XI Congress of FEAMC
Gdansk, 11-14 September 2008

NATURAL LAW AND STATUTORY LAW IN CONTEMPORARY EUROPEAN MEDICINE

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Session I

Prof. Wojciech Laczkowski (Poland)

Ethical and legal dilemmas of contemporary Europe

Europe is departing from traditional values which are its cultural foundations. Especially as far as universal Christian morality, derived from natural law, is concerned. Politicians and lawyers are trying to justify the phenomenon with the need of the nation to be neutral in its philosophy of life. Meanwhile the neutrality, though sounds attractive, is a fictitious rule as it is not and cannot be observed. Legislators cannot avoid declaring their position on the most basic issues concerning human beings and their communities. Their opinions are reflected in numerous legal regulations and public authority practice refering to philosophy of life issues. Those are for example issues concerning human life (such as abortion, euthanasia), legalization of homosexual couples, contents of educational programs, family life rules, and many others which deal with morality. Legislation and public authority practice in those spheres either affirm or negate systems of values connected with a given philosophy of life or religion. In result, it cannot be called neutrality.

In consequence, it would be better to replace the term neutrality, which causes hypocrisy, with such axiological system which is honest and in agreement with reality and make it basical for legislation and public authority practice. In Europe it could be a system derived from Christian values or from materialistic views (which has recently been a rule).

I am in favour of the first one as 1 believe that all serious ethical and legal dilemmas of contemporary Europe which can contribute to European cultural, civilizational and demographical degradation, result from our departure from Christian values in favour of relativistic ideas and materialistic views. Therefore, we must speak about the problem, even though it is not popular and politically correct.

Prof. Marek Safjan (Poland)

What law do we need at the time of the rapid development of the new biotechnology and medicine?

Dominant and commonly shared opinion by the both scientist as well as the people outside of the scientific milieu is that contemporary law is not catching up on the progress of modern medicine and the biotechnology. The simple assumption that the law making process is too slow as a result of what law is not adapted to the expectations of the society has a little explicative value. The above referred argument should not be used as the sole justification of the present situation. The problem is of a much complex nature. Insufficient content and as well as the quality of the legal rules in the discussed field has its source in many different factors. For that reason it is an oversimplification to simply blame, for the above-described defects of the modem biomedical provisions of law, the slow lawmaking process. For the first time in history, law is confronted with so serious conflict of the fundamental principles. This conflict can not be resolved through the automatic transposition of ihe achievements of the modem science into the legal provisions. Neither the scientific milieu, the lawyers themselves nor the particular academics should be allowed to decide autonomously on the direction of the legal regulations development, in the discussed field or to determine the acceptable borderlines for the potential sphere of the application of the specific legal sanctions. The freedom of the science and the scientific research or the benefits resulting from the progress of the modern medicine should not be treated as the purpose in itself. The above referred values can not be placed at the highest level of the law system's axiological structure but they should rather be balanced with the other values e.g. the ones which are protected by a very large infrastructure of the protection being the fundamental human rights. The law has its own mission to fulfill, its own purposes to realize, often not being the mirror image of those, contributing to the scientific progress, expectations, wishes and fascinations. Secondly, another factor which complicates the lawmaking process is the pluralistic character of modem democratic societies.

Within such societies particular groups express different axiological preferences, have different approach to the life concept as well as to the hierarchy of values which should be protected. The law should not be the simple transposition of the dominant moral and ethical values represented by the majority of a given society nor it should be treated as the simple instrument of formal confirmation given by the state for the dominant religious convictions. The lawmaker should respect the different axiological sensibility and it should avoid the solutions which would provoke the conflicts between the ethical convictions of individuals and the possible legal choices. In other words: the law has to leave the necessary space for free moral choices made by everyone in such context.

The connections between the law and moral system arise each time when the debate relates the legal paradigms which are determined by the ethical values. In the light of the above said the answer is required to the following question: to what extent legal regulations must express or simulate the content of ethical values? What are the interactions between the values being treated as the essential values of the system and the possible solutions which should be adopted by the given law system? Is admissible the solution where the essential values are to be limited by the application of the particular legal regulations?

The future direction of development of the legal system in the biomedical matters strongly depends on the

establishment of the adequate balance between the individual interests and the general interest of society.

Only in such perspective, the modem dispute on the hierarchy and the content of the protected values, should be placed. In the center of the dispute there are such values as the individual right to the autonomy, to the self determination as well as the right of making free choices by the individual in the sphere of his or her private life.

Around these issues the ongoing debate is focused as well as the main contradictions, doubts and uncertainty of ethical and legal evaluations appear. The question: what law we need ? is directly related to the another issue, namely: what should be the methodology of creating the new laws, taking into account the pluralistic and democratic character of our modem society?

My conclusion is that we need a new approach towards such issues or in the other words a new methodology for the lawmaking process. The crucial element of the new lawmaking methodology should be in rny view based on the wide public debate which allows for identification of all the most important field? of conflicts and in the next stage for working out the necessary consensus.

Fr. Olivier De Dinechin, SJ (France)

How to present natural law to doctors

Aims: Faced with current references in Church teaching to "natural law", doctors nowadays often have difficulties in understanding and so in applying the term. These difficulties arise either from the place accorded to scientific thinking in biomedicine, from medical decision-making in special cases or in the social plurality of doctors and patients. The aim of this contribution is to clarify the classical notion, to propose an intelligible equivalent, and then to explain the function of reference to natural law (or its equivalent) in relation to civil law and medical practice.

Method:

- First, the ambiguities inherent in the tends 'law' ewd 'natural' are highlighted and equivalents proposed, e.g. the moral law of reason, recognizable by conscience, the content of which should be "the objective values of the human person" (Pope John Paul II)
- Secondly, the paper presents an analysis of the medical relationship, in which there is an appeal to articulated moral norms, based on potentially universal norms that every conscience gifted with reason can recognize as valid.

Results:

- The "pact of confidence" (Paul Ricoeur), the foundation of the medical relationship, which makes possible a medical contract, requires a framework of norms articulated and ratified by the medical profession.
- The "medical code of deontology" must be socially and politically acknowledged, and take its place in civil law.
- Civil law itself, especially facing questions of life and death in medical practice, must be grounded on universally recognizable medical bases.
- The medical decision, which is always unique, is sometimes based on ethical reflection as much as technical expertise. The working out of this ethical decision operates on three levels:
  (i) analysis of the particular situation (intention, aims, circumstances, foreseeable consequences);
  (ii) rules of medical deontology and laws in the particular field concerned;
  (iii) universal principles of medical ethics, directly related to the laws of human reason.

Conclusions:

With the help of shared reflection on experience, this perspective could help doctors to form their consciences, in the working out of ethical decisions in difficult cases, as well as in improving and making more precise the deontological rules of the profession as well as those of civil law.

Tomasz Kakol, PhD (Poland)

How I see naturalistic argumentation against IVF, embryonic stem cell research and abortion

Aims: As a Catholic and philosopher as well I am especially interested in questions de rationibus fidei (Thomas Aquinas). Closely related with these is the problem of providing naturalistic (i.e. without invoking God and/or soul) justification of Catholic ethics, in particular bioethics. In the current speech I inquire

1. whether Robert Spaemann's (naturalistic) arguments for the claim that every human being is a person (in his book Personen.Versuche ueber den Unterschied zwischen ueber den 'etwas' wid 'jemand'; call it 'the personalistic thesis') are successful;
2. whether ir is possible to support Spaemann's (and mine, and - in general - Catholic) ethical intuitions in the absence of the personalistic thesis.

Methods: Logical analysis; reconstruction in the identity (in particular, personal identity) theory and in the so-called possible worlds framework.

Results:

Ad 1. Spaemann's arguments are unsuccessful;

Ad 2. an alternative argumentation is possible on the basis of:
a) the moral importance of the identity;
b) the moral importance of the "person-making" teleology.

Conclusions: Naturalistic justification of Catholic bioethics is possible. However, due to the contemporary shift in moral philosophy (see, e.g., Peter Singer's highly controversial [to say the least] views), the noble term 'person' sometimes seems to be very dangerous when used in ethics (Bernard Nathanson).

Session II

Prof. Jean-Francois Mattei, PhD (France)

Ethical and legislative answers in front of genetically transmitted diseases

After the creation of the French national committee for biomedical ethics in 1983, there was another ten years of reflection and debates before a bill was introduced to Parliament in 1993. The bill dealt with a number of problems relating to artificial fertilization and organ transplant but completely overlooked medical genetics.

The tremendous complexity of genetic issues probably accounts for it. Furthermore, relations between politics and genetics have long been mistrusted for historical reasons.

Drafting the bioethics bill on artificial fertilization and organ transplant in France clearly showed how diificuit it is to legislate too late, once practice has commonly been established in everyday life. The development of prenatal diagnosis, of the diagnosis before the implantation of the egg, DNA fingerprints, and the promise of gene therapy, made it absolutely necessary to legislate on prescription, follow-up and quality control.

Voted in 1994 with the purpose of being revised five years later, nevertheless it was not before 2004 that the law was discussed again, modified and revised. Central to that second debate were issues involving cellular therapy for genetic diseases. All these issues will be discussed again with a view to its next revision scheduled in 2009.

Dorota Kornas-Biela (Poland)

Interdisciplinary care for families with a prenatal diagnosis of an anomaly

The greater availability of prenatal diagnosis techniques leads to exterminating children who are prenatally diagnosed as children with health problems, by the means of selective abortion. For this increasing group of children, only because of the fact that they have not yet managed to be born, the criterion of the quality of life is used to exclude them from the society by selective abortion. Therefore, parents especially need assistance in situations where they:
(1) consider the decision to undergo examinations,
(2) resign from examinations and anxiously await their child's birth,
(3) wait for prenatal examinations,
(4) undergo them,
(5) wait for their result,
(6) receive a result confirming a disease or congenital defect in their child, (7) consider "what next",
(8) decide to have a child with a health problem and require support during pregnancy, delivery, postpartum and early contacts with an endangered child, as well as when they
(9) decide to have a selective abortion of a "defect child" and struggle with emotional consequences of the child's death caused by themselves.

Depending on the stage and the parents'decision, they need a multi-professional approach (of a medical-psychological-pedagogical team). It is an unsolvable problem who, when, and in which form should support the parents who experience the dramatic situations. Thus, it is especially important to develop different forms of professional help for parents enabling them to make a decision to have a child with a health problem, and to assist them during the time of waiting for the birth of their handicapped child in order to optimalize the child's development and include him or her into the family at this very early stage of prenatal and perinatal development. Especially the prenatal diagnosis of a lethal anomaly is a monumental moment in a family's life. Most parents opt for termination, which may include feticide. Extensive counseling and education presented by a multidisciplinary team and perinatal palliative care (perinatal hospice) offers an alternative. The model is based on the hospice philosophy of living life fully and enjoying each moment. The families who make the difficult choice to continue a pregnancy after the diagnosis of a fatal fetal anomaly benefit from support, guidance and comfort provided to them.

Prof. Filippo Boscia, M.D. (Italy)

Medically assisted reproduction

Medically Assisted Reproduction (MAR) has raised several complex ethical issues during the last decade, not only at a mere theoretical level, but also at a practical level in the policy field. Different ethical and

biolegistative guidelines have been enforced in the European countries and, at a first sight, they do not give rise to a unified European perspective.

The most commonly used reproductive technologies are briefly presented. The analysis is then pointed to a critical characterisation of the key ethical concepts of reproductive autonomy and of child welfare. The correct line between the two concepts previously characterised, capable of setting out a just equilibrium, is difficult to draw and this situation ofmereological confusion brings about several misconceptions at different levels.

Finally, the balancing between reproductive autonomy and child welfare amongst the different biolaw policies of the European countries is reviewed with particular emphasis on national legislations, striving to point up similarities and differences.

S. Prof. Barbara Chyrowicz, MPS, PhD (Poland)

The problem of begining of human life in the context of the controversy on the essence of humanity

Although the progress of science (specially biology and genetics) is continually bringing new problems for bioethics, they all relate to the same human beings whose welfare in the context of medical practice has been defended by the Hippocratic Oath ever since the 5th century BC. There is currently no theory of ethics which does not declare its grave concern for the good of human being. If, despite their unanimously declared concern for Man's welfare, ethical theories vary widely among each other as to what they regard as morally good, it is because they differ fundamentally in their understanding of the essence of humanity. Contemporary moral philosophy offers a fairly large number of mutually exclusive Concepts of Person. In the context of bioethical dilemmas, the dispute on the understanding of the person basically relates to the way in which the respective ideas of the person view the relationship of that which is "personal" to that which is "human", more specifically defined as the nature of the species Homo sapiens. Attempts to separate the "human" from the "personal" element ignore the fact that the being of a person consists in the living of human life. The two questions: "Is every human being a person?" and "From which point in time is a human being a person?" are strictly interrelated, and the answers to them by the proponents of the various concepts of the person will depend on what the given concept regards as fundamental for the status of the person.

Session III

Prof. Janina Suchorzewska M.D. (Poland)

Medical, ethical and legal problems associated with the decision to limit the life support treatment

Progress in artificial support of the life functions has recently added numerous possibilities to interfere with the process of dying. Frequently it determines the time of ending human life.

This paper presents medical, ethical and legal problems that follow necessary decisions to limit rescue and life-prolonging interventions. These decisions require not only medical criteria, but also deep ethical reflections taking into consideration holiness of life as well as its finite length. Respect for patient's autonomy defines his own notion of goodness.

In the paper I will discuss various elements that determine the range of therapies that can be used. The overview of problems related to religion, culture, legal and economical conditions will also be given. The presentation shows problems of therapeutic limits used in Poland as compared with the rules accepted in other countries.

In the global medicine common principles are based on medical criteria. These criteria use potential ability to live according to the prognostic factors. Very important role in the decision process is also assigned to the respect for human autonomy. However, in real situations the right of that autonomy shows substantial differences all over Europe. In Poland the analysis of resuscitation results is commonly based on the prognostic factors. These factors are crucial when resigning from the ineffective therapy. In difficult situations, concerning limits of ineffective therapies leading to natural death, doctors consult Polish Physicians Ethical Code and sources within teaching of the Catholic Church. Polish law obligates to giving aid in each life-threatening situation but it does not define the limits of the life supporting treatment.

Francois Blin[1], MD, & Solange Grosbuis[2], MD (France)
Former Heads of the Intensive Care Units of Gonesse[1], and Versailles[2]

End of life in the Intensive Care Untt

Intensive Care is a discipline which dates back to the 1950s. It has expanded the scope of therapy to maintain artificial survival of patients beyond any therapeutic resource. There were several well-known examples.

Then the problem of the justification for such care arose. Pope Pius XII gave a few guidelines in his two 1957 speeches to the Italian anaesthesiologists;

• "The abolition of pain and consciousness ... is it permitted ... (even if it is expected that the use of narcotics shortens life)?... Yes."
• "The duty in case of serious illness, to take the necessary care to preserve life andheahh... requires only the employment of ordinary means... i. e. means that impose no extraordinary burden... The interruption of attempted intensive care is only indirectly the cause of the cessation of life, and the double effect principle should be applied in this case..."
- "The doctor can act only with the patient's permission ..."

These positions were echoed not only in subsequent texts of the Church, but also in the world-wide medical literature, in the "guidelines" of Intensive Care Societies, and sometimes mentioned during legal proceedings.

They probably influenced some end-of-life legislation („Leonetti" Act in April 2005 in France, for example).

In April 2003 in Brussels, a Consensus Conference entitled "Challenges in end-of-life care in the Intensive Care Unit", brought together the five largest Intensive Care Societies in Europe and North America. Faced with the possibility of withholding or withdrawing life-sustaining therapy, the main recommendations were:

• Concerted decision-making involving the health care team (nurses included) and the patient's representatives;
• The possibility of maintaining treatment for a fixed period, in case of conflict:
• It is the attending physician's responsibility to decide on the reasonableness of the planned action.
• Respect for die patient's autonomy, and his possible refusal of treatment;
• Sufficient analgesia... even if this analgesia may accelerate death;
• Respect for moral and legal principles prohibiting treatments specifically designed to accelerate death.

These last three recommendations are consistent with the intuitions of Pius XII.

Prof. Wojciech Rowinski M.D, (Poland)

Ethical aspects and future of transplantation medicine

Imagination is more important than knowledge. Knowledge is limited,
Imagination encircles the world. However... Truth is, what stands the test of time
Albert Einstein

Organ transplantation has become very successful method of treatment of an end stage organ disease. However the waiting list of patients waiting for such a treatment are growing exponentially due to insufficient organ availability. It is often said, that this medical specialty has fallen victim over its own success. Although the longest survivors live like normal family and professional life, many patients, especially those waiting for the heart or the liver transplant die without possibility to be treated.

Transplantation medicine, like no other medical specialty, is connected with a wide range of very difficult ethical issues. Among these are: availability of the treatment, consent for cadaveric donation, allocation of available organs, new categories of living unrelated donors and economic aspects of this method of treatment. All of these issues will be discussed.

Prognosis of the future for the transplantation medicine is truly difficult. Prospect from the past that "induction of tolerance will soon be possible" (1975), wide xenogenic tissue utilisations (2000), fetal brain cell transplantation to treat some neurologic disorders, and transplantation of cells instead of a whole organs proved either wrong or ethically unjustifiable.

The research in the nearest future will focus on induction tolerance and prevention of ischemic changes.

However the development of nuclear reprogramming opens the possibility of obtaining stem cells from the adult somatic cell. This will lead to raising several cell lines (by culture) which might support function of the diseased

organs (heart, liver) or replace it (insulin producing cells).

The new field - regenerative medicine will also create new possibilities. Studies are carried out on hybrid and totally artificial implantable artificial devices...

Let me only hope, our future will be different than described by Aldous tiuxles in 1932 in his novel "Brave new World" in which he described "Bokanovsky process" - making ninety six humans being grown from only one egg where only one grew before. Progress.

Session IV

Xavier Sanz-Latiesas, MD (Spain)

Access to health care: the problem of burden of cancer world-wide

Modern oncology is presenting big advances in cancer treatment. Improvements in surgery, radiation technologies and the constant advances in systemic treatments of chemotherapy or biological therapies, as isolated therapy or in combination, are promising and give some hope to the definitive cure of cancer. Or also can turn it into a chronic condition. Nevertheless enormous differences exist world-wide for access to

the above mentioned treatments. While in the developed world the advances are growing, undeveloped countries scarcely benefit of these treatments or are not applied at all. Many patients are not even diagnosed. And even more, in many cases palliative treatments are not available. In undeveloped countries, infectious conditions have displaced to a second term the problem of cancer detection and treatment. For 2020, having found solution to the most serious infectious diseases, cancer will turn probably into a health problem of high magnitude. With increased life expectancy in poorest countries the burden of cancer will increase and will reach the current rates present in developed countries.

There are limited initiatives to confront the predictable increase in cancer rates and the needs to face to. In many countries do not exist long term health programs to fight against the disease. Some initiatives from institutions as IAEA (program PACT and their Model Demonstration Sites in chosen countries) UICC, IARC and others, are trying to provide the necessary means and organisation models in countries without resources.

As for the societies or specialists'associations in oncology minimal initiatives exist to change the situation, and in the majority are unaware of burden of the problem world-wide.

In present communication a deeper analysis of the situation will be discussed and the needs world-wide will be shown. Specific solutions will be proposed to be added the current ones. Also a valuation will be done from moral point of view according lo the mission of the doctor supported by the social teaching of Catholic Church.

Prof. Jan Borowiec M.D. (Sweden)

Discrimination of old age people in treatment and research investigations

The population of old people is growing in western countries since many years. The expected life length in Sweden is 77 years for men, 82 years for women. Conservative assumptions predict that 65 years-&-over population in USA will grow from 35 million in 2000 to 78 million in 2050 (from 13% to 20% of USA population). Scientific and technological progress also in medicine together with social strategies of welfare state contributed largely to this situation. Aiming at the way to knock at the door of immortality we have reached the stage next to Tithonos syndrome. Instead of meaningful and peaceful years there may be years of anxiety, pain and lack of dignity.

Ageism may be seen in various fields of medicine, e.g. rates of potentially life saving cardiological and/or cardiosurgical have been reported to vary widely by age. Particularly older women are less likely to undergo optimal treatment of their heart diseases. Age has been used as a criterion for participation in many research studies, which led to insufficient material for reliable evidence based treatment guidelines of geriatric illnesses.

In many countries the medical education in gerontology has not achieved similar status as pediatrics. Course in gerontology varies between 19 to 106 hours at Swedish Medical Universities. In USA in the beginning of XXI century there were only 9 000 geriatricians (compared to 42 000 pediatricians) while estimates of the need hovered around 30 000. The concept of "rationing in health care" has been proposed to balance the huge cost of health care in the elderly. In Sweden the pharmaceutical costs amounted to 5 billions Skr in patients older than 75 years (25% of total in 2006).

What are the causes and what are the possible solutions for the medical future of older people? These complex questions will be addressed during the lecture.

Prof. Miroslaw Jarosz, MD (Poland)

Commentary on priorities of the World Health Organization

Priorities of the WHO in the scope of the public health were determined in two important documents: European Charter on Counteracting Obesity (2006), and Second European Action Plan for Food and Nutrition Policy (2007).

Especially the European Charter on Counteracting Obesity is the document obliging all countries of European Region WHO for appropriate action in the area of improved nutrition and physical activity. European Charter on Counteracting Obesity was adopted and signed by the ministers and delegates of 48 countries of WHO European Region. The commitment to strengthen action on counteracting obesity and to place this issue high on the political agenda of the governments was declared. It was also stated that present situation indicates the necessity of immediate action. Also the search for innovation, adjustments to local conditions and new research on certain issues can improve the effectiveness of policies. Moreover it was affirmed that obesity is a global public health problem.

There was acknowledged the role that Charter can play in setting an example and thereby mobilizing global efforts.

In the commentary on priorities of the World Health Organization should be emphasized that the most important problem of public health and the threat for civilization development is the growing overweight and obesity epidemic. Particularly for the reason, that this pathology is increasing at children and adolescents in the dramatic way. The main concepts of WHO will not be solved without complementary and intersectoral

cooperation of Ministry of Health, Ministry of Agriculture and Rural Development, Ministry of National Education, Ministry of Science and Higher Education, Ministry of Finance, Ministry of Labour and Social Policy, Ministry of Sport and Tourism, Ministry of Economy. Therefore we should support the main point of European Charter on Counteracting Obesity that the balance between the responsibility of individuals and that of government and society must be struck. Holding individuals alone accountable for their obesity should not be acceptable.

Tomasz Zdrojewski, MD (Poland)

Comment on the priorities of the European Union in public health for years 2008 - 2013

In the Article 129 of the Maastricht Treaty, the main directions of action for Member States and the European Community in the field of public health were quoted. In the latest documents approved by the European Commission and the Council of Europe, needs for professional and complex activities of Member States were emphasized, i.e. importance of health policy, responsibility of politicians, law regulations, fiscal policy and trade rules.

For communicable and non-communicable diseases (the most important causes of the burden of disease in EU), planning and activities should be based on proper monitoring of risk factors and diseases, identification of factors (incl. socio-economic differences) which influence effectiveness of prevention and therapy, adequate quality of care and equal access to health care. In the European Heart Charter of 2007 multi-factorial pathogenesis of cardiovascular disease and resulting from this fact need for addressing all risk factors in modern prevention was underlined. The health promoting and preventive measures should be started in childhood. In the Decision N° 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health for years 2008-13, the authors state that good societal health is an important condition for economic productivity and welfare. Expenses for healthcare are not only costs, but also important investments. The actual charges (direct and indirect costs) result from poor health and lack of adequate investment in health area. Seven leading risk factors - tobacco, alcohol, high blood pressure, high cholesterol, overweight, low fruit and vegetable intake and physical inactivity - account for 60% of tlie Disability Adjusted Life-Years. Thus, Member States and the Community should place emphasis on improving the health condition of children and young people and promoting a healthy lifestyle, and a culture of prevention among them. The priorities should be also given to reduction of health inequalities, development of risk management capacity and promoting preventive procedures. The newest European Parliament and the Council Programme should be recognized as a clear guide for health policy in the region. Even though the Commiinii.y fully respects the responsibilities of Member States for the organization and delivery of health services, an adherence to these recommendations should be treated as medical, social, economic and ethical issue.

Session V

Fr. Prof. Eberhard Schockenhoff, PhD (Germany)

Connection of human dignity and the protection of life

The lecture wants to show the connection between human dignity and the protection of life. Physical life is not only a better good, which the human person is able to use like a tool but it is rather the existential basis for all manifestations of human life, for their mental acts and intellectual abilities. Therefore the respect for human dignity, which qualifies one for freedom and autonomous lifestyle, has to include the protection of physical life.

The principle that human life deserves respect, support and welfare from its beginning until its death is not only a religious demand but also an expression of a democratic culture wilh mutual acceptance.

Prof. AIicja Grzeskowiak (Poland)

Objection 0f doctors'conscience in reference to human life issues

The right to object doctors'conscience in reference to human life issues arises from the conflict between the duty to observe the established law and moral duty depended on human conscience. This conflict might be solved thanks to the institution of human conscience objection based on the rule to give the right to individual behaviours which are in agreement with human conscience but opposed to legal regulations.

The question of refusal to perform certain duties, ordered by law because they are in oppostion to the conscience of the person obliged to do it, has achieved special topicality in certain professions. It is mainly the profession of the doctor as its mission is to save human life and health. Doctors make decisions which are ethical concerned with the beginning or end of human life. its dignity and privacy. In those decisions there are many conflicts between the conscience and the law. The law should not force a doctor to perform actions which are against the nature of its profession, especially to act against human life. However, it is

becoming to do so. The profession of the doctor now includes actions which are not to cure a patient for example abortion, euthanasia, contraception, sterilization, pre-abortion diagnosis, fetus selection. The list of activities, according to law, to be done by a doctor, which might cause the conflict of the conscience is becoming wider as a result of the bioethic development, supported reproduction. It is getting to include wider spheres of doctors' professional actions such as for example organ transplantations, research experiments, biotechnology or genetic engineering.

The new reason for the right to object doctors'conscience in many countries was given by the legalization of the trade ofpostcoital contraceptives, mainly those contraceptives which prevent the implantation of the egg and in result have abort ifacient effect. Another problem is the participation of a doctor in perform ing capital punishment using so called fatal injection. The majority of legally binding doctors' duties are contradictory to moral values and that made it necessary to guarantee the institution of the conscience objection so that doctors would not be leaglly bound to perform duties which are against their conscience.

On the other hand, however, the basic human law includes the right to free conscience and that should guarantee doctors the right to object their conscience. Doctors' deontological codes include such clauses, nevertheless in common law it is very frequent to disrespect the right of doctors to refuse to perform actions which are against thier conscience. Doctors refer to the conscience clause more and more often and this fact causes the campaign against this institution, the conscience clause has got new subject and object limits, distorting its sens. Moreover, there are voices to abolish the conscience clause beacuse it is contradictory to patients rights.

Considering the problem of conscience objection it must be accepted that in the situation when the law is not based on moral values the right to doctors' conscience objection must be quaranteed.

Fr. Prof. Erwin Bischofberger, SJ, PhD (Sweden)

The concept of autonomy in relation to the euthanasia discussion

Autonomy is the main moral principle invoked by the promoters of euthanasia. The concept of euthanasia is here defined as a physician's intentional termination of a terminally sick and severely suffering patient at his or her demand. This definition has been adopted by the National Medical Ethics Council of Sweden. This paper is going to focus on tile essential moral ground of euthanasia, i.e. the autonomy of the patient. The definition of euthanasia implies the selfdetermination of the human person over his life and his death. If a patient freely and consciously demands a lethal drug injection the health care system would have to comply.

This concept of autonomy is, however, not safe against questioning inquiry, for the following reasons:

1) The right to euthanasia is based on the individual's right to autonomy. The problem is that the former right must not logically follow from the latter right. In other words: An autonomous person may (with some distinct exceptions) refuse all medical treatment but not demand a certain treatment.

2) One may suppose that the decision about euthanasia is part of the unique relation between the patient and his/her doctor. If a patient suffering from incurable cancer is asking the doctor for a lethal drug and the doctor is willing to correspond to this demand many reasonable persons would support such a treatment. But there is a problem. May it morally be justified to dispose of and even own the life of another person?

3) An example may clarify the problem. Slavery is forbidden today. This prohibition is based on the moral insight that a certain person cannot take possession of another person, not even if he/she expressively aks to be owned by somebody else. Why is it morally not defensible to become another person's slave inspite of the autonomous desire to do so?

4) The well founded responsibility for each other has to do with the personalistic concept of the human person as a bearer of social obligations and binding agreements. It is based on the conviction that we must not kill anyone inspite of the fact that we are asked to do so. Behind and above autonomy we find the innate and inhering dignity of each human person.

Euthanasia is not a solution to human pain and suffering, it is rather a capitulation. A well established palliative care system seems to me to solve the requirements of the health care system and of the autonomy of the patient.

Prof. Stephan Sahm, MD (Germany)

Medical acts at the end of life: attending the dying to preserve humanity versus euthanasia

End of life issues are discussed throughout Europe with increasing intensity. So far only a minority of countries have liberalised acts of active euthanasia such as the Netherlands. Nevertheless, this may change, e.g. in Germany an outbreak of the debate has just recently been prompted by a former senator of justice of the city of Hamburg who has assisted an old lady in her suicide.

Laws that permit acts of euthanasia had been called a break of the legal tradition of continental Europe. Yet, those who argue in favour of liberalising active euthanasia, i.e. to kill patients, force us to discuss it. The taboo not to kill patients which is to preserve can maintained only if reasonable arguments can be brought forward that buttress it.

With respect to motives to care for the sick and to uphold humanity in medical care religious doctrine are without alternative. Here Catholic teaching has its role that cannot be displaced by reference to reason alone.
In order to protect dignity of death against euthanasia it is the task of all those who care for patients at the end of their lives to present an argument that is comprehensible by reason. This is mandatory on order to have the voice heard in the public domain.
Many of the authors that promote active euthanasia as an act of mercy refer to a weak point in current concepts that describe medical acts at the end of life. In particular the concept of passive euthanasia seems to be misleading in many ways. Empirical research as well as well as philosophical analysis show that it is blurring. Proponents of active euthanasia often base their argument on this fact. Hence, clear cut concepts are needed in order to reject active euthanasia consistently, in particular with respect to morally justified acts of forgoing treatment at the end of life.
An alternative concept elaborated by the German Medical Council in its pertinent document will be discussed: instead of passive euthanasia the notions "limitation of treatment" and "change in the treatment objective" is used.
Based on this concept arguments brought forward by proponents of active euthanasia, i.e.
i) as justified by reference to patients'autonomy and
ii) by invoking a state of medical exigency, can be consistently rejected.
Hence, it is shown that active euthanasia is a fundamental break of the commandment not to kill.

Fr. Dr. Piotr Krakowiak, SAC, PhD

Hospice is life, too. cooperation of health care professionals, the Church, volunteers and media as a response to the growing needs of ageing Europe

The medieval idea of the hospice was revived and rediscovered in 1960's by Cicely Saunders in the UK, Elisabeth Kubler-Ross in the USA and Mother Theresa in Calcutta. Experience of hospice care in Poland teaches that cooperation between The Church, the health care system and the voluntary service can effectively improve the situation of terminally ill through joint action. The mass media, playing a key role in cultural and social life, can be helpful in educating the pub! ie about ways of helping and changing situation of terminally ill, as proven by the recent experience of the hospice movement in Poland.
History of Voluntary Work in Hospices in Poland will be presented with the stress on Solidarity and cooperation of the Church and health care professionals in difficult time of transition. The meaning of spirituality in Hospice Care and active participation of the Church in Palliative Care in Poland will be presented. The role of public education regarding the end of life issues will be described as a joint action of hospice movement and the Church through pastoral and media activities, such as "Hospice is Life, too" national educational campaign. Appeal and encouragement for hospice volunteers will be presented as one of the human and Christian vocations for the society and for the Church. Then the origins, development and further steps on the national program of development of hospice volunteer service "Lubie pomagac - I like to help" will be presented, as an existing agenda of helping ageing society in caring for terminally ill. At the end the innovative and controversial yet effective program of re-education of prisoners through voluntary service for the terminally ill in hospices will be presented. "Sentenced to care - prisoners in hospice" program and its future will be presented as a way to search new methods to help those in need.

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Action of the catholic physicians to the challenges of the family institution in Lithuania

Aim: We are clearing existing challenges to the family institution against the penetration of the processes of globalization and to define the actions of Catholic physicians to them.
Method: Based on Christian values, FIAMC and FEAMC decisions, we are evaluating the family institution, relationships between them and Catholic physicians, also their contribution to create new laws to protect the family institution.
Results: Moral values of our Nation were destroyed tremendously during 50 years of the Soviet occupation. Moral diseases together with the process of globalization, also culture of death during occupation, were disclosed after restoration of Independence 1990.03.11. As a result of it family is going through crisis. The divorce rate was only 0.5% before WWII. As of today it has reached 70%. Marriage is becoming less popular; more people are choosing to live together without the sanctity of marriage. Aggressive homosexual behavior and self advertisement are becoming wide spread. Into this process, very actively are penetrating EU recommendations and decisions related to the family and other issues: abortion, in vitro fertilization, homosexual "couples" legalization, permission for them to adopt and etc. 53% of married couples are getting divorce, about 10 000 children are left without fathers; There is very low rate of birth - only 1.3 (32 000); 13 726 abortions were performed and 8 979 children were born out of wedlock in 2007. Catholic

physicians can influence above mentioned processes with their own personal life, by counseling and being supportive of their patients, participating in discussions about new laws related to the family institution. In order to achieve a stronger voice, they must participate in physician Catholic organizations (Lithuanian Catholic Academy of Science, "For human Life" Lithuanian association), being active in educational policy.

Conclusion: Challenges to the family institution are: declining spiritual values of society; the essence of marriage and family life is totally misunderstood; young individuals arc not being prepared for family life; fear of family life's duties and responsibilities; sex cult which is followed by culture of death; culture of life is not supported by the government. The duties of Catholic physician's are: to explain to patients about the dangers of all moral diseases and their effect on their family's successful life; responsibility to treat not only physical but moral diseases too; to influence the government to issue and approve laws which can protect the family institution; to fight for the culture of life; to join organizations that support the same ideas and values in order to achieve better results; to participate in educational activities against moral diseases.

Prof. Alina Shaulauskiene, MD (Lithuania), Janina Tartiliene, MD, PhD, Dalia Bartkevichiene, MD, PhD, Danielius Serapinas, MD, PhD

The situation of life protection from its beginning to natural death in Lithuania

The Law Code calls: *Choose life, then, that you and your descendants may live. Every day choose life!*

The relevance of issues of human life from its conception to natural death is obvious - slow self-annihilation of the ethnic communities of the European nations, including those of Lithuania, is threatening. Since 1955 to date, the Order of the Health Minister has been in effect in Lithuania, legitimising legal artificial surgical abortions by the choice of the woman till the twelfth week of pregnancy. The draft Law on the Protection of Life in the Pre-Natal Phase, worked out by the proponents of life, has been recently submitted to our Parliament (2008-02-08).

With liberal and social democratic parties prevailing at the Parliament, there is little hope that this law will be passed and the commenced life will be safe from its conception. Positive attitudes are reflected only by the Catholic press, public Christian-approach organisations, the Church.

Over the last of the 17 years of the restored Lithuanian independence (from 1991 to 2007), the number of births in Lithuania has dropped almost two times (from 852 269 to 422 491). The number of artificial voluntary abortions has decreased even five times over the same period (from 40 786 to 8 781). Due ro abortions, Lithuania has lost 364 123 of its future citizens over the seventeen years of the restored Lithuanian independence, and the size of the total Lithuanian population has been lost over the last fifty years. 133 mothers died as a result of abortions during this period of time. The Order of the Lithuanian Health Minister allows in vitro artificial fertilisation. This profitable service is offered in private medical clinics, as the state still lacks funds to acquire expensive medical equipment, although this is being discussed.

The Parliament of the Republic of Lithuania has rejected the Draft Law on Medical RU-486 (Mifepristone) Abortion. The fight over sexual education programmes in schools is quite intense in Lithuania. Liberal approach proponents have been losing so far. Euthanasia is not legitimate is Lithuania. Palliative medical care is inadequate. There are several pain clinics, the Mother and Child Home, critical pregnancy centres. The graduates of the Kaunas Medical University take the Hippocratic Oath, renewed on the initiative of the Lithuanian Doctors'Association "For the Sake of Life" in 1998. The overriding precept of the oath is to protect every human life from fertilisation to natural death.

Those who can live shall be given birth and live, as this is the most sacred inherent right of every individual.

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