope to the next step. We can end up at the bottom of the moral gap without even realising how we got to a place that would have shocked us at first. (25) The sad example of how the "slippery slope" operates in reality is the history of abortion. If technology can help actually abort a foetus easily and safely, then why not do it for women facing a life-threatening pregnancy? Next, the victims of rape and incest were included: why should these victims have to endure the trauma of bearing an unwanted child? Supporting arguments soon focused on the problem of other "unwanted pregnancies." Abortions became common during the second and even third trimester (as partial birth abortions). (26) The technology today enables us to prolong life in different ways. But soon of fear that there is a possibility of being forced to endure an unnatural, lingering dying process and/or our bodies kept functioning longer after we die.

Usually a typical picture is drawn of an old man tied down in bed, in constant pain, clearly dying. He has tubes in every natural body orifice and in several artificial ones. The doctor is keeping him alive, perhaps to obtain a larger fee, perhaps because the doctor does not want to admit that he is losing the battle for this man's life. This is echoed commonly in retirement communities where senior citizens can be heard to say, I don't want you to keep me alive with all those tubes. When my time comes, let me go.' (27)

And here proponents of euthanasia find good soil to sow their deadly seeds. Here it is worth noticing that patients who are dying will go on to die regardless of whether treatment is given or not, but dying patients are actually not the ones whom the proponents of "assisted suicide" and euthanasia have in their sights. They are looking for people who are not in pain, on life support systems, but are by their judgements a burden. It could be people who have had strokes, multiple sclerosis, Alzheimer's disease. These are people who someone thinks ought to die but who won't. The proponents of euthanasia want them to get dead. (28) Many euthanasia activists consider the "Living Will" just the first step on the road to all kinds of euthanasia. (29) They know that if they can get society to make the first critical step, all of the subsequent steps - no matter how many or how long they are - will be much easier. Once a society accepts the "Living Will," it completely changes the measuring of human worth. "The quality of life" ethic changes the focus from the spiritual to the physical, mental, emotional. A person's usefulness to society, to his family, and even to himself is measured by the condition of his body and his mind. Once the proponents of euthanasia make this transformation from the "sacredness of life" ethic to the "quality of life" ethic, they can justify anything behind the masks of "compassion" and "altruism." (30) After a "Living Will" as the first step in the pro-euthanasia strategy follows the other - passive euthanasia - followed by assisted suicide and active voluntary euthanasia. The last step would be on the very bottom - involuntary euthanasia. The other steps became a reality when Dr. Jack Keveorkian had assisted in the suicides of scores of people. The goal of pro-euthanasia activists is a world - wide "right to die." But as Brian Clowes says: "As we learned with contraception and abortion, when the courts extend a new 'fundamental human right' to one group of people, it is unconstitutional to deny it to other groups of people. This means that if incurably ill people receive a 'right' to euthanasia, it is inevitable that the courts will quickly expand the 'right' to include every citizen in the United States. Anti-lifers first justified the contraception and abortion 'rights' under the 'hard cases' - and within 5 years expanded them to include any reason whatever and at any time during preg-
nancy. Right now, they are justifying euthanasia for the ‘hard cases’ of terminally ill and comatose people and those suffering unbearably painful conditions. Even life will inevitably expand the ‘right’ to euthanasia, just as they did with abortion, so that anyone of any age will be able to kill themselves with the ‘aid’ of a ‘Doctor Death’ for any reason whatsoever.” (31)

The authorising of killing patients for their own benefit (according to proponents of euthanasia) when they are suffering excruciating pain or have a bleak future could open the door to a policy of killing patients for the sake of social benefits such as reducing financial burdens. Voluntary euthanasia might open the door to non-voluntary and perhaps involuntary euthanasia. The danger in permitting some killing is that it would habituate people to doing it and to accepting killing in general. (32)

If direct killing of a competent individual at his or her own request becomes a legal right, the simple application of these now accepted legal principles might well legalise direct killing of those who have made no such request. This will occur without any further policy decision by voters or legislators – simply by the action of the courts when an appropriate case is heard. (33) Legalisation of non-voluntary euthanasia will directly bring about legalisation of non-voluntary euthanasia.

Society might gradually move in the form of killing handicapped new – born to avoid social and familial burdens. There could be a general reduction of respect for human life as the official rational for killing. Unfortunately, the principle is formulated in terms of quality of life or meaningful life. Sometimes it is formulated in terms of the naturalness and goodness of death. Sometimes it is formulated negatively and brutally by talking about certain non-competent persons as vegetables or cabbages. (34)

The holocaust under Nazi rule continues to serve as a powerful vision of the bottom of the slippery slope for a society that adopts mercy killing. The Nazis started by accepting euthanasia for the incurably ill and then moved on to their policies of genocide: “Whatever proportions [the Nazi] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. But it is important to realise that the infinitely small wedge-in lever from which this entire trend of mind received its impetus was the attitude toward the unrehabilitable sick.” (35)

The Nazi program did not begin with voluntary euthanasia. The Nazis did proceed from more to less restricted non-voluntary euthanasia, and they proceeded from non-voluntary euthanasia to genocide. Although this program was called euthanasia, the term simply camouflaged mass murder. Non voluntary euthanasia involves a very serious injustice right from the beginning. (36)

“As the euthanasia movement rolls on in many Western countries,” Brian Clowes stresses, “those who combat the ‘culture of death’ must learn from those who made grievous mistakes regarding the value of human life.” (37)

As we see, the ‘slippery slope’ danger is real. “The camel’s nose does get under the tent: once opened, the movement of the door to death by human choice may be constantly widening, and likely a never narrowing movement.” (38) And it does not matter how we will call certain action – voluntary, non-voluntary, or involuntary euthanasia, or physician-assisted suicide – we see that what connects them is homicide. Beginning with an exceptional permission of euthanasia out of pity for a terminally ill person who requests it, there is a move towards granting power to euthanise anyone whose life is deemed unworthy of being lived. Once it has been agreed to violate the principle of the absolute respect for life, once its sacredness and unmanipulability have been repudiated, then somebody else has power over the life and death of disabled people. It could even become a “duty” to take the moral responsibility for putting an end to such “useless” and burdensome lives. It is a great injustice “when certain people, such as physicians or legislators, arrogate to themselves the power to decide who ought to live and who ought to die”. Moreover, “the act of euthanasia appears all the more morally repugnant if it is done without the consent of those who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages.” (39)

**Conclusion**

We see “in the earthly life of each individual human being, however damaged, a weight and significance such that the termination of that life can never rightly be chosen as a means of advancing overall human welfare – not even the welfare of that damaged individual himself.” (40) For Christians, life is God’s gift, and its end is to be determined by Him. God is sovereign over life and death: we have no jurisdiction in this area; therefore, we have no mandate to end lives.

God’s dominion includes all of life, which means that suffering is a part of God’s providence. Therefore, suffering that cannot be relieved by modern medical means is to be accepted as from the hand of a loving God who knows what he is doing, even when we do not understand. In looking at suffering and impending death, the Christian should see God’s sovereign hand and purpose, as well as the opportunity for ministering to the weak and vulnerable.

**Notes**

Abstract

Human beings are made in the image and likeness of God and are therefore of intrinsic worth or value, beyond all prices. Almost all Christian pro-life arguments spring from the fountain of personal dignity. Euthanasia would make moral sense only if it were possible to say, morally, that this dignity had vanished. To commit euthanasia is to act with the specific intention that somebody should be nobody. This is the fundamental error of all immorality in human relations. To commit euthanasia is to fail to see the intrinsic worth or dignity of the person. The judgement that what has worth, intrinsically, somehow does not have worth, is both morally and ethically wrong. The ethics of euthanasia is based on dualistic anthropology and wrong moral presuppositions underlying the defence of euthanasia, namely, proportionalism and consequentialism. The basic claim of proponents of the ethics of euthanasia is that human persons are consciously experiencing subjects whose dignity consists of their ability to make choices and to determine their own lives. Bodily life, according to them, is a condition for personal life because without bodily life one cannot be a consciously experiencing subject. It means that bodily life is distinct from personal life. Thus, the bodily life is a fundamental good for the person, not good of the person. It thus follows that there can be such a thing as a life not worth living — one can judge that bodily life itself is useless or burdensome, and when it is, the person, i.e., the consciously experiencing subject, is, i.e., this useless and morally wrong. The ethics of euthanasia is based on dualistic anthropology and wrong moral presuppositions underlying the defence of euthanasia, namely, proportionalism and consequentialism. 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The request of the patient for his/her life to be terminated by a physician that result in the death of a patient. Administration of a lethal substances, or using any other forgoing of the life-saving procedures or treatment, meaning death. It refers to the deliberate cessation or origination from Greek “eu” meaning good and “thanatos” (patient does not ask for it), c) forced euthanasia (patient of the patient.

Introduction

As a coined word euthanasia – ‘good and gentle death’, originates from Greek “eu” meaning good and “thanatos” meaning death. It refers to the deliberate cessation or forgoing of the life-saving procedures or treatment, administration of a lethal substances, or using any other means by a physician that result in the death of a patient. The request of the patient for his/her life to be terminated by the physician is considered being an indispensable part of the notion (“voluntary euthanasia”). Euthanasia is usually believed to be performed for not to let a terminally ill patient to suffer any longer (“merciful death”). [1]

Sometimes, two ‘categories’ of euthanasia are outlined: 1. Active euthanasia – the physician performs a concrete act, which brings about the death of the patient (e.g. administration of a lethal dose of a drug). 2. Passive euthanasia – cessation or forgoing of the life-saving procedures by a physician, with an aim to bring about the death of the patient.

Other categorisation distinguishes: a) voluntary euthanasia (patient asks for it), b) non-voluntary euthanasia (patient does not ask for it), c) forced euthanasia (patient does not want it).

Historical Remarks

In antiquity, the terminally ill would not be allowed to enter Asklepion. Hanging in the entrance of the temple, there was an inscription stating, “According to the will of Gods, death is prohibited to enter to a holy site.” (1) Plato (427 – 347 BC) argued that Asklepios should dedicate the art of medicine to those patients, who had the likelihood of getting well with the treatment. Physicians ought not to maintain treating the terminally ill, since it would neither be to the patient’s nor to the public’s benefit (2). Aristotle (384 – 322 BC) agreed with his master Plato and stated that medical treatment should be ceased for the terminally ill, and it would be to the benefit both of the physician and the patient.

Spartans, citizens of the Greek city-state Sparta, threw their newborn babies with visible somatic defects to the depths of a declivity. As a similar pattern, Indians left the terminally ill to the flow of the Ganj River (2).

Hippokrates’ Oath, on the other hand, strongly opposes euthanasia. In Corpus Hippokraticum, Hippokrates argues: “The physician is responsible for completely restoring patients health as well as stopping their suffering,” and “He is also charged with the duty to carry out the treatment of the terminally ill.”

Meaning gentle and good death in Greek, the word “euthanasia” was commonly used during the Roman period. Historian Suetonius (120 BC) recorded, that when Emperor Augustus heard about the quick and painless death of a patient, he used the word and wished ‘euthanasia’ for himself and his family. (3)

Galenos (129 – 199 AC) treated the pain in his patients with opium. Hospices for the care of terminally ill patients began to appear early in the Middle Age.

Ambroise Paré (1510 – 1590), the pioneer of modern surgery, who lived in the 16th century, argued that the choice between life and death belonged only to God; since the suffering of a patient or recovering of his/her health was within the boundaries of the God’s will. (4)

Francis Bacon (1561-1626) used the term “euthanasia exterior” to describe the act’s aim to end the life of the terminally patient, not to waste the time and effort with the treatment.

In the 19th century, however, Thomas Percival (1740-1804) discussed the physician-patient relationship in his book Medical Ethics (1803). It was a period when euthanasia was strongly opposed. (5)

In the beginning of the 20th century, Emile Durkheim (1857-1917), as a sociologist, argued that ethical views dominant during the ancient periods and the middle ages were static, but on the other side, ethical codes connected and developing with the public were dynamic. (6)

Early Attempts of Euthanasia Legislation

Euthanasia was first legalised in 1906 upon the proposed bill by Miss Ann Hall (1875-1943) to the New York Medical Academy. The proposal included the following crucial idea: “A patient suffering from an incurable disease causing intolerable pain is to have the right to ask an authorisation to end his/her suffering from a commission including four members.”

The Parliament of Iowa passed the proposal providing the permission for death of congenitally defect, disabled and mentally retarded children. But the congress convened in Washington strongly refused to pass the draft law (7).

The issue was also discussed at the International Tuberculosis Congress in 1907, in the German Parliament in 1913, and in the House of Lords in 1936 (8).

Situation in Some Countries

Active euthanasia is illegal in the US. However, the patient may demand cessation of particular medication or surgery, and the physician should act according to the expressed wishes of the patient.

In the Netherlands, both ‘passive’ and ‘active’ euthanasia is legal. The law regulates the ‘right to die’ as follows (9): 1. The patient is to demand the application of euthanasia. 2. The suffering of the patient is to be at an intolerable level. 3. Every medical mean is to be applied first. 4. The patient is to be fully informed about euthanasia. 5. The physician in charge is to consult two other physicians capable of taking decisions independently.

Euthanasia is illegal also in almost all EU countries – a recent exception being Belgium. In some regions of Australia, there were attempts to make euthanasia legal, but the law was later struck down by the parliament.

It was stated in the declaration of the World Medical Association (WMA; Madrid, 1987) that to perform the assisted suicide or euthanasia is not ethical, even when the patient gives his/her relatives permission to act in this regard. (12)

Turkey

Similarly to many countries in the world, euthanasia has not been legalised in Turkey. The Article 13/3 of Me-
Euthanasia is sometimes compared with what happens at the cellular level within the process of apoptosis – physiologically programmed death of the cell. The cells that reach the end of their life span, or those genetically or otherwise damaged, undergo this cascade of events that are pre-programmed in their genome (genes for apoptosis). The result of these processes is the cell ‘suicide’. A cell has to leap this process in order to become malignant. (15).

Notes

[1] Euthanasia is sometimes compared with what happens at the cellular level within the process of apoptosis – physiologically programmed death of the cell. The cells that reach the end of their life span, or those genetically or otherwise damaged, undergo this cascade of events that are pre-programmed in their genome (genes for apoptosis). The result of these processes is the cell ‘suicide’. A cell has to leap this process in order to become malignant. (15).

Bibliography


Abstract

The paper gives a brief conceptual and historical overview of euthanasia. These are supplemented by considerations of the attitudes to euthanasia and assisted suicide in Turkey. At present, euthanasia is neither accepted nor authorised in Turkey. This is due both to deontological and legal reasons. It is also not regarded positively by the general public.

Key words: euthanasia, assisted suicide, conceptual and historical issues, situation in Turkey

Abstrakt

Práca podáva stručný koncepčný a historický prehľad problematiky eutanázie, ktorý doplná informáciami o postojoch k eutanázií a asistovanej samovražde v Turecku. Ani eutanázia, ani asistovaná samovražda nie sú v súčasnosti v Turecku akceptované, ani povolené, a to z deontologických, ako aj z legislatívnych dôvodov. Ani široká verejnosť eutanázií v Turecku neakceptuje.

Kľúčové slová: eutanázia, asistovaná samovražda, konceptné a histórické aspekty, situácia v Turecku.

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Conclusion

Although the problem of euthanasia started to gain a widespread attention throughout the world, becoming a relatively frequent topic for legislative initiatives and public media campaigns, at present, it is neither accepted nor authorised in Turkey. This is due both to the deontological and legal reasons. The surveys concerning the public opinion on the issue have shown that euthanasia is not regarded positively by the Turkish population.
Relationships between Central Ethics Committee and Ethics Committees

Central Ethics Committee, Ministry of Health; Institute of Medical Ethics and Bioethics; Bratislava, Slovak Republic

Legal situation concerning ethics committees in Slovakia

The first document devoted to ethics committees (ECs) was published by the Ministry of Health of the Slovak Republic (MH SR) in June 1992, entitled “Guidelines for the establishment and work of ECs in health care facilities and research institutions” (2). These guidelines, which at the time of their publication were quite progressive and comprehensive, will soon be replaced by the specific and detailed regulations of the MH SR to be issued under the new health legislation, which comes into force on Jan. 1, 2005 (see below).

At present, from the legal point of view, ECs in the Slovakkia Republic are established according to the requirements of either:

a) §40 par. (4) of the Law No. 277/1994 Coll. on health care – for ECs to review biomedical research projects (this will be completely replaced by the law No. 576/2004 Coll. on health care, see below); or

b) §16 par. (2) sub-paragraph j) of the Law No. 140/1998 Coll. on drugs and health equipment – for ECs to review protocols of drug clinical trials.

The requirements set in the above mentioned laws are rather general and simple. Local ECs themselves, however, and the health care facilities and research institutions, when establishing and developing these bodies, have been respecting, still on a voluntary basis, the relevant international requirements and standards (especially those of the GCP) as reflected in the ECs’ statutes and standard operating procedures (SOPs) (3).

New health legislation – Law No. 576/2004 Coll. on health care (to be in force since January 1, 2005) pays a considerable attention to the problem of ECs. It provides for 3 types of ECs:

a) Central Ethics Committee (CEC) of the Ministry of Health, established by the minister of health; to advise the minister, other ministries and top state institutions (government, president,...) on bioethical issues, and to perform other tasks of a national bioethics body

b) Ethics Committees (ECs), established by directors of health care facilities or biomedical research institutions to:

- review protocols of clinical trials or biomedical research projects planned to be performed in that facility/institution, and to provide a follow up of the research protocol approved (“research ethics committee”), and/or
- advice the director of health care facility or of biomedical research institution providing also health care on ethical aspects of health care provided by the facility/institution (“clinical ethics committee”)

c) Regional Ethics Committees (RECs) to review and follow up multicentre clinical trials and multicentre biomedical research projects (with the exception of the review of the ‘local aspects’ of research projects).

The law requires the Ministry of Health to issue the comprehensive regulation on ECs. It is being elaborated just now by a task force sponsored by CEC.

Relationships between Central Ethics Committee and Ethics Committees

CEC, according to its statutes issued by the minister of health (June 2002), is expected, among its other duties, to provide guidance to (local) ECs in the health care facilities and biomedical research institutions in whole country. (In the near future, when RECs are established, they will be expected to serve with guidance to ECs at their territory.)

In practice, representatives of ECs (usually their chairs or secretaries) approach CEC members (usually the chair), or CEC as such, with requests for clarification, or guidance on more difficult, new, or unclear cases they meet in their review or consultation work, or – so far quite rarely – in the clinical practice of ‘their’ health care facilities. These requests are either posed in writing – then the CEC’s chair responds in writing, consulting, if necessary, other members of CEC (and informing CEC on its subsequent plenary meeting), or seeking advice from the whole CEC on its next scheduled plenary meeting; or the requests are posed during informal telephone consultations that are usually given by the CEC chair.

Since 2002, the tradition of regular meetings of ECs representatives and members with CEC presidium and members has been re-established (going back to the early phase of CEC work in years 1990 – 1992). Usually, these meetings are connected either with an international bioethics conference held in Bratislava, or with a specially organized course on actual ethical issues (up till now those were predominantly research ethics issues).

The web page for ECs is being established within the web page of CEC hosted by the server of the Ministry of Health (www.health.gov.sk). It should be operational by the end of January 2005.

Exceptionally, upon a specific request from the (local) EC, CEC is taking upon itself an ethics review of the research project, which is felt by the EC to exceed its competence and the competence of any other EC (or REC) in the country (e.g. unprecedented research projects utilizing newest (bio)technologies, stem cells, gene therapies, etc.). (4)

Conclusion

Systematic efforts have been present in the Slovak Republic since early 90-ties of the last century, to build a functioning system of ethics committees (ECs) in the health care facilities (“clinical ECs”) and institutions of biomedical research (“research ECs”). During the latest years, these efforts are being transformed into substantial legislative improvements. Also, concrete means of mutual communication and support between CEC and LECs in the country are being developed and introduced gradually. The main aim of these activities is to improve the situation concerning the application of ethics in health care and in biomedical research. To provide a better protection of the patients, and of subjects of research studies – including those involved in the clinical trials of new drugs, and, ultimately, to enhance favourable conditions for the practice of medicine and provision of health care in Slovakia.

Notes

Altruism and trust lie at the heart of research on human subjects. Altruistic individuals volunteer for research because they trust that their participation will contribute to improved health for others and that researchers will minimize risks to participants. In return for the altruism and trust that make clinical research possible, the research enterprise has an obligation to conduct research ethically and to report it honestly. Honest reporting begins with revealing the existence of all clinical studies, even those that reflect unfavorably on a research sponsor’s product.

Unfortunately, selective reporting of trials does occur, and it distorts the body of evidence available for clinical decision-making. Researchers (and journal editors) are generally most enthusiastic about the publication of trials that show either a large effect of a new treatment (positive trials) or equivalence of two approaches to treatment (non-inferiority trials). Researchers (and journals) typically are less excited about trials that show that a new treatment is inferior to standard treatment (negative trials) and even less interested in trials that are neither clearly positive nor clearly negative, since inconclusive trials will not in themselves change practice. Irrespective of their scientific interest, trial results that place financial interests at risk are particularly likely to remain unpublished and hidden from public view. The interests of the sponsor or authors notwithstanding, anyone should be able to learn of any trial’s existence and its important characteristics.

The case against selective reporting is particularly compelling for research that tests interventions that could enter mainstream clinical practice. Rather than a single trial, it is usually a body of evidence, consisting of many studies, that changes medical practice. When research sponsors or investigators conceal the presence of selected trials, these studies cannot influence the thinking of patients, clinicians, other researchers, and experts who write practice guidelines or decide on insurance-coverage policy. If all trials are registered in a public repository at their inception, every trial’s existence is part of the public record, and the many stakeholders in clinical research can explore the full range of clinical evidence. We are far from this ideal at present, since trial registration is largely voluntary, registry data sets and public access to them varies, and registries contain only a small proportion of trials. In this editorial, published simultaneously in all member journals, the International Committee of Medical Journal Editors (ICMJE) proposes comprehensive trials registration as a solution to the problem of selective awareness and announces that all eleven ICMJE member journals will adopt a trials-registration policy to promote this goal.

The ICMJE member journals will require, as a condition of consideration for publication, registration in a public trials registry. Trials must register at or before the onset of patient enrollment. This policy applies to any clinical trial starting enrollment after July 1, 2005. For trials that began enrollment before this date, the ICMJE member journals will require registration by September 13, 2005, before considering the trial for publication. We speak only for ourselves, but we encourage editors of other biomedical journals to adopt similar policies. For this purpose, the ICMJE defines a clinical trial as any research project that prospectively assigns human subjects to intervention or comparison groups to study the cause-and-effect relationship between a medical intervention and a health outcome. Studies designed for other purposes, such as to study pharmacokinetics or major toxicity (e.g., phase 1 trials), would be exempt.

The ICMJE does not advocate one particular registry, but its member journals will require authors to register their trial in a registry that meets several criteria. The registry must be accessible to the public at no charge. It must be open to all prospective registrants and managed by a not-for-profit organization. There must be a mechanism to ensure the validity of the registration data, and the registry should be electronically searchable. An acceptable registry must include at minimum the following information: a unique identifying number, a statement of the intervention (or interventions) and comparison (or comparisons) studied, a statement of the study hypothesis, definitions of the primary and secondary outcome measures, eligibility criteria, key trial dates (registration date, anticipated or actual start date, anticipated or actual...
date of last follow-up, planned or actual date of closure to data entry, and date trial data considered complete), target number of subjects, funding source, and contact information for the principal investigator. To our knowledge, at present, only www.clinicaltrials.gov, sponsored by the United States National Library of Medicine, meets these requirements; there may be other registries, now or in the future, that meet all these requirements.

Registration is only part of the means to an end; that end is full transparency with respect to performance and reporting of clinical trials. Research sponsors may argue that public registration of clinical trials will result in unnecessary bureaucratic delays and destroy their competitive edge by allowing competitors full access to their research plans. We argue that enhanced public confidence in the research enterprise will compensate for the costs of full disclosure. Patients who volunteer to participate in clinical trials deserve to know that their contribution to improving human health will be available to inform health care decisions. The knowledge made possible by their collective altruism must be accessible to everyone. Required trial registration will advance this goal.

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Martin B. Van Der Weyden, M.D.
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ETHICAL CODE OF THE PHARMACEUTICAL INDUSTRY IN SLOVAKIA
(Excerpts)

Contents

Preface
Preamble

1. Nature and availability of information and claims
1.1 Responsibility
1.2 Provision of substantiating data
1.3 False or misleading claims
1.3.1 Unapproved products and indications
1.4 Good taste
1.5 Unqualified superlatives
1.6 New products
1.7 Comparative statements
1.8 Imitation
1.9 Medical ethics
1.10 Distinction of promotional material

2. Product information
2.1 Full product information
2.2 Abridged product information
2.3 Changes of clinical significance

3. Promotional material
3.1 Journal advertising
3.1.1 Full advertisement
3.1.2 Short advertisement
3.1.3 Company commissioned articles
3.2 Materials for use by medical representatives
3.2.1 Printed promotional material
3.2.2 Audiovisual promotional material
3.2.3 Brand name reminders
3.2.4 Medical literature/reprints
3.2.5 Computer-based promotional material
3.3 Mailings
3.4 Document transfer media
3.5 Promotional competitions

4. Medical representatives

5. Product samples

6. Trade displays

7. Travel and sponsorship

8. Research
8.1 Post marketing surveillance (PMS) studies
8.2 Market research

9. Relations with healthcare professionals
9.1 Entertainment
9.2 Medical educational material
9.3 General renumeration

10. Public relation and media relation
10.1 Press releases
10.2 Press conferences
10.3 Radio and TV
10.4 Entertainment and incentives

11. Marketing of pharmaceuticals on internet
11.1 Advisory (educational) web page
11.2 Company web page

Appendix
Operating Procedures for Complaints
Glossary – Pg. 7 of Operating Procedures for Complaints
Excerpts

Preface
The pharmaceutical industry* promouves the concept of good health, and a positive, health-oriented approach to daily living. Recognising that medicines play a vital role in the prevention, amelioration and treatment of disease states, the industry undertakes:

- to provide medicines that conform to the highest standards of safety, efficacy and quality;
- to ensure that medicines are supported by comprehensive technical and informational services in accordance with currently accepted medical and scientific knowledge and experience;
- to use professionalism in dealing with healthcare professionals*, public health officials and the general public.

The industry is committed to the quality use of medicines and rational prescribing, and supports that its products be used in accordance with the directions and advice of healthcare professionals. To ensure that the information* is available upon which to make informed prescribing decisions, it is necessary for the manufacturer* to disseminate to healthcare professionals the specialised product information gained during the research and development process, and from experience gained in clinical use. In doing so, the manufacturer draws attention to the existence and nature of a particular product* by appropriate educational and promotional measures.

With the full cooperation of the industry, there is now adequate legislation designed to safeguard the public by ensuring that all products marketed meet standards of quality, effectiveness and safety which are acceptable in the view of present knowledge and experience.

While it is possible to legislate satisfactorily for the testing, manufacture and control of medical products, appropriate standards of marketing conduct cannot be defined by the same means. For this reason, responsible manufacturers have concurred in the promulgation of the Code of Conduct and submitted to its constraints.

A Member* of the ADL, GENAS and SAFS (see Editorial note) undertakes to comply with the SAFS Statutes and the Code of Conduct of Pharmaceutical Industry in Slovakia.

Complaints against any activity of a member company should be made to the Ethical Committee of Pharmaceutical Industry in Slovakia as provided for in the Code (Operating procedures).

Note: A glossary of terms is provided. The first inclusion in the Code of a term defined by the glossary is denoted by asterisk (*).

Preamble

(a) This Code of Conduct sets out standards of conduct for the activities of companies when engaged in the marketing of prescription products used under medical supervision as permitted by Slovak legislation. The Code owes its origin to the determination of the ADL, GENAS and SAFS to secure universal acceptance and adoption of high standards in the marketing of prescription products for human use.

(b) Acceptance and observance of the Code is a condition of membership of the ADL, GENAS and SAFS, and a Member must comply with both the letter and the spirit of the Code. Members should ensure that all agents acting on their behalf are fully conversant with the provisions of this Code. Pharmaceutical companies outside the associations are invited to accept and observe this Code.

The Code shall be supervised and administered by the Ethical Committee. The Committee may issue determinations from time to time for the purpose of interpretation of certain sections of the Code. Complaints concerning alleged breaches of the Code should be reported to the Ethical Committee.

(c) A major guiding principle of the Code is that, whenever a promotional claim* is made for a product, it shall be accompanied by Slovak Product Information.*

(d) Failure to comply with the Code will result in sanctions being applied under the provisions of operating procedures. Adherence to this Code in no way reduces Members' responsibilities to comply with the Slovak legislation and Codes, including the IFPMA Code. Promotion* of prescription-only products to the general public is prohibited by law.

PROVISIONS OF THE CODE

1. Nature and availability of information and claims

1.1. Responsibility
It is the responsibility of Members, their employees and their medical/technical advisers to ensure that medical content* included in all promotional material* is correct*, fully supported by the product information, literature* or „Data on File“*, where the latter do not conflict with the former. Activities of company representatives* must comply with the Code at all times.

1.2. Provision of Substantiating Data
Further to the information supplied or generally available, the manufacturer will, upon reasonable request, provide healthcare professionals with additional accurate and relevant information about products which it markets.

Substantiating information must not rely solely on data on file.

Data cited in promotional material in support of a claim, including "data on file" or "in press" must be made available to healthcare professionals and industry companies upon request.

1.3. False or Misleading Claims
Information, medical claims* and graphical representations about products must be current, accurate, balanced and must not mislead either directly, by implication, or by omission.

Information, claims and graphics* must be capable of substantiation*, such substantiation being provided without delay at the request of health professionals.

1.3.1. Unapproved products and indications. Products that have not been approved for registration by ŠÚKL must not be promoted. However, samples of unapproved products may be displayed and educational material* made available at International Congresses* and local Congresses in accordance with Section 6. This restriction also applies to unapproved indications for registered products.

1.4. Good Taste
Promotional material (including graphics and other visual representations) should conform to generally accepted standards of good taste and recognise the professional standing of the recipients.

1.5. Unqualified Superlatives
Unqualified superlatives must not be used. Claims must not imply that a product or an active ingredient is unique* or has some special merit, quality or property unless this can be substantiated. The word "safe" must not be used without qualification.

1.6. New Products
The word "new" must not be used to describe any
product, presentation, or therapeutic indication which has been available and generally promoted for more than 12 months in Slovak Republic.

1.7. Comparative Statements
Comparison of products must not be disparaging, but must be factual, fair and capable of substantiation and referenced to its source. In presenting a comparison, care must be taken to ensure that it does not mislead by distortion, by undue emphasis or in any other way. "Hanging" comparatives - those which merely claim that a product is better, stronger, more widely prescribed etc must not be used.

"Data on file" when used to substantiate comparative statements must comply with the requirement of Section 1.2.

1.8. Imitation
Promotional information should not imitate the devices, copy, slogans or general layout adopted by other manufacturers in a way that is likely to mislead or confuse.

1.9. Medical Ethics
Doctors’ names or photographs must not be used in any way that is contrary to medical ethics.

1.10. Distinction of Promotional Material
Promotional material must be clearly distinguishable as such.

2. Product Information
Certain types of promotional material described in Section 3 must be accompanied by either full or abridged product information. Wherever required, product information must appear in a type size of not less than 2 mm on a background sufficiently contrasting for legibility. Major headings should be easily identifiable. Product information must not be overprinted or interspersed with promotional phrases or graphics and must clearly identify any recent change of clinical significance.

2.1. Full or abridged product information must accompany all promotional material in the Slovak Republic.

2.2. Abridged Product Information may be used in medical publications.

2.2.1. Abridged Product Information must accurately reflect the full Product Information but may be a paraphrase or précis of the full Product Information.

2.2.2. Under the heading "Abridged Product Information", the following shall appear:
(a) Approved indications for use, (b) Contra-indications, (c) Clinically significant warnings, (d) Clinically significant precautions for use, (e) Clinically significant adverse effects and interactions, (f) Available dosage forms, (g) Dosage regimens and routes of administration, (h) Dependence potential of clinical significance, (i) Reference to special groups of patients.

Where the full Product Information does not include items under these headings, such headings are not required to be included in the document.

2.3. Changes of Clinical Significance
2.3.1. Where a change of clinical significance relating to product safety is incorporated into the Product Information, it should be indicated in all representations of the Product Information for a period of 12 months from the date of change by an asterisk(s) to a footnote in type size of not less than 2 mm: Please, note change(s) in product information.

2.3.2. The full text of the changed section should be included in any abridged Product Information during this period.

2.3.3. Where a Member is not actively promoting the product, written advice of the change to product information should be forwarded to the appropriate healthcare professionals.

3. Promotional Material*

3.1. Journal Advertising
Journal Advertising must conform with the requirements of one or other of the following categories. The information required shall appear in each publication in a type size of not less than 2 mm, and should appear on a background sufficiently contrasting for legibility.

3.1.1. Full advertisement*
3.1.1.1. A full advertisement must contain the following within the body of the advertisement: (a) The brand name of the product, (b) The INN of the active ingredient(s), (c) The name of the registration holder and its mailing address in Slovak Republic, (d) The full or abridged Product Information.

3.1.1.2. A full advertisement is mandatory for the advertising of all new chemical entities or the advertising of new indications for 12 months from the date of first advertising in medical publications, or longer at the discretion of the advertiser.

3.1.1.3. The Product Information should be placed adjacent to the body of the advertisement. Where it is not practicable to do so, the advertisement must carry a statement in type size not less than 2 mm to the effect of the following statement: Please review Product Information before prescribing. In this publication, product information can be found .... At the point ..., insert the page number in the publication where the information can be found or reference to an adequately referenced product information section or advertisers index. Product Information should form a fixed part of the journal.

3.1.1.4. The use of an abridged advertisement is permitted after 12 months from first advertising of a new chemical in medical publications.

3.1.1.5. The abridged Product Information should be placed adjacent to the body of the advertisement. Where it is not practicable to do so, the advertisement will carry a statement in not less than 2 mm type size, to the effect of the following statement: "Please review product information before prescribing. In this publication, product information can be found .... At the point ..., insert the page number in the publication where the information can be found or reference to an adequately referenced product information section or advertisers index. Product Information should form a fixed part of the journal.

3.1.2. Short advertisement
3.1.2.1. A short advertisement is designed to remind a prescriber of a product's existence, and must not contain promotional claims. The sole use of a short advertisement within any one issue of a publication is not permitted before 12 months from first advertising of a new chemical entity or before 12 months following a change of clinical significance made to the Product Information.

3.1.2.2. A short advertisement must contain: (a) The brand name of the product, (b) The INN of the active ingredient(s), (c) The name of the registration holder and its mailing address, (d) A statement to the effect that further information is available on request from the supplier.

3.1.2.3. A short advertisement may contain: (a) up to 5 words describing therapeutic class, but without the use of promotional phrases, (b) graphics, (c) a statement of available dosage forms, (d) a statement referring to the location of product information in a reference manual.

No other material is permitted.

3.1.3. Company Commissioned Articles
3.1.3.1. Company Commissioned Articles must be
identified as such in a type size of not less than 2 mm.

3. 1. 3. 1. The Member which is responsible for the insertion of the Company Commissioned Article must be clearly identified at either the top or the bottom of the Company Commissioned Article in a type size of not less than 2 mm.

3. 1. 3. 2. Company Commissioned Articles must conform to all relevant provisions of Section 1 of this Code.

3. 1. 3. 3. Company Commissioned Articles must conform to the requirements of sections 3.1.1. and 3.1.2. of the Code of Conduct.

3. 2. Materials for use by Medical Representatives*

A major guiding principle of the Code is that, whenever a promotional claim is made for a product, it shall be accompanied by product information. Where multiple forms of promotion items are intended to be distributed at one time, the product information must appear at least once.

3. 2. 1. Printed promotional material

3. 2. 1. 1. All Member printed promotional material must include the following information: (a) The brand name of the product, (b) The INN of the active ingredient(s), (c) The name of the registration holder and its mailing address in Slovak Republic, (d) Full or abridged Product Information, (e) The date of the issuing or of the revision.

3. 2. 1. 2. Where it is impractical to print the Product Information on the body of the promotional material, the promotional material will carry a statement to the effect of the following in a type size of not less than 2 mm: "Please review Product Information before prescribing. Product Information accompanies this item." The item is then to be accompanied by a full or abridged Product Information document.

3. 2. 2. Audio-visual promotional material

3. 2. 2. 1. All audio-visual promotional material must be accompanied by a document which contains the following information: (a) The brand name of the product, (b) The INN of the active ingredient(s), (c) The name of the registration holder and its mailing address in Slovak Republic, (d) Full or abridged Product Information.

3. 2. 2. 2. Where an audio-visual item is demonstrated, the product information document must be given to the individual reviewing the promotional material, or offered to the audience in a group situation on completion of the presentation.

3. 2. 3. Brand name reminders*

Brand name reminders or promotional items of insignificant value, provided free of charge, are permissible as long as they are related to the health care provider's work and/or entail a benefit to patients.

3. 2. 3. 1. Brand Name Reminders or Promotional Items must include the following information: (a) The brand name of the product, (b) The INN of the active ingredient(s).

3. 2. 3. 2. Brand Name Reminders or Promotional Items are not to contain any promotional claims/and or statements.

3. 2. 3. 3. Where the nature of a Brand Name Reminder or Promotional Item is such that it is demonstrably and obviously impractical to display legibly the brand name of the product and the INN of the active ingredient(s) as required in Section 3.2.3.1, the Brand Name Reminder or Promotional Item must be accompanied by a document containing the information specified in Section 3.2.3.1.

3. 2. 3. 4. Where the nature of a Brand Name Reminder or Promotional Item is such that it is demonstrably and obviously impractical to display legibly the notation "See Warning" as required in Section 2.3.1, a Brand Name Reminder or Promotional Item must not be used for that product.

3. 2. 4. Medical literature/reprints

3. 2. 4. 1. The general tenor of any reprints of journal articles, proceedings of symposia or summaries of literature used in promotion must be consistent with the Product Information.

3. 2. 4. 2. Quotations from medical literature or from personal communications must accurately reflect the meaning of the author and significance of the study.

3. 2. 5. Computer Based Promotional Material

3. 2. 5. 1. Computer based promotional material must comply with all relevant provisions of this Code.

3. 2. 5. 2. Where an individual product is being promoted the appropriate Product Information must be given to an individual reviewing the promotional material, readily accessible via the computer based material or offered to an audience in a group situation on completion of the presentation.

3. 2. 5. 3. Where the Product Information is included in interactive data system, instructions for accessing it must be clearly displayed.

3. 3. Mailing*

3. 3. 1. Mailings must comply with all relevant provisions of Section 1 of this Code.

3. 3. 2. The full or abridged Product Information as applicable must be included in all mailings where promotional claims are made.

3. 3. 3. Mailings should only be sent to those categories of health professionals whose need for, or interest in, the particular information can be reasonably assumed. Requests to be removed from promotional mailing lists must be complied with promptly and no name restored except at specific request or with written permission.

3. 3. 4. Exposed mailings including postcards, envelopes or wrappers must not carry matter which might be regarded as advertising to the general public or which could be considered unsuitable for public view.

3. 4. Document Transfer Media

Unsolicited telegrams, telexes and electronic transmissions, or replicas thereof, must not be used for promotional purposes.

3. 5. Promotional Competitions

3. 5. 1. Promotional competitions must fulfil all of the following criteria:

(i) The competition is based on medical knowledge or the acquisition of medical knowledge.

(ii) The prize is directly relevant to the practice of medicine or pharmacy.

(iii) Individual prizes offered are to be of low monetary value or be an item of educational material.

3. 5. 2. Entry into a competition must not be dependent upon prescribing or recommending of a product and no such condition shall be made or implied.

3. 5. 3. The conduct of competitions shall comply in all respects with relevant Slovak regulations.

4. Medical representatives

4. 1. Medical representatives must only use promotional material which conforms to the provisions of Section 3 of this Code. Verbal statements made about a product must comply with the provisions of Section 1 of this Code.

4. 2. Members have a responsibility to maintain high standards of ongoing training for representatives.

4. 3. Medical representatives should possess sufficient medical and technical knowledge to present information on the company’s products in an accurate current and balanced manner and should be cognisant of all provisions of this Code.
4.4. Medical representatives should at all times maintain a high standard of ethical conduct in the discharge of their duties.

4.5. Medical representatives must not employ any deception to gain an interview.

4.6. Medical representatives should ensure that the frequency, timing and duration of calls, together with the manner in which they are made, are such as not to cause inconvenience. The wishes of an individual doctor, or the arrangements in force at any particular establishment, must be observed by medical representatives.

4.7. Medical representatives must not use the telephone to promote products to the medical profession unless the agreement of the doctor has been obtained.

4.8. Wherever a promotional claim is made, the medical representative will provide product information.

4.9. Under no circumstances shall representatives pay a fee in order to gain access to a healthcare professional.

5. Product Samples

Care should be exercised by Members that the distribution of Samples is carried out in a reasonable manner.

5.1. Samples may only be supplied to physicians for going familiarisation with products. Product information and Consumer Product Information, when available, should be offered at the time of distribution or included in the product pack.

5.2. Sample packs should be clearly identified as such and must be labelled in such a way that it is clear expressed they are medical samples and not for sale.

5.3. Representatives must take adequate precautions to ensure the security of samples in their possession. Members should develop an appropriate recording system so that, if a product recall is necessary, relevant samples will be included in the recall.

5.4. Drug donation to hospital should be at a reasonable level and should be of public knowledge.

5.5. On request, Members must promptly accept the return of samples of their products.

6. Trade displays

General Principle: Trade displays are important for the dissemination of knowledge and experience to the healthcare professions. The prime objective in organising such displays should be the enhancement of medical knowledge. Where hospitality is associated with symposia and congresses, it should always be secondary to the main purpose of the meeting.

6.1. Trade displays must only be directed to healthcare professionals.

6.2. A trade display must include, in a prominent position, the name of the sponsoring company.

6.3. Exhibitors must comply with all requirements of the sponsoring institution when mounting and conducting an exhibit.

6.4. Product information for products being promoted must be available from the display stand.

6.5. Samples must not be made available for collection from unattended stands, nor be supplied to unauthorised or non-qualified persons.

6.6. Competitions that are held as part of a Trade Display must be consistent with the requirements of Section 3.7 of this Code.

6.7. All promotional materials used at Trade Displays must be consistent with the requirements of Sections 1.3.1 and 3.2 of this Code.

7. Travel and sponsorship

7.1. The following applies to Members sponsoring delegates travelling from or within Slovak Republic to symposia and/or congresses:

- Travel may be subsidised provided the meeting is directly related to the healthcare professional’s area of expertise.
- A reasonable level of accommodation expenses may be covered.
- Expenses for family or travelling companion(s) should not be paid by the sponsoring Member.
- Travel agenda and programme should be approved by company General Manager.
- At least 60% of working hours* (at the place without travelling time) should be dedicated to work.
- Participation should not be made dependent on request to prescribe determined amount of certain drug.

7.2. Where attendees are being sponsored to attend symposia, meetings are to be held in appropriate centres and geographically adequate locations.

7.3. The symposia’s focus should be on scientific and medical matters and hospitality should be secondary to the main purpose of the event.

8. Research

The following provisions apply to Market Research* and Post-Marketing Surveillance Studies*, whether the research is carried out directly by the manufacturer or by an organisation acting under its direction.

General: Clinical trials of products approved for registration are not covered by the above categories.

8.1. Post-Marketing Surveillance (PMS) Studies

8.1.1. Post-Marketing Surveillance Studies should have scientific or medical merit and not be designed for, or conducted as, a promotional exercise.

8.1.2. Post-Marketing Surveillance Studies must have a formal protocol, a requirement for data collection and generation of a report. Report should be suitable for publication on medical journals or for presentation at a conference.

8.1.3. Only patients being treated for approved indications of the product are to be included in the Post-Marketing Surveillance Study.

8.1.4. Decisions by the medical profession to prescribe the product should be based on their clinical judgement.

8.1.5. No starter packs or free trade packs* should be distributed as part of the Post-Marketing Surveillance Study.

8.1.6. Any payment to the medical profession must be commensurate with the work involved.

8.2. Market Research

8.2.1. Market Research studies must be clearly identified as such when the initial approach is made.

8.2.2. Any payment must be kept to a minimum and should not exceed a level commensurate with the work involved.

8.2.3. Promotion should not be represented as Market Research or research of any type.

9. Relations with healthcare professionals

Members may choose to support professional activities, by financial or other means. Such support must be able to successfully withstand public and professional scrutiny, and conform to professional standards of ethics and of good taste.

9.1. Entertainment. Entertainment or other hospitality offered to healthcare professionals should be appropriate, secondary to the educational content and in proportion to the occasion.
9.2. Medical Educational Material

9.2.1. Materials supplied for medical education must include the name of the manufacturer and its mailing address in the Slovak Republic.

9.2.2. Material supplied for medical education may include promotional claims and/or statements, but must comply with Section 3 of the Code of Conduct.

9.3. General Remuneration.

Any remuneration for services rendered should not exceed what is commensurate with the services supplied. The remuneration must not be dependent upon prescribing of a determined amount of certain product and no such condition shall be made or implied.

10. Public and media relations

Information delivered to public has to be used exclusively for improvement of public knowledge from medical and healthcare area only. Such information about new chemical entities, new drugs and ways of treatment delivered to public and media has to be:

- truthful, verified, full, clear and understandable;
- would not contain any unproved assumptions and expectations;
- would not create an false illusion for patients about treatment efficacy or unverified hope for certain improvement of his health status;
- would not have intention to cheat journalist or patient or intention to damage competitor.

No pressure has to be created to media professionals to publish delivered information. They have to have freedom for their own decision how they will use information according to their professional opinion and reader's interests.

Media have to be not financially motivated by advertising or other bar ters to publish certain information about prescription drugs. In this case it is advertising which is prohibited by law.

10.1. Press releases. Press release has to follow all rules stated under point 10. Content of press release has to use proved facts without advertising messages.

10.2. Press Conferences. Information delivered to journalists has to follow all rules stated under point 10. It is recommended to use as speakers for medical information, methods of treatment and drug related information preferably medical professionals which are not company employees. Entertainment or other hospitality have to be appropriate and in proportion to the occasion.

The standard part of press conference has to be press release.

10.3. Radio and TV. Radio and TV broadcasts have to follow all rules stated under point 10.

10.4. Entertainment and incentives. Entertainment or other hospitality offered to journalists should be appropriate and in proportion to the occasion and must not motivate or oblige journalists to publish information delivered by company in wished manner. The journalists would be invited by company for foreign trips or trips within Slovakia for educational or expert purpose only and hospitality should be secondary to the main purpose of event.

11. Marketing of pharmaceutical products on Internet

Generally:

- Whole Internet communication of Members and their products has to be in accordance with other regulations described in the Ethical Code.
- For the purpose of marketing and promotion activities Internet is considered to be an public information and advertising medium.

- Advisory/educational web page or company web page must clearly state who is the orderer and who is the guarantor of the web page content.

11.1. Advisory/Educational Web Page

- It is dedicated and used by wide public.
- It can contain information about diseases, principals of treatment, prevention but trade /brand names of products cannot be used (names of substances can be used ).
- It must contain recommendation that if the disease is suspected or problems with treatment appear it is necessary to contact medical doctor.
- The web page content must not urge laic public to use a treatment if it is not necessary.
- "Advisor" which acts on web page must be a medical doctor and his full name, specialisation and working place must be published.
- All questions and answers discussed on web page must have to be archived for one year.
- It can not contain visualisation of concrete drug package with the name of drug and also can not contain any other visualisation of drug or drug form which could help to recognise it (for example the picture of pill with the name of the drug).
- Illustrative visualisation of drug could be only general picture, which will not indicate concrete product.
- If graphic design contains features taken from drug visual, than product name can not be used.

11.2. Company web page

- It contains information about company and its activities.
- Company web page can contain portfolio with the product brand names with complete SPC and package insert leaflet.
- Before the specialist will enter the page with the product information he has to passed through the page with claim: following information is for medical specialists only (for medical doctors and pharmacists) and if the laic will read them misunderstanding of content can seriously damage his health although he will not act according them.
- Additionally, to enter web page with these product information it is necessary actively (by click) to mark an answer that person is specialist as it is described.
- If the company web page contains list of company products (portfolio with brand names) it can not be advertised to wide public and marketing and advertising activities which support the sales of new product can not be supported by advertising tend to company web page.
- Company page can contain information about product prices and reimbursement. Web page provider is obliged to update these data after every change.

Note of the Editor

The code has been approved by all three associations of pharmaceutical companies and medicinal drugs distributing companies in Slovakia, namely by the Slovak Association of Research based Pharmaceutical Industry in Slovakia (SAFS), Association of Producers of Generic Drugs (GRNAS) and Association of Distributors of Drugs (ADL), and has been made valid for all member companies since October 1, 2004. "Explanatory Notes" (omitted in this excerpt) form an integral and important part of the Code. They elaborate further the principles set out in the Code and provide more detailed guidance for their application. The full text of the Code in PDF can be downloaded at e.g. http://www.safs.sk
ETICKÝ KODEX FARMACEUTICKÉHO PRIEMYSLU NA SLOVENSKU
(Výťažky)

Obsah
Pредлов
Úvod

1. Povaha a dostupnosť informácií a tvrdení
1.1. Zodpovednosť
1.2. Poskytovanie preukazných údajov
1.3. Napodobňovanie
1.4. Dobrý vkus
1.5. Nové produkty
1.6. Porovnávacie tvrdenia
1.7. Napodobňovanie
1.8. Lekárska etika
1.9. Zodpovednosť
1.10. Rozlišenie propagačného materiálu

2. Informácia o produkte
2.1. Úplná informácia o produkte
2.2. Skrátená informácia o produkte
2.3. Klinicky významné zmeny

3. Propagačný materiál
3.1. Reklama v časopisoch
3.2. Materiály na použitie lekárskymi zástupcami
3.3. Audiovizuálny propagačný materiál
3.4. Počítačový propagačný materiál
3.5. Propagačné súťaže

4. Lekárski zástupcovia

5. Vzorky produktov

6. Obchodné výstavy

7. Cestovanie a sponzorstvo

8. Výskum
8.1. Postmarketingové pozorovacie štúdie (PMŠ)
8.2. Priemysku trhu

9. Vzťahy so zdravotníckymi pracovníkmi
9.1. Zážaba
9.2. Vzdelávacie materiály pre lekárov
9.3. Všeobecné odmenovanie

10. Vzťahy s verejnosťou a médiami
10.1. Oznámenia pre tlač
10.2. Tlačové konferencie
10.3. Rozhlas a televízia
10.4. Zážava a prostriedky motívovania

11. Marketing farmaceutických výrobkov na Internete
11.1. Poradenská (vzdelávacia stránka)
11.2. Firemná stránka

Prílohy:
Postupy pri posudzovaní stážností
Slovenské – od str. 7 v Postupoch pri posudzovaní stážností

Výňatky

Pредлов
Farmaceutický priemysel¹ propaguje koncepciu dobro- rého zdravia a pozitívneho, na zdravie orientovaného prítu- stupu ku každodennému životu. Užívaný, že lieky zo- hrávajú dôležitú úlohu v prevencii, zlepšení a liečbe ocho- rení, sa farmaceutický priemysel zaväzuje:
• zabezpečovať lieky, ktoré spláňajú najvyššie štanda- dy bezpečnosti, účinnosti a kvality;
• zabezpečovať, aby lieky sprevádzali komplexné technické a informačné služby v súlade s aktuálne uz- návaným medicínským a vedecím poznanim a skú- senosťami;
• preukazovať profesionálnu pri styku so zdravot- níckymi pracovníkmi¹, predstavitelmi verejného zdra- hvána a verejnou.

Priemysel sa angažuje za kvalitné využívanie liekov a racionalné predpisovanie a podporuje, aby sa jeho pro- dukty využívali v súlade s pokynmi a radami zdravotníckych odborníkov. Ak sa zabezpečila dostupnosť informácií¹, na základe ktorých je možné robiť kvalifikova- vané rozhodnutia pri predpisovaní liekov, je potrebné, aby výrobca¹ rozširoval medzi zdravotníckymi odborníkmi odborné informácie o produkte, ktoré získal počas vý- skumného a vývojového procesu, a skúseností získané v klinickom používaní. Touto činnosťou výrobca upriam-uje pozornosť na existenciu a vlastnosti príslušného pro- duktu¹ vhodnými vzdelávacími a propagačnými pro- striedkami.

S ponúkou podporou priemyslu zvýšila v súčasnosti do- statočná legislatíva, ktoré verné cieľom je chrániť verejnosť tým, že zaručuje, aby všetky produkty používané na trhu spláň- li štandardy kvality, efektívnosti a bezpečnosti, ktoré sú prijateľné z pohľadu súčasných poznatkov a skúsenosťí. Kým skúšanie, výrobu a kontrolu je možné legislatíve uspokojivo uzákoniti, nemožno tými istými prostriedkami definovať vhodné štandardy marketingového správania. Preto sa zodpovední výrobčovia zhodli na zverejnenie etic- kého kódu a podriadi sa jeho obmedzeniam.

Člen¹ ADL, GENAS a SAFS (vid Poznámku editora) sa zaväzuje dodržiavat štandardy správania farmaceutického priemyslu na Slovensku. Státna vedecké a zdravotnícky právne predpisy. Kódex má pôvod v odhodlaní ADL, GENAS a SAFS zabezpečiť všeobecné prijatie a dodržiava- nie vysokých štandardov v marketingu produktov na predpis na ľudské použitie.

Poznámka: Pripojený je glosár odborných termínov. Prvé uvedenie termínu, ktorého definícia je v glosári, je označené hviezdičkou (*).
(c) Základným riadiacim princípom kódexu je to, že kedykoľvek sa o produkt viete určené širokej verejnosti, musí ho sprevádzať slovenská informácia o produktu.

(d) Nedodržanie kódexu bude mať za následok sankcie, ktoré sa budú udeľovať podľa ustanovení postupov pri podávaní stážnosti. Dodržiavanie tohto kódexu nižšieho stupňa je potrebné a musí dodržiavať slovenské právne predpisy a kódeky vrátane Kódexu IFPMA. Zákonnú platnosť mu tiež poskytuje štát.

Ustanovenia Kódexu

1. Povaha a dostupnosť informácií a tvrdení

1.1. Zodpovednosť

Informácia, ich zamestnanci a zdravotnícky/technický poradcovia sú zodpovední za zabezpečenie toho, aby bol medicínsky obsah* zaradený do všetkých propagačných materiálov* korektný*, alebo pod týmito názovmi (napr. „medzinárodný“) sa mala poskytovať úplná a dostupné informácie o produkti. Názov „medzinárodný“ sa mohlo použiť len v prípade, že sa používajú množstvom lekárov a spoločností.

1.2. Poskytovanie preukazných údajov

Informácie o produkti musia byť správne, presné a vyvážené a nesmú implikovať, že produkt alebo jeho aktívna složka sú unikátne* alebo majú nejakú zvláštnu prednosť kvôli významnú zmenu* . Ak sa uvádza klinicky významná zmena týkajúca sa bezpečnosti produktu, musí sa preukázať všetky informácie o produkti.

1.3. Neprávdivé alebo zavádzajúce tvrdenia

V lekárskych publikáciách sa môže používať skrátená informácia o produktoch. Všetky mená lekárov alebo fotografie sa nesmú používať spôsobom, ktorý by odporoval lekárskej etike.

1.4. Dobrý vkus

Propagačný materiál (vrátane grafických a iných viacúčelových prezentácií) by sa mal podriadiť všeobecne uzávieraniu príjemcov.

1.5. Neoprávnené superlatívy

Neoprávnené superlatívy sa nesmú používať. Tvrdenie, že produkt alebo jeho aktívna zložka sú unikátne* alebo majú nejakú zvláštnu prednosť kvôli významnú zmenu* . Ak sa uvádza klinicky významná zmena týkajúca sa bezpečnosti produktu do informácie o produkti, musí sa zavedieť na všetkej niečo pri podávaní sťažností. Dodržiavanie tohto kódexu nížšieho stupňa je potrebné a musí dodržiavať slovenské právne predpisy a kódeky vrátane Kódexu IFPMA. Zákonnú platnosť mu tiež poskytuje štát.

1.6. Nové produkty

Slovo „nový“ sa nesmie použiť na opis žiadneho produktu, prezentácie alebo terapeutické indikácie, ktoré boli dostupné v minulosti.

1.7. Porovnávacie tvrdenia

Porovnávanie produktov nesmie byť znevažujúce, musí byť veľmi, početné a musí sa dať preukázať alebo doložiť odkazom na zdroj. Pri uvádzaní porovnania je potrebná opatrnosť a je potrebné zaistit, aby porovnávanie nezavádzať skresľovaním, nenáležitým dôrazom alebo inak. Nemá sa používať také komparatívne prírovnania, ktoré by tvrdia, že produkt je lepší, silnejší, častejšie doložený a pod. Ak sa používajú na zdôvodňovanie porovnávacích tvrdení „archivované údaje“, musia v byť v súlade s požiadavkou časti 1.2.

1.8. Napodobňovanie

Propagačné informácie by nemali napodobňovať proizvedy, kópirovať alespoň všetkých grafických úpravach. Ak sa použijú iné názvy, používať zmlčaním. Vždy je potrebné uvádzať určitú tvrdená informácie o produktoch musia byť správne, presné a vyvážené a nesmú implikovať, že produkt alebo jeho aktívna složka sú unikátne* alebo majú nejakú zvláštnu prednosť kvôli významnú zmenu* . Ak sa uvádza klinicky významná zmena týkajúca sa bezpečnosti produktu, musí sa preukázať všetky informácie o produkti.
3. 2. Úplné znenie zmenenej časti sa musí uvádzať počas tohto obdobia v každej informácii o produkte.

3. 3. Ak člen aktívne neprapaguje produkt, musí sa zmena informácie o produkte písomne oznámiť príslušným zdravotníckym odborníkom.

3. Propagačný materiál*

3. 1. Reklama v časopísoch

Reklama v časopísoch musí byť v súlade s požiadavkami jednej z nasledujúcich kategórií. Požadovaná informácia sa musí objaviť v každej publikácii vytlačená veľkosťou pisma nie menšou ako 2 mm a musí byť z dôvodov čitateľnosti dostatočne odlišená od pozadia.

3. 1. 1. Úplná reklama*

3. 1. 1. 1. Úplná reklama musí obsahovať v rámci reklamného útvaru nasledovné: (a) Obchodnú značku produktu, (b) INN aktívnych látok (látky), (c) meno držiteľa registrácie a jeho poštovú adresu v Slovenskej republike, (d) Úplnú alebo skrátenú informáciu o produkte. 3. 1. 1. 2. Úplná reklama je povinná pre reklamu všetkých nových chemických látok* alebo nových indikácií počas 12 mesiacov od dátumu prvej reklamy v lekárskych časopísoch alebo dňa, na ktorom bol počas prezentácie odovzdaný dokument, ktorý obsahuje nasledovné informácie: (a) obchodnú značku produktu, (b) INN aktívnych látok (látky), (c) meno držiteľa registrácie a jeho poštovú adresu v Slovenskej republike, (d) Úplnú alebo skrátenú informáciu o produkte, (e) dátum vydania alebo revízie. 3.1.1.3. Informácia o produkte musí byť umiestnená vedľa útvaru reklamy. Ak to nie je prakticky uskutočniteľné, musí reklama obsahovať o tom, vytlačenú aspoň 2 mm veľkosťou pisma nasledovného obsahu: "Pred predpisovaním prezrite si láskavo informáciu o produkte. V tejto publikácii informáciu o produkte nájdete..." V tomto bode ..., vložte číslo strany v publikácii, kde sa informácia nachádza, alebo odkaz na príslušné doporučené časti s informáciou o produkte alebo index inzerentov. Informácia o produkte musí byť pevnou súčasťou časopisu. 3. 1. 1. 4. Použitie skrátené reklamy je dovolené po 12 mesiacoch od uvedenia prvej reklamy novej chemikálie v lekárskych publikáciách.

3. 1. 1. 5. Skrátená informácia o produkte by mala byť umiestnená vedľa útvaru reklamy. Ak to nie je prakticky uskutočniteľné, musí reklama obsahovať o tom, vytlačenú aspoň veľkosťou pisma nasledovného obsahu: "Pred predpisovaním prezrite si láskavo informáciu o produkte. V tejto publikácii informáciu o produkte nájdete..." V tomto bode ..., vložte číslo strany v publikácii, kde sa informácia nachádza, alebo odkaz na príslušné doporučené časti s informáciou o produkte alebo index inzerentov. Informácia o produkte musí byť pevnou súčasťou časopisu.

3. 1. 2. Krátká reklama

3. 1. 2. 1. Krátká reklama má pripomenúť predpisujúcu existenciu produktu a nesmie obsahovať propagáčné tvrdenia. Použitie iba krátkej reklamy v rámci jedného článku publikácie nie je dovolené pred uplynutím 12 mesiacov od prvého uverejnenia reklamy na nové chemické látky alebo pred uplynutím 12 mesiacov po významnej klinickej zmene zaznamenané v informácii o produkte. 3. 1. 2. 2. Krátká reklama musí obsahovať: (a) Obchodnú značku produktu, (b) INN aktívnych látok (látky), (c) Názov držiteľa rozhodnutia o registrácii a jeho poštovú adresu, (d) Formuláciu o tom, že je možné získať na požiadanie ďalšie informácie od dodávateľa.

3. 1. 2. 3. Krátká reklama môže obsahovať: (a) do 5 slov opisujúcich terapeutických tried*; (b) grafické prostriedky, (c) využitie o dostupných formách dávkovania, (d) vytlačenú aspoň 2 mm veľkosťou pisma nasledovného obsahu: "Pred predpisovaním prezrite si láskavo informáciu o produkte. V tejto publikácii informáciu o produkte nájdete..." V tomto bode ..., vložte číslo strany v publikácii, kde sa informácia nachádza, alebo odkaz na príslušné doporučené časti s informáciou o produkte alebo index inzerentov. Informácia o produkte musí byť pevnou súčasťou časopisu.

3. 1. 3. Články zadané spoločnosťou

3. 1. 3. 1. Články zadané spoločnosťou je potrebné označit ako také veľkosťou pisma nie menšou ako 2 mm.
súhrnu literatúry použitej v propagácii musí byť v súlade s informáciou o produkte.

3. 2. 5. Počítačový propagáčny materiál
3. 2. 5. 1. Počítačové propagáčné materiály musia dodržiavať všetky príslušné ustanovenia tohto kódexu.
3. 2. 5. 2. Pri propagácii individuálneho produktu musí dostáť jednotlivce prezerajúci si propagáčny materiál ľahko dostupný cez počítač alebo ponúkaný publiku v skupinovej situácii po skôršom prezentácií príslušnú informáciu o produkte.
3. 2. 5. 3. Ak je informácia o produkte vložená do integrovaného systému, musia byť inštrukčné jasne znázornené.
3. 3. Poštové zásilky
3. 3. 1. Poštové zásilky musia dodržiavať všetky relevantné ustanovenia časti 1 tohto kódexu.
3. 3. 2. Podľa potreby musí byť zaradená do všetkých poštových zásielek, v ktorých sú uvedené propagáčné tvrdenia, úplné alebo skratená informácia o produkte.
3. 3. 3. Poštové zásilky sa môžu posielat iba tým kategóriám zdravotníckych pracovníkov, u ktorých možno primerane predpokladať ich potrebu alebo záujem. Žiadostami o vyrozdanie z reklamného adresa sa potrebne zabezpečiť, že všetky výzvy sú zodpovedné a že všetky poštové zásilky sú v súlade s požiadavkami časti 1.3.1 a 3.2 tohto kódexu.
3. 3. 4. Obnovená zásilka vrátane pohľadnicí, obálu, prebalov nesú mať na sebe obsah, ktorý by sa mohol považovať na reklamu pre širokú verejnosť, a ak je to potrebné, musia byť nesmie súvisiť s obchodnými účelmi.
3. 4. Média používané na prenos dokumentov
3. 4. 1. Nevyžiadané telegramy, telexy a elektronicke prenosy alebo replíky na ne sa nesúvia využívať na propagáčne účely.
3. 5. Propagačné súťaže
3. 5. 1. Propagačné súťaže musia splniť všetky nasledujúce kritériá:
(i) Súťaž sa zakladá na medicínskych znalostiach alebo informácii o produkte.
(ii) Cena priamo súvisí s praxou medicíny alebo farmácie.
(iii) Žiadostami o prednaplnenie záväzku je možné, že sa mohol považovať za nevhodný pre zrak verejnosti alebo praktických možností.
3. 6. Lekárske zástupcovia
4. 1. Lekárske zástupcovia musia používať iba propagáčný materiál, ktorý vyhovuje ustanoveniam časti 3 tohto kódexu. Slovne vyhlásenia o produkte musia byť v súlade s ustanoveniami časti 1 tohto kódexu.
4. 2. Členovia sú zodpovední za udržiavanie vysokých standardov a sústavné školenie zástupcov.
4. 3. Lekárske zástupcovia musia mať dostatočné lekárske a technické vedomosti, aby prezentovali informáciu o produktoch spoločnosti presne, aktuálne a vyvážene, a mali by byť oboznámnené so všetkými ustanoveniami tohto kódexu.
4. 4. Lekárske zástupcovia musia vždy udržiavať výsoký etický standard správania pri výkone svojich povinností.
4. 5. Lekárske zástupcovia nesú mať používať žiadne podvodné triky s cieľom dostihnúť tak štetnity, ako je nezákonné.
4. 6. Lekárske zástupcovia sa musia postarať o to, aby frekvencia, načasovanie a dlžka návštev, ako aj spôsob, akým sú robené, neodhalovali. Lekárske zástupcovia musia dodržiavať prijatia jednotlivého lekára alebo organizácie predpisy platné v konkrétnej zariadení.
4. 7. Lekárske zástupcovia nesú mať využívať na propagáciu produktov medzi lekárom alebo podľa potreby umiestniť v súlade s príslušným kódexom.
4. 8. Kedykoľvek sa robi propagáčné tvrdenie, poskytne lekárske zástupcu informáciu o produkte.
4. 9. Za žiadnych okolností nebude lekársky zástupca platíť za to, aby získal prístup k zdravotníckemu pracovníkovi.
5. Vzorky produktov
Členovia musia dohliadnuť, aby sa distribúcia vzoriek robila primerným spôsobom.
5. 1. Vzorky sa môžu lekárom dávať iba na dokonalé oboznámenie sa s produktmi. V čase distribúcie musí byť použitá ašiať na alebo do balíčka produktov zaradená informácia o produkte, a ak je k dispozícii, aj informácia o produkte prípadnej podmienky.
5. 2. Balíčky vzoriek musia byť iba také, že sa možno identifikovať, a je možné, že sa môžu používať iba na dokonalé oboznámenie sa s produktmi. V čase distribúcie musí byť použitá ašiať na alebo do balíčka produktov zaradená informácia o produkte, a ak je k dispozícii, aj informácia o produkte prípadnej podmienky.
5. 4. Dary liekov pre nemocnú majú byť všetky alebo v prípade výnimiek informácia o produkte,
5. 5. My a požiadanie musia členovia promptne prísť na právne vzorky svojich produktov.
6. Obchodné výstavy
Všeobecný princíp. Obchodné výstavy sú pri širení poznatkov a skúseností medzi zdravotníckymi pracovníkomí dôležité. Hlavným cieľom pri organizovanej takýchto výstavách je povzbudzenie lekárskej verejnosti. Ak je pripravená k tomu, aby sa použili aj informácie o produktoch, musia byť v súlade s príslušnými zodpovednosťami.
6. 1. Obchodné výstavy musia byť určené iba pre zdravotníckych pracovníkov.
6. 2. Obchodná výstava musí mať na prominentnom mieste uvedené meno spoluzodržiavača.
6. 3. Informácie o produktoch, ktoré sú prezentované, musia byť k dispozícii v súlade s príslušnými zodpovednosťami.
6. 4. Informácie o produktoch, ktoré sú propagované, musia byť k dispozícii v súlade s príslušnými zodpovednosťami.
6. 5. Nemôže sa umožniť brat vzorky zo stánku bez dozoru ani ich dávať neoprávneným alebo nekvalifikovaným osobám.
6. 6. Súťaže, ktoré sa uskutočňujú ako súčasť obchodnej výstavy, musia byť v súlade s príslušnými zodpovednosťami.
6. 7. Všetky propagáčné materiály používané pri obchodných výstavách musia byť v súlade s príslušnými zodpovednosťami.
7. Cestovanie a sponzorstvo
7. 1. Na cestách sponzorujúcich delegátxov cestujúcich zo Slovenskej republiky alebo v rámci Slovenskej republiky na sympóziá a kongresy sa vzťahuje nasledovné:
- Cestovné možnosti sú povinné udržiavať výsoké standardy všetkých zodpovedných subjektov, aby sa zabezpečilo príslušné ubytovanie a dobré počas všetkých druhov aktivity.
- Lekárske zástupcovia musia mať dostupné informácie o produktoch spoločnosti presne, aktuálne a vyvážene, a mali by byť oboznámnené s všetkými ustanoveniami tohto kódexu.
- Lekárske zástupcovia musia vždy udržiavať výsoký etický standard správania pri výkone svojich povinností.
- Lekárske zástupcovia nesú mať používať žiadne podvodné triky s cieľom dostihnúť tak štetnity, ako je nezákonné.
- Lekárske zástupcovia sa musia postarať o to, aby frekvencia, načasovanie a dlžka návštev, ako aj spôsob, akým sú robené, neodhalovali. Lekárske zástupcovia musia dodržiavať prijatia jednotlivého lekára alebo organizácie predpisy platné v konkrétnej zariadení.
- Lekárske zástupcovia nesú mať využívať na propagáciu produktov medzi lekárom alebo podľa potreby umiestniť v súlade s príslušným kódexom.
ubytovacích výdavkov. • Sponzorujúci člen nemá hraditi výdavky za rodinu alebo spolucestujúceho/sa osobu/y. • Čestný poriadok a program majú byť schválené generálnym riaditeľom spoločnosti. • Najmenej 60 % pracovného času* (na mieste určenia bez dopravy) má byť venované práci. • Účasť nesmie byť podmienená žiadostou o predpisovanie stanoveného množstva určitého lieku.

7. 2. Ak sú účastníci sponzorovaní, aby sa zúčastnili na sympoziách, stretnutia sa majú uskutočňovať vo vhodných centrech a geograficky adekvátnych lokalitách. 7. 3. Cieľom sympózia by mal byť vedecký alebo medicínsky záujem a pohostinnosť by mala byť druhoradou k hlavnému účelu podujatia.

8. Výskum

Nasledovné ustanovenia sa vzťahujú na prieskum trhu* a postmarketingové pozorovacie štúdie* bez ohľadu na to, či ich vykonáva výrobca alebo organizácia konajúca podľa jeho inštrukcií.

Všeobecne: Vyššie uvedené kategórie nezahŕňajú klinické skúšky produktov schválených na registrácii.

8. 1. Postmarketingové pozorovacie štúdie (PMS)

8. 1. 1. Postmarketingové pozorovacie štúdie by mali mať vedeckú alebo lekársku hodnotu a nemali by byť zodpovedané v medicínskom časopise alebo prezentáciu na konferencii v súlade s časťou 3 etického kódexu.

8. 1. 2. Postmarketingové pozorovacie štúdie musia mať formálny protokol, čo je požiadavkou na zber údajov k uvedenému produktu.

8. 2. Prieskum trhu

8. 2. 1. Studie prieskumu trhu musia byť ako také zreťažené identifikované pri uvoľnom kontakte.

8. 2. 2. Každú platbu lekárom musí zodpovedať práci, ktoré sa týka.

9. Vzťahy so zdravotníckymi pracovníkmi

Členovia si môžu zvoliť, že budú finančne alebo inak podporovať odborné aktivity. Takéto podpora musí byť v súlade s profesionálnymi standardmi etiky a vikusu.

9. 1. Zába

Zába alebo pohostinnosť venovaná zdravotníckym odborným pracovníkom by mala byť vhodná, sekundárna k vzdělávacímu obsahu a zodpovedajúca danej príležitosti.

9. 2. Vzdělávacie materiály pre lekarov

9. 2. 1. Materiály poskytované na vzdělávanie lekarov musia obsahovať meno výrobca a jeho poštovú adresu v Slovenskej republike.

9. 2. 2. Materiál poskytnutý na vzdělávanie lekarov môže obsahovať propagačné tvrdenia a vyhlásenia, ale musí byť v súlade s časťou 3 etického kódexu.

9. 3. Všeobecné odmeňovanie

Každé odmeňovanie za poskytnuté služby nesmie pre- výšiť to, čo je primerané za dodané služby. Odmeňovanie nesmie závisieť od predpisovania stanoveného množstva niektorejho produktu a žiadna takáto podmienka sa nesmie dať ani implikovať.

10. Vzťahy s verejnosťou a médiami

Informácie, ktoré sú verejnosti poskytované, musia byť vylučne použité na zlepšenie informovanosti verejnosti v lekárskej a zdravotníckej oblasti. Takéto informácie o nových chemických látkách, nových liekoch a spôsoboch liečby odovzdávané verejnosti a médiámu musia byť:

• pravdivé, overené, úplné, jasné a zrozumiteľné; • ne- smú obsahovať žiadne nepodložené predpoklady a očaká- vania; • nesmú vytvárať u pacienta fašistickú ilúziu o účinnosti liečby alebo neoverenú nádej na určité zlepšenie jeho zdravotného stavu; • nesmú mať zámer okladať najmä pacienta alebo pacienta alebo zámerne poškodiť konkurenta.


10. 1. Oznámenia pre tlač

Oznámenia pre tlač musia dodržiavať všetky pravidlá uvedené v bode 10. Obsah tlačových oznámení musí vy- užívať dokázané fakty bez reklamných výpovedí.

10. 2. Tlačové konferencie

Informácie poskytované novinárom musia dodržiavať všetky pravidlá uvedené v bode 10. Odporúča sa, aby sa pri lekárskych informáciách, metódoch liečby a informá- ciách týkajúcich sa liekov ako informujúcich využívali radšej lekárske odborníci, ktorí nie sú zamestnancom spoločnosti.

Zábava a iné prejavy pohostinnosti musia byť vhodné a primerané danej priležitosti. Standardnou súčasťou tlačových konferencií musí byť oznámenie pre tlač.

10. 3. Rozhlas a televízia

Rozhlasové a televízne vysielania musia dodržiavať všetky pravidlá uvedené v bode 10. Odporúča sa, aby sa pri lekárskych informáciách, metódoch liečby a informáciách týkajúcich sa liekov ako informujúcich využívali radšej lekárske odborníci, ktorí nie sú zamestnancom spoločnosti.

Novinár bývajú požívané spoločnosťou na pobytu do zahranicí alebo pobytu v rámci Slovenska iba za účelom vzdelzváhania alebo z odborných dôvodov a pohostinnosť by mala byť druhoradou k hlavnému účelu podujatia.

11. Marketing farmaceutických výrobkov na Internete

Všeobecne:

• Všetka internetová komunikácia týkajúca sa prezen- tácie členov a ich produktov na Internete musí byť v sú- lade s ustanoveniami Etického Kódexu. • Internet pova- žujeme v súvislosti s marketingovými a propagačnými aktivitami za informačné a reklamné médium pre širokú verejnosť. • Na poradenskej (vzdělávacej) internetovej strán- ke ako aj firemnej internetovej stránke musí byť zreteľná uvedený zadávateľ a garant obsahu internetovej stránky.

11. 1. Poradenská (vzdělávacia) stránka

Je určená preč širokú laickú verejnosť. • Môže obsa-
hoval informácie o ochoreniach, princípy liečby ochorení a jeho prevencie, ale bez udania konkrétnych (obchodných) názovov liekov. Musí obsahovať odporúčanie, že v prípade podozrenia z ochorenia a šírnosti s liečbou treba kontaktovať lekára. • Obsah stránky nebude laických verejnosti nabádať k liečbe. • “Poradca”, ktorý pôsobí na stránke musí byť konkrétny lekár a musí byť uvedené jeho plné meno a adresa. • Vsetky otázky a odpovede v rámci “poradne” treba archivovať po dobu jedného roka. • Vizuál krabicky konkrétného lieku s názvom lieku nesmie byť umiestnený na edukačnej stránke a takisto žiadne iné zobrazenie lieku a liekovej formy, ktoré by ho mohlo identifikovať (napríklad tabletky s názvom lieku). • Ilustračná snímka lieku môže zobrazenia len vseobecný obrazok, ktorý nebude navodzovať konkrétny produkt. • Ak sú pri grafickom riadení stránok použité prvky vizuál konkrétného lieku, nesmú obsahovať názov lieku.

11. 2. Fíremná stránka

• Fíremná stránka obsahuje informácie o výrobcovi, jeho aktivitách. • Fíremná stránka môže obsahovať aj portfólio liekov s kompletným znením SPC a príbalovej informácie. • Predtým, ako sa odborník k týmto informáciam dostane, musí prejsť cez stránku, na ktorej bude upozornené o tom, že “nasledujúce informácie sú určené len odborněj verejnosti t.j. lekarom a farmaceutom, a v prípade, že ich budete čítať laik, môže nesprávne porozumieť nasledujúcim textom význačku jeho verejnosti a takisto reklamné aktivity na podporu predaja nového produktu nesmú byť propagované smerom k laickej verejnosti a stránka obsahuje zoznam liekov (portfólio), tak stránka nesmie byť umiestnený na edukačnej stránke a takisto žiadne iné

Psaná úvahy

Poznámka editora

Kódex bol prijatý všetkými troma asociáciami farmaceutických spoločností a distribútorov liekov na Slovensku, tj. Slovenskou asociáciou farmaceutických spoločností orientovaných na výskum (SAFS), Asociáciou výrobcov generických liekov (GENAS) a Asociáciou distribútorov liekov (ADL), a uvedený do platnosti od 1. oktobra 2004. „Vysvetlky“ (vynéchané v týchto výťažkoch) tvoria integrálnu a dôležitú súčas Kódexu. Rozvijajú ďalšie princípy ustanovené v Kódxce a poskytujú podrobnúšie územnenie pre ich aplikáciu. Únny text Kódxu vo forme PDF možno získať napr. na internetovej adres http://www.safs.sk

STATEMENT ON EUTHANASIA IN CHILDREN

International Federation of Associations of Catholic Physicians (FIAMC)

The recent decision of permitting euthanasia on children under the age of 12 years in Holland is another violent laceration of the very fundamentals of our social living together.

Officially aimed to put an end to “unbearable suffering” it actually permits the killing of human persons without their consent. This happens in a society, like the Dutch one, in which euthanasia on adults has been legally performed even in depressed persons and where, as documented by official studies, there is already an illegal, but tolerated, euthanasia performed by physicians on non-consentient patients [1, 2]. Once again, the decision proposes a death solution in situations, which could be afforded by means palliative care. It moreover raises the suspicion of a financial interest of public authorities, since it decreases the “burden” of a prolonged and expensive care in clinical conditions for which any extension of life duration is considered meaningless.

More importantly, it opens the door, on a national scale, to the “mercy” killing of other mentally incompetent persons, to be eliminated, without their consent, for reasons based on an external appreciation of their quality of life.

In the same direction goes a decision issued on August 26th by the Kentucky Supreme Court, granting legal authority to the state of Kentucky to end the life of a citizen of the state. The case involved a mildly retarded black male, Matthew Woods, who was placed on a ventilator after suffering cardiac arrest at the age of 54. The state requested permission to remove his life support, contrary to the wishes of Woods’ guardian ad litem.

Although Woods died of natural causes during the litigation process, the Court agreed to rule on the legality of the state’s request, because of the legal questions involved. Prior to his natural death, Woods had never expressed whether he wanted life-supporting measures removed.

Catholic doctors call all their colleagues, medical doctors still committed to the Hippocratic Oath, to feel the moral imperative to contrast the slippery slope that, step by step, is permitting the public authorities to take decisions on which lives are worthy to be lived. The next steps will be the Mental Capacity Bill under scrutiny by the British Parliament [3] and the attempt to change the Ethical Code of Belgian Doctors made by local authorities [4]. The risks of such an attitude, in terms of violence and discrimination, should be evident for physicians and call them to resist and fight.

Udine, 2 September 2004

Prof. Gian Luigi Gigli, MD
President of FIAMC

Notes


KONFERENČNÍ / CONFERENCES

PODPORA ETIKY V KLINICKÉ PRAXI – SÚČASNÝ STAV A PERSPEKTÍVY V ľUDOVÍE Multilateral konzultatívna konferencia Bratislava, 18. – 19. novembra 2004

Cieľom konferencie bolo zhodnotiť súčasný stav problématiky etického podpory medicínskeho (prípadne ošetrovateľského) rozhodovania v klinickej praxi v európskom pohľade a načrtnúť perspektívy jej riešenia na pôde Rady Európy. Bezprostredným podnetom pre usporiadanie tejto konferencie boli závery Konferencie národných etických komisií (a podobných inštitúcií) – COMETH, ktorá sa konala v decembri 2003 v Strasburku, ako aj iniciatíva a pozvania Centrálnou etickou komisiou MZ SR.

Zvýšený záujem o túto súčasnú tradíciu, ale aj relativitne novú oblasť podnietilo akcelerovanie rozvoja moderných diagnostických a liečebných metód súčasnej medicíny. Ide o aplikáciu v klinickej praxi (napr. viac než 10-ročná existencia etických komisií, aktivná ich činnosť po stránke odbornej (výchovných) a konštruktívnej (praktických) činnosti, významnú roli v ťažkých situáciách, u niektorých podujatí, ako aj na početné medzinárodné odborné spolupráce, výmena informácií, 'know-how' a riešenie etických problémov, a aj na početné medzinárodné odborné spolupráce, výmena informácií, 'know-how' a riešenie etických problémov.

Medzinárodný život môže mať závažný význam aj na početné medzinárodné odborné spolupráce, výmena informácií, 'know-how' a riešenie etických problémov.

Závažný význam má i v budúcnosti mala mať medzinárodná spolupráca, výmena informácií, 'know-how' a riešenie etických problémov.


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No. 1 - 2

- Povodné práce/Original papers .......................................................... 2
  - Religion and Bioethics. [Náboženstvo a bioetika.] S. Holm .......... 2

- Krátké príspevky/Brief Communications .......................................... 5
  - Edukácia stratégia medicínskej etiky v rámci Slovenskej spoločnosti
    pre výchovu a vzdelávanie pracovníkov v zdravotníctve. [Educational
    Strategy for Medical Ethics in Slovak Association for Education of
    Health Care Professionals.] L. Badalík, T. Marček, V. Ozorovský, M. Mojzešová, Z. Takačová .... 5

  - Hodnotenie významnosti cieľov Programu SZO „Zdravie pre všetkých v 21. storočí“ z pohľadu posluchákov
    predmetu Master of Public Health. [Prioritising of the Goals of the WHO Program „Health for all
    in the 21st Century“ from the Point of View of Students of Master of Public Health.] L. Badalík, V. Ozorovský, Z. Takačová, M. Mojzešová .... 6

- Dokumenty/Documents ...................................................................... 7
  - Statút Centrálné etické komisie Ministerstva zdravotníctva Slovenskej republiky ..................... 7
  - Statutes of the Central Ethics Committee of the Ministry of Health of the Slovak Republic (English Translation) .... 10
  - 25 Recommendations on the Ethical, Legal and Social Implications of Genetic Testing (excerpts) ........... 13
  - 25 odporúčaní týkajúcich sa etických, právnych a sociálnych dôsledkov genetického testovania
    (výňatky; slovenský preklad) ............................................................. 16
  - Address of John Paul II to the Participants in the International Congress on “Life-sustaining Treatments
    [Prijehov Ján Pavla II k účastníkom medzinárodného kongresu „Leiečba udržujúca život a vegetatívny stav:
     Vedecký pokrok a etické dilemy“, Rim, 20. III. 2004.] .................................. 19
  - Considerations on the Scientific and Ethical Problems related to Vegetative State. [Úvahy o vedeckých a etických
    problémoch vegetatívneho stavu.] World Federation of Catholic Medical Associations (FIAMC) .... 20

- Správy, oznamy/Reports, Announcements ......................................... 21
  - 3rd National Meeting of Ethics Committees in the Slovak Republic. [3rd National Meeting of Ethics
    Committees and Local Ethics Committees in the Slovak Republic. [Účasť medzi Centrálnou („Národnou“) etickou
    komisiou a lokálnymi etickými komisiou v Slovenskej republike.]] J. Glasa ................. 20
  - New Challenges for Medicine and Health Care in Europe
  - Pokyny pre autorov/Instructions for Authors ..................................... 23

- Thomas Percival (1740–1804) .............................................................. 1

- Povodné práce/Original papers .......................................................... 2
  - Why is the Ethics of Euthanasia Wrong? [Prečo je etika eutanázie nesprávna?] A. Narbekovas, K. Meilius ........ 2

- Krátké príspevky/Brief Communications .......................................... 7
  - Euthanasia: the Concept and the Situation in Turkey. [Eutanázie: pojem a situácia v Turecku.] D. Uvey, D. A. N. Gökte, I. Basagaoglu .... 7
  - Relationships between the Central (“National”) Ethics Committee and Local Ethics Committees
    in the Slovak Republic. [Vzťahu medzi Centrálnou („Národnou“) etickou komisiou a lokálnymi etickými
    komisiou v Slovenskej republike.] J. Glasa ........................................... 9

- Dokumenty/Documents ...................................................................... 10
  - Reimposition: A National Committee from the International Ethics Editor. [Registrácia klinických štúdií: Vyhlásenie Medzinárodného výboru editorov medicínskych časopisov.] .......... 10
  - Ethical Code of the Pharmaceutical Industry in Slovakia (Excerpts) ................................. 11
  - Etický kódeks farmaceutického priemyslu na Slovensku (Výňatky) ......................... 17
  - Statement on Euthanasia in Children. [Stanovisko k eutanáziu u detí.] FIAMC ......... 22

- Konferencie/Conferences ................................................................. 22
  - Podpora etiky v klinické praxi – Súčasný stav a perspektívy v Európe. [Ethics Support in Clinical Practice
    in the 21st Century] from the Point of View of Students of Master of Public Health. 
    [Prioritising of the Goals of the WHO Program „Health for all
    in the 21st Century“ from the Point of View of Students of Master of Public Health.] L. Badalík, V. Ozorovský, Z. Takačová, M. Mojzešová .... 6

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