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OD REDAKCIE / EDITORIAL

Perspektívy bioetiky v stredo- a východoeurópskom kontexte

Udalosti na svetovej politickej, hospodárskej, bezpečnostnej a kultúrnej scéne poukazujú na vzrast významu etických hodnôt vo vzťahu k riešeniu kľúčových existenciálnych problémov súčasného človeka a ľudstva, ba i s ohľadom na samotnú existenciu ľudskej kultúry a jej zachovanie a rozvoj v najbližších desaťročiach. Ukazuje sa, že azda nikdy nemalo ľudstvo k dispozícii také mohutné prostriedky na zničenie seba i ostatnej živej prírody na Zemi, ako je tomu v našich dňoch. Ešte nikdy nemal človek také technické a technologické prostriedky, ktoré by – ako je tomu dnes – umožnili v globálnom meradle uspokojenie základných potrieb dôstojného života pre všetkých členov ľudskej rodiny (potrava, bývanie, odev, hygiena, zdravotná starostlivosť, atď.), pravda, za predpokladu iného prístupu k rozdeľovaniu týchto dohier. Nikdy si ľudia nebolí bližšie, ako im to umožňujú súčasné komunikačné technológie, ale azda nikdy svet nebol rozdelený toľkými trhlinami nenávisť, protikladov a násilia. Ešte nikdy nebola civilizácia človeka tak dobre zabezpečená voči nepriazni prírody a jej živlov, ale azda ešte nikdy nebol civilizovaný svet takým nebezpečným a ohrozeným miestom, ako je tomu dnes pre strach z terorizmu, či zlyhania technických alebo ľudských faktorov. Súčasný človek prišiel až k samotným molekulárnym prameňom života. Rozlúštil jeho základný kód. Má v rukách prostriedky na ovplyvňovanie svojej biologickej budúcnosti..., ale má dnes azda ešte menej jasno, než voľakedy, v tom, aká by táto budúcnosť mala byť a kam by mala smerovať.

V situácii nezmerných paradoxov životnej situácie súčasného človeka predstavuje bioetika – ako multidisciplinárna oblasť štúdia princípov, noriem a pravidiel hodnotenia ľudského konania a správania v oblasti medicíny, zdravotníctva a praktickej aplikácie biológie a iných vied o živej prírode – určitú nádej a možný jednotiaci priestor aktuálneho diškurzu o budúcnosti ľudskej civilizácie (či už vedomého alebo "odborného", alebo toho, ktorý sa uskutočňuje neformálne a naplnia rôznymi obsahmi priestor "spoločenského vedomia", verejnej mienky, či formuje postoje a názory jednotlivcov, rodín, či väčších skupín spoločnosti – až po definovanie etnických, národných, štátnych, kontinentálnych alebo globálnych záujmov).

V krajinách strednej a východnej Európy sa tieto otázky neraz zdajú predčasné, "nepraktické", či umelé – "máme svoje špecifiká, i svoje vlastné starosti; čo nás do problémov, ktoré sú za hranicami „nášho sveta“ – i tak ich nemôžeme ovplyvniť". Napriek tomu sa týmto otázkam, ani týmto problémom naše krajiny, ani "naši ľu-

(pokračovanie na str. 16)

LETTING, DIE AND MERCY KILLING

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Abstract

We are all called to make moral decisions, not only about preserving life and health, but also about accepting our death and dying. There are situations, when it is morally right, and indeed obligatory, to allow a dying person to die in peace and dignity. But there is a world of difference between allowing a peaceful death, and deliberately setting out to bring death of the person either by acts of commission (s.c. 'active euthanasia'), or by acts of omission (s.c. 'passive euthanasia'). The word "killing" seems proper for euthanasia, because "to kill" does mean "to intentionally cause the death of someone." It can be morally acceptable to withhold or withdraw a treatment precisely because it is reasonably judged as inefficacious (futile), or excessively burdensome for the patient. One's reason for withholding such treatment must not be a judgement about the desirability of putting an end to the patient's *life*, but a judgement about the desirability of putting an end to the *treatment*, which is futile or burdensome.

Key words: euthanasia, principle of double effect, direct and indirect killing, morality, ordinary – extraordinary means, usefulness and burdensomeness, allowing to die

Introduction

Those who promote an ethics of euthanasia do not distinguish at all or do not distinguish sharply between direct killing a person by taking lethal action against him and allowing or permitting a person to die his own death. For them the end or purpose of both – direct killing by taking lethal action or by allowing somebody to die, is the same: to contrive or bring about the patient's death. To see the difference between killing and letting somebody die his own death is very important to the doctor, because the doctor who chooses to kill the patient becomes exactly what he is doing: he becomes a killer. The doctor – patient relationship is in danger. How can you trust your doctor who has the intention and is given the legal option of killing you? In Holland hospitalised elders hire others to watch over them so their doctor does not kill them. Do we want that happen everywhere?

I. Killing as a Side-Effect of Other Action

Although one is responsible for nonintentional killing of innocent persons, it is not always morally wrong to cause this effect. Here we think it is helpful to examine the *morality of killing as a side effect of other actions*. An absolute prohibition on murder cannot be confined to intentional killing. But not all deliberate action involving risk can be prohibited. So it must be possible to have sufficient excuse for risking or accepting death as a side effect. The

statement that this is possible is known to Catholic moral theology as the "principle of double effect." [1]

According to Thomas J. O'Donnell, the principle of the double effect is merely an analytical approach to a problem, which enters to a greater or lesser degree into practically every human act. Often the problem is so slight that it is solved by the simplest act of the moral conscience. Sometimes a more clearly elaborated analysis of the principle is needed in order to evaluate a given action in its relation to right order. [2]

The problem is that no human act is a completely closed, controlled, and independent unit. Any human act has a myriad diversity of other effects and repercussions in the lives of others, which may be foreseen to some extent, even though not directly intended or willed. [3] Due to the many life situations in which foreseen but unintended evil effects are associated with doing good, the question always arises: "Does the obligation to avoid evil oblige one to abstain from a good action in order to prevent a foreseen but merely permitted concomitant evil?" [4]

Thomas J. O'Donnell gives an answer to this question, saying "one can be obliged only to take reasonable means to prevent evil. Hence, all things considered, if the intended good effect is so great that its omission would be, in the judgement of men, too high a price to pay for the prevention of the evil, then there is no obligation to abstain from the good action and sacrifice its good effect in order to prevent the concomitant evil." [5]

Thomas J. O'Donnell gives the definition of the Principle of the Double Effect, saying the following: "An action, good in itself, which has two effects, an intended and otherwise not reasonably attainable good effect, and a foreseen, but merely permitted, evil effect, may licitly be placed, provided there is a due proportion between the intended good and the permitted evil." [6] Later on, he gives an explanation of each of the key words of the principle:

- **An action:** Since we are dealing here with the question of the morality of an action, the action is understood to be a specifically human action, placed freely and with advertence.
- **Good in itself:** The action, in itself, and considered apart from the concomitant evil effect, must be a morally good or at least indifferent action.
- **Which has two effects:** Both the good and evil effects are actually results of the action in question.
- **An intended good effect:** The intended good effect is called the "direct voluntary" effect. It is the good, which really determines the will to act.
- **Otherwise not reasonably attained:** If the good effect could be obtained in some other way, equally expeditious and effective, and without the concomitant evil effect, obviously this would have to be done. In such a case there would be no proportionate reason for permitting the evil effect.
- **And a merely permitted evil effect:** This is called the "indirect voluntary" effect: that is, although foreseen as an evil effect resulting from the action, it is in no way an object of the act of the will (it is not intended). Its only connection with the will is indirect, and in this way: that the act, which is the object of the will, does in some way cause the evil effect. [7]

Here we are talking about the condition that there be a proportionate reason for accepting the bad side effect. But some proportionalists maintain that this shows that classical moral theology was committed to proportionism. As Germain Grisez says:

"If so, however, the classical moralists would not have required a double effect analysis. They did so because in fact they held that certain things are always wrong, regardless of ulterior good consequences. When the classical moralists required a "proportionate reason" for freely accepting side effects, they implied that the good

sought and the evil accepted could be rendered commensurate. They did not say how this might be done. But the commensuration they required could be explained without admitting the commensuration of premoral goods and bads the proportionalist requires. For one can say that the reason for accepting bad side effects is “proportionate” if their acceptance does not violate any of the modes of responsibility. For example, by this criterion one who risked the death of healthy children in medical experiments would lack a proportionate reason, for to take such a risk would be unfair.” [8]

According to Germain Grisez, “the principle of double effect” could be summarised as follows: “One may perform an act having two effects, one good and the other bad, if four conditions are fulfilled simultaneously:

1. The act must not be wrong in itself, even apart from consideration of the bad effect. (Thus, the principle was not used to deal with the good and the bad effects of an act admittedly excluded by an absolute norm.)

2. The agent’s intention must be right. (Thus, if one’s precise purpose is to destroy, damage, or impede some basic human good, the deed carrying out this purpose could not be justified by the principle.)

3. The evil effect must not be a means to the good effect. (Thus, if one chooses to destroy, damage, or impede some basic human good, although one chooses this for the sake of a good one might otherwise rightly pursue, the deed carrying out this choice could not be justified by the principle.)

4. There must be a proportionately grave reason to justify the act. (Thus, even if all the other conditions were fulfilled, one still might be obliged by the moral significance of the expected bad effect to abstain from the action.)” [9]

As we see, freely accepted side effects must be distinguished from chosen means to one’s ends. To accept side effects contrary to a human good is not to determine oneself against it. (For example, direct sterilisation is an action, in which one chooses to sterilise, while indirect sterilisation is an action in which one chooses something else and accepts sterility as a foreseen side effect). [10]

As we see, the Principle of the Double Effect is valid and defensible as a reliable guideline for doing good and avoiding evil. If individuals had to abstain from performing good actions because of foreseen evil side effects, many would be tempted to use that prospect of evil side effects as an excuse to pass up opportunities of doing good. [11]

An act of killing the innocent is wrong in itself, but as we saw, it may nevertheless be permissible to allow the bad effect of a person’s death to occur if this effect is a nonintended consequence of an action performed for the sake of a good effect. The good effect is seen as direct and intended; the harmful effect is seen as indirect, unintended, or merely foreseen. In other words, the principle allows an agent to bring about a bad effect indirectly that it is not permissible to bring about directly. The effect is indirect because it is not intended either as a means to another end or as an end in itself. [12]

The principle of double effect states a possibility: “Where you may not aim at someone’s death, causing it does not necessarily incur guilt – it can be that there are necessities which in the circumstances are great enough, or that there are legitimate purposes in hand of such a kind, to provide a valid excuse for risking or accepting that you cause death. Without such excuse, foreseeable killing is either murder or manslaughter.” [13]

But there are cases where it strikes people that there is little difference between direct and indirect killing. George V. Lobo says, “it should be clear that the principle of the double effect has real validity *only* when one admits moral absolutes or the concept of intrinsically evil acts. If all the circumstances and the subjective intention

(*finis operantis*) are included in the moral object, then there is no sense in the distinction between direct and indirectly voluntary.” [14] As we know, the distinction between direct and indirect voluntary is the keystone of traditional ethical reasoning.

It will be helpful to present an example where we could apply all four conditions of the principle of double effect. There is a classic example about removal of a cancerous uterus that results in the foreseen but not intended death of the foetus:

“The action of removing the cancerous uterus in this situation is a permissible obstetrical procedure that has good and bad effects. The physician intends only the good effect (saving the mother’s life), not the bad effect (the death of the foetus). This claim about the acceptability of the agent’s intention is made, in part, because the foetus’ death is not a means to the end of saving the mother’s life. If the foetus’s death were a means, it would be intended along with the end. But saving the mother’s life is only contingent upon the foetus’s removal, not upon its death. Its death is an unintended though foreseen effect and is neither an end nor a means to an end.” [15]

There can be truly dramatic situations, such as a “borderline case,” when a physician determines that it is necessary to perform a foetal craniotomy – now rare – in order to save a woman in labour. Here the woman will die if the foetus’s head is not crushed. But this procedure is disqualified by the principle of double effect because killing of the foetus is the means to the good end of saving the mother’s life. The foetus’s death would be directly willed and brought about – it would be an act of murder. But, as we know, the end is not enough to justify the means. This procedure has been condemned in the Roman Catholic tradition for failing to meet the conditions of the principle of double effect. [16]

If in making a choice one usually *only* foresees side effects without intention to achieve them as a goal or as a means, one has some responsibility for such side effects. As the Catechism of the Catholic Church says: “*Unintentional* killing is not morally imputable. But one is not exonerated from grave offence if, without proportionate reasons, he has acted in a way that brings about someone’s death, even without the intention to do so.” [17]

The Congregation for the Doctrine of the Faith in the Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation reminds us of the obligation to avoid disproportionate risks. It implies that the doctor “above all ... must carefully evaluate the possible negative consequences which the necessary use of a particular exploratory technique may have upon the unborn child and avoid recourse to diagnostic procedures which do not offer sufficient guarantees of their honest purpose and substantial harmlessness. And if, as often happens in human choices, a degree of risk must be undertaken, he will take care to assure that it is justified by a truly urgent need for the diagnosis and by the importance of the results that can be achieved by it for the benefit of the unborn child himself.” [18]

According to Germain Grisez, “Even if one knowingly brings about someone’s death as a side effect, one is not responsible for *intentional* killing if one neither wants the death nor chooses to kill,” but “since side effects can be avoided by choosing not to do the act of which they are consequences, a person has some responsibility for any death foreseen as resulting, or possibly resulting, from carrying out a choice.” [19]

One could and should accept one’s own death as a side effect when this is done because of duty or in doing some work of mercy. For example:

“Mary, a fire-fighter, jumps out of a window into a net to save herself, leaving to the flames a child whom she could and, given her duty as a fire-fighter, should have

saved. She does not intend but only accepts the child's death, and her self-preserving act otherwise would be morally good. But since the child's death results from Mary's dereliction of duty, she is guilty of it." [20]

We see that in this case fairness is violated. Fairness also can require that a risk of death not be accepted. Responsibilities to others make it clear that it is unfair to accept a risk of death to them or even to oneself. For instance, business partners who market a product whose use might lead to fatal accidents, while warning their own loved ones not to use it, unfairly risk customers' death. [21]

II. Acting and Omitting to Act

Here it is also important to show whether there *is a moral distinction between acting and omitting to act*. The Sacred Congregation for the Doctrine of the Faith in the *Declaration on Euthanasia* is very clear when it says that "By euthanasia is understood *an act* or an *omission* which of *itself* or by *intention* causes death in order that all suffering may in this way be eliminated." [22]

Also, the Catechism of the Catholic Church is very strict and clear on putting an end to lives:

"Thus an *act* or *omission* which of itself or by intention causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgement into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded." [23]

But in the discussions of killing and allowing to die, there is sometimes the unclear status of the distinction between active measures (as in active euthanasia or killing) and passive measures (as in passive euthanasia or allowing to die). The President's Commission on this issue says the following:

"The distinction between acting and omitting to act provides a useful rule-of-thumb by separating cases that probably deserve more scrutiny from those that are likely not to need it. Although not all decisions to omit treatment and allow death to occur are acceptable, such a choice, when made by a patient or surrogate, is usually morally acceptable and in compliance with the law on homicide; conversely, active steps to end life, such as by administering a poison, are likely to be serious moral and legal wrongs. Nonetheless, the mere difference between acts and omissions - which is often hard to draw in cases - never by itself determine what is morally acceptable. Rather, the acceptability of particular actions or omissions turns on other morally significant considerations, such as the balance of harms and benefits likely to be achieved, the duties owed by others to a dying person, the risks imposed on others in acting or refraining, and the certainty of outcome." [24]

The reason for doubting the significance of the distinction is that acts of omission can be morally wrong as acts of commission can be morally right. According to the President's Commission, being passive is in itself no indicator of moral innocence nor is being active a reliable indicator of moral guilt. Both forms of behaviour can lead to ethically justified or ethically unjustified death. [25]

But the analysis of these distinctions need not be repeated in decision making for each individual patient. The Commission intends to point to the underlying factors that may be germane and helpful in making decisions about treatment or no treatment and, conversely, to free individual decision making and public policy from the mistaken limitations imposed when slogans and labels are substituted for the careful reasoning that is required. [26]

On the analysis of some omissions, it clearly is possible to kill in the strict sense by deliberately letting so-

meone die. If one adopts the proposal to bring about a person's death and realises this proposal by not behaving as one otherwise would behave, then one is committed to the state of affairs which includes the person's death. This commitment, although carried out by a non-performance, is morally speaking an act of killing. It involves the adoption and execution of a proposal contrary to the basic good of human life. Thus, any case in which one chooses the proposal that a person die and on this basis allows the person to die is necessarily immoral. [27] It could be illustrated by the following example:

If a child is born suffering from various defects and if the physicians and parents decide that the child, the family, and society will all be better off if the burdens entailed by the child's continued life are forestalled by its death, and if they therefore adopt the proposal not to perform a simple operation, which otherwise would be done, so that the child will die, then the parents and physicians morally speaking kill the child. The fact that there is no blood spilled, no poison injected, that the death certificate can honestly show that the child has died from complications arising from its defective condition - none of this is morally relevant. The moral act is no different from any other moral act of murder. [28]

In the case when a patient's death is imminent (death is expected within a matter of days), failing to treat and thus hastening death is seen by some not even to be a case of an omission that leads to death - failing to treat is said to be merely avoiding prolonging the dying process. To hold that such a failure to treat is neither a fatal act nor an omission is wrong and misleading. Everybody knows that no one can prevent a person's ever dying; death can only be postponed by preventing it at the moment. To postpone death for only a very short time is less important, but that is relevant to whether an omission is wrong and how serious the wrong is, not whether it is an omission that leads to a patient's death. [29]

Hastening death is bringing about death, but no one lives forever, and so all killing merely hastens death. The essential factor from a moral point of view is not whether a person killed already is dying, but whether one's performance or omission executes a proposal that one bring about the state of affairs which includes the person's being dead when one thinks that otherwise they might be alive. [30]

Even though the patient may die when life support is removed, the intention of the people removing life support should never be to kill the patient. Rather, their intention is to stop something futile (ineffective therapy) or to remove a burden imposed by the therapy (burdensome therapy). The resulting death is not directly intended but is foreseen and permitted. [31]

One's adopting a proposal to bring about a person's death does not require that one regard the person's death as desirable in itself. One might regret that a patient is suffering from a painful and mortal disease; one might wish that a retarded, insane, or senile person were normal and vigorously healthy. One might feel deep compassion for the person to be killed; one might be very reluctant to kill the person. Nevertheless, if one adopts a proposal of hastening death - for example, by injecting an overdose of opiates - one does an act of killing in the strict sense. [32]

According to sound ethical principles, there are good reasons to hold that we are not obliged to apply useless therapy. The omission of such a therapy is at least morally indifferent. Allowing the person to die is not an act of omission. It is the disease, the natural cause, which terminates the life of the patient. The omission of the therapy for that person is not a killing.

Sometimes deciding whether a particular course involves an act or an omission is less clear. Stopping a respirator at the request of a competent patient who could

have lived with it for a few years but who will die without it in just a few hours is such an ambiguous case. Does the physician omit continuing the treatment or act to disconnect it? Discontinuing essential dialysis treatments or choosing not to give the next in a sequence of antibiotic doses are other events that could be described either as **acts or omissions**.

Usually one or more of several factors make fatal actions worse than fatal omissions:

1. The motives of an agent who acts to cause death are usually worse (for example, self-interest or malice) than those of someone who omits to act and lets another die.

2. A person who is barred from acting to cause another's death is usually thereby placed at no personal risk of harm; whereas, especially outside the medical context, if a person were forced to intercede to save another's life (instead of standing by and omitting to act), he or she would often be put at substantial risk.

3. The nature and direction of future life denied to a person whose life is ended by another's act is usually much greater than that denied to a dying person whose death comes slightly more quickly due to an omission of treatment.

4. A person, especially a patient, may still have some possibility of surviving if one omits to act, while survival is more often foreclosed by actions that lead to death. [34]

Each of these factors – or several in combination – can make a significant moral difference in the evaluation of any particular instance of acting and omitting to act. However, the distinction between **omissions leading to death and acts leading to death** is not a reliable guide to their moral evaluation. Health professionals have a special role-related duty to use their skills, insofar as possible, on behalf of their patients, and **this duty removed any distinction between acts and omissions**. [35] Thus, the fact that one “did nothing” is not of itself proof that there is not the gravest responsibility for a death because omission is not mere non-doing. Something not done is omitted if it ought to have been done. [36]

A valid distinction may therefore arise between an act causing certain death (for example, a poisoning) and an omission that hastens or risks death (such as not amputating a gangrenous limb). But sometimes death is as certain following withdrawal of a treatment as following a particular action that is reliably expected to lead to death. Merely determining whether what was done involved a fatal act or omission does not establish whether it was morally acceptable. Some actions that lead to death can be acceptable: very dangerous but potentially beneficial surgery or the use of hazardous doses of morphine for severe pain. Some omissions that lead to death are very serious wrongs: deliberately failing to treat an ordinary patient's bacterial pneumonia or ignoring a bleeding patient's pleas for help would be totally unacceptable conduct for that patient's physician. [37]

The action/omission distinction does not always correspond to the usual understanding of whether the physician or the disease is the cause of death, and so the attribution of what caused a death cannot make acts morally different from omission. The physician's behaviour is among the factual causes of a patient's death both in acting and in omitting to act. All activities or non-activities with the purpose of terminating a patient's life are defined as morally wrong because they are acts of killing. [38]

III. Withholding and Withdrawing Treatment

Dealing with the question of letting die and mercy killing is worth examining as to whether the **distinction between withholding and withdrawing treatment is of moral significance**. Sometimes physicians allow compe-

tent patients to refuse a life-sustaining treatment, but they are uncomfortable about stopping a treatment that has already been started because doing so seems to them to constitute killing the patient. [39]

However, confusion persists about the distinction between withholding (not starting) and withdrawing (stopping) treatments. Many professionals and family members are more comfortable withholding treatments they have never started than withdrawing treatments they have started. But does this psychological fact have moral significance, and should acts of withdrawing (stopping) be viewed as killing rather than letting die?

(A) Allowing to die by withholding medical means

It is sometimes morally acceptable to allow those in tragic medical situations to die by deliberately withholding medical means. We are speaking here of medical conditions in which the advanced stages of disease or the known results of severe injury are correctly seen as the primary cause of death. When death is not intended but merely foreseen as a side effect of withholding useless and therefore extraordinary treatment, it is appropriate to regard the cause of death to be not the omission of treatment, but the terminal disease. To use medical means aggressively in such circumstances can make such intervention both artificial and cruel. [40] We can see it in the following case:

A sixty-eight-year-old doctor who suffered severely from terminal carcinoma of the stomach collapsed with a massive pulmonary embolism. He survived because one of his young colleagues performed a pulmonary embol-ectomy. Upon recovery, the doctor-patient requested that no steps be taken to prolong his life if he suffered another cardiovascular collapse. He wrote an authorisation to this effect for the hospital records. Viewing his pain as too much to bear given his dismal prospects, he asked to be allowed to die, under specified conditions. However, he did not ask to be killed. [41]

Withholding medical treatment is not permissible or tolerable in cases like the Baby Doe case. To withhold ordinary treatment – that would be readily given to other infants – because the infant has Down's Syndrome, is a conscious omission that intends the death of that infant. Such acts of omission could be a result of the tendency to think of all cases of withholding treatment as “passive euthanasia” and to think of acts of commission as “active euthanasia.” If one thinks that the former but not the latter is morally and legally permissible, one may be willing to omit actions on the grounds that the resultant harm is nature's course, whereas one would be unwilling to commit any action that would hasten death. [42]

But here we should say that the terms “active euthanasia” and “passive euthanasia” should be avoided because their use often leads to inappropriate decisions. The main point here is that intentionally causing death is wrong either by commission or by omission (such as withholding care that is beneficial and is not excessively costly). We believe that in withholding extraordinary treatments one does not intend to hasten death or directly cause the death even when one foresees and allows it, but that in withholding ordinary treatments one does intend to kill. [43]

(B) Allowing to die by withdrawing medical means

Withdrawing treatment is often a more open, visible and dramatic act than withholding it, and this fact allows a greater range of interpretations and misinterpretations. Omissions usually are not given the moral weight they deserve.

What does not appear in experience – a murder with no blood spilled, with no deadly deed done – seems somehow less real and so less serious. Also, so far as the censure of other people is concerned, omissions are easy

to get away with. But one's primary duty is to promote basic human goods, to work to protect life and make it flourish. And this primary duty is as much betrayed – perhaps, indeed, more often betrayed – by omissions as by actions executed by an outward performance. [44]

The discomfort about withdrawing treatments appears to reflect the view of many caregivers that the action renders them more responsible for a patient's death than not starting a treatment to sustain life. This fact argues for more caution about withdrawing treatment than about withholding it.

The moral burden of proof is generally heavier when the decision is to withhold rather than to withdraw treatments. Often only after starting treatments will it be possible to make a proper diagnosis and prognosis as well as to balance prospective benefits and burdens. The distinction between withholding and withdrawing treatment also may lead to over-treatment in some cases, that is, to continuation of a treatment that has been started although it would have been permissible never to have started it in the first place. Also, the distinction may lead to under-treatment. A sharp distinction between not starting and stopping treatments, combined with a reluctance to stop treatments, creates a dangerous situation for patients. Their wishes and interests may be violated if care-givers are afraid to commence treatments on the grounds that it is somehow wrong to withdraw a treatment when it has become clear that its continuation is unwarranted. [45]

Therefore, does a *moral difference* exist between withholding and withdrawing medical means? As is the case with the distinction between acting and omitting, many other facts of moral importance may differentiate the appropriateness of a particular decision not to start from one to stop. Yet whatever considerations justify not starting should justify stopping as well. Thus, the Commission concludes that neither law nor public policy should make a difference in moral seriousness between stopping and not starting treatment. [46]

The moral evaluation of either action depends on such things as intention and the impact of treatment that is withheld or withdrawn, rather than on whether physical movement is involved in the action that permits an earlier death.

Conclusion

Sometimes there are very good reasons why we have the right (or even obligation) to allow the dying to die their own death. But there is a world of difference between allowing or permitting death and deliberately setting out to bring death about. We ought not to deliberately seek death either for others or ourselves.

Passive euthanasia is not to be identified with withholding or withdrawing treatments when the intention is not to kill but to end *treatments* that are judged ineffective or unduly burdensome. It is called euthanasia because the life – preserving treatment is denied because one judges that the *life* preserved is burdensome and hence ought to be removed from the person, and then the means chosen to remove this burdensome life is to withhold or withdraw treatment.

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and Practice (Braintree, Massachusetts: The Pope John Center, 1987), 247. 5. O'Donnell, *Medicine and Christian Morality*, 32. 6. *Ibid.*, 32. 7. O'Donnell, *Medicine and Christian Morality*, 32-33. 8. Grisez, *Christian Moral Principles*, 299-300. 9. *Ibid.*, 307-308. 10. *Ibid.*, 238. 11. Cf. GRIESE, Orville N., *Catholic Identity in Health Care: Principles and Practice*, 253. 12. Cf. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 127-128. 13. A Working Party Report, *Euthanasia and Clinical Practice: Trends, Principles and Alternatives*, 48. 14. George V. Lobo, *Guide to Christian Living: A New Compendium of Moral Theology* (Westminster, Maryland: Christian Classics, Inc., 1987), 350. 15. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 129. 16. Cf. *Ibid.*, 129. 17. Catechism of the Catholic Church, n.2269. 18. Congregation for the Doctrine of the Faith, "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation" (March 10, 1989), *Origins* 16:n.40, March 19, 1987, p.711 with Cf. Pope John Paul II, Discourse to Participants in the Pro-Life Movement Congress, December 3, 1982. 19. Germain Grisez, *Living a Christian Life*, 482. 20. *Ibid.*, 483. 21. *Ibid.*, 486. 22. Declaration on Euthanasia, 8 (emphasis added). 23. Catechism of the Catholic Church, n.2277 (emphasis added). 24. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*, 61. 25. Cf. Brendan Minogue, *Bioethics: A Committee Approach* (Sudbury, Massachusetts: Jones and Bartlett Publishers, 1996), 67. 26. Cf. *Ibid.*, 62. 27. Grisez and Boyle, *Life and Death with Liberty and Justice*, 415. 28. *Ibid.*, 415. 29. Cf. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment*, 65. 30. Grisez and Boyle, *Life and Death with Liberty and Justice*, 415. 31. Cf. Benedict M. Ashley and Kevin D. O'Rourke, *Ethics of Health Care: An Introductory Textbook* (Washington, D.C.: Georgetown University Press, 1994), 220. 32. Cf. *Ibid.*, 145. 33. Andrew C. Varga, *The Main Issues in Bioethics* (Ramsey, N.J., Paulist Press, 1984), 281. 34. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment*, 66. 35. *Ibid.*, 66-67. 36. A Working Party Report, "Euthanasia and Clinical Practice: Trends, Principles and Alternatives," 46. 37. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatment*, 67. 38. Cf. John Keown, "Further Reflections on Euthanasia in the Netherlands in the Light of the Rummelink Report and the Van Der Mass Survey" in *Euthanasia, Clinical Practice and the Law*, ed. Luke Gormally (London: The Linacre Centre for Health Care Ethics, 1994), 225. 39. Cf. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, 73 - 74. 40. Cf. Hessel Bouma III, Douglas Diekema, Edward Langeran, Theodore Rottman, Allen Verhey, *Christian Faith, Health, and Medical Practice*, ed. Jan Walhout (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1989), 291. 41. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1989), 134 - 135. 42. Cf. Hessel Bouma III and all, *Christian Faith, Health and Medical Practice*, 292-293. 43. Cf. *Ibid.*, 294. 44. Grisez and Boyle, *Life and Death with Liberty and Justice*, 422. 45. Cf. Beauchamp and Childress, *Principles of Biomedical Ethics*, 149-150. 46. Cf. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life-Sustaining Treatments: Ethical, Medical, and Legal Issues in Treatment Decisions*, 77.

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D.C.: Georgetown University Press, 1994. 3) A Working Party Report. "Euthanasia and Clinical Practice: Trends, Principles and Alternatives." In *Euthanasia, Clinical Practice and the Law*, ed. Luke Gormally, 3-109. London: The Linacre Center for Health Care Ethics, 1994. 4) Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. New York: Oxford University Press, 1989. 5) Bouma III, Hessel, Douglas Diekema, Edward Langeran, Theodore Rottman and Allen Verhey. *Christian Faith, Health and Medical Practice*, ed. Jan Walhout. Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1989. 6) Catechism of the Catholic Church. Mahwah, New Jersey: Paulist Press, 1994. 7) Congregation for the Doctrine of the Faith. "Instruction on Respect for Human Life" in its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day" (February 22, 2987). In *AAS* 80 (1988). 8) GRIESE, Orville N. *Catholic Identity in Health Care: Principles and Practice*. Braintree, Massachusetts: The Pope John Center, 1987. 9) Grisez, Germain. *The Way of the Lord Jesus: Christian Moral Principles*. Vol. 1. Chicago: Franciscan Herald Press, 1983. 10) Grisez, Germain. *The Way of the Lord Jesus: Living a Christian Life*. Vol. 2. Quincy, Illinois: Franciscan Press, 1993. 11) Grisez, Germain, and Joseph M. Boyle. *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*. Notre Dame, Indiana: University of Notre Dame Press, 1979. 12) Keown, John. "Further Reflections on Euthanasia in the Netherlands in the Light of the Rummelink Report and the Van Der Mass Survey." In *Euthanasia, Clinical Practice and the Law*, ed. Luke Gormally, 219-240. London: The Linacre Center for Health Care Ethics, 1994. 13) Lobo, George V. *Guide to Christian Living: A New Compendium of Moral Theology*. Westminster, Maryland: Christian Classics, Inc., 1987. 14) Minogue, Brendan. *Bioethics: A Committee Approach*. Sudbury, Massachusetts: Jones and Bartlett Publishers, 1996. 15) O'Donnell, Thomas J. *Medicine and Christian Morality*. New York: Alba House Press, 1996. 16) President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*. Washington, D.C.: U.S. Government Printing Office, 1983. 17) Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (Boston: St. Paul Books and Media, 1980). 18) Varga, Andrew C. *The Main Issues in Bioethics*. Ramsey, N.J.: Paulist Press, 1984.

Abstrakt

Narbekovas, A., Meilius, K.: Letting Die and Mercy Killing. [Nechať zomrieť a milosrdné zabitie.] Med. Eth. Bioet., 10, 2003, No. 3 – 4, p. 2 – 7. Sme povolání prijímať morálne rozhodnutia, nielen o zachovaní života a zdravia, ale aj ohľadom akceptovania našej smrti a umierania. Sú situácie, kedy je morálne správne, a skutočne zaväzujúce, nechať umierajúcu osobu zomrieť v pokoji a dôstojnosti. Ale je obrovský rozdiel medzi pripustením pokojnej smrti a úmyselným navodením smrti osoby, či už konkrétnym konaním (tzv. 'aktívna eutanázia') alebo zdržaním sa istého konania (tzv. 'pasívna eutanázia'). Použitie výrazu "(úmyselné) zabitie" vo vzťahu k eutanázii je vhodné, lebo vyjadruje "úmyselné spôsobenie smrti niekoho". Z morálneho hľadiska môže byť dovolené nezačať alebo ukončiť liečbu, ktorú v daných podmienkach možno označiť za zbytočnú (angl. futile), alebo neúmerne zaťažujúcu pacienta. Dôvodom pre nezačatie alebo ukončenie takejto liečby však nesmie byť rozhodnutie o žiaducom ukončení života pacienta, ale rozhodnutie o ukončení danej liečby pre jej zbytočnosť alebo nadmernú záťaž pacienta. *Kľúčové slová:* eutanázia, princíp dvojitého účinku, priame a nepriame zabitie, morálka, riadne – mimoriadne prostriedky, užitočnosť a záťaž, nechať zomrieť.

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PRESENTING THE UNIVERSAL COSMIST ANTHROPOLOGY AND BIOETHICS OF INDIVIDUAL'S HEALTH

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Abstract

Developing the original philosophical system, which was described for the first time in *Medical Ethics and Bioethics* (2000), author outlines in this paper the conception of the universal Cosmist [1] anthropology and the deduced notion of the bioethics of individual's health. The proposed approach in bioethics is characterised as *personcentric, health-centric* and *cosmist functional*. Significantly, author's reasoning and substantiating relies on his original philosophical fundamentals: cosmological, ontological, anthropological. Substantially, Cosmist anthropology and universal bioethics treat a man as the bio-social-cosmist creature, but not merely a bio-social one. The core notion of this innovative approach is a person's basic (Cosmist) Functionality, the realisation of which leads a man [2] to the entire ontogenetic wellbeing.

Key words: philosophy of Process, Cosmist universal anthropology, basic functionality, bioethics of individual's health

„Philosophy is a science and therefore, like every other science, it seeks to establish truths that have been strictly proved and are therefore binding for every thinking being and not only for a particular people or nation.“

Nicolei O. Lossky [3]

From the very origin the question remains of whether bioethical knowledge actually exists. Bioethics is a multidisciplinary field of knowledge. But may be it is more „para“ than „multi“? Is it really possible to conduct the bioethical expertise in medicine, especially in family medicine? Basically, the term „bioethics“ itself carries a deep contradiction in its meaning, insofar it covers both the scientific substance (based on „bios“ - life sciences achievements) and the ethical substance (based on „ethike“ - philosophical reasoning). To all appearances current bioethics will preserve (and even worsen) this ambiguity and controversial character in its future developments. Hence, are we capable to achieve the foundation for clear practical activities in bioethics?

To my firm belief, the given situation is a direct challenge to the creation of a new basis for bioethics. The judgement of Nicolei Lossky, which serves to me as an epigraph, clearly shows the way to reaching this basis - through the synthesis of an *a priori* (intuitive, phenomenological) knowledge with an *a posteriori* knowledge (of objective, empirical, and descriptive essence), although

Editorial Note: *Though the editor does not share the philosophical positions taken by the author, the paper is published in the journal to allow exchange and interaction among different systems of thought that are developed in Central and Eastern Europe, and still largely denied the access to the contemporary international bioethical discourse.*

this kind of synthesis is the greatest philosophical sin. Significantly, Lossky had endowed with particular powers the philosophical branch ‘**cosmology**’. To prove this it might be sufficient to demonstrate his understanding of the task of philosophy:

“...having studied the basic elements and aspects of the world, philosophy must detect the interconnection between them, which forms the world-whole. Moreover, the world-whole, studied by the branch of metaphysics called cosmology, contains concrete individual elements of such significance as for instance, the biological evolution, the history of humanity – and philosophy must answer the question as to their meaning and their place in the world-whole.” [4]

We do need the cosmological thinking. Life on Earth is a universal phenomenon in its substance. The latter is the undeniable fact of natural sciences. Hence, we are substantially inadequate in comprehension the cosmological (in Lossky’s meaning) foundations for *universal* bioethics. I claim that either we will reach the creation of the rational basis for universal bioethics or the professional status, institutionalisation and future developments of bioethics remain beyond the area of their lucid objective understanding. Likewise, I fully support the claim of Prof. Jozef Glasa, who puts forward the need for a new underlying anthropological paradigm:

“The anthropological paradigm seems to be the decisive point of reference. It represents a particular conception of what the human being is; an image which implicit or explicit grounds for everyday choices, thus determining models of behaviour, criteria for evaluation and motivation for action. The term „human nature,“ a guiding principle for ancient and medieval cultures, has become a question for the modern and postmodern culture of contemporary mankind. On the other hand, human nature can be observed as an object of a great anthropological project that should help to understand what and who human beings really are, their proper place in the biosphere and in the universe... Within the global project of human nature, it has to have a say in the case for the future of mankind.” [5]

Cosmist Basic Notions and Terms

The substantial characteristic of my original philosophical system was previously given in *Medical Ethics and Bioethics* (Vol. 7, 2000, No. 1-2, p. 14-17) and other publications [6]. Here, I want to develop in depth some core notions and terms, which might be crucial for understanding the whole concept. I am content to exhibit my points now taking into account the critical comments of the colleagues that were caused by my presentation of the material on the XVIIth European conference on philosophy of medicine and health care in Vilnius, 2003 [7].

Primarily, my cornerstone cosmological notion is **CEPLE**: *Cosmic Evolutionary Process of Life on Earth* (my abbreviation for it is simply **Process**). Process is an objective phenomenon verified by numerous scientific disciplines, including comparative anatomy, biochemistry, etc., related to evolutionary history and, chiefly, to molecular biology. Therefore, Process is an *a posteriori* notion precisely of objective and empirical essence. Simultaneously, Process is an *a priori* notion, for it is solely revealed through rational (intuitive) cognition. Hence, the notion of Process integrates *a posteriori* and *a priori* thinking, disclosing the approach for universal comprehension of the phenomenon of the life on Earth.

The other substantial notion, which stresses the universality of the life on Earth, is ‘**subject**’. In Cosmist philosophy ‘subject’ means the *integrated functional subject*, which forever integrates autonomously and hierarchically other subjects (to be the functional whole) and,

simultaneously, always being functionally integrated by the higher organised subject (organism). In other words, from the cosmist point of view *subject* means every living organism on Earth: molecule, cell, biological organism, biosphere, human being, family, community, social body, society, mankind, and, ultimately, Process itself (CEPLE) - the one common whole cosmic evolutionary process of the life on Earth.

Another cornerstone notion is ‘**emergent future**’, which means the successive appearing of the integrated macro-level of the ontogenesis of a subject’s (man’s) wellbeing (the university for a schoolboy; the vocational body for a graduate, etc.). In this, the term „emergence“ substantially has the accepted meaning: the rise of a system that cannot be predicted or explained from antecedent conditions.

Further, I would like to stress the cosmist meaning of the term ‘**society**’. This has not the prevailing political meaning, but it relates to any community, structure, organisation, or any other socially functioning body of people having common purposes of their organisation.

It is also important to distinguish the meaning of the terms ‘**cosmist**’ and ‘**cosmic**’: the former stresses two points: a) the intrinsic *subjective* origination of the primary perceptions of man’s creative activity; b) the *deliberate* character of a person’s creative activity, aimed at the achievement of the most desirable possible state of adaptation and development on the current level of her or his existence and, simultaneously, the gratifying ascent on the successively higher level of man’s entire ontogenesis. In other words, a person performs cosmist creative activity basically on his or her own. In turn, the term ‘**cosmic**’ puts a particular emphasis that a subject is ultimately the function of Process. Finally, writing the word ‘Cosmist’ [1] with a capital letter or in Italics accentuates its reference to the original philosophical system I have proposed.

Finally, the term ‘**creativity**’ has no correlation with supernatural factors, but designates precisely a person’s inherent natural ability and energy to create: to originate, to design, to invent, to bring into existence, etc. new products, or results, or effects, etc. of one’s creative activity.

Original cosmological principles lay the foundation for the advancement of a framework of ontological assumptions - the so-called **ACW** system: of **Absolute** (in regard to the all-embracing evolutionary Process), **Cosmist** (universal, functionally intentional realisation of the ascending ontogenesis of any subject - living organism: biological, personal or societal, including man), **Wholism** (with reference to universal functional integration of any subject into one whole - self-unfolding and evolutionary ascending - Process). The definition of the ACW system is already given in [6] (Khroutski; 2000).

Cosmist Anthropology: Reconciling Scientific and Humanistic Paradigms

The cornerstone conception of the Cosmist anthropology is the establishment of the three distinct functional macro-orders of man’s existence (functioning):

- ◆ Homo Sapiens *animalis* (HSA) - the direct function of the Biosphere.
- ◆ Homo Sapiens *sapiens* (HSS) - the direct function of Society.
- ◆ Homo Sapiens *cosmicus* (HSC) - the direct function of Process.

Both HSA and HSS are always *Bio-Social* creatures, and not **Bio-Social-Cosmist** creatures. In other words, man in this perspective is a bio-organism, social actor, and unique person in his adaptation to the society, but he or she is not a Cosmist agent carrying out his personal

(functional, specific) contribution to the one common Process. Cosmist philosophy replaces „being“ (a basic concept that serves as a starting-point for any serious metaphysician) by „functioning,“ as a more basic Cosmist concept, which points to the necessity of active evolution for every living subject.

A crucial point is: In recognising the notion of Process we obtain the substance to which all Earth's living subjects can be functionally reduced. Every living subject on Earth is ultimately a function of Process - of the ultimate self-evolving organism of life. Reasonably, then, every living subject on Earth has its/his/her *basic (ultimate, cosmist) functionality*. The notion of man's *basic functionality* means that any subject is intrinsically and basically dedicated for the realisation and execution ultimately of the special function.

In light of the Cosmist concept, **basic cosmist functionality (BCF)** governs human ontogenesis. In other words, *basic functionality* hierarchically organises man's entire repertory of biological and social needs in one integral order. This order, in principle, repeats the hierarchy of the main stages of biological and social evolution on Earth. Hence, biological and social needs may be considered tools for BCF to implement its self-unfolding and ultimate self-actualisation. In other words, all biological and social needs of human beings conform to the ultimate end of his or her specific functional contribution to wellbeing in the shared Earth life Process. The latter is mainly possible at the high *creative* level of mature social stability, the culminating point of man's ontogenesis.

In course of this reasoning the fundamental principle of CosmoBiotypology has emerged. CosmoBiotypology may serve as a concrete cosmist law, which states: Every living subject on Earth is a natural (more accurately, *cosmic*) function of the higher-level congenerous subject and ultimately of Process itself. Thus, every living subject on Earth naturally bears the biotypological traits of this intrinsic basic functionality and naturally relates to the appropriate ecological-social environment. In other words, **the principle of CosmoBiotypology** establishes the functional identity and thus the universal meaning of the three macro-orders of man's entire wellbeing: satisfying subjective feelings and perceptions; adequate position in the social-ecological environment; and biological constitution or biotype. The latter serves precisely to fulfil the person's *cosmist functional* assignment. Thereby, the CosmoBiotypological principle aspires to universalise biomedical, social, and human knowledge - to unite rationally man's subjective knowledge with objective knowledge of man and, thus, to reconcile previously incompatible scientific and humanistic paradigms.

Conclusion

Prof. Darryl Macer, director of the Eubios Ethics Institute, distinguishes at least three ways to view bioethics:

1. *Descriptive bioethics* is the way people view life, their moral interactions and responsibilities with living organisms in their life.

2. *Prescriptive bioethics* is to tell others what is ethically good or bad, or what principles are most important in making such decisions.

3. *Interactive bioethics* is discussion and debate between people, groups within society, and communities about 1 and 2 above. [8]

In this course I claim the existence of the fourth way - **bioethics of individual's health**, the essence of which is a person's self-realising his or her inherent route of wellbeing [9] (healthy, safe, satisfactory, happy) ontogenesis. Fundamentally, the proposed universal bioethics of individual's health is truly *personcentric, health-centric*

and of true wholistic *subject-subject* [10] essence. Moreover, relying on Cosmist philosophical fundamentals, I logically claim that: A) exclusively the **personalist (subjective)** level of consideration is appropriate for the universal comprehension of phenomena of the life on Earth, including the individual health of a man; and B) that exclusively the **cosmist functional** approach can reach the universal comprehension of the entire living world on Earth: biological, personal, and societal.

Notes

[1] 'Cosmist' is a basic term in my theorising, which reflects the subjective (personal, responsible) and universal (in relation to a subject's 'Basic Functionality') integration of a subject (a person) into the surrounding world. The definition of the meaning of the terms 'cosmist', 'subject', and 'Basic Functionality' follows below in the text. The term 'cosmist' functions in the text both as adjective and noun (mainly as adjective). The analogy can be drawn with the term „personalist“, which likewise functions both as adjective and noun. [2] The term 'man' is traditionally referred to the human race in general, or „mankind“. [3] This sentence opens the chapter „Characteristic Features of Russian Philosophy“ in N. Lossky's book „History of Russian Philosophy“: New York, 1951. [4] Lossky 1951, p. 402 [5] Glasa J.: Bioethics: A Case for the Future of Man. 2001 (<http://business.hol.gr/~bio/HTML/PUBS/VOL6/HTML/glasa.htm>) [6] Khroutski, K.S.: 2000. Individual Health: New Definition and Ontological Background. Medical Ethics & Bioethics (Bratislava) 7: pp. 14-17; Khroutski, K.S.: 2001. Introducing Philosophical Cosmology. World Futures 57(3): pp. 201-212; Khroutski, K.S.: 2001. The Doctor of Tomorrow - Physician, Psychologist, Philosopher: Towards the Cosmist-Hippocratic Ethics in Biomedicine. Appraisal 3(4): pp. 135-146; Khroutski, K.S.: 2002. Epistemology of civilised man's diseases. E-Logos (<http://nb.vse.cz/kfil/elogos/epistemology/khrou1-02.htm>); Khroutski, K.S., and Peicius, E.: 2003. Introducing the Emergence-Discourse Method to Philosophy of Medicine and Bioethics: In Search for Rational Comprehension of Individual Health. Eubios Journal of Asian and International Bioethics 13(1): pp. 15-20. (E-access: <http://www.bio1.tsukuba.ac.jp/~macer/ejaib131.htm>); Khroutski, K.S.: 2003. Integrative Mental Mapping Project Under the 'EDM' Processing: The Thesis. Eubios Journal of Asian and International Bioethics 13(3): pp. 93-98. [7] Khroutski, K.S.: 2003. Introducing the notion of „Civilised Man's Diseases“: Philosophical substantiation. ESPMH Conference, Vilnius 2003 - Abstracts. Medicine, Healthcare & Philosophy 6: p. 193. [8] Macer, D. R. J.: 1998. Bioethics is Love of Life: An Alternative Textbook / Darryl R. J. Macer. Christchurch, N.Z.: Eubios Ethics Institute. [9] I would like to use my core term „wellbeing“ as 1) a noun - as a state of being contented, healthy, etc.; and 2) as an adjective, having the sense of 'successful, satisfactory, healthy, safe, happy, etc.'. [10] The subject-subject pattern means that an explorer (a subject: scientist, doctor, specialist in bioethics, etc.) treats any phenomenon of the one common evolutionary process of the life on Earth (Process) not simply as an object of scientific observation or analytical reasoning, but likewise as the equally (in relation to her or him) integrated - in relation to Process - subject, which (who) has its/his/her own functional assignment and, thus, its/his/her own as past and present as emergent future being and wellbeing.

Abstrakt

Khroutski, K. S.: The Universal Cosmist Anthropology and Bioethics of Individual's Health. [Univerzálna kozmistická antropológia a bioetika individuálneho zdravia.] Med. Eth. Bioet., 10, 2003, No. 3 – 4, p. 7 – 9. Rozvíjajúc svoj originálny filozofický systém, po prvý raz uvedený v časopise *Medicínska etika & Bioetika* v roku 2000, autor popisuje koncepciu univerzálnej kozmistickú antropológiu a z nej dedukovaný pojem bioetiky individuálneho zdravia. Navrhovaný prístup v bioetike možno charakterizovať ako „osobo-centrický“, „zdravie-centrický“ a „kozmisticko-funkcionálny“. Autorovo uvažovanie a dôvodenie podstatne stavia na originálnych filozofických základoch jeho prístupu: kozmologickom, ontologickom a antropologickom. Kozmistická antropológia a univerzálna bioetika v autorovom poňatí chápu človeka ako biosociálno-kozmistickú bytosť, nie iba ako bytosť bio-sociálnu. Kľúčovým pojmom autorovho prístupu je základná (kozmistická) funkcionálna osoba, ktorej uskuotočnenie privádza človeka k dosiahnutiu jeho celistvého ontogenetického dobra (angl. wellbeing). *Kľúčové slová:* filozofia procesu, kozmistická univerzálna antropológia, základná funkcionálna, bioetika individuálneho zdravia.

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SOME FACTORS AFFECTING HEALTH CARE FOR THE ELDERLY IN POLAND

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Abstract

By adopting the historical perspective, the author accounts for the developments of the past two decades in Poland, which have especially affected the elderly people in regard to their access to medical care and the quality of the medical services they are offered. During that period, alongside with other developments, the once-espoused values seemingly became forgotten, or less prominent in everyday's life. This affected also the notion and practice of solidarity, which should involve not only a mutual support and co-operation, but also a shared responsibility for, among other things, the health care provision for the needy and vulnerable persons. As regards the provision of health care for the elderly, the situation in Poland has evolved in a concrete historical continuation. Its origins are embedded in the past, and it is closely related to the pre-veiling moral norms, country's economical situation, and the present state of the health care system. Author concludes that, if the old age (poetically referred to as the "life's sunset") is to retain the radiance of the setting sun, it is essential that premature ageing and the attendant diseases should be prevented as much, and as early as possible, by promotion of healthy lifestyle and adequate health care also for the younger people, before they enter the senescence.

Key words: ageing, health care, quality of life, historical aspects

The demographic developments in Europe after the Second World War have made the industrialised part of the continent a land of wrinkled faces. This process has also affected Poland, where the proportion of the elderly people is steadily increasing. If the ageing of the society continues at the present rate, an estimated 9.5 million of Poles will have passed the age of 60 by 2020. The increasing population of senior citizens accompanied by a drop in natural increase is perceived as a social disaster, which, according to some commentators, is already underway. The growing numbers of the elderly are a burden on the health service and the welfare system. The fate of future senior citizens is truly deplorable, as even today the situation of elderly is hardly enviable, while the quality of medical services available to them leaves much to be desired.

Old people often complain that they are treated like objects or dismissed as a useless burden. Their health problems are not always duly appreciated by the medical personnel. This is often reflected in the way the patient is addressed, with the use of impersonal forms or the third person (*Let him/her sit down, what's his/her problem? What does he/she complain about?*), or sometimes he is addressed "granddad, granny". Old people are often tactlessly reminded of their age and half-mockingly advised to take note of their birth date, which, surely, is not nice. Access to many types of therapy is restricted for the elderly, for "economical reasons". All this creates a pessimistic view on the public health system. Various explanations have been put forward to account for such a sad state of affairs: insufficient investments in the health sector, excessive work burden laid upon the medical

personnel, low wages, etc. However, this segment of social life is neither better, nor worse than other segments in Poland. It is as good, or as bad as the people of whom it is made up. Hence, some shocking cases of abuse take place from time to time, to which mostly old people fell victims.

Everyone in Poland was appalled by the ghastly scandal in the Ambulance Service of the city of Łódź, whose employees informed the local undertakers about new deaths, for remuneration. In pursuit of material benefits, they sometimes went as far as to administer lethal doses of Pavulon to patients, rather than attempting to save their lives! Investigation is underway to discover, how long this abominable practice went on and how many people left this world prematurely in this way. These were mostly people above 60, whose only fault was their age and the attendant ailments. The Łódź scandal plainly revealed the pitiful situation of the elderly people, left at the mercy of the callous medical personnel.

One should, therefore, reflect on the reasons behind this situation. In my search for the factors that affect the provision of medical and welfare benefits to the elderly in Poland, I deliberately leave aside the obvious economical and organisational considerations (the abortive and generally criticised health care reform in Poland). I will concentrate instead on those aspects – equally important, in my opinion – which are usually ignored. These include the hostile views on the old age harboured by medical practitioners in the past, as well as the sociocultural factors that shape the attitudes towards elderly today, as reflected, for instance, in the generally accepted vocabulary referring to the elderly.

There are many words and phrases pertaining to the old in Polish, with clearly negative connotations: *stary, starzec, stary dziad, staruch, stara baba, stare ucho* (very roughly: *old fogey, old sod, dodo, hag, old bag*, etc). These are all terms of derision and abuse. Coarse jokes are all too often made about the limited physical and mental abilities that go with old age. Both the epithets and the jokes show that old age is treated as a social deviation. Strikingly, the common denominator is the perception of the elderly as a "dysfunctional element". The roots of this approach are in the past.

The present attitudes of the Poles towards old age started to take shape in the 19th century. In the context of the problem in hand, I will concentrate solely on the negative aspects, transmitted through the processes of upbringing and socialisation.

The views on old people were largely shaped by the medical ideas relating to old age. In their search for the cause of ageing, physicians tried to grasp the nature of this phenomenon, which was by no means easy. To understand the old age, one had to find out, for the beginning, at what age it began and what it consisted in. Both philosophers and physicians made such attempts. The latter analysed the question from the point of view of the diseases typical of old age, stressing their nasty character. Highly pessimistic and disapproving views of the old age are the principal components of the early definitions of this natural period in human life, which was seen almost as a punishment. Old age was perceived through the symptoms of diseases.

This may be exemplified by the definition put forward by Dr. Karol Kaczkowski in the first half of the 19th century. His reflections on the old age were included into his lectures on hygiene, held at the lycée in Volhynia (later published). His ideas became quite influential. Kaczkowski wrote: "At 45 or 50, men enter ripe age (in the case of women, this happens a little earlier in life). Their vessels begin to lose flexibility and, worn out with use, they slowly and imperceptibly begin to slide into decay. As the years advance, old age comes, which lasts

until the age of 70 or above, were senility closes the cycle of human metamorphoses.” During that period in life, wrote Kaczkowski, not only physiological, but also psychological changes occurred: “The mental faculties, directed by constant experience, are no longer susceptible in ripe and old age to the frenzy of imagination, but become driven instead by cool deliberation” (1). But the most significant changes take place in the internal organs, whose activity “slows down, weakens or comes to a halt altogether”. Therefore, as the years go by, vision and hearing weaken, while the hair turns grey and falls out. At that time “there is an astonishing loss of harmony between all organs: in short, the entire human machinery is about to disintegrate. Thus, by its very nature, old age must bring about infirmity, feebleness and all manners of suffering.” In this way Kaczkowski explained the causes of old-age ailments (2).

These were natural consequences of the passage of time, which the medicine of that era was unable to alleviate, and which man had no choice but to endure. This attitude was important in establishing the popular view about the uselessness of all therapeutic measures – an opinion reinforced by the poor quality of medical services in those days.

Some comfort was offered to the elderly by the fact that old age did not necessarily mean solely disease and suffering. If one was free from ailments, in a state “when the mind is healthy and joyful and bodily sufferings are few”, it could be called a happy old age, which, however, was only seen as the reward of a “youth well spent”. Many thinkers believed that old age was the reflection of an entire life story (3). If marked by disease and infirmity, it signified the beginning of the eternal punishment while still on earth. Such a view was reinforced by the juxtaposition of the patterns of old age among various social groups (peasants, bourgeoisie, and workers); the common element of each was an emphasis on the negligible ‘utility’ of an old person.

In the 19th century, the idea took root that at some, vaguely defined point at the beginning of old age, one should discontinue one’s hitherto activities, change one’s lifestyle and attire. Old women would dress in stately black – the colour expressing sadness and mourning. Their dress would tend to be old-fashioned, which was an external expression of their being left behind and marginalised. After passing the working age, people were almost automatically excluded from the active circles of society. This was especially the case with the country and urban poor, who often relegated their old people to the margin in a humiliating way. Sometimes old people would leave home and go begging on their own accord, so as not to be a burden upon their children. In his Nobel-Prize winning novel, *The Peasants*, Władysław Reymont included a moving scene in which old Agata, no longer able to work on the farm, leaves her native village.

The capacity to perform some duties was the measure of the utility of people in those families (and social groups) who had to earn their livelihood by working. In the eyes of those occupationally active, people unable to work any longer were through with their lives. When an old man fell ill, the relatives would send for a local healer at best – never for a doctor – and usually just prayed for a speedy death of the sufferer.

The problem of “useless” old people gave rise to a movement to aid the elderly. The first nursing homes were created, which, by taking care of the aged, relieved younger people from the moral responsibility to provide for their old kinsmen. That period saw the beginning of a lonely old age, reinforced by technological developments, and the progress of education.

In the 19th century, mechanisation rendered the skills acquired at home – typical of the previous epochs –

insufficient and obsolete. Kindergartens and schools reduced the need for assistance from grandma, or an old aunt. Grandchildren did not care anymore for grandmother’s or grandfather’s lore and knowledge, as these were out of touch with the ongoing changes. A two-generation family thus began to emerge, in which the participation of the grandparents was limited to special occasions, such as family feasts and festivals. All this had an impact on the formation of attitudes towards the elderly people, too.

The heritage of our ancestors permeates all aspects of our lives (4). The modern perception of old age as a separate category, which undoubtedly goes back to the 19th century, significantly affects today’s views on the old people, which has a direct impact on their quality of life. Even nowadays, you can find lots of articles creating unfriendly views about the old people. Such views treated as a formal statement by experts on a given subject are responsible for giving a shape of indifferent environment for the elderly (5). An especially painful experience for the elderly is the indifference, lack of understanding, and the sense of being a burden to others, which they experience in contacts with the health service and welfare employees, whose attitudes towards the old age were shaped by the reality, in which they grew up. On looking back to the past, the callous treatment of old age patients – who can be boring, insist on being listened to, keep asking the same question or are impatient – becomes easier to explain.

In a sense, the old Latin adage: “*Senectutem ut adipiscentur, omnes optant, eandem accusant adeptam*” (*Everybody desires to live to an old age, which they curse once they attain it.*) does reflect the present situation of the elderly in Poland. These people, when still in their prime, when *Solidarity* entered the political scene, had had high hopes for this political movement. The systemic and economical transformation, which has been going on in Poland since 1989, has brought about numerous changes, both favourable and unfavourable ones. Those, who gained the least, were the elderly people, of whom the largest part had suffered a loss in their societal status. Old age, combined with poverty and disability, had made them the most disadvantaged social group. Their physical decrepitude and worn-out looking, unfortunately, inspire no solidarity today.

It is the highest time, however, to set about for changing this situation, because the numbers of old people are growing. Already nowadays, the number of the elderly and their health condition are becoming a major societal problem. Therefore, the government policy should aim to build, in a responsible fashion, a beneficial environment to sustain the health and overall wellbeing of the elderly.

Among other initiatives, also the programs “*Education for Old Age*” should be launched on a large scale. Everyone should be equipped with a body of knowledge on the prevention of ‘old age diseases’, and on the possibilities of an active attitude to his/her life and environment when grown old. This, in fact, should start at least from an early adulthood. The geriatric prevention programmes should put off and minimise the need for the hospital treatment and stave off disability. This way also the necessary costs of the health care for the elderly would be a bit contained, and also put for their best use (“Adding life to the years” approach). It should be striven for such changes that would allow the elderly people having a better chance for a happy old age. Hopefully, this would also allow to formulate a new, more optimistic version of the old Latin adage: “*Senectutem ut adipiscentur, omnes optant, eandem laudant adeptam*” (*Everybody desires to live to an old age, which they praise once they attain it.*)

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3. *Ibid.*, p. 6; “Dziennik Zdrowia dla Wszystkich Stanów” [A Health Journal for People of All Stations], 1801, No. 1, p. 27; J. Majer, *O stuletnim życiu w krajach polskich w porównaniu z trwaniem życia prawidłowem* [A Hundred Years’ Life in the Polish Lands as Compared with the Proper Life Span], Kraków 1881, p. 18 – 19.
4. According to A. Szyszko-Bohusz, we inherit not only physical characteristics, but also psychological traits, which the author interprets “as a peculiar continuation, continuity in time, peculiar genetic memory, which boils down in fact to the biological immortality of both the parent organisms and their consciousness, continued in their descendants.” See A. Szyszko-Bohusz, *Nieśmiertelność genetyczna. Czy dziedziczymy świadomość?* [Genetic Immortality: Do We Inherit Consciousness?], Kraków 1996.
5. UJ. Korwin-Mikke, *Państwo opiekunów* [Protectors’ State], “Dziennik Polski” 2003, nr. 201.

Abstrakt

Kalamacka, E.: Some Factors Affecting Health Care for the Elderly in Poland. [Niektóre faktory wpływające na zdrowotną starość o starých lidí v Polsku.] *Med. Eth. Bioet.*, 10, 2003, No. 3 – 4, p. 10 – 12. Autorka zo širšej historickej perspektívy venuje pozornosť vývoju v Poľsku v priebehu posledných dvoch desaťročí, ktorý sa zvlášť nepriaznivo dotkol starých ľudí vo vzťahu k dostupnosti a kvalite zdravotnej starostlivosti, ktorá sa im poskytuje. Počas uvedeného obdobia, spolu so zmenami v iných oblastiach, prišlo k oslabeniu vnímania kedysi prominentných životných hodnôt. To sa týka aj pojmu solidarity a jej uplatnenia v každodennej praxi. Solidarita by totiž mala zahŕňať nielen vzájomnú podporu a spoluprácu, ale aj poskytovanie zdravotnej starostlivosti pre chudobné a zraniteľné osoby. Situácia v oblasti poskytovania zdravotnej starostlivosti starým osobám sa v Poľsku vyvinula v konkrétnej historickej kontinuite. Jej zdroje siahajú do minulosti, pričom je aktuálne ovplyvnená prevažujúcimi morálnymi normami, ekonomickou situáciou a súčasným stavom zdravotníckeho systému. Autorka uzatvára, že pokiaľ si má starý vek (poeticky označovaný za “západ života”) udržať “vyžarovanie zapadajúceho slnka”, je nevyhnutné venovať sa čím včasnejšej prevencii predčasného starnutia a chorôb starého veku, a to aj podporovaním zdravého životného štýlu a adekvátnej zdravotnej starostlivosti o mladšie osoby, ešte dlho pred dosiahnutím veku staroby. *Kľúčové slová:* starnutie, zdravotná starostlivosť, kvalita života, historické aspekty.

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RECOMMENDATION REC(2003)10 OF THE COMMITTEE OF MINISTERS TO MEMBER STATES ON XENOTRANSPLANTATION

*Adopted by the Committee of Ministers on 19 June 2003
at the 844th meeting of the Ministers’ Deputies*

Preamble

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members;

Having regard to the European Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine and its Additional Protocol Concerning Transplantation of Organs and Tissues of Human Origin;

Having regard to the European Convention for the Protection of Vertebrate Animals used for Experimental and other Scientific Purposes;

Having regard to the Resolution of the Committee of Ministers (78) 29 on the harmonisation of legislation of member states relating to removal, grafting and transplantation of human substances, the Final Text of the 3rd Conference of European Health Ministers (Paris, 16-17 November 1987) and the Recommendation R (97) 15 of the Committee of Ministers to member states on xenotransplantation;

Bearing in mind Recommendation 1399 (1999) of the Parliamentary Assembly on xenotransplantation;

Bearing in mind recent reports from the OECD, the WHO and other national and international organisations;

Taking into account the shortage of organs and tissues of human origin available for transplantation;

Considering that xenotransplantation might be one of the possible therapeutic responses to this shortage;

Noting that xenotransplantation remains largely an experimental activity and that research is essential for the achievement of progress in this field;

Aware of the risks of rejection and illness xenotransplantation may cause in the recipient patient;

Mindful of the considerable risks which might arise from xenotransplantation in the field of public health and the transmission of diseases;

Considering that it is the responsibility of each member state to adopt adequate measures in order to address them and conscious that in some countries no appropriate regulations exist;

Considering that public health concerns require common provisions applicable in all the member states of the Council of Europe in which xenotransplantation is envisaged;

Considering that worldwide cooperation between states in this field is necessary;

Considering that no clinical xenotransplantation research should take place unless sufficient efficacy and safety is demonstrated through pre-clinical research;

Conscious that the need for such a demonstration will considerably limit the number of xenotransplantations in the coming years, thus allowing for an appropriate risk assessment;

Considering that xenotransplantation of cells and tissues is already being carried out in a number of states and that stringent regulations are thus urgently required;

Mindful of the social, ethical, cultural, legal and psychological problems which might be associated with xenotransplantation;

Mindful of the ethical and welfare issues associated

with the use of animals for xenotransplantation and the associated research;

Noting the public concern over the issues related to xenotransplantation and stressing the importance of undertaking a public debate on this subject,

A. Recommends that the governments of member states:

- ◆ take the necessary measures to put their legislation and practice in the field of xenotransplantation in conformity with the following principles and guidelines with a view to minimising the risk of transmission of known or unknown diseases and infections to populations;
- ◆ co-operate in the setting-up of world-wide surveillance procedures and agreements;
- ◆ ensure a wide dissemination of this recommendation, in particular among all persons, organisations and bodies, public or private, responsible for organising and carrying out xenotransplantation;
- ◆ take steps to make the provisions of this recommendation subject to public debate.

B. Decides that this recommendation will be reexamined at appropriate intervals and not later than in three years' time.

C. Instructs the Secretary General to bring the contents of this recommendation to the attention of the non-member states and international organisations which have participated in its preparation and to invite them to participate in the setting-up of an international surveillance network.

GUIDELINES

Chapter I – Object, scope and definitions

Article 1 – Object of the recommendation

This recommendation aims

- ◆ to protect, in both the short and long term, public health, patients, their close personal contacts and the professional staff involved in xenotransplantation, and
- ◆ to provide adequate protection for the animals used in xenotransplantation.

Article 2 – Scope of the recommendation

This recommendation covers all xenotransplantation activities involving human beings as recipients.

Article 3 – Definition

For the purpose of this recommendation, xenotransplantation is defined as any procedure that involves the transplantation or infusion into a human recipient of:

- ◆ live animal cells, tissues or organs, or
- ◆ human body fluids, cells, tissues or organs that have had *ex vivo* contact with live animal cells, tissues or organs.

Chapter II – General provisions

Article 4 – Xenotransplantation – the setting

No xenotransplantation should be carried out in a member state that does not provide regulation for xenotransplantation activities in conformity with the provisions of this recommendation.

Article 5 – Xenotransplantation authorisation

No xenotransplantation activity should be carried out in a member state unless authorisation is given by a body officially recognised as competent for this purpose, in accordance with the provisions contained in the following two paragraphs:

1. Authorisation for clinical xenotransplantation re-

search should only be given if:

- a. pre-clinical research has demonstrated, in accordance with internationally accepted scientific standards, that:
 - i. in the light of current scientific knowledge it is highly probable that there is no risk, in particular of infection, for public health;
 - ii. the potential level of efficacy and safety for the patient may justify the intervention having regard to the risks incurred;
- b. all substantive and procedural conditions generally applicable to clinical research are fulfilled.

2. Xenotransplantation should not be authorised other than in clinical research unless, on the basis of clinical data:

- i. there is adequate evidence, in accordance with internationally accepted scientific standards, that no risks, in particular of infection, to the general population exist, and
- ii. the therapeutic benefit of the xenotransplantation has been established.

Article 6 – Xenotransplantation teams and centres

No xenotransplantation should be carried out unless it is undertaken by an accredited team in an authorised centre.

a. The teams carrying out the xenotransplantation should be appropriately qualified and comprise all the necessary scientific and medical expertise.

b. The centres should have received an authorisation by the competent bodies prior to beginning the xenotransplantation.

Chapter III – Protection of Public Health

Article 7 – Public Health protection plan

Member states should have a plan in place to address any events, in particular of infection, possibly related to a xenotransplantation which could compromise public health.

In particular, public authorities should take appropriate measures, in conformity with the principles of necessity and proportionality, to respond to events of transmissible or previously unknown illness related to xenotransplantation. These measures, if exceptional circumstances so require, might include isolation.

Article 8 – Collection and storage of biological samples and information

Information and biological samples concerning the source animals used in xenotransplantation and the recipients should be collected and stored in order to ensure traceability and long-term monitoring.

Article 9 – Follow-up

1. All protocols for clinical research should be accompanied by a plan to ensure the traceability and monitoring of the recipients, their close personal contacts and the professional staff involved in xenotransplantation in order to detect and deal with any adverse events, in particular of infection, possibly related to xenotransplantation.

The plan should include communication without delay to the competent body at national level of any such events.

2. Any xenotransplantation other than in clinical research should be accompanied by a plan to:

- ◆ ensure the traceability of the recipient as well as, depending on the circumstances, of other persons mentioned in paragraph 1;
- ◆ monitor, wherever necessary, the persons mentioned in paragraph 1.

The plan should include communication without delay to national public health authorities of any events, in particular of infection, possibly related to xenotransplantation and which could be of relevance to public health.

Article 10 – Precautions relating to the transmission of disease

All appropriate measures, in accordance with internationally recognised criteria, should be taken to prevent the risk of transmission of infectious agents from source animals.

Only animals bred specifically for xenotransplantation should be used. An appropriate Quality Assurance system encompassing all the stages from the production of the source animals to the final collection of the xenotransplants should be set up.

Article 11 – Prohibition relating to the use of non-human primates

1. Non-human primates should not be used as source animals for xenotransplantation.

2. Exceptionally, authorisation for the xenotransplantation of cell lines obtained from non-human primates may be given if:

- ♦ the conditions under Article 5 are fulfilled, and
- ♦ specific protective measures for these animals have been addressed. This implies that Great Apes should not be used as source animals in xenotransplantation.

Chapter IV – Protection of patients and close personal contacts

Article 12 – Conditions for patient participation

No xenotransplantation should be carried out unless the following specific conditions are fulfilled:

- i. There is no other appropriate therapeutic method of comparable effectiveness available for the patient.
- ii. The data resulting from pre-clinical research suggest or, where appropriate, the data resulting from prior clinical research indicate a clear therapeutic benefit for the xenotransplantation patient. In particular these data should:
 - ♦ have demonstrated an adequate function of the xenotransplant in relevant models for an appropriate period of time through a clinically applicable methodology,
 - ♦ provide sufficient reasons to believe that rejection can be overcome and that the xenotransplant can function adequately in humans.
- iii. The risks which may be incurred by the patient are not disproportionate to the potential therapeutic benefit of the procedure.

In particular, the evaluation through pre-clinical research of the risks for adverse events and transmission of infectious agents to the recipient, as based on international standards for laboratory results and diagnostic assays, should have demonstrated sufficient safety.

Article 13 – Information to be given to patients

1. Patients participating in a xenotransplantation should be adequately informed in a comprehensible manner of the nature, objectives, possible benefits, potential risks and consequences of the procedure, as well as of any constraints that may be linked to it.

2. In particular patients should also be made aware of the constraints of monitoring and precautionary measures that may become necessary subsequent to xenotransplantation. Such measures will, according to the principles of necessity and proportionality, be adapted to the circumstances and adjusted in accordance with the assess-

ment, based on current scientific and medical knowledge, of the risks generated by each of the procedures involved, and may in particular include:

- a. the collection of personal data and inclusion in a register;
 - b. the provision by the medical team, in accordance with Article 14, of information concerning the risks of infection and the constraints associated thereto;
 - c. long-term medical monitoring including repeated biological samples being taken and archived;
 - d. reporting any significant unexplained symptoms or illness that may arise after the xenotransplantation;
 - e. maintaining contact with the medical team;
 - f. taking precautions with respect to sexual activity;
 - g. the need for the patient to agree that information is provided by a medical team to any future close personal contacts, in accordance with Article 14, concerning the risks of infection and the constraints associated thereto;
 - h. the other constraints which might be applicable if circumstances so require, in particular the possibility of isolation which may become necessary in the event of a contagious or previously unknown illness occurring.
3. Patients should be informed that, in accordance with Article 21, constraints mentioned hereinabove may be imposed if the person concerned refuses to comply with them.

Article 14 – Information to be given to close personal contacts of the patient

To protect close personal contacts and warn of the possible risks they might pose to the general public, the patient's close personal contacts should, with his or her consent, be informed by the medical team of the patient's envisaged participation in a xenotransplantation, of the risks of infection and of the consequences for them of such participation, and in particular, of the constraints which may be applicable.

The patient should also ensure that such information is provided to any future close personal contacts.

Article 15 – Information to be given to the professional staff involved in xenotransplantation

Professional staff involved in xenotransplantation should be fully aware of the risks of infection as well as the possible consequences and constraints which may derive from their participation in xenotransplantation.

Article 16 – Consent to xenotransplantation

1. No xenotransplantation should be carried out without:
 - i. the documented, specific, free and informed consent of the patient to the procedure and any necessary specific constraints; and
 - ii. the provision by the patient to the medical team of the necessary information concerning his or her current close personal contacts and the acceptance by the patient that his or her current and future close personal contacts be given information in accordance with Article 14.
2. Prior to xenotransplantation, the consent to carry out the intervention may be freely withdrawn at any time.

Article 17 – Counselling and support

The patients and their close personal contacts should be given proper information and have access to counselling and support by experts outside the team both before and after the xenotransplantation. This informing and counselling process should include the biomedical, ethical, psychological and social aspects of xenotransplantation.

Article 18 – Right to medical care

A refusal to participate, or a withdrawal of consent prior to the xenotransplantation, should not prejudice the patient's right to receive all other appropriate medical care in due course. The patient's consent to participate

in a xenotransplantation should not prejudice his or her right to benefit from an allotransplant that becomes available while awaiting xenotransplantation, if medically indicated.

Article 19 – Patients not able to consent

1. Where xenotransplantation has been authorised for use other than in clinical research according to Article 5 paragraph 2, it may be carried out on a person not able to consent only if the following conditions are fulfilled:

- ♦ there is no therapeutic alternative of comparable effectiveness available to the patient,
- ♦ taking into account the constraints and conditions to which the person will or may be subjected according to Articles 13 and 14, the intervention is expected to result in a direct and important benefit for the patient, and
- ♦ the representative or an authority or a person or body provided for by law, after receiving the information referred to in Article 13, has authorised both the intervention and the provision of the necessary information to the present and future close personal contacts of the patient.

2. Patients unable to consent should not undergo clinical xenotransplantation research as referred to in Article 5, paragraph 1.

Exceptionally, a patient unable to consent may participate in a clinical xenotransplantation research intervention if the following specific conditions are fulfilled:

- ♦ there is adequate indication, on the basis of prior clinical research, that the xenotransplantation might be lifesaving,
- ♦ there is no alternative means of saving the life of the patient,
- ♦ taking into account the constraints and conditions to which the person will or may be subjected according to Articles 13 and 14, the intervention is expected to result in a direct and important benefit for the patient, and
- ♦ the representative or an authority or a person or body provided for by law, after receiving the information referred to in Article 13, has authorised both the patient's participation in the clinical xenotransplantation research and the provision of the necessary information to the present and future close personal contacts of the patient.

Article 20 – Confidentiality

All personal data relating to the recipient person and, where such data exist, their close personal contacts should be considered to be confidential.

Without prejudice to the provision of Article 8, such data should be collected, processed and communicated according to the rules relating to professional confidentiality and personal data protection.

Article 21 – Compulsory constraints

If, after the xenotransplantation has been carried out, the recipient or his or her close personal contacts refuse to comply with the constraints associated with xenotransplantation, public authorities should intervene and take appropriate measures, where public health protection so requires, in conformity with principles of necessity and proportionality.

Depending on the circumstances and in accordance with the procedures provided for by national law, such measures might include registration, compulsory medical follow-up and sampling.

Chapter V – Protection of animals

Article 22 – Compliance with animal protection regulations

All animal use in xenotransplantation should comply with the provisions of the *European Convention for the pro-*

tection of vertebrate animals used for experimental and other scientific purposes including the principles of Appendix A and *Council Directive 86/609/EEC on the approximation of laws, regulations and administrative provisions of member states regarding the protection of animals used for experimental and other scientific purposes* including Annex II.

These provisions should apply to source animals in addition to their sires and dams in source production units, pre-transplantation holding facilities, tissue harvest areas and during transport.

Article 23 – Husbandry, care, use and requirements of animals

The husbandry and care for all animals used in xenotransplantation should take account of their physiological, social and behavioural needs and should be designed to ensure their well being, particularly where breeding animals are maintained for long periods. The pain, suffering or distress and the number of animals used should be minimised.

Article 24 – Responsibility for husbandry and care of animals

There should be clearly assigned and documented responsibilities for husbandry and care of the animals used in xenotransplantation from birth to death, with a sufficient number of appropriately trained and competent staff available to inspect and care for them.

Article 25 – Surgical derivation and early weaning techniques

Surgical derivation and segregated/medicated early weaning production techniques should only be used where essential to produce animals of appropriate health status for use in xenotransplantation.

Article 26 – Transport of animals

Transport of animals for xenotransplantation should be kept to a minimum. If transportation is necessary, adequate arrangements should be made for the dispatch, receipt, acclimatisation and quarantine of animals in order to minimise the associated stress. The relevant national and international legislation/regulations (including European Union *Directive 95/29/EEC* modifying *Directive 91/628/EEC* on the protection of animals during transport, and the European Convention for the Protection of Animals During International Transport (revised)) should be complied with.

Article 27 – Organ and tissue procurement from animals

Analgesia or anaesthesia should be used for the procurement of organs, tissues and cells for xenotransplantation, where it is necessary to minimise pain, suffering and distress of the animals.

If, as a result of the procurement, the subsequent health and welfare of the animals would be compromised, the animals should be killed by an appropriate method.

Sequential harvest of solid organs from individual animals should not be permitted.

Article 28 – Collection of animal records

Detailed records should be maintained of the derivation, source, use and final disposal of all animals bred for or used in xenotransplantation. Any unusual or unexpected traits or events should be recorded.

Article 29 – Pre-clinical research

The provisions of Articles 22 to 28 should also apply to animals used in pre-clinical research carried out to support clinical xenotransplantation research.

Chapter VI – Provisions relating to the ethical, social and psychological acceptability of xenotransplantation

Article 30 – Public debate

In accordance with the principles stated in Article 28 of the Convention on Human Rights and Biomedicine, member states should take active steps to ensure that the fundamental questions raised by xenotransplantation are the subject of appropriate public discussion particularly in light of relevant medical, psychological, cultural, ethical, legal, social and economic implications.

Chapter VII – Co-operation between parties

Article 31 – International co-operation in medical research

Member states should co-operate through international surveillance procedures and agreements. They should also take appropriate steps to facilitate the co-ordination of research in xenotransplantation in order to improve its efficacy and safety, to avoid unnecessary duplication and to minimise animal use and suffering.

Article 32 – International co-operation in public health

Every member state should communicate without delay to national public health authorities of other member states and other concerned states any events, in particular of infection, possibly related to a xenotransplantation which could compromise public health.

Chapter VIII – Compensation for undue damage

Article 33 – Compensation for undue damage

The person who has suffered undue damage resulting from a xenotransplantation is entitled to fair compensation according to the conditions and procedures prescribed by law.

Chapter IX – Reports on the implementation of the recommendation

Article 34 – Implementation of the recommendation

On receipt of a request from the Secretary General of the Council of Europe any member state should furnish an explanation on the manner in which its legislation and practice in the field of xenotransplantation integrate the principles and guidelines of this recommendation, on any xenotransplantation activity and on any adverse event as referred to in Article 9.

(pokračovanie zo strany 1)

V krajinách strednej a východnej Európy sa tieto otázky neraz zdajú predčasné, „nepraktické“, či umelé – „máme svoje špecifiká, i svoje vlastné starosti; čo nás do problémov, ktoré sú za hranicami „nášho sveta“ – i tak ich nemôžeme ovplyvniť“. Napriek tomu sa týmto otázkam, ani týmto problémom naše krajiny, ani „naši ľudia“ zrejme nevyhnú. Zmenšovanie „dediny sveta“ spôsobuje, že sa i „problémy ľadovcov v Antarktíde“ stávajú našimi problémami... V zjednocujúcom i fragmentujúcom sa svete, či Európe, paradoxne stále viac – a stále menej, záleží na každom jednotlivom hlase. Demokratickými metódami sa totiž rozhodne – akože ináč, z vôle menšiny – o bytí či nebytí, šťastí či nešťastí dnešného človeka i ľudstva, ako aj generácií, čo prídu potom, keď my tu už dávno nebudeme... (ak prídu). Krajiny strednej a východnej Európy prichádzajú k debátne i rozhodovaciemu stolu trochu oneskorene. To môže byť rovnako výhodou i handicapom. Záleží na reprezentantoch. Môžu priniesť do debaty nové impulzy, môžu podporiť rozumné postoje i riešenia, môžu pripomenúť aj pravdy, či skutočnosti, na ktoré sa už akoby v dnešnom „rozvinutom“ svete zabudlo.

Jozef Glasa, vedúci redaktor

Perspectives of Bioethics in the Central and East European Context

The political, economical, security and cultural realities of contemporary world do point out increasing importance of ethical values. Especially, when acceptable solutions for the key existential problems of contemporary man and mankind are sought. Moreover, these values are there, when the very human civilisation – and its preservation and development in decades to come – are at stake. It has been repeatedly noted that the present situation of mankind is framed by severe and unprecedented paradoxes. Never ever before, it had at its disposal such enormous means for self-destruction, and for annihilation of the whole living nature on Earth. Never before, the man possessed such technical and technological resources, which would allow – on a global scale – to fulfil the basic needs of a decent life for all members of the human family (food, habitat, clothing, hygiene, health care, etc.). However, only then, when radically different attitudes would direct the distribution of these goods. Never ever before, people had been closer to each other, as it has been made possible with the modern communication technologies. But almost never before the world has been so dramatically divided by so many unfortunate ruptures of hatred, contradictions, and violence. Never before, the human civilisation has been so effectively secured and guarded against the adverse effects of the nature and its magnificent forces. But almost never before, the world has been such a dangerous and unsecured place, as it is being nowadays because of the fears of terrorist attacks, or the threats of failures of human or technical factors. Contemporary man has come to the molecular origins of his life. He has revealed its basic code. He has in his hands the means for influencing his own biological future... But he is perhaps more unclear, than ever, about what this future should be like, and towards what kind of destiny it should be directed.

In the situation of these immense paradoxes, bioethics – as a multidisciplinary field of study of the principles, norms and rules of evaluation of human deeds and behaviour in the field of medicine, health care, and practical applications of biology and other life sciences – does represent some hope and a possible uniting space for the actual multifaceted discourse about the future of human civilisation and its universal meaning. (Whether a conscious one, or even ‘professional’, or of that, which happens informally and fills in by various contents the space of the ‘societal conscience’, public opinion, or which gives shape to the attitudes or beliefs of individuals, families, or bigger groups of the society – up till defining various ethnic, national, state, continental or global interests).

For the countries of Central and Eastern Europe, these questions may sometimes seem premature, ‘non-practical’, or artificial. “We have our specificities, and our own problems; why to think about the problems that are far beyond the borders of ‘our world’. Anyway, we cannot make any difference concerning them.” Nevertheless, despite these playing down efforts and comments of some, neither our countries nor ‘our people’ will be spared from confronting these quandaries. Growing the ‘world village’ small provides for that even the “problems of icebergs in Antarctica” become our own ones... In the world, or in the ‘enlarged’ Europe, that is being both increasingly united and fragmented, paradoxically, more than ever – and less than ever, any single voice counts. Indeed, the fate, the happiness or despair of contemporary man and mankind will be decided by democratic processes (or their distortions), and precisely by the will of minority(ies). The fate of the generations to come, when we, already for a long time, will not be inhabitants of this world... (if they come).

The countries of Central and Eastern Europe are invited to the debate, and to the decision-making European (and global) table(s) with some delay(s). This may be considered both an advantage and a handicap. Much will depend on their will, and on their representatives. They can bring into the debate new, valuable impulses; they may support wise attitudes and solutions; and they can recall the truths, or facts, that seemingly have been forgotten in the ‘brave new (developed) world’ they enter.

Jozef Glasa, editor

7th CONFERENCE OF NATIONAL ETHICS COMMITTEES: CONFERENCE COMMUNIQUÉ

89 participants from 40 countries took part in the 7th Conference of National Ethics Committees (COMETH) held in Strasbourg on 1-2 December 2003. The main themes of the Conference were bioethics education and biobanks. The Conference also held a brief discussion on clinical ethics committees and heard presentations of recent Opinions prepared by National Ethics Committees. The Conference concluded that:

Bioethics education

Issues concerning bioethics are of increasing importance to society, to health care professionals and to policy makers, and such issues are increasingly debated in public;

Such public debate is warmly welcomed, and should take place on an informed basis;

Responding to new bioethical challenges requires contributions from, and debate between, all sectors of society. National Ethics Committees have an important role in promoting such multidisciplinary debate;

Bioethics education is therefore increasingly important for all sectors of society. The Conference welcomed initiatives to develop bioethics education in schools, including that by the Council of Europe and for young people generally, and encouraged the further development of such initiatives;

Two types of information are needed: broadly based information enabling people to develop their own views about the ethical implications of new developments, and technical information on specific new developments under debate;

Members of research ethics committees, who have a central role in protecting the rights and dignity of persons who participate in research, should be adequately trained to fulfil their role and have access to appropriate continuing education and training;

The Conference asked the Council of Europe to act as an intermediary to enable National Ethics Committees to share information on educational initiatives in bioethics and material used in that context.

Clinical ethics

Health care professionals constantly face decisions with an ethical dimension in their work. The World Medical Association Resolution of 1999 recommended that training in medical ethics and human rights be obligatory for all medical schools; the Conference endorsed that resolution and would broaden it to include all health care professionals;

The increasing availability of support and advice for health care professionals on clinical ethics, for example by clinical ethics committees, was welcomed. The Conference encouraged states to promote appropriate mechanisms for clinical ethics support that are appropriately resourced, and to ensure that those playing a role in such mechanisms are adequately trained for that role.

Research on biological materials

The development of large biobanks in several countries has the potential to lead to significant medical advances in the future. The Conference highlighted the importance of developing such biobanks on an appropriate ethical and legal basis, and emphasised the importance of appropriately informing those whose biological materials are included in a biobank of the implications of their involvement;

Research on biological material such as human tissue that has been obtained for purposes other than research (for example, that is left over after a surgical operation)

has already lead to important medical advances, and is likely to lead to further advances in the future; it should therefore be supported;

However such research must be adequately regulated, with attention paid to the ethical, legal, social and commercial implications of such research. The Conference recognised that no international legal instrument presently regulated such research, and supported the work of the Council of Europe to develop an appropriate instrument.

Approved by the Bureau of COMETH, and by the participants of 7th Conference of National Ethics Committees (COMETH), Strasbourg, December 3, 2003.

STATEMENT ON THE CULTURAL VALUES OF NATURAL SCIENCES

Pontifical Academy of Sciences

At its Plenary Session of 8-11 November 2002, the Pontifical Academy of Sciences discussed the various contributions made by scientific activity and education to the culture of humankind. Seeing „culture“ as a set of free and responsible learned ways of acting, behaving and taking decisions, as opposed to inherited patterns of behavior and instincts, the Pontifical Academy of Sciences wishes to issue the following Statement.

If by science we mean the sophisticated arts of mathematics, aesthetics, architecture, metallurgy, it is possible to describe ancient Egypt, China, Mesopotamia as the first homes of science. The knowledge base built up by studies in the natural sciences beginning with the theoretical practice of the ancient Greeks as a selfless form of the search for truth, and then developed by the method of Galileo and his heirs, constitutes a fundamental dimension of human culture.

Since that time, this dimension has shaped human history and is now an irreversible part of one's destiny. It is a value in itself which provides both a science-based view of the world and people and extensive opportunities to improve living conditions through applications in such areas as health, life expectancy, food security, sustainable growth, energy and water resources, information and communication, and the preservation of the environment.

In the context of these applications, a worldview where science and its values play their role in the quest for truth, together with the ethical wisdom developed down the centuries, can be of great help in assessing policies and technology so as to reduce the possible risks that accompany many such applications. Thus, a global awareness of the need to engage in a responsible evaluation of human impact can lead to the implementation of sustainable developments which guarantee good for all people. Many national and regional Academies of Science, as well as international scientific unions and inter-academy organizations, are ready to help political and cultural leaders, governments and companies in a careful and prudent assessment of the new technologies.

The rigorous standards generally applied in scientific research with regard to data collection and interpretation and experimental design, and the ethical rules that govern scientific practice, impart intrinsic cultural value to scientific work. Similarly, the steadily enriched scientific knowledge base, sharing the values and contents of science, represents a force of great value for education and can act to improve the conditions of human lives.

For these reasons, the broad knowledge base of the natural sciences constitutes a dynamic and open trans-disciplinary foundation that is of relevance to all human beings at all levels of education. In order to benefit fully from this knowledge base, societies should develop

scientific education, starting from primary school, and ensure that their scientists responsibly take care that the progress of science and technology goes to the advantage of all men and women.

Successful scientific research strongly depends on originality, creativity and invention. These requirements are similar to those of other cultural activities in the various fields of the arts and in the social and human sciences. All of these fields make their specific contributions to the heritage of human culture; they are complementary and cannot replace each other.

Today, more than ever before, what is required is a new humanism which takes into account all aspects of human culture, and where human, social and natural sciences can work together as partners. This will greatly contribute to improving the overall knowledge of our world and our place in it, to increasing the respect for future generations, to promoting what is human in people, to safeguarding the environment, and to fostering sustainable growth and development.

In this way, science will help to unite minds and hearts, encourage dialogue not only between individual researchers and political and cultural leaders, but also between nations and cultures, making a priceless contribution to peace and harmony amongst the peoples of the world. Science, so much appreciated in the teaching of John Paul II, when it is in harmony with faith can fully participate in this new humanism. The members of the Pontifical Academy of Sciences make an appeal to the readers of this Statement to fully recognize the valuable contribution made by the natural sciences to human culture.

Taken from the news service of Zenit International News Agency, www.zenit.org, document: ZE03061622.

KONFERENCIE / CONFERENCES

Depresia

Správa z medzinárodného kongresu Rím, 13. – 15. novembra 2003

V dňoch 13. – 15. novembra 2003 sa v Ríme konal už 18. svetový kongres organizovaný Pápežskou radou pre zdravotníckych pracovníkov (PRPZP). Témou kongresu bola 'Depresia', ako mnohostranný a častý problém v živote dnešného človeka, so zvláštnym zameraním nielen na jeho aspekty medicínske (psychiatrické), psychologické a sociálne, ale aj na také stránky tohoto problému, ktoré sa len zriedkavo dostávajú do pozornosti odborníkov v súčasnom medzinárodnom kontexte: spirituálne, filozofické a teologické.

Kongres, na pozadí situácie človeka súčasnej doby, uviedol kardinál Javier Lozano Barragán (prezident PRPZP): depresia je "problémom, ktorý sa netýka len fyzického zdravia ale aj zdravia duševného. Je problémom skutočne holistickým, pretože sa dotýka ľudskej bytosti v celej jej komplexnosti." I keď depresia patrí medzi závažné ochorenia – a jej diagnostika a liečba je doménou lekárov – psychiatrov, neraz je spôsobená aj zážitkom absurdity a absencie zmyslu života. Môže viesť až k smrti človeka - samovraždy. V ére postupujúcej sekularizácie spoločností v európskom i globálnom meradle, sa smrť nezriedka javí ako nutný konečný dôsledok kultúry. Keď človek nenachádza odpovede na základné otázky zmyslu života (existenciálne problémy), všetko sa mu môže zdať absurdným. Smútok a strach zo zániku a zničenia pôsobia až zničujúcim vplyvom. Podľa Barragána je pre človeka validnou a definitívnou odpoveďou na depresiu skúsenosť víťazstva nad smrťou (transcendencie), ktorú ponúka kresťanstvo. [1] Korene pozorovanej pandémie de-

presie sú spleť. Súvisia aj s hlbokými rozpormi 'postmodernej' doby, filozofickými koreňmi súčasného myslenia a jeho odrazom v aktuálnej kultúre: relativizmus, nihilizmus, historicizmus, návrat k mysticismu a pseudo-náboženstvám, fragmentácia spoločnosti na princípoch rozdielnosti, sociálna nerovnováha na báze plurikultúrnej a plurirasovej tolerancie, desakralizácia sveta a prírody, absencia dôvery v racionalitu človeka. Z človeka rozumného sa stáva človek sentimentálny, iracionálny. Racionalizmus nahrádza relacionizmus, objektívnu pravdu „uhly pohľadu“. V nekonečne pluralistických monológov (homo Babylus) sa človek mení aj v homo potens, pre ktorého jediným zlom je "potlačenie", ktorému je vlastne všetko dovolené. To spôsobuje extrémnu fragmentáciu spoločnosti, a napriek všadeprítomnej tolerancii, stáva sa človek ešte viac slabým a krehkým, opustným tvorom bez cieľa. Zostáva na sociálnej a kultúrnej púšti sám. Kardinál José Saraiva Martins označil depresiu za akúsi "chrípku psychiatrie". Venoval sa jej analýze z pohľadu klinického, i z pohľadu biblickej antropológie. Vymedzil klinické prípady depresie na pozadí koincidencie viacerých príčinných a vyvolávajúcich faktorov. Upozornil na potrebu odlišenia bežného ľudského nešťastia od klinickej depresie. Nešťastie a smútok sú univerzálnou ľudskou skúsenosťou, sprevádzajú človeka od pradávna, o čom svedčí bohatstvo reflexie venovanej zármutku, ktorá sa uchovala v biblických žalmoch (55, 5-6; 88, 1-6; 102, 1-12; 42, 10; 43, 2; 30; 28) a starozákonných biblických príbehoch. V nich vyniká najmä postava Jób (ktorého označuje za "patróna depresívnych"). Biblickou odpoveďou na depresiu je otvorenie sa bezpodmienečnej láske Boha, ktorý človeka nekonečne presahuje (zmŕtvychvstanie).

Vlastné rokovanie kongresu pokračovalo v plenárnych zasadaniach, ktoré umožnili konzistentne a komplexne podať obraz témy depresie, a to na vysokej odbornej úrovni. **I. Stav depresie prítomný v súčasnom svete** – obsahom boli predovšetkým prednášky lekárov – psychiatrov a neurológov, ako aj informácie ďalších odborníkov približujúcich jednotlivé aspekty problému depresie. Sprostredkovanie multidisciplinárneho pohľadu a vysoká úroveň prezentovaných prednášok i diskusie boli mimoriadne silným odborným zážitkom. **II. Svetlo viery vo svete depresie** – prednášky teológov, psychológov, zástupcov pomáhajúcich profesií, zástupcov rehoľných spoločností a hnutí, atď. prispeli k analýze možností duchovnej odpovede na fenomén depresie. Všimli si aj problém viny a miesta skúsenosti s depresiou v živote človeka, vrátane skúseností osôb hlbokého duchovného života trpiacich depresiou (depresia a 'svätí'). **III. Čo by sa malo urobiť?** (aby sa podarilo vymaniť z uzavretého kruhu depresie) – prednášky analyzovali možnosti prístupu a pomoci z duchovného (spirituálneho) hľadiska (v terminológii biblických čností – viera, láska – dobročinnosť, nádej). Tento prístup nenahrádza ani nekonkuruje príslušnej profesionálnej diagnostike a liečbe, ktoré už v prípade depresie ako choroby dosiahli vynikajúcu úroveň a spoľahlivé klinické výsledky. Môže však ponúknuť podstatnú pomoc, oporu a existenciálne východisko pre pacienta – a ovplyvniť jeho ďalšie smerovanie, aktivity, i celkovú spokojnosť a kvalitu jeho ďalšieho života.

Kongres priniesol množstvo nových poznatkov, vynikajúcu možnosť kontaktov s poprednými európskymi a svetovými odborníkmi. Vyznačoval sa širokým multidisciplinárnym záberom. Neopakovateľná historická, kultúrna, duchovná i aktuálne – moderná atmosféra 'Večného mesta' boli v kontraste s programovo "depresívnou" tematikou kongresu vynikajúcimi prirodzenými "antidepresívami" a vytvorili viac než dôstojnú kulisu podujatia. Kongres obsahoval množstvo podnetov i pre sekulárne zameraných odborníkov, ktorí ho navštívili vo veľkom počte. Umožnil lepšie pochopenie špecifického odborného, kultúrneho a spirituálneho prínosu, ktorý pre

danú oblasť predstavuje dvetisícročná tradícia kresťanstva a jeho pozoruhodnej angažovanosti v oblasti zdravotníckej, psychologickéj a charitatívnej pomoci.

Doc. PhDr. Mária Glasová, PhD.

[1] Card. Barragan, J. L. (2003), La depression. XVIII^{ème} Conférence Internationale, Congress materials, Pontificium consilium pro pastorali valetudinis cura, Roma.

O KNIHÁCH / BOOK REVIEWS

Pharmacogenomics

Social, Ethical, and Clinical Dimensions

Ed. M. A. Rothstein, Wiley-Liss, A John Wiley & Sons, Inc., Ho-boken, N.J., USA, Hb, 368 pgs, ISBN 0-471-22769-2 (cloth)

Pharmacogenomics – usually referred to as the use of genomic technologies in assessing differential response to pharmaceuticals, is a relatively new branch of genomics research and application. It is also an intensively growing field, with a rapid accumulation of new knowledge entering quickly scientific, and even popular literature, and attracting attention of media and policy makers around the globe, especially in the countries with a more developed science and health care systems. The illusions, and false hopes are confronting real achievements, and still quite a modest harvest of results already able to be used in the clinical practice and further research.

This timely book presents a multidisciplinary analysis of the scientific, clinical, economic, ethical, social, and legal implications of pharmacogenomics. It begins, in Chapter 1, with the results of a comprehensive public opinion survey on pharmacogenomics in the USA. The chapters of the book are organised into 4 major sections:

1. Science and society (containing chapters on pharmacology and toxicology in the genomics era, and on implications of population genetics for pharmacogenomics),

2. Research and development challenges and considerations (chapters on genome research and minorities, drug development strategies, drug development, regulation and genetically guided therapy, intellectual property and commercial aspects of pharmacogenomics),

3. Clinical applications (chapters on integration of pharmacogenomics into medical practice, clinical utility of pharmacogenetics and pharmacogenomics, medical liability for pharmacogenomics, the challenges of pharmacogenomics for pharmacy education, practice, and regulation),

4. The social dimension (chapters on economic implications of pharmacogenomics, pharmacogenomics and social construction of identity, pharmacogenomics: considerations for communities of color, constitutional issues in the use of pharmacogenomic variations associated with race).

The volume is completed by the Epilogue (Part 5), which is devoted to some policy applications of the knowledge accumulated in this new field of research and development. The book is based on the first hand expertise of the contributing authors, many of whom count as leading personalities in the areas covered by their contributions. The reader is challenged by the new, original bulk of knowledge, treated in a distinguished way of a reliable scholarship, allowing comprehension and following the text even for the one not so much familiar with the new terminology (or the technical “jargon”) of the volatile advancing discipline.

The volume is a must reading for pharmacologists and clinical pharmacologists, researchers in drug development and clinical evaluation, policy makers, internists and students of medicine. To all those, who need to grasp

a timely introduction to the scientific, clinical and social impact of this swelling area of knowledge, which is expected to reshape considerably the way medical therapy is understood, developed, and used in our near future.

Assoc. prof. Jozef Glasa, M.D., PhD.

Ethik in der Klinik – ein Arbeitsbuch Zwischen Leitbild und Stationsalltag

N. Steinkamp, B. Gordijn, Wolter Kluwer Deutschland GmbH (Luchterhand), Neuwied – Köln – München, 2003, ISBN 3-472-05258-9, hb, 314 pgs.

En extremely useful book, well written, nicely organised, comprehensive, thought provoking, practice oriented. Authors' aim in filling the gap in the current (not only German) literature on practical application of ethical reasoning, and ethically informed decision making in the clinical practice has been achieved with an outstanding scholarship and distinguished didactic mastership. I find the book especially useful not only for the members of ethics committees, or others involved in dealing with difficult ethical dilemmas at the bedside and in outpatient settings, but also for the students of medicine, psychology, nursing, theology, and other, helping professions', who deal with difficult situations of deciding on, life-and-death' problems.

This valuable volume begins with an introduction chapter on the meaning and importance of proper dealing with ethical problems in contemporary medicine and health care, not least from the point of view of the health care facilities. The reader is also introduced to the outline, and to the working use of the book itself. The next chapter is devoted to a very useful introduction to the **basic concepts** of (morals and) ethics, while examples of different approaches to, practical' ethical reasoning are given in some more details. The third chapter gives an overview of the **development of institutional structures** developed during previous few decades to deal with ethical problems in clinical practice in Europe and USA (various approaches, incl. different types of 'ethics committees' or similar structures are given, together with account on pros and cons of those various solutions). The next chapter is devoted to the analysis of concrete approaches in dealing with ethical problems faced in everyday clinical practice (namely a 'top - down' and 'bottom - up' models are characterised in a greater detail), which leads authors to the proposal and description of an original **Clinical Ethical Interaction Model**. The fifth chapter deals in a comprehensive manner with problem of establishment and work of **ethics committees**, giving also some concrete case-examples on how these committees can approach their various tasks. The sixth chapter analyses the **clinical case review** in a ward, giving account on various approaches to be used in these settings. The seventh chapter gives many useful hints for a successful **implementation** of clinical ethical analysis in health care institutional practice, while various options for the ethics committee are discussed. A very useful appendix, consisting of a good recent bibliography and both authors' and key words registers completes the book.

The book should be recommended as a must reading for the categories of professionals listed above, but also as a must have handbook proudly belonging to the useful 'know-how' resources of the practising health professional, other help professions' member, and health care facility's administrator in German speaking settings. An English translation should early be considered to make profit of this valuable book available also to a non-German speaking audience.

Assoc. Prof. Jozef Glasa, M.D., PhD.

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