

MEDICÍNSKA ETIKA & BIOETIKA

MEDICAL ETHICS & BIOETHICS

ČASOPIS
PRE
MEDICÍNSKU ETIKU
A BIOETIKU

JOURNAL
FOR
MEDICAL ETHICS
AND BIOETHICS

ISSN 1335-0560

BRATISLAVA, SLOVAK REPUBLIC
Autumn - Winter 2015 Vol. 22 No. 3 - 4

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CITÁT / QUOTATION

WMA STATEMENT ON ETHICAL ISSUES CONCERNING PATIENTS WITH MENTAL ILLNESS¹

“Historically, many societies have regarded patients with mental illness as a threat to those around them rather than as people in need of support and care. In the absence of effective treatment, to prevent self-destructive behaviour or harm to others, many persons with mental illness were confined to asylums for all or part of their lives.

Today, progress in psychiatric treatment allows for better care of patients with mental illness. Efficacious drugs and psychosocial interventions offer outcomes ranging from complete recovery to remission for varying lengths of time.

The adoption in 2006 of the United Nations Convention on the Rights of Persons with Disabilities constituted a major step towards viewing them as full members of society with the same rights as everyone else. It is the first comprehensive human rights treaty of the 21st century. It aims to promote, protect and reinforce the human rights and dignity of all persons with disabilities, including those with mental impairments.

Persons with major mental illnesses and those with learning disability have the same right to preventive services and interventions to promote health as others members of the community, for which they often have greater need because they are more likely to live unhealthy lifestyles.

Patients with psychiatric morbidity may also experience non-psychiatric illness. Persons with mental illness have the same right to health care as any other patient. Psychiatrists and health care professionals who provide mental health services should refer patients to other appropriate professionals when patients need medical care. Health care professionals should never decline to provide needed medical care solely because the patient has a mental illness.

Physicians have the same obligations to all patients, including patients with mental illness. Psychiatrists or other physicians who treat patients with mental illness must adhere to the same ethical standards as any physician.

The physician's primary obligation is to the patient and not to serve as agents of society, except in circumstances when a patient presents clear danger to himself/herself or others due to mental illness.”

¹Výber z textu Stanoviska z roku 1995 (revidovaného v roku 2015) dostupného na webstránke Svetovej asociácie lekárov (časť Preambula) / Excerpts from the 1995 Statement (revised 2015) taken from the webpage of the World Medical Association (WMA) (part Preamble): www.wma.net

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A BRIEF OUTLINE OF THE DEVELOPMENT OF ETHICS CONSULTATION SERVICES IN THE USA

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Introduction

Ethics support for the clinical practice in medicine – and to certain extent also for practice in other professions concerned with providing help to the people in difficult situations, such as psychologists, social workers, speech therapists etc. – may be provided within various arrangements with regard to its form, content, professional ‘providers’ and committed resources. In Europe, there are varying systems and degrees of its implementation in different countries, depending on the particularities concerning historical developments of the health care systems, as well as those of the professions concerned. [8] With several exceptions, to mention e.g. Italy, France or Netherlands, it is mostly felt though that clinical ethics support in Europe, in most instances, is still in its infancy. This certainly is the prevailing situation in the countries of the former ‘Soviet bloc’ (Central and Eastern Europe – CEE), with exceptions being mostly at the institutional or regional level (e.g. particular hospital or teaching inpatient medical institute). The need for such support is increasingly voiced, however, both by the concerned physicians or other care or help providers, and by the professionals in ethics, moral theology, or in the spiritual accompanying (such as hospital chaplains). [1, 16] Not yet is this need articulated much by the patients, their relatives, or by the patients’ organizations.

Working in the milieu of the faculty of medicine, this yet unmet need became of a particular interest to the author of this paper. After some personal studies of the matter, he became specifically interested in the historical development and present situation of ethics consultation services in the United States of America (US), as in a possible inspiration and resource when considering establishing and development of ethics clinical support services in his own country – Czech Republic, and possibly beyond, especially in CEE countries around. The results of these first, exploratory studies made for the informational basis and strong impetus in writing of this brief ‘historical’ overview.

The author believes that in the developments of ethics consultation services in US, it is possible to perceive an increasing need to confront in both more systemic and more practical manner the ethical challenges resulting primarily from the development of medicinal technologies as well as from the development of a pluralistic, increasingly fragmented society. At its beginning, the developments of clinical consultation in US were mostly intuitive. During the later decades, the benefit of ethics consultation began to be recognised in medical practice and health care provision, which was later on reflected in its subsequent institutionalisation.

Since there is just a little or almost no experience with ethics consultation in the Czech Republic, it is not easy to anticipate the exact directions its further development may take. It could be speculated, however, that those may, to at least to some extent, be similar to the ones in the US: at the beginning there will gradual collection and growing of the necessary theoretical and practical expertise by devoted ‘pioneers’ providing ethics support in clinical, practical settings, hope-

fully winning some gradual acceptance and generating a genuine interest and need among their colleagues – clinicians and/or care givers/providers, and thus leading to the gradual acceptance and institutionalization of such services. However, as the US experience shows, these developments may take decades to complete – and this may be the most likely scenario also in the Czech Republic and/or in other CEE countries.

Altogether, the author believes that the reader find this brief outline interesting and useful.

Beginnings

The predecessors to the current ethics consultation services were the “medico-moral committees” established in the US catholic health care facilities back in the 1920s. [18] According to the Ethical and Religious Directives [9] of the Catholic Hospital Association from 1949 [19], they were to supervise the adherence to the teachings on contraception, sterilisation, abortion and euthanasia. They were usually comprised of doctors and nurses; sometimes the hospital chaplain was also a member. [12]

It is no coincidence that bodies similar to nowadays ethics committees have arisen in the US Roman Catholic health care institutions: rapid developments in medicine were posing new, disturbing questions to the existing, well established moral teachings and traditional ways of decision-making. This, of course, might also have been true for other health care facilities, even for the primarily non-religious, ‘secular’ ones. In the Roman Catholic environment, however, these moral questions were more challenging to the very mission and way of functioning of the health care facilities, as well as of their medical personnel, which had been expected to abide by the catholic moral teaching in its professional deeds and care provision. So the answers sought were more aimed to provide the practical moral justification (or prohibition) of the novel procedures encountered, than just to come to terms with the new moral (ethical) problems. [12]

Another important moment in the development of ethics committee was brought about by the decision by the US Supreme Court regarding an induced abortion. [24] This judgment was providing a legal distinction on when an abortion is a crime and when it is not. The judgment was based on the division of a pregnancy into three trimesters: when performed during the first trimester (1st to 3rd month) of pregnancy the abortion was not considered a crime. It would have been considered so, when performed in the third trimester (7th to 9th month). For the pregnancy in the second trimester, it was necessary to decide, whether there were any serious medical reasons to believe that the pregnancy could not continue normally – then, the abortion was not considered a crime. Various US clinics reacted to this decision by establishing the so-called “abortion committees”. They were entrusted with a task to decide, whether the legal conditions for terminating the particular pregnancy had been fulfilled. [20]

Further developments of ethics consultation

The first, more clearly defined structures devoted to the ethics consultation were established gradually in the US in 1970s. The advent of new diagnostic and therapeutic possibilities and of the new moral/ethical questions that came in with them [17], together with the heated professional and public debates that suddenly broke out [11] might be considered the most important moments that called these bodies into existence.

Most likely, the first professional to mention the term “clinical ethics” was Dr. Joseph Fletcher of the University of Minnesota’s School of Medicine (in 1976). He also said that doctors in their decision-making often used situational ethics instead of using the ethics of rules. He himself called his ap-

proach “clinical ethics” or “deciding what to do case by case, using guidelines to be sure, but deciding what to do by the actual case or situation of the patient”. [5]

The God's Committee

A significant moment in the development of ethics consultation came with the emergence of need to choose the patients for treatment using the newly developed haemodialysis machines. On November 9, 1962, the US journal *Life* published an article entitled “They Decide Who Lives, Who Dies” [2]. It described the work of “The Admissions and Policies Committee of the Seattle Artificial Kidney Centre at the Swedish Hospital”, which later became known as the “God's Committee”. The members of the Committee were a surgeon, lawyer, priest, bank official, housewife, state official, and a businessman. They were selected by the King County Medical Society in Seattle. The article does not go into any further detail as to how this committee had been established. Its members were supposed to represent a kind of ‘microcosm’ of the contemporary society. [2]

The Committee's task was to decide, which of the patients chosen by the doctors of the Seattle Artificial Kidney Center at the Swedish Hospital should had to be connected to the artificial kidney: revolutionary and still a highly experimental treatment at that time – about 100.000 patients with end stage kidney diseases had been dying annually in the US with no life-saving treatment available. About 50 such patients of the Center were suitable for the new dialysis treatment just developed. Five of these were supposed to be chosen and were indeed eventually connected to the dialysis.

The members of the Committee were provided with neither guidelines for their decision-making, nor with any specific moral criteria to be used in their deliberations: they were literally told that the final decision is up to them. In the article, the actual members described how they had coped with possible issues to be considered or where they themselves saw the Committee's task as a whole. For some, financial aspects were important, together with the patient's prognosis (including the question about the payment for the treatment provided). Some reflected upon, whether they, as ‘mere people’, could indeed decide about the life or untimely death of another person. Others realised that if the doctors would have had to make such a decision under these circumstances, it would had to lead to a huge conflict of interest. One of the Committee's members claimed that one of the roles of it was to protect the doctors from the pressure of emotions connected with the non-medical contexts of their profession, because otherwise they would not had been able to concentrate well enough on their medical roles. The Committee's work, quite unintentionally, opened up many new medical ethical themes and issues. One important aspect was also connected with the shroud of secrecy around the Committee's establishment and decision-making work, which had been quite a shocking revelation to the unprepared US public, followed by considerable uproar and paving the way for subsequent political and legislative decisions.

It could be observed that the Committee ‘pioneered’ a new, more complex approach in making of the important medical decisions: the recognition that also other than medical horizons should be incorporated into the practical deliberations ‘at the bedside’. Thus, non-medical (non-biological) concerns and motivations entered into the decision making processes for/against the particular treatments. It was also recognised that each of the participants and those affected by the medical decisions concerned had their own opinions, perspectives and values: doctors and other medical staff members, patients and their relatives and friends, hospitals (and their wards), treatment payers etc. – and that all these had to be taken into account seriously.

Ethics committees

In further US national developments, it was the US case law that gave a considerable impetus for the establishment and work of ethics committees as bodies endowed with responsibility and necessary moral authority to deal, in a more systematic and organised manner, with ethical issues arising within the health care provision.

According to Albert Jonsen [12] this support apparently arose by chance. A court in New Jersey handling the case of Karen Ann Quinlan cited an article by the paediatrician Karen Teel [26]. In the paper, she had called for the creation of commissions that would decide on the appropriate therapy for the critical new-borns. According to Teel, the establishment and work of such bodies should be justified by the following arguments: firstly, the parents might not be able to make such difficult decision without serious preconceptions weighing them down and, secondly, doctors were not the ones that should be making such decisions. Karen Teel, Jonsen claimed, also mistakenly thought that such committees are already set up in many hospitals, even though she probably only had known about the aforementioned “God's Committee” in Seattle. The court recommended that the doctor should consult with an “Ethics Committee” or some other similar body of the institution in which Karen Ann Quinlan was hospitalised with regard to the issue of disconnecting her from the life-support systems: “*Should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support ... to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized.*” [22]

Another court decision at around the same time refused, on the contrary, the creation of such committees. [23] Nevertheless this court opinion was not entirely enforced to practice because of the publication of an important document issued by the President's Commission for the Study of Ethical Problems in Medicine & Biomedical and Behavioral Research [14]: “*Health care institutions should explore and evaluate ... various administrative arrangements for review and consultation, such as 'ethics committees,' particularly for decisions that have life or death consequences.*”

The document recognised the importance and necessary roles of ethics committees at that time, and it also introduced two important principles in connection with their establishment and work: the principle of representativeness and the principle of interdisciplinarity. [21] The first principle required that not only the representatives of a hospital should be considered for the committee's membership, but also the representatives of the area (city, community) that the hospital served should be included. The second principle required that with addition to the health care professionals, such as physicians and nurses, also various other professions should be represented among the committee's membership: an internist, professionals of other medical disciplines, an attorney, a hospital administrator, a social worker, a psychiatrist, a member of the clergy and a patients' advocate. [15]

In 1994, the American Medical Association issued the recommendations regarding an establishment and work of ethics committees [3]. From 1995, it requires all institutions that provide medical services in the US to have mechanisms established for dealing with ethical dilemmas. [7]

Ethics consultation services

Following the above mentioned developments, much effort and constant advocacy had been seen for having some form of the ethical consultation established within the health care institutions. According to the survey, published by E. Fox and co-workers in 2007, 100% of the hospitals with more than

400 beds and 81% of all hospitals in US had some means established to provide the ethics consultation. [6]

The importance that the US as a country has placed on the clinical ethics consultation can be illustrated, for example, by the development and works of the IntegratedEthics® program, an extensive activity run by the National Center for Ethics in Health Care that is connected to the US Department of Veteran Affairs (a state organisation that takes comprehensive care of the military veterans). [13] Since 2008, the program has been implemented in 152 health-care facilities and in 21 regional health-care networks working under the VA Department. The fact that this leading US institution implemented such a complex program to provide access to the ethics consultation in its health-care units highlights the recognition of the benefit this service offers within the comprehensive health-care services provision.

The well perceived necessity of ethics consultations is also seen in US health care facilities efforts and mechanisms established to provide for an easy and not much limited access to those services, at many instances closing to the “24 hours 7 days a week” schedule. [25]

Conclusion

This brief overview of the more recent US developments in the area of ethics support provided within the health care services realm documents a relatively long time period required to have the necessary structures, mechanisms, as well as the professional expertise and acceptance by health care professionals and providers successfully established. Clearly, ethics consultation services in the US are deemed necessary and useful, and they are used regularly and frequently by the health professionals, health administrators, and, even more importantly, by the patients themselves and their relatives. Indeed, they already have become and are considered nowadays an indispensable part of the health care provision and an important mean in attaining its good quality and securing the patient-oriented approach and respect for his/her relevant wishes, personal values, attitudes and preferences. Thus, contributing to safeguard, within the area of their responsibility, competence and direct influence, a humane dimension of the present day health care provision: face-to-face with the breath-taking technical-technological developments, increasing economical and managerial pressures and other factors working to the contrary. These facts and experience gathered ‘at the other side of the Atlantic’ may be of interest and positive inspiration for professionals in Europe, including those working in the countries of Central and Eastern Europe, facing similar problems and challenges.

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Abstract

A brief overview of the gradual development of clinical ethics support services in the USA documents a relatively long time period required to have the necessary structures, mechanisms, as well as the professional expertise availability and wide acceptance by the health care professionals and providers established within a country health care system. In USA, the ethics consultation services have become, and are considered nowadays an indispensable part of the health care provision, an important mean in attaining its good quality and securing the patient-oriented approach and respect for his/her relevant wishes, personal values, attitudes and preferences. The experience in developing and practical provision of the ethics consultation services gathered ‘at the other side of the Atlantic’ may be of good interest and positive inspiration for the health care and other professionals in Europe, including those working in the countries of Central and Eastern Europe, facing similar problems and challenges.

Key words: ethics consultation, clinical ethics, USA, ethics committees

Abstrakt (slovenský preklad-redakcia)

Krátky prehľad postupného vývoja služieb klinickej etickej podpory v USA dokumentuje relatívne dlhé časové obdobie, ktoré je potrebné na to, aby sa v rámci zdravotníckeho systému danej krajiny podarilo vybudovať a sfunkčniť príslušné štruktúry a mechanizmy, ako aj zabezpečiť potrebné profesionálne skúsenosti a širokú akceptáciu takýchto služieb zo strany zdravotníckych pracovníkov a poskytovateľov. V USA sa etické konzultačné služby postupne stali a dnes sú považované za nevyhnutnú súčasť poskytovania zdravotnej starostlivosti, za významný prostriedok na dosiahnutie jej náležitej kvality a zabezpečenia jej orientácie na pacienta, na rešpektovanie jeho prianí, osobných hodnôt, postojov a preferencií. Skúsenosti nahromadené pri budovaní a poskytovaní etických konzultačných služieb 'na druhej strane Atlantiku' môžu byť zaujímavou a pozitívnou inšpiráciou pre zdravotníckych pracovníkov a ďalších odborníkov, osobitne pre tých, ktorí pracujú v krajinách strednej a východnej Európy, keď sa vo svojej práci stretávajú s podobnými problémami a požiadavkami.

Kľúčové slová: etická konzultácia, etické poradenstvo, klinická etika, USA, etické komisie

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PHYSICIANS' ETHICAL RESPONSIBILITIES

The stigma and discrimination associated with psychiatry and the mentally ill should be eliminated. Stigma and discrimination may discourage people in need from seeking medical care, thereby aggravating their situation and placing them at risk of emotional or physical harm.

Physicians have a responsibility to respect the autonomy of all patients. When patients who are being treated for mental illness have decision-making capacity, they have the same right to make decisions about their care as any other patient. Because decision-making capacity is specific to the decision to be made and can vary over time, including as a result of treatment, physicians must continually evaluate the patient's capacity. When a patient lacks decision-making capacity, physicians should seek consent from an appropriate surrogate in accordance with applicable law.

The therapeutic relationship between physician and patient is founded on mutual trust, and physicians have a responsibility to seek patients' informed consent to treatment, including patients who are being treated for mental illness. Physicians should inform all patients of the nature of the psychiatric or other medical condition, and the expected benefits, outcomes and risks of treatment alternatives.

Physicians should always base treatment recommendations on their best professional judgment and treat all patients with solicitude and respect, regardless of the setting of care. Physicians who practice in mental health facilities, the military, or correctional institutions may have concurrent responsibilities to society that create conflicts with the physician's primary obligation to the patient. In such situations, physicians should disclose the conflict of interest to minimize possible feelings of betrayal on the patient's part.

Excerpts from the 1995 WMA Statement on Ethical Issues Concerning Patients with Mental Illness (revised 2015) taken from the web of the World Medical Association (WMA): www.wma.net

MEDICAL ETHICS AND THE END OF LIFE: WHAT KIND OF MEDICAL ETHICS DOES RESPECT HUMAN DIGNITY?

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Introduction

Contemporary discussions in the field of medical ethics and bioethics very often touch upon the value of human life, especially with regard to its beginning and its end. For example, we may mention here just the new technological possibilities (*ital. poiesi tecnologica (téchne)*) [1] that are considered or used at the beginning of human life, which – in the words of the pope Benedict XVI – is then so frequently „manipulated, as bio-technology places it increasingly under man's control”[2]. On the other hand, *mens eutanastica* [3] poses still a greater threat to the human life in particularly vulnerable, dependent situations. It is usually presented as an expression of (self) empowerment over the human life, which it arbitrarily considers as having no right or dignity to exist. Both examples represent areas of medical ethics, where conflicting positions – those in favour of every human life and those against an „unworthy” life – meet or confront each other. These issues, clearly, have great practical importance and they deserve continuous attention and in depth study.

This paper firstly tries to give a brief overview of the broad field of contemporary medical ethics, focusing in particular upon its most important inspirations or foundations. Further on, it then underlines some practical applications regarding the questions and related decision making in the end of life situations. The paper does not intend to offer a list of all actual questions regarding the end of life situations. Rather, it presents two visions currently dominating the medical ethical realm (the „secular” and „personalistic”), and it shows how the opposing views upon the current bioethical issues are stemming from these different approaches. Then it also discusses how those are embodied into solutions regarding the end of life.

From ethics to medical ethics

Generally speaking, ethics is understood as the „science of human habits and behaviour, which critically reflects on human actions with the goal to verify their value and authenticity and to draw from them positive approaches, favouring an evolution of better forms”[4]. The diversity of ethical inspirations is well known. They take into consideration not only the general principles (respect of life and freedom, refusal of injustice, personal responsibility), but also the particular vision of God, of the world and of the human person. From this point of view, we may distinguish the Hebrew, Christian, Islamic, Buddhist, individualistic/liberal, sociologist/collectivist, pragmatic/utilitarian, personalistic ethics, etc. [5]

There are various ways how to describe the relationship between ethics and medicine. For example, there are formulations like „ethics is the spirit of medicine”, „ethics is the spirit of man”, „ethics is the spirit of medicine because it is the spirit of man” [6]. In simple words, medical ethics is defined as that ethics which „examines moral questions which arise from the practice of medicine”[7] or „the analysis of decisions in medicine”[8]. By others, medical ethics is understood as applied ethics in medicine and as a part of professional ethics [9].

Inspirations of medical ethics - two models

There are two influential theoretical models present in contemporary medical ethics. They are inspired by two different understandings of the world in general and also by two different currents of nowadays' philosophy: the first is „lay” in nature, while the other has „religious” significance.

The first model

It is described as „lay”, „quality of life”, „secular”, „availability of life” [10] or „closed to Transcendental” [11]. According to this model, the man is considered as the source of ethical norms, not God or any natural order. Man in his liberty is free to choose a particular norm of behaviour. Moreover, he is the one who can assign the norm to be followed. Consequently, man can also change the norms of his behaviour or he can propose new ones.

Very briefly, here we present some of the important characteristics of the „lay” medical ethics and its inspirations: 1) the presupposition that holds that „God does not exist”; 2) the managerial principle of „quality”, not the „dignity” or „sanctity” of the human life; 3) the conviction that ethics has solely human foundation; 4) refusal of ontological-normative concept of „nature”; 5) the principle of „autonomy” as the fundamental aspect for reflection and practice; 6) the principle of „availability of life”; 7) progress of knowledge as instrument of the human progress; 8) negation of suffering; 9) different values of „quality” of lives; 10) „functional” concept of the person – separation of human being and the person; 11) pluralism as value; 12) refusal to every kind of reduction of personal freedoms; 13) refusal of absolute deontological principles; 14) acceptance of abortion, euthanasia, homologous and heterologous assisted in vitro fecundation (FIVET) as legal practices [12]. These characteristics tend to be very powerful in practice: without God, they become justifications for taking one's life or for killing the others. From the existing spectrum of different „lay” or „secular” models, we limit ourselves in this paper to the post-modern model, which is very much present in the so-called “West”.

According to G. Vattimo, post-modernity has abandoned the „strong” (it. „forti”) categories of traditional metaphysics. Inspired by F. Nietzsche and M. Heidegger, it offers a „weak” or „weakened” (it. „debole”) vision of being. Philosophy, intended as a „weak thinking” (it. „pensiero debole”), has lost its foundational role and, consequently, the truth is presented as a continuous interpretation, and is no more bound by any correspondence between concept and reality. One may notice a radical „temporalization” of being and its structural weakening or “enfeeblement” [13] (it. *strutturale indebolimento*).

From this point of view, anthropology of post-modernity is „weak” (it. „indebolita”). For a schematic comparison between modernity and post-modernity, it is possible to use three notions or subjects, typical for every form of culture: God, world, man. From a theological point of view (seen from the perspective of faith), for modernity, these terms are „strong”, i.e. it sees God as Creator, the world as a created entity, and the man as a creation. For the post-modernity, the same terms have become „weak” categories. Accordingly, it is possible to speak about three anthropological characteristics of post-modernity: 1) weakened perception of God; 2) weakened perception of the world, and 3) weakened perception of man [14].

The post-modern culture is expressed through exceeding individualism, which is possessive and anarchic, which considers man as an absolute reality. The most important anthropological characteristics of the post-modern man may be outlined as follows: 1) man is not a person, but only an individual; 2) man is basically good; 3) man has full autonomy; 4) joy comes from pleasure, and not from virtue; 5) it is contract that binds, not the law; 6) absence of historical memory [15].

So it may be observed that if God disappears from the scene of the world, the world too becomes „weak”: it will be not understood as the creation of God, but as an object, a thing; even, a deposit of things. That world will be presented to man, which can satisfy not only his needs, but also his different desires and that is why it can be abused without limits. A „weakened” world offers to the man a possibility to exercise his will of power. He lives in the absence of God and of the truth of his own being. From this comes out his crisis of sense and of the ethical orientation. The post-modern man became „weak” in his whole reality. He lost the religious and sacral sense of his life, which he perceives in a non-personal mode: only as a material to be analyzed, produced, and also to be abused and easily thrown away. He abandons and rejects the ontological concept of person; creates an ontological distinction between an individual and a human person. Consequently, he does not consider himself and others as persons, but only as individuals. This approach opens the way to manipulation and even persecution of every kind of the human beings. Postmodern man considers his own life, and the life of others insignificant [16]. But this position too, does not offer him an existential security, which is expressed particularly in front of the pain and suffering.

Nietzsche's concept of „death of God” created a vacuum. In such vacuum, there comes forth the „Superman” (it. *Superuomo*). He becomes a measure for himself. This position is also used for human life based on the idea of reincarnation and an endless time. According to the post-modern, nihilistic vision, human life has lost its intrinsic value and consequently it is then exposed to every kind of arbitrary manipulation.

The post-modern inspiration

What does the post-modern inspiration offer to medical ethics? We shall present it through outlining briefly the positions of its two principal proponents: Hugo Tristram Engelhardt (1941), an American philosopher of German origin, and Peter Singer (1946), an Australian philosopher.

Hugo Tristram Engelhardt

Engelhardt is indeed convinced of the importance of bioethics for the future. [17] He calls the bioethicists „the priests of the secular morality and of the political institutions” [18] of the contemporary culture. He calls the post-modern health workers „cosmopolitans” and defines them as „men and women who can live in peace and procure the sanitary care in this world without fundamental moral conflicts. They are the contemporary realization of „Superman” of Nietzsche. They can see the destruction of old traditions and prosper even in the slender area of post-modern times” [19]. Engelhardt expects an enhancement of the human capacities, which will be aimed at the manipulation of human nature for individual goals. What does Engelhardt anticipate for the future? Taking into consideration the progressive ageing of the western societies, he proposes a very clear vision:

„In the future [...] the risk will increase all the more not only that of supporting the typical weaknesses of old age, but also of spending months, if not years, in the institutions, which assure complete health assistance. This risk can be eliminated only by seeking the consent of individuals to dispose themselves to be killed without pain, if they find themselves in certain situations” [20].

The same author, however, in his further arguments, comes to an extreme utilitarian and, we say, also inhuman position: „A very patriotic citizen, who suffers from a terminal and debilitating disease, can commit suicide to reduce the burden placed upon the public health system. [...] Those who do not consider killing as an immoral act, could think of disposing themselves in advance as their duty to be killed, when certain situations arise” [21].

Engelhardt aims with these proposals also at the contemporary religions and in particular at Christians. According to him, in the name of a liberal cosmopolitan ethos and of self-determination, it is necessary to do away with the traditional Christian past and to accept suicide and euthanasia. In the name of secular and neo-pagan culture, he invites religions to reorient the required duties for their own members: „The religion could help the health workers and the familiars to accept the decisions of patients who opt for an assisted suicide and for an active voluntary euthanasia”. Moreover, according to the same author, Christians „could encourage the decisions regarding death, which protects values, freedom and dignity of their neighbours” [22].

Peter Singer

Taking into consideration the questions at the end of life, Peter Singer takes similar positions. With regard to the acceptance of euthanasia, he writes:

„In the United States, where the individual rights are always underlined, [...] a change probably will come, as it happened in Oregon, more as the recognition of right to assisted suicide than as legalisation of active voluntary euthanasia. But the most certain thing is that, in the next decade, and perhaps even before, the citizens of different countries, following the example of Holland, will be able to acquire the right to control their own death” [23].

His proposal for medical ethics, rather provocative and unemotional, is formulated as follows: „Step by step we will learn to think that, in case of terminal or incurable patients, a correct exercise of the medical profession includes also the practice of euthanasia, if the patient puts forward a free and well informed request (for euthanasia)” [24].

According to Singer, for „satisfying own desire to control death”, it could be possible to achieve its legalization. What could be its modes? He expresses his own opinion: „If the right for assisted suicide will not come by the tribunals and parliaments, in countries which permit the electors to express themselves directly about such questions, it could come through a referendum” [25]. It is clear, that, to satisfy such desires, a „new ethics” is necessary, with „new commandments”. In his „new” approach to human life and death, he presents the „five new commandments”, which are in clear opposition to those of the „traditional ethics” or to the „old” commandments [26]:

1. „The first old commandment: accept every human life as endowed with the same value.” – „The first new commandment: recognize that value of human life changes.”
2. „The second old commandment: never destroy an innocent human life intentionally.” – „The second new commandment: take the responsibility for consequences of your decisions.”
3. „The third old commandment: never take your life and always try to be careful so that others do not do it.” – „The third new commandment: respect the desires of persons to live and to die.”
4. „The fourth old commandment: grow and multiply.” – „The fourth new commandment: bring children into the world only if they are desired.”
5. „The fifth old commandment: accept every human life as invariably more precious than every non-human life.” – „The fifth new commandment: don’t create discriminations based upon species.” [27]

In short, the life as a whole has no sense for Singer or Engelhardt. The value of human life is relative, obscure, with no recognition of the ontological and of the axiological gradualism and differences. The status of human person is recognized only for conscientious individuals and for those who are able to express their will. As might be seen, the post-modern inspi-

ration of medical ethics leads to fear in front of unknown situations, particularly in front of suffering, pain, old age, the terminal state of human life and in front of death. Facing such pressures, it chooses the „better solutions”: suicide, assisted suicide, and euthanasia.

The second model

It is referred to as „religious”, and is indicated by terms such as „dignity of life”, „sanctity of life”, „sacrality of life”, „catholic”, „indispensability” of human life, „ontologically founded personalism” [28] or „opened to Transcendental” [29]. In brief, the following principles of inspiration of „dignity of life”, „sanctity of life”, or „personalistic” may be listed: 1) Principle of protection of physical life. 2) Principle of liberty and responsibility. 3) Therapeutic principle or principle of totality. 4) Principle of social responsibility and subsidiarity. 5) Principles of beneficence, autonomy and justice. [30]

The inspiration of „dignity” or „sanctity of life”

So what does the inspiration of „sanctity of life” offer to medical ethics? We hold that, above all, it offers a strong *personalistic culture* that distinguishes itself markedly in comparison to the “weak” contractual, utilitarian, pragmatic, nihilistic and cynical visions of human life that stem from the post-modern inspiration. The inspiration by „sanctity of human life” places the person at the centre, with all his/her dignity. It reaffirms the fundamental value of every human person. In the field of medical ethics, this position comes into practice through the principles of ontologically founded personalistic inspiration. It allows and requires the humane accompaniment of the terminally ill patient that is marked by the full respect of the terminally ill and of the dying patients as subjects.

The inspiration of „sanctity of life” recognizes the intrinsic value and dignity of the patient in the terminal phase of his/her disease. [31] And so, no one can appropriate the right to renounce the means necessary to live. The opposite position cannot be justified, not even for some particular situations, where there could be a sense of „non-utility” of a particular person. The central lines of responsible acting are presented in following the principle of graduality, proportionality of care and veracity. It is necessary to allow the patient having a space for hope. Only in this way, all the persons, who accompany terminal patients and dying persons, can become protagonists of humanization of the final phase of physical human life. [32]

As an extraordinary example, the movement and the medical discipline of palliative care are inspired by this approach. Palliative care develops effective structures that allow interpersonal relationships really worthy of a man and that bring about an art of humane accompaniment of the terminally ill and of dying patients. The movement of palliative care puts into practice the first ethical imperative of the Christian inspiration: to serve life, that means, to assist it until its natural completion. It is necessary to recognize here a special merit of having reminded the contemporary medicine of its interpersonal dimension. Palliative medicine is faithful to the classical principles of Hippocratic medicine „*sanare infirmos*”, „*sedare dolorem*”. It stands against the principle of „usefulness” so typical for the utilitarian thinking. All professional associations, present and active in the field of palliative care, give concrete testimonies to the value of human life and to human dignity. Such associations promote moral values and new culture of accompanying and being present, which is an effective counterbalance to the rising „anti-culture” of abandonment, exclusion, throwaway, and escape – to the „culture of death”.

Palliative care also opposes „aggressive medical treatment” (it. *l'accanimento terapeutico*): it does not try to prolong the physical life of a patient “at all costs”, or even to prolong it

this way in the one who is already dying in the terminal phase of his/her illness, but rather, it put into practice specific medical and nursing procedures that can effectively treat various devastating symptoms, such as pain, and thus alleviate the suffering of the patient. [33] Palliative care represents a valid, humane alternative to the assisted suicide and euthanasia. Palliative care permits the patient to live humanely also through the terminal phase of his/her illness or disability, and also through the final moments of his/her life, and to die with dignity. These positions were reconfirmed and appreciated also by the *Pontifical Academy for Life*. [33]

It is necessary to emphasize a key-principle for responsible acting in the field of medical ethics: the principle of proportionality of treatments. According to it, the standard (usual; medically indicated in concrete circumstances) treatments and the palliative ones are considered as proportional means to be offered by contemporary medicine. According to the inspiration of „sanctity of life”, it is obligatory to use proportional means in the terminal phase of life, and it is not obligatory to use the non-proportional ones (extraordinary or disproportionate). With these procedures, the life, which is not the absolute and the highest value, is not prolonged in artificial mode, but it is assured of the full human and Christian accompanying. This position is underlined also in the encyclical letter *Evangelium vitae*. „In such situations, when death is clearly imminent and inevitable, one can in conscience „refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted“. [...] To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death”. [34] It is very important to add that the standard care also entails appropriate hydration and nutrition, providing comfort and appropriate hygienic care, treatment of decubital ulcers, etc. The *Charter for Health Care Workers* affirms this as follows: „The administration of food and liquids, even artificially, is part of the normal treatment always due to patients, when this is not burdensome for them: their undue suspension could amount to euthanasia in a proper sense”[35].

The model of „dignity” or „sanctity of life” underlines the ethical responsibility, respect and defence of life. These are proposed as concrete ways of action and are intimately interconnected: the one, who acts responsibly, respects and defends life, and only the one who respects and defends life, acts responsibly and morally. From here, many fields and activities spring forth, whether at the national or at the international level, to which all members of human society are invited. Among others, the following areas can be mentioned: the economic, cultural, social, political, legislative etc. Important roles are to be played by the family, e.g. education of children to altruism and solidarity with the weak, ill, and the poor. It is necessary to require and support a good quality, continuous humane and professional formation and education of health care workers, to help them to remain up-to-date and motivated in fulfilling the demanding mission of their professions.[36] A specific role belongs also to volunteering and to the associations of health care professionals.

An integral part of the defence and respect of the human life is connected with efforts that are aimed at finding a positive meaning of its terminal phase. Pain, suffering and dying that belong to human life, can be liberated, “saved” from their „futility” by applying in practice the vision of „dignity” and „sanctity of life”. In a Christian perspective, this is possible through Jesus Christ, who freely accepted suffering and death. Only He, through His saving grace, can offer a dying person the transcendental meaning of that dramatic terminal phase of his/her life.

In summary, the model of inspiration by the „sanctity of life”, confirms the responsible acts in the medicine against the flight from suffering in the terminal phase. Against the non-

responsibility and non-maturity of the post-modern man, the same inspiration confirms the ethical and personal responsibility, professional and human maturity; against the weakened concept of God and man, and the consequent disorientation of man, the model of „sanctity of life”, proposes a reliable and safe direction. Against abandonment, nihilism, pragmatism and cynics towards human life caused by assisted suicide and euthanasia, the model of „sanctity of life”, proposes a full and strong sense of life – also for that life which is in the condition of suffering, pain and terminal phase. This model proposes the direction towards Him and with Him who is „the way, the truth and the life”, (Jan 14,4). In other words, against the post-modern or weakened inspiration with its destructive and non-human proposals to act in the field of medical ethics, we propose *the inspiration of dignity and sanctity of life or strong inspiration* with its creative and dignified proposals.

We can formulate the following guidelines for moral acting in the medical ethics regarding the end of life: No to aggressive medical treatment. No to abandonment of assistance. No to suicide and to assisted suicide. No to euthanasia.

But, yes, to graduality and proportionality of the cures. Yes to palliative care. Yes to truth and hope. Yes to full human and Christian assistance and accompanying. Yes to respect of life, even in its terminal phase. Yes to respect of natural death.

Conclusions

As we have seen, the inspiration or the foundation of the medical ethics is very important. This point is decisive for a position in favour of human life or against it. Benedict XVI conveniently writes regarding this matter:

„A particularly crucial battleground in today’s cultural struggle between the supremacy of technology and human moral responsibility is the field of bioethics. [...] In this most delicate and critical area, the fundamental question asserts itself force-fully: is man the product of his own labours or does he depend on God? Scientific discoveries in this field and the possibilities of technological intervention seem so advanced as to force a choice between two types of reasoning: reason open to transcendence or reason closed within immanence. We are presented with a clear either/or”. [37]

And the same Author continues: „Yet we must not underestimate the disturbing scenarios that threaten our future, or the powerful new instruments that the „culture of death” has at its disposal. [...] Underlying these scenarios are cultural viewpoints that deny human dignity. These practices in turn foster a materialistic and mechanistic understanding of human life”[38].

To accept life means to accept also the eventual diseases, the pain, the suffering and the certainty of death. In accepting this, a dignified and important role can also belong to medical ethics inspired by „sanctity of life”. The inspiration by the „sanctity of life” stresses that the suffering and the way leading to death, with all their fragilities, are the integral part of the human existence. God, who is revealed in Jesus Christ, wanted to be really God of the weak. To accept all these weaknesses, connected with the end of life, together with Him, illuminates the mystery of man and strengthens the one who is going through a delicate path to own dying and to own death. To practice the medical ethics, inspired by the „sanctity of life”, means also to live and to strengthen the „culture of life” or „culture of care” [39] - as Pope Francis often recommends.

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Veatch describes ethics and medical ethics as follows: „Ethics is the enterprise of disciplined reflection on the moral intuitions and moral choices that people make. Medical ethics is the analysis of choices in medicine. [...] medicine refers to the entire range of choices made in the medical sphere. Medical ethics covers choices made not only by physicians, but also by other health professionals – nurses, pharmacists, hospital chaplains, and so forth. More important, it covers choices made by medical lay people – patients, parents, legislators, public officials, and judges,„ VEATCH RM, „*Medical Ethics*. An Introduction,„ in: Veatch RM. *Medical Ethics*, Boston – London – Singapore 1972, p. 1. [9] Cf. MALHERBE JF. *Per un'etica della medicina*, Cinisello Balsamo (Milano) 1989; CAFARO A, COTTINI G. *Etica medica. 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Đačok J. Medical Ethics and the End of Life: What Kind of Medical Ethics Respects Human Dignity? / Medicínska etika a koniec života: Aká medicínska etika rešpektuje dôstojnosť človeka? Med. Etika Bioet. 2015; 22(3-4): 6-10.

Abstract

The paper gives a brief outline of the contemporary medical ethics spectrum with regard to its most important inspirations and tendencies that are at the same time of utmost importance for an informed decision making within the health care context. In presenting two currently prevailing visions, or mostly held general positions – the „secular“ or the „personalistic“ – the author describes how these are embodied into the opposing views upon the various medical ethical issues. In particular, how holding of these general positions may influence the solutions of practical questions encountered by a patient, his or her physician and/or care provider, or of the family members within the end of life situations.

Key words: end of life, personalistic bioethics, secular bioethics, decision making

Abstrakt

Práca prináša stručný pohľad na spektrum súčasnej medicínskej etiky s ohľadom na jej najvýznamnejšie inšpirácie a smerovania, ktoré majú zásadný význam pre informované rozhodovanie v kontexte zdravotnej starostlivosti. Prezentujú dve v súčasnosti prevládajúce vízie či najčastejšie zastávané pozície – „sekulárnu“ a „personalistickú“ – autor ukazuje, ako sa tieto premietajú do opačných názorov na rozličné medicínsko-etické otázky. Najmä, ako zastávanie týchto pozícií môže ovplyvňovať riešenia praktických otázok, s ktorými sa pacient, jeho lekár alebo poskytovateľ starostlivosti či členovia rodiny stretávajú v situáciách na konci života.

Kľúčové slová: koniec života, personalistická bioetika, sekulárna bioetika, rozhodovanie

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WMA RESOLUTION ON GLOBAL REFUGEE CRISIS

World Medical Association (WMA)

*Adopted by the 66th General Assembly, Moscow, Russia,
October 2015*

The WMA recognises that mass movement of people often follows disasters that flow from armed conflict or natural phenomena as populations seek to escape danger and deprivation. The current mass movement of the populations, to escape the effects of armed conflict including bombing, lack of access to utilities, clean water, and the destruction of homes, schools and hospitals, has been numerically larger than any mass movement of populations in over 70 years.

While the WMA recognises that countries may have concerns about their ability to absorb significant numbers of new migrants, we recognise that people fleeing warfare, or natural phenomena are doing so because they are desperate and often face life-threatening conditions. They are afraid for their health, safety and welfare, and that of the family members who accompany them.

Most countries have signed international treaties giving them binding obligations to offer aid and assistance to refugees and asylum seekers. The WMA believes that, when there are events, including on-going events such as conflict, which generate refugee crises, governments must increase their efforts to provide assistance to those in need.

This should include ensuring safe passage for refugees, and appropriate support after they enter countries offering refuge. Recognising that the disaster from which they have fled, and the vicissitudes of the journey, may have led to health problems it is essential that receiving countries establish systems to provide health care to refugees.

Governments should seek to ensure that refugees and asylum seekers are able to live in dignity within their country of refuge and make all efforts to enable their integration into their new society. The international community should seek to obtain a peaceful solution in Syria under which the population can either stay at home safely or, if they have already left, safely return home.

The WMA recognises that mass population movement cause significant stress on existing populations of countries as well on those who become refugees. We believe that governments and international agencies including the United Nations must make more concerted efforts to reduce the pressures that lead to such movements, including rapidly providing extensive relief after natural phenomena, and making more efforts to avert or stop armed conflict. Re-establishing security of food, water, housing, sewerage, education and health care, and improving public safety, should make a significant impact and reduce the numbers of refugees.

The WMA:

- Recognises that the process of becoming a refugee is damaging to physical and mental health;
- Commends those countries that have welcomed and cared for refugees, especially those currently fleeing Syria;
- Calls on other countries to improve their willingness to receive refugees and asylum seekers;
- Calls on national governments to ensure that refugees and asylum seekers are enabled to live in dignity by providing access to essential services;
- Calls on all governments to work together to seek to end

local, regional, and international conflicts, and to protect the health, safety and welfare of populations;

- Calls on all governments to cooperate in providing immediate help to countries facing the effects of natural phenomena, remembering that those already the most socio-economically disadvantaged will face the most challenges;
- Calls upon global media to report on the refugee crisis in a manner that respects the dignity of refugees and displaced persons, and to avoid bigotry and racial or other bias in reporting.

Text prevzatý z webovej stránky Svetovej asociácie lekárov / Text taken from the web-page of the World Medical Association (WMA):
www.wma.net

WMA RESOLUTION ON THE INCLUSION OF MEDICAL ETHICS AND HUMAN RIGHTS IN THE CURRICULUM OF MEDICAL SCHOOLS WORLD-WIDE

World Medical Association (WMA)

*Adopted by the 51st World Medical Assembly, Tel Aviv,
Israel, October 1999 and revised by the 66th WMA General
Assembly, Moscow, Russia, October 2015*

Preamble

Medical School curricula are designed to prepare medical students to enter the profession of medicine. Increasingly, in addition to core biomedical and clinical knowledge, they teach skills including critical appraisal and reflective practice. These additional skills help to enable future doctors to understand and assess the importance of published research evidence, and how to evaluate their own practice against norms and standards set nationally and internationally.

In much the way same that anatomy, physiology and biochemistry are a solid base for understanding the human body, how it works, how it can fail or otherwise go wrong, and how different mechanisms can be used to repair damaged structure and functions, there is a clear need for physicians in training to understand the social, cultural and environmental contexts within which they will practice. This includes a solid understanding of the social determinants of health.

Medical ethics includes the social contract made between the health care professions and the societies they serve, based upon established principles, on the limits that apply to medical practice. It also establishes a system or set of principles through which new treatments or other clinical interventions will be sieved before decisions are made on whether elements are acceptable within medical practice. There is a complex intermingling of medical ethics and the duties of physicians to patients, and the rights patients enjoy as citizens.

At the same time physicians face challenges and opportunities in relation to the human rights of their patients and of populations, for example occasions for imposing treatments without consent, and will also often be the first to observe and to itemize the infringement of these rights by others, including the state. This places very specific responsibilities upon the observing physician.

Physicians have a duty to use their knowledge to improve the wellbeing and health of patients and the population. This will mean considering social and societal change, including legislation and regulation, and can only be done well if doctors can take a holistic view within clinical and ethical parameters.

Physicians should press government to ensure legislation supports principled medical practice.

Given the core nature of health care ethics in establishing medical practice in a manner that is acceptable to society and that does not violate civil, political and other human rights, it is essential that all physicians are trained to perform an ethics evaluation of every clinical scenario they may encounter, while simultaneously understanding their role in protecting the rights of individuals.

Physicians' ability to act and communicate in a way that respects the values of the individual patient is a prerequisite for successful treatment. Physicians must also be able to work effectively in teams with other health care professionals including other physicians.

Failures of individual physicians to recognize the ethical obligations they owe patients and communities can damage the reputation of doctors both locally and globally. Therefore it is essential that all doctors are taught to understand and respect medical ethics and human rights from the beginning of their medical school careers.

In many countries ethics and human rights are an integral part of the medical curriculum, but this is not universal. Too often teaching is undertaken by volunteers, and can fail if those volunteers are unable or unavailable to teach, or if that teaching is unduly idiosyncratic or inadequately based upon clinical scenarios.

The teaching of medical ethics should become an obligatory and examined part of the medical curriculum within every medical school.

Recommendations

1. The WMA urges that medical ethics and human rights be taught at every medical school as obligatory and examined parts of the curriculum, and should continue at all stages of post graduate medical education and continuing professional development.
2. The WMA believes that medical schools should seek to ensure that they have sufficient faculty skilled at teaching ethical enquiry and human rights to make these courses sustainable.
3. The WMA commends the inclusion of medical ethics and human rights within post graduate and continuing medical education.

Text prevzatý z webovej stránky Svetovej asociácie lekárov / Text taken from the web-page of the World Medical Association (WMA): www.wma.net

WMA DECLARATION ON ALCOHOL

World Medical Association (WMA)

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

1. The burden of disease and injury associated with alcohol consumption is a critical challenge to global public health and development. The World Medical Association offers this declaration on alcohol as its commitment to reducing excessive alcohol consumption and as a means to support its members to assist them in promulgating harm-reduction policies and other measures.

2. There are significant health, social and economic problems associated with excessive alcohol use. The harmful use of alcohol kills approximately 2.5 million people every year (almost 4% of all deaths worldwide), and is the third leading risk factor for poor health globally, accounting for 5.5% of disability-adjusted life years lost. The WMA Statement on Reducing the Global Impact of Alcohol on Health and Society addresses these problems in more detail.
3. Effective alcohol harm-reduction policies and measures will include legal and regulatory measures that target overall alcohol consumption in the population, as well as health and social policy interventions that specifically target high-risk drinkers, vulnerable groups and harms to people affected by those who consume alcohol.
4. There are many evidence-based alcohol policies and prevention programmes that are effective in reducing the health, safety and socioeconomic problems attributable to harmful use of alcohol. However many countries have relatively weak alcohol policies and prevention programmes that are ineffective at protecting health and safety, and preventing harm. International public health advocacy and partnerships are needed to strengthen and support the ability of governments and civil society worldwide to commit to, and deliver on, reducing the harmful use of alcohol.
Health professionals have an important role to play in preventing, treating and mitigating alcohol-related harm, using effective preventive and therapeutic interventions.
5. The World Medical Association has a leadership role to encourage and support the development and implementation of evidence-based national alcohol policies by promoting and facilitating partnerships, information exchange and health policy capacity building.

OBJECTIVES

In developing policy, the WMA recommends focusing on the following broad objectives:

- **Strengthen health systems** to identify and improve a country's capacity to develop policy and lead actions that target excessive alcohol consumption.
- Promote the development and evaluation in all countries of **national alcohol strategies** which are comprehensive, evidence-based and include measures to address the supply, distribution, sale, advertising and promotion of alcohol.
- Through government health departments, accurately **measure the health burden** associated with alcohol consumption through the collection of sales data, epidemiological data, and per capita consumption figures.
- Support and promote the role of **health and medical professionals** in early identification, screening and treatment of harmful alcohol use.
- **Dispel myths** and dispute alcohol control strategies that are not evidence-based.
- Reduce the impact of harmful alcohol consumption in **at risk populations**.
- Foster multi-disciplinary **collaboration** and coordinated **intersectoral action**.
- **Raise awareness of alcohol-related harm** through public education and information campaigns.

PRIORITIES

The following priorities are suggested for WMA members, national medical associations and governments in the development of integrated and comprehensive policy and legislative responses.

Regulate affordability, accessibility and availability

Pricing policies

Increase alcohol prices, through volumetric taxation of products based on their alcohol strength, and other proven pricing mechanisms, to reduce alcohol consumption at the population level, particularly in heavy drinkers and high risk groups.

Accessibility and availability

Regulate access to, and availability of, alcohol by limiting the hours and days of sale, the number and location of alcohol outlets and licensed premises, and the imposition of a minimum legal drinking age. Governments should tax and control the production and consumption of alcohol, with licensing that emphasises public health and safety and empowers licensing authorities to control the total availability of alcohol in their jurisdictions.

Public authorities must strengthen the prohibition of selling to minors and must systematically request proof of age before alcohol can be purchased in shops or bars.

Regulation of non-commercial alcohol

The production and consumption of non-commercial forms of alcohol, such as home brewing, illicit distillation, and illegal diversion alcohol to avoid taxes, should be curtailed.

Reduce harmful alcohol use

Regulation of alcohol marketing

Alcohol marketing should be restricted to prevent the early adoption of drinking by young people and to minimise their alcohol consumption. Regulatory measures range from wholesale bans and restrictions on measures that promote excessive consumption, to restrictions on the placement and content of alcohol advertising that is attractive to young people. There is no evidence that industry self-regulation and voluntary codes are successful at protecting vulnerable populations from exposure to alcohol marketing and promotion.

Increase public awareness of harmful alcohol consumption through product labelling and public awareness campaigns

In conjunction with other measures, social marketing campaigns should be implemented to educate the public about harmful alcohol use, to support drink driving policies, and to target the behaviour of specific populations at high risks of harm. Public awareness measures can also include health warning labels on alcohol products, mandated by an independent regulatory body.

The role of health and medical services in prevention

Health, medical and social services professionals should be provided with the training, resources and support necessary to prevent harmful use of alcohol and treat people with alcohol dependence, including routinely providing brief advice to motivate high-risk drinkers to moderate their consumption. Health professionals also play a key role in education, advocacy and research. Specialised treatment and rehabilitation services should be available and affordable for alcohol dependent individuals and their families.

Drink driving measures

Key drink-driving deterrents should be implemented, which include a strictly enforced legal maximum blood alcohol concentration for drivers of no more than 50mg/100ml, supported by social marketing campaigns and the power of authorities to impose immediate sanctions.

Respond to the alcohol industry

Limiting the role of the alcohol industry in alcohol policy development

The commercial priorities of the alcohol industry are in di-

rect conflict with the public health objective of reducing overall alcohol consumption. Internationally, the alcohol industry is frequently included in alcohol policy development by national authorities, but the industry is often active in opposing and weakening effective alcohol policies. Ineffective and non-evidence-based alcohol control strategies promoted by the alcohol industry and the social organisations that the industry sponsors should be countered. The role of the alcohol industry in the reduction of alcohol-related harm should be confined to their roles as producers, distributors and marketers of alcohol, and not include alcohol policy development or health promotion.

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KONFERENCIE / CONFERENCES

VÝZVY A ZODPOVEDNOSŤ KRESŤANSKEJ BIOETIKY

Bratislava, 19. júna 2015

Odborná konferencia *Výzvy a zodpovednosť kresťanskej bioetiky* sa konala 19. júna 2015 v konferenčných priestoroch hotela Barónka v Bratislave – Rači. Hlavným organizátorom bola Subkomisia pre bioetiku Teologickej komisie Konferencie biskupov Slovenska (SpB TK KBS). Odbornú garanciu konferencie a organizačnú spoluprácu spoločne poskytli Ústav zdravotníckej etiky Slovenskej zdravotníckej univerzity v Bratislave a Ústav medicínskej etiky a bioetiky n. f. Podujatie sa konalo pri príležitosti 20. výročia vydania encykliky pápeža sv. Jána Pavla II. *Evanjelium života*.

Kvalitne pripravená konferencia priniesla kvalifikovaný pohľad na medicínsku (zdravotnícku) a etickú problematiku v troch aktuálnych témach, ktoré sa stali náplňou jednotlivých panelov odborného programu podujatia: (1) surogátne (náhradné) materstvo, (2) starostlivosť o nevyliciteľne chorého a zomierajúceho pacienta, (3) novšie poznatky a možnosti pomoci deťom s poruchami autistického spektra a ich rodinám. Pozvaní odborníci z príslušných oblastí medicíny, ošetrovateľstva, etiky a teológie sa spoločne venovali každej zo zvolených tém tak, aby ponúkli účastníkom konferencie vyvážený a ucelený interdisciplinárny pohľad. Zamerali sa na najmä riešenie konkrétnych praktických problémov a aktuálne dostupné možnosti pomoci. Obohatením bloku venovanému problematike autizmu bola prednáška lekárky Dr. Paola de Rosa z univerzitnej nemocnice Bambino Gesù v Ríme: zaujala najmä predstavením nových možností včasnej diagnostiky a intervencie, a to už u malých detí.

V slávnostnom úvode sa účastníkom konferencie prihovoril Mons. Stanislav Zvolenský, bratislavský arcibiskup. Poukázal na závažnosť preberanej problematiky a na praktický – pastoračný záujem Cirkvi o tieto otázky, s ktorými sa dnes často stretávajú jednotlivci i rodiny na Slovensku. Cirkev často nemá k dispozícii potrebné konkrétne štruktúry pomoci, avšak je povolaná a povinná apelom na morálne priority, ktoré vychádzajú z kresťanského pohľadu na človeka, povzbudzovať a podporovať všetkých ľudí dobrej vôle, osobitne kresťanov, aby sa aktívne pri riešení týchto otázok angažovali. Či už v rámci svojich osobitných povolaní, alebo aj formou dobrovoľníckej angažovanosti. Na druhej strane, na Slovensku okrem aktivít Slovenskej katolíckej charity funguje viacero obdivuhodných iniciatív a zariadení pomoci, zväčša na regionálnej alebo miestnej úrovni. Reálne potreby sú však oveľa väčšie. A to aj vzhľadom na ťažké podmienky, v ktorých dnes žijú mnohé mladé i viacdetné rodiny, ale aj starší či chorí ľudia a dôchodcovia.

Duchovný rozmer podujatia načrtol v úvodnom slove Mons. Milan Lach SJ, predseda Subkomisie pre bioetiku. Pripomenul, že bez potrebného duchovného základu strácajú aktivity zamerané na pomoc ľuďom v zdravotnej alebo inej životnej núdzi správne smerovanie aj účinnosť. Obetavá služba bližnému je jednou z najcharakteristickejších črt kresťanstva – a mala by zjednocovať naše spoločné úsilie, ako aj otvárať nás spolupráci s inými ľuďmi dobrej vôle a k prehĺbeniu našej duchovnej identity.

Najvýznamnejšie črty encykliky sv. pápeža Jána Pavla II *Evanjelium života* vo vzťahu k aktuálnym otázkam súčasnej bioetiky priblížil v úvodnej prednáške dekan CMBF UK v Bratislave ThDr. Ing. Vladimír Thurzo, PhD. Ide o vskutku prorocký dokument, v ktorom je možné nájsť odpovede a usmernenia pre mnohé problémy dneška: sú totiž nezriedka prejavom alebo dôsledkom konfrontácie dvoch navzájom protikladných životných kultúr: kultúry života a kultúry smrti. Prednášateľ osobitne upozornil na teologickú prepracovanosť encykliky, ktorá presne definuje pojmy a má pozoruhodnú štruktúru i výstavbu predkladanej argumentácie.

Tzv. náhradné (surogátne) materstvo

Téma prvého diskusného panelu obsahovo nadväzovala na *Stanovisko SpB TK KBS k niektorým etickým aspektom tzv. náhradného materstva*, publikované v decembri 2014. Na riziká a mnohé paradoxy tzv. náhradného (surogátneho) materstva vo vzťahu k telesnému a psychickému zdraviu ženy upozornil gynekológ MUDr. Ivan Wallenfels (Žilina). Tento postup prevracia a rozbíja jednu z najkrajších úloh ženy – matky, ktorou je prijať do svojho života a priviesť na svet svoje dieťa. Poznatky o fyziológii tehotenstva, zásadnom význame pôsobenia organizmu ženy pre vývin počatého dieťaťa, a to už od prvých minút jeho existencie, poukazujú na mnohé negatíva, ktoré v hluku reklamy surogátneho materstva nezriedka celkom unikajú pozornosti. Čo to všetko znamená pre samotné dieťa, najčastejšie počaté niektorou z metód tzv. asistovanej reprodukcie a nosené ženou, ktorá sa mu má stať po narodení cudzou (a zvyčajne aj neznámou), priblížil z pohľadu pediatra MUDr. Andrej Hrádický (Trenčín).

Na teologické aspekty, osobitne na najkrikľavejšie rozpory s morálnym učením Katolíckej cirkvi poukázal morálny teológ ThLic. Ján Viglaš (Badín). Kritiku surogátneho materstva z pohľadu súčasnej bioetiky priniesla spoločná prednáška bratislavských autorov (prof. Jozef Glasa, doc. Terézia Krčméryová, doc. Mária Glasová), v ktorej sa zdôraznili narušenia základných etických princípov a ľudskej dôstojnosti vo vzťahu ku všetkým zúčastneným stránkam, osobitne voči „objednanému“ dieťaťu, „náhradnej“ matke a „objednávajúcim“ rodičom dieťaťa, ale aj voči lekárom, zdravotníkom a pracovníkom iných profesií, ktorí sa na neetických postupoch („zle“) potrebných na realizáciu surogátneho materstva podieľajú. Autori poukázali na hlboké etické pochybenia aj v prípade tzv. altruistického surogátneho materstva, ktoré sa mylne predstavuje ako dobrý, súcitný čin pomoci bezdetnému páru.

Aktuálnu situáciu v krajinách Európskej únie a súčasne iniciatívy na pôde Európskeho parlamentu priblížila MUDr. Anna Záborská (Bojnice). Je spoluautorkou iniciatívy zameranej na úplný zákaz týchto postupov – predovšetkým v záujme ochrany práv a dôstojnosti „náhradných“ matiek a „objednaných“ detí, ale aj na ochranu celej spoločnosti voči kriminálnym a iným nekalým činnostiam, ktoré tento novodobý, veľmi výnosný obchod (so ženami a s ich deťmi) sprevádzajú.

Starostlivosť o nevyliciteľne chorého a zomierajúceho

Tému otvorila prehľadová prednáška z pohľadu lekára: Prof. Jozef Glasa a MUDr. Helena Glasová (Bratislava) pripomenuli význam dobrého rozlišovania pojmov a správnej terminológie, aby sa vyhlo nedorozumeniam v bioetickej debate, ale najmä v praxi. Medicínske rozhodnutia na konci ľudského

života patria v práci lekára k tým (naj)ťažším. Dnes sa právom kladie dôraz na zapojenie samotného pacienta a jeho príbuzných do rozhodovacieho procesu. Avšak títo zvyčajne nie sú na riešenie podobných otázok dostatočne pripravení, čo sťažuje potrebnú spoluprácu a vzájomné porozumenie. Vystáva teda naliehavá potreba lepšej informovanosti, ba elementárnej edukácie širokej verejnosti. Mala by byť zameraná na lepšie pochopenie podstaty a na skvalitnenie takéhoto zdieľaného spolurozhodovania. Cieľom vždy musí byť hľadanie skutočného dobra chorého: aby sa mu poskytovala taká starostlivosť, ktorá rešpektuje a čo najlepšie naplňuje všetky jeho potreby. Vráťane potrieb spirituálnych (duchovných).

Prakticky orientovaný pohľad morálnej teológie predstavil ThDr. Michal Vivoda, PhD. (Bratislava). Upozornil na potrebu pojmovej jasnosti a rozlišovania a poukázal na silné posolstvo nádeje a duchovnej sily, ktorú potrebujú nielen ťažko chorí pacienti, ale aj všetci, ktorí sa im snažia pomáhať: najbližšia rodina, priatelia – a v neposlednom rade aj samotní zdravotnícki pracovníci.

Východiská a praktické aspekty lôžkovej hospicovej starostlivosti priblížili MUDr. Jana Brtňanová a MUDr. Zuzana Otrubová (Trenčín, Banská Bystrica). Významu a možnostiam pomoci pacientovi a jeho rodine formou domácej hospicovej starostlivosti sa venovala MUDr. Eva Vlčková (Handlová). Ide o starostlivosť, ktorá sa pri plnom rešpektovaní dôstojnosti a všetkých dimenzií potrieb terminálne chorého pacienta zameriava na zlepšenie a udržanie primeranej kvality života, čo zahŕňa nielen dôslednú liečbu jeho zdravotných ťažkostí (sympťomov) ale aj rôznorodú ďalšiu pomoc a podporu, ktorá nevynecháva ani jeho najbližších. To sa prejavuje aj v celom spektre poskytovanej ošetrovateľskej starostlivosti a pri sprevádzaní pacienta na tomto ťažkom, ale – za vhodných podmienok potrebnej poskytovanej pomoci – aj ľudsky hodnotnom a dôstojnom úseku jeho životnej cesty, ako podčiarkla vo svojom príspevku sestra M. Gorazda Holbová (Trenčín).

Významnou súčasťou zdravotnej starostlivosti o nevyliciteľne či terminálne chorého, ako aj o zomierajúceho pacienta musí byť vždy aj primeraná duchovná starostlivosť a sprevádzanie zdôraznil v prednáške „nemocničný kaplán“ PhLic. Juraj Jendrejovský (Martin). Pri naplňaní spirituálnych (duchovných) potrieb pacienta na sklonku jeho života nejde výlučne o vysluhovanie sviatostí či o iné náboženské úkony: spirituálne potreby majú aj „neveriaci“ pacienti. Ide teda o zdieľanie otázok a odpovedí o zmysle života a danej situácie konkrétneho človeka. O ľudskú – a pokiaľ možno i o duchovnú blízkosť „tu a teraz“ tomuto človeku – pacientovi, ktorého život sa práve naplňuje.

Autizmus – aktuálne poznatky a možnosti pomoci

Blok uviedla tlmočená pozvaná prednáška zahraničného hosťa – detskej lekárky Dr. Paola de Rose z Nemocnice Dieťaťa Ježiša v Ríme. Okrem výnimočných informácií o nových možnostiach včasnej diagnostiky a intervencie už u detí v útlom veku sa osobitne venovala závažným problémom rodín, ktoré vychovávajú dieťa s niektorou z porúch autistického spektra, a predstaveniu potrieb a možností pomoci. Tieto rodiny sú nezriedka podstatne obmedzované v možnostiach spoločenského kontaktu, ba až izolované, a to nielen vo vzťahu k bežnej spoločnosti, ale napríklad aj v rámci farského spoločenstva. Riešia každodenne množstvo neľahkých praktických problémov – a narážajú na elementárne nepochopenie, nezáujem, či dokonca na pomýlené odsudzovanie. Preto potrebujú viac kvalifikovanej odbornej, ale aj vhodnej ľudskej pomoci a pochopenia.

Domácu zostavu členov tohto panelu uviedla prehľadnou prednáškou o aktuálnom stave poznatkov o vzniku a podstate autizmu a o možnostiach pomoci ľuďom s poruchami autistického spektra, tejto „novej epidémie 21. storočia“, prof. Daniela Ostatníková (Bratislava). Spolu so svojimi spolupracovníčkami v Akademickom centre pre štúdium autiz-

mu (ACUA) na Lekárskej fakulte UK v Bratislave predstavila pozoruhodný výskumný program centra, ako aj viaceré aktivity zamerané na konkrétnu pomoc. O manažmente pacientov s poruchami autistického spektra v našich podmienkach – a v porovnaní s možnosťami a vlastnými odbornými skúsenosťami v zahraničí referovala MUDr. Silvia Hnilicová (Bratislava). Dôležitou zaujímavosťou bola informácia o novo uvádzanom teste určenom pre pediatriu, ktorý umožňuje včasný záchyt porúch autistického spektra už v útlom detstvom veku, čo je podkladom možnosti včasnej odbornej intervencie. Na osobitné potreby pomoci rodinám s deťmi s autizmom poukázala doc. Mária Glasová (Bratislava). Možnosti konkrétnej pomoci zo strany štátnych inštitúcií sú nateraz veľmi obmedzené, zanedbané. Rodina často nenachádza potrebnú radu a podporu, ostáva na svoje problémy sama. To znamená dlhotrvajúci stres pre všetkých jej členov.

Pozoruhodné informácie o mnohorakej práci a aktivitách súkromnej základnej školy a materskej škôlky pre žiakov a deti s autizmom v Prešove priniesla jej riaditeľka a iniciátorka Mgr. Eva Turáková (Prešov). Samotná existencia a výsledky viacročného úsilia tejto špeciálnej školy/škôlky si zaiste zaslúžia obdiv, ale aj nasledovanie. Prednáška bola ukážkou toho, čo dokáže spojenie kvalifikovanej profesionálnej pomoci a obetavého osobného nasadenia.

Na význam a potrebu duchovnej pomoci pre rodiny s autistickým dieťaťom poukázal vdp. Mgr. Patrik Maľarčík (Jusko-va Voľa, Prešovská eparchia).

V diskusii zazneli aj svedectvá matiek autistických detí, ktoré priblížili ťažkosti a problémy, s ktorými musia denne zápasíť, keď sa chcú riadne postarať o tieto svoje „deti so špecifickými potrebami“. Svedectvá v súlade s vyjadreniami členov panelu poukázali na to, že výchova dieťaťa s poruchou z autistického spektra v rodine je vždy svedectvom mimoriadne obetavosti rodičov, ale aj ostatných členov rodiny. Zaslúžila by si – a potrebovala by rozhodne väčšie spoločenské uznanie i konkrétnu podporu a pomoc, vrátane cieľenej finančnej podpory špeciálnej psychologickej a pedagogickej starostlivosti.

V záverečnom slove sa účastníkom konferencie opäť prihovoril Mons. Milan Lach SJ. Zdôraznil záujem Cirkvi o prerokovávané otázky a jej blízkosť k ľuďom, ktorí dnes potrebujú nielen medicínsku a inú kvalifikovanú pomoc – a pre túto pomoc je nevyhnutné žiadať zlepšenie podmienok a podpory – ale zároveň potrebujú aj pomoc duchovnú, duchovne sprevádzanie. Poľudšťovanie a zlepšovanie úrovne zdravotnej i sociálnej starostlivosti na Slovensku je úlohou a zodpovednosťou nielen samotných zdravotníkov, ale aj všetkých štruktúr, ktoré majú pre ich poskytovanie zabezpečovať potrebné podmienky, akými sú zdravotné poisťovne, vláda a parlament.

Prof. MUDr. Jozef Glasa, CSc., PhD.

ÚMEB n.f., Bratislava

RECENZIE / BOOK REVIEWS

HEALTH AND HUMAN RIGHTS IN EUROPE

B. Toebes, M. Hartlev, A. Hendriks, J. R. Hermann (eds.)

Intersentia, Cambridge – Antwerp – Portland, 2012,
310 pgs, pb, ISBN 978-94-000-0151-0

Problematika zdravia a ľudských práv je relatívne novou oblasťou práva. Prístup analyzujúci túto oblasť znamená použitie medzinárodnej, európskej a národnej legislatívy vo vzťahu k širokej škále problémov zdravia a zdravotníctva, vrátane prístupu k zdravotnej starostlivosti, ochrane zdravotných údajov, kvalite liekov a liečivých prípravkov, ako aj celého

radu medicínsko-etických a bioetických otázok. Dosaiaľ však stále chýba hlbšie porozumenie rozličných a mnohorakých styčných plôch medzi zdravím a ľudskými právami, ako aj dôsledkov tohto prístupu pre právny výskum a prax. Zaplniť túto podstatnú medzeru sa pokúša recenzovaná publikácia. Načrtáva právny obsah a dôsledky tejto novej problematiky, pričom sa cieľene zameriava na európsky kontext, keďže tento kladie špecifické otázky nielen z právnej a politickej perspektívy, ale aj z hľadiska zdravotnej problematiky a hodnotenia výsledkov zdravotnej starostlivosti.

Po kvalifikovanom prehľadovom úvode do problematiky zdravia, zdravotnej starostlivosti a ľudských práv v Európe (vrátane stručného historického prehľadu jej vývoja a návrhu teoretických východísk použitého metodologického prístupu) si publikácia najskôr všíma, ako sa kľúčové európske inštitúcie – Rada Európy a Európska komisia – angažujú v otázkach zdravia a ľudských práv (Časť I). Následne opisuje význam najdôležitejších ľudských práv týkajúcich sa tejto oblasti a venuje sa širokej škále tém a prístupov, ktoré sa dotýkajú zdravia a ľudských práv, vrátane problematiky práv pacientov, reprodukčného zdravia a záležitostí terminálnej starostlivosti, smrti a zomierania (časť II). Napokon diskutuje postavenie rôznych zraniteľných skupín osôb, osobitne zdravotne postihnutých, starých a detí (časť III). V záverečnej časti (časť IV) knihy sa v užitočnom prehľade uvádzajú najdôležitejšie závery jednotlivých kapitol, spolu s viacerými otázkami, ktoré ostali otvorené, ako aj s odporúčaniami pre prax a budúci výskum v tejto interdisciplinárnej oblasti práva, ktorej praktický význam bude pravdepodobne v blízkej budúcnosti ďalej narastať.

Kniha spája príspevky ôsmich medzinárodných odborníkov v oblasti ľudských práv a zdravotníckeho práva, pochádzajúcich zo štyroch krajín severnej Európy (Dánsko, Holandsko, Island, Nórsko). Autori pri písaní publikácie vstúpili do plodného dialógu, v ktorom sa zaujímavým spôsobom pokúsili o prienik sfér zdravotníckeho práva a práva riešiacieho otázky ľudských práv. Výsledkom sú výborne dokumentované a navzájom vnútorne súvisiace kapitoly, ktoré ako celok poskytujú pozoruhodne komplexný a ucelený pohľad na preberanú problematiku.

Ide o knihu, ktorá je zvlášť vhodná pre kurzy zdravotníckeho práva vo vzťahu k otázkam ľudských práv – a to tak pre vyučujúcich, ako aj pre študentov. Poskytuje veľmi dobrý základ pre všetkých, ktorí by sa tejto problematike chceli venovať hlbšie, či už na úrovni výskumu alebo zdravotnej politiky. Vzhľadom na praktické zameranie viacerých príspevkov môže pomôcť pri orientácii aj v prístupe ku konkrétnym problémom v zdravotníckej praxi, pri ktorých ide o konflikty na úrovni zdravotnícko-právnej a ľudsko-právnej. Dôležitým aspektom je medzinárodný náhľad na preberanú problematiku s akcentom na európske reálie – preto kniha predstavuje užitočný zdroj informácií aj pre odborníkov, ktorí sú s otázkami ľudských práv a zdravotníckeho práva konfrontovaní pri svojej expertnej alebo politickej práci v európskych inštitúciách.

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Physicians must never use their professional position to violate the dignity or human rights of any individual or group, and should never allow their personal desires, needs, feelings, prejudices or beliefs to interfere with a patient's treatment. Physicians must never abuse their authority or take advantage of a patient's vulnerability.

Excerpts from the 1995 WMA Statement on Ethical Issues Concerning Patients with Mental Illness (revised 2015) taken from the web of the World Medical Association (WMA): www.wma.net

ACCESS TO MEDICINES

The interface between patents and human rights. Does one size fit all?

J. A. Sellin

Intersentia, Cambridge, 2014, 493 pgs, pb

ISBN 978-1-78068-247-1

Dostupnosť potrebných účinných liekov predstavuje celosvetovo nedoriešený a ťaživý problém zdravotnej politiky, a to osobitne v rozvojových krajinách, kde nedostupnosť základných (esenciálnych) liekov znamená každodenne a vo veľkom rozsahu pôsobiaci zhubný zdravotný (chorobnosť a úmrtnosť), sociálne a ekonomické dôsledky.

Publikácia sa osobitne zameriava na jeden z významných aspektov dostupnosti liekov: na dostupnosť základných (esenciálnych) liekov vo vzťahu k ľudským právam a patentovej ochrane nových liečiv. Častým tvrdením v tejto oblasti je, že patentová ochrana nových liekov znamená ich vyššie ceny, čo negatívne vplýva na ich dostupnosť pre pacientov. To často znamená, že pacienti z reálnych ekonomických dôvodov nemajú možnosť dostať potrebné lieky. To však predstavuje situáciu nenaplnenia ich základných ľudských práv, osobitne práva na zdravie a zdravotnú starostlivosť. Kniha analyzuje tieto otázky z perspektívy práva – a to tak v kvalifikovanom medzinárodnom pohľade, ako aj z hľadiska domáceho práva a reálnej situácie vybraných krajín (Južná Afrika, India, Uganda), kde autorka realizovala konkrétny výskum v rámci práce na svojej doktorskej dizertácii (ktorá sa následne stala základom na spísanie tejto pozoruhodnej publikácie).

Prvá časť knihy (kapitoly 1 a 2) poskytuje užitočný úvod do sledovanej oblasti a venuje sa jednak definovaniu samotnej problematiky (dostupnosť liekov) v medzinárodnom kontexte a opisu použitej metodológie (ciele pôvodného výskumu, výskumné otázky, zdroje informácií, hodnotenie a interpretácia údajov a poznatkov, výber skúmaných krajín).

V druhej časti (kapitoly 3 – 5) autorka rozoberá medzinárodný právny rámec dostupnosti liekov z pohľadu ľudských práv a kladie otázku, či dostupnosť základných liekov predstavuje osobitné ľudské právo v spojení s právom na život, na zdravie a zdravotnú starostlivosť a s právom na sľuboch z pokroku vedy. V ďalšom analyzuje z hľadiska patentovej ochrany nových liečiv dosiaľ najvýznamnejší medzinárodný dohovor – TRIPS (Agreement on Trade-Related Aspects of Intellectual Property Rights), ktorý bol prijatý v

rámci Svetovej obchodnej organizácie (WTO – World Trade Organization). Následne si kladie otázku, či tento dohovor nie je v rozpore s niektorými ustanoveniami Medzinárodného dohovoru o ekonomických, sociálnych a kultúrnych právach (kapitola 5).

Tretia, osobitne zaujímavá časť publikácie obsahuje konkrétne štúdie v troch vybraných krajinách (kapitoly 6 – 8). Každá štúdia začína úvodným prehľadom situácie v tej-ktorej krajine a pokračuje jednak analýzou ľudsko-právnej problematiky z hľadiska jej riešenia v príslušnej domácej legislatíve a ďalej opisom existujúcich domácich právnych predpisov patentovej ochrany nových liečiv. Všíma si spôsob definovania aktuálne platných štandardov a analyzuje rozsah novej flexibility, ktorú pre danú oblasť práva tieto predpisy v danej krajine poskytujú – s ohľadom na možnosti zohľadnenia jej špecifickej situácie a potrieb. Ide o možnosť stanoviť primeranú rovnováhu medzi oprávnenými požiadavkami na dostupnosť nových liekov pre pacientov a ich náležitú patentovú ochranu. Autorka si kladie a rieši otázku, či rovnaká legislatíva v tejto oblasti by skutočne zodpovedala potrebám a možnostiam každej krajiny – alebo či a nakoľko, v akom rozsahu, sú oprávnené špecifické zmeny a právne úpravy.

V záverečnej kapitole autorka uvádza koncízny prehľad zistení a záverov svojho rozsiahleho teoretického i praktického skúmania, spolu s návrhom odporúčaní pre prax a ďalší výskum.

Kniha predstavuje výnimočne kvalitný zdroj informácií nielen pre odborníkov venujúcich sa tejto komplexnej problematike na úrovni vedeckého výskumu a postgraduálnych vzdelávacích programov, ale vzhľadom na prehľadné, koncízne spracovanie a vynikajúce dokumentovanie problematiky (294 citácií, okrem toho zoznam vyše 100 medzinárodných a národných dokumentov, súdnych rozhodnutí atď.) aj pre odborníkov a serióznych aktivistov v oblasti praktickej zdravotnej, liekovej politiky, osobitne vo vzťahu k adekvátnej dostupnosti potrebných liekov a rešpektovania a naplnenia obsahu základných ľudských práv.

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Časopis *Medicína etika & Bioetika – Medical Ethics & Bioethics* je kompletne dostupný na web-stránkach Ústavu medicínskej etiky a bioetiky n. f. - www.bioetika.sk a www.bioethics.sk.

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