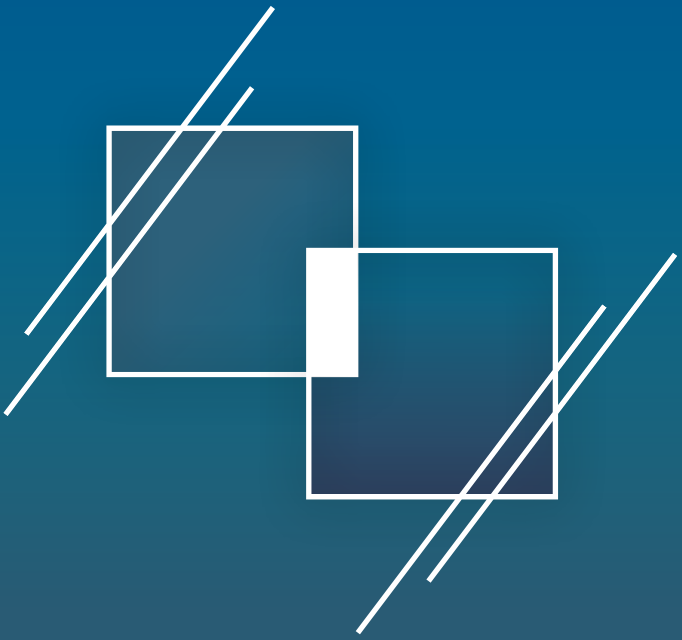
DRAŽENKO TOMIĆ

Bioethical miscellany



University of Zagreb
Faculty of Teacher Education

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Contents

4. BIOETHICAL MISCELLANY

Preface

The book *Bioethical Miscellany* presents some bioethical topics, i.e. some (ethical) dilemmas from everyday dealings with (human) life and (human) environment. The nexus of all topics is the possible endangerment of (human) dignity, the quality of (human) life and even the proclaimed level of (human) rights. The book is part of a project that presents bioethical topics from the professional quarterly journal *Glasnik Hrvatskog katoličkoga društva* (*Journal of the Croatian Catholic Society*), which has been published by the association of the same name since 1991 (see Tomić, 2021a,b). Until the publication of this book, topics dealing with the issues of relationships toward children and childhood were researched (and published). Also, other articles have been published (or are in the process of being published), as stated below.

Some topics covered in this book may be the subject of a more detailed inquiry within the obligatory university course *Ethics* or elective courses dealing with bioethical issues. It is assumed that the material is presented in a way acceptable to humanist-minded individuals of all worldviews.

The first chapter of *Bioethical Miscellany* discusses ethics in the (natural) environment, wherein topics related to genetics and cloning are covered. Some topics of the second chapter deal with the contact areas between ethics and psychiatry, with a particular emphasis on psychiatry itself and society's attitude towards people with mental disabilities. Some topics of the third chapter deal with the issue of the end of human life, such as determining the moment of an individual's death, the vegetative state, palliative care and organ donation or transplantation. The last chapter brings together different topics: addiction, suicide, discussions about HIV, demographic challenges, the Hippocratic tradition and the appeal of conscience among medical professionals. The cited literature is listed after each chapter for more straightforward navigation. Three hundred forty-five different papers have been cited.

Readers should note that all the quotations in this book are from Croatian sources, i.e. from translations of original Croatian texts into English, so no original quotations were used.

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1.

ECOETHICAL TOPICS

Care for the Preservation of the Environment and Biodiversity

Environmental responsibility towards future generations implies rational management of natural resources. However, some phenomena are still worrying. Based on the fact that there is no quality human life without a quality environment, Host (1995) concludes that it is necessary to reduce environmental pollution, preserve and restore the ecosystem and respect cycles and balance within individual systems. In addition, it is necessary to pay attention to a community's cultural values, control research in the biomedical field, particularly genetic research in food management, and encourage education for environmental responsibility towards oneself, others and the environment. Host lists some points of concern:

> ... pollution of the environment (land, water, air); reduction of natural resources; demographic expansion in developing countries associated with severe economic, political and social problems; disobeying inherited moral principles, mostly under the influence of the mass media; uncontrolled research in all biotechnological disciplines with the possibility of developing new, potentially hazardous, forms of life for humans. (1995, p. 54)

By quoting Wojtyla, Host (2003) asserts that caring for the environment is a sign of hope for the survival of this world.

Ecological and sustainable food, fibre and energy must be one of the imperatives of sustainable development. Šerman (1995) states that "sustainable agriculture" means insisting on the conscious use of environmental principles in creating self-sustaining ecosystems. In this sense, it is necessary to encourage organic agriculture, the so-called "technology without digging", solar technology and the development of polyculture instead of the currently prevailing monoculture technologies. The principles of "sustainable agriculture" aim to ensure that more energy is produced than consumed, the soil is not wasted, nutrients are circulated and local food needs are met. At least part of the above can be achieved by intelligent landscape and crop design. Permaculture ethics are based on caring for the Earth, caring for people and sharing fair shares with all. "Care for the Earth" implies the preservation of the remaining polyvalence and biological diversity on Earth, "caring for people" means creating settlements for real human needs and "fair shares for all" means adjusting consumption to human needs and not to greed. Šerman (1995) concludes that these efforts would preserve the habitats of other species, provide enough food for people experiencing poverty and preserve an unpolluted Earth for future generations.

Adequate disposal of medical waste is one of the aspects of caring for the environment. Šmalcelj (1994) claims that large amounts of health products that medical institutions produce daily (medicaments, radioactive substances, disposable natural or synthetic materials, etc.) can significantly pollute the environment, and the same author reflects on the disposal of this waste. As reported by Vukšić (2012b), Vrček has asserted that pollution of surface and underground waters by medicaments and their degradation products is still present, and the consequence of the mass consumption of medicaments is their uncontrolled release into sewage and wastewater. Water quality checks indicate increased amounts and types of medicinal substances, which can disturb the ecological balance. Water pollution by medicaments in the Republic of Croatia was not regulated by law at one time, so some legislation on the dispensation and consumption of medicaments would also be desirable. Consultations were held on the disposal of old medication (Adon, 2021d). The following options for disposal or destruction are mentioned: incineration (in cement plants), pyrolysis, injection into oil wells and other technologies or disposal options such as export (Plavšić, 1995). At one time, the danger of plastic was highlighted not only as waste but also as a source of hormonal toxins. As reported by Vukušić (2013b), Vrček claims that all plastic is more or less a source of endocrine disruptors and that, in contact with food or drink, some types of plastic release the hormonal poison bisphenol. It happens in concentrations that can cause health problems.

Plavšić (1995) states that substantial amounts of donated material arrived in Croatia during the war and post-war years. About 90% of the donations met all the European quality criteria. The first "donation waste" came from small donors who, in good faith, collected aid for Croatia in various ways. It is also possible that some donors wanted to eliminate excess goods and avoid their country's high waste disposal costs. Plavšić enumerates:

> *medicines* (old, unusable, problematic composition, registered in countries with mild legislation, etc.); *medical products* (non-sterile or low-quality materials, incompatible equipment in Croatia, outdated products, incomplete materials, e.g. for diagnostics, etc.); *chemicals* (expired, unusable, prohibited for use due to chemical composition, etc.); *equipment* (old and defective, scrapped, incomplete, incompatible with other equipment, without service support, etc.); *foodstuffs* (with an expired date of use, unhealthy, inappropriate taste or composition for the local population, poorly stored and transported, in inappropriate packaging, etc.); *other*, such as fabrics made of mixed fibres, problematic packaging, etc. (1995, p. 35)

He states that in terms of donation waste, the best studied are donations of health materials, especially medicines, where medicaments with an expired date of use make up the most significant part of those unsuitable. The author describes in detail the efforts to dispose of expired medicines. Šaler and Glavina (2006) write about the participation of pharmacists in the classification, processing, registration and distribution of medicines from donations.

Wojtyla has concluded that the ecological crisis exposes man as a ruthless exploiter (acc. to Host, 2003). The ecological crisis is a moral problem rooted in disrespect for life. Ružička (2004b) writes that the solution to the problem of environmental pollution through the interaction of natural sciences and the humanities is a contribution by Pozaić's anthology *Ecology, Scientific-Ethical-Theological Questions and Horizons*. Among other things, the collection elaborates on environmental protection, ecology in forestry, sustainable development, encouraging nature protection, ecoethics, co-responsibility in environmental protection, conventions on nature and environmental protection.

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Genetically Modified Plant Organisms

Želježić (2006) writes about genetically modified organisms in food, their production, detection and dangers. The author states that antibiotic-resistant tobacco was produced in 1983, and a delayed-rot tomato about ten years later. At one time, the largest manufacturers of GM food were the USA, Argentina, Canada, Brazil and China, followed by the Republic of South Africa, India, Spain, Mexico and others. Genetic modification was used to make plants resistant to herbicides and insects. The expectations from the second generation of genetically modified plants are:

> increased resistance to stress (drought, frost, salinity), changed developmental characteristics (male sterility, reduced susceptibility to rotting, accelerated growth, nitrogen fixation), changed nutritional composition (more protein, composition of fats, more fibre and vitamins), synthesis of pharmaceuticals (vaccines, hormones, enzymes), production of industrial raw materials (biomass, lignin, plastic) and bioremediation (soil decontamination). (Želježić, 2006, p. 14)

Obtaining genetically modified plants requires much knowledge and specialised equipment. The very method of detecting genetically modified organisms in food is very complex. It is done through tests based on the polymerase chain reaction (PCR technique). It determines the presence of DNA inserted into the plant. Želježić (2006) warns of some difficulties: consumption of food originating from GPO causes fear of allergic reactions, a possibility that introducing new genes into plants will increase their toxicity, genetic markers in genetically modified food increase the resistance of bacteria to antibiotics, insects resistant to toxins appear, GP plants could disrupt the existing balance in the ecosystem during pollination and the formation of new plant strains.

Genetically modified food products can have a negative impact on the environment, claims Jošt:

> Biotechnology thus wants to incorporate genes into some agricultural plants that would increase the yield, which should provide the world with more food. Likewise, by inserting some genes, agricultural plants would be protected from the effects of pests and thus reduce or eliminate the need to use insecticides and pesticides that are harmful to health. (acc. to Ružička, 2002, p.2)

None of the outlined goals have been achieved – due to social injustice concerning its distribution, food is still scarce in certain parts of the world, the unnatural protection of plants has disturbed the ecological balance and genetic engineering has created some new proteins that humans are not used to, which causes allergic reactions. Despite this, the profit frenzy inevitably leads to the ever-increasing production of GMO food. Engdahl's book *Seeds of Destruction* focuses on geopolitics and genetically modified food (acc. to Peraica, 2006).

Šerman notes new methods of genetic modification of foodstuffs. He presents the results of several studies on changes in biodiversity due to genetically modified crops and modern food production (2006, p. 6). He has stated that at the end of 2003, Great Britain concluded a four-year study on the ecology of agricultural areas under genetically modified rapeseed, sugar beet and maize. The project involved monitoring the diversity of animal species that survive under realistic conditions of herbicide application for the three mentioned genetically modified plants. The researchers visited 283 experimental fields and collected and analysed one million plants, 750,000 seeds and one and a half million invertebrates caught in traps and suction devices. It has been found that modified crops and herbicides can dramatically affect the fauna of agricultural land, which proponents of invasive food production will have to consider. Continuing the article, Šerman (2006) writes about organic food production. The article indicates an increased interest in, for example, composting and soil biodiversity.

At the end of the 20th century, numerous authors announced a new biotechnological revolution thanks to GMOs. However, according to Vukšić (2013), who reports Vrček's claims, only two of the numerous patents that have appeared since then have achieved commercial value. According to Vrček, the GMO crop production industry is advocated mainly by multinational companies because of the enormous profits. The disadvantage of using modified crops is an additional burden on the environment due to using more chemicals and reducing biodiversity. Crops resistant to herbicides (containing glyphosate) raise concerns about the alleged development of tumours. Unlike the US, Europe resists GMO crops as a precautionary measure. Croatia also follows EU legislation, although the law still has many loopholes.

Jošt (1999) deals with the horizontal transfer of genes and the possible consequences of this process in an exhaustive article accompanied by a significant amount of literature. Research in mutational, population, quantitative, human, prenatal and molecular genetics is significant. There are numerous benefits in agriculture, such as creating new varieties of cultivated plants, domestic animal breeds, cytogenetics and others. The author defines genetic engineering (recombinant DNA technology) as a change in the genetic structure of a living organism by transferring the hereditary basis between unrelated species of living beings. He claims gene manipulation can take on terrifying proportions and escape human control. Moreover, while atomic waste loses power over time, genetic waste multiplies and spreads by itself, and its power grows. He notes with regret that the achievements of genetic engineering in the race for profit advance much faster than human conscience and responsibility. The possible consequences of genetic engineering are the additional narrowing of biological diversity and the already small number of plants necessary for human nutrition in favour of a few economically profitable genetically modified species (maize, rapeseed, potatoes and soybeans). The appearance of superweeds is also possible. Moreover, Jošt claims that today genetic determinism is considered a big fallacy.

> The expected effect of horizontal gene transfer is based on a misunderstanding of what genes are and what they can do. As a rule, a gene controls the expression of several phenotypic properties (pleiotropic gene effect). Also, one property is often determined by the action of several genes, the expression of which depends on a series of external (environmental) conditions. (1994, p. 24)

Furthermore, he points out a marked increase in antibiotic resistance:

> In reality, the occurrence of new virulent pathogens and the spread of antibiotic resistance are just some of the changes caused by the horizontal gene transfer favoured by genetic engineering. It is believed that the appearance of new strains of bacteria is the result of such activity... Although natural vectors for gene transfer have always existed, especially in the world of microorganisms, they were specific for the host, so the transfer occurred mainly between individuals of the same species. Accordingly, genetic engineering opened the way for the horizontal transfer of genes in a way that nature had not known until now. (1999, p. 27)

Želježić does not dismiss the difficulties mentioned above in using GMOs but reminds us that

> such ardent opponents of the use of genetically modified crops in human nutrition are not bothered by the use of pharmaceutical products obtained by growing genetically modified microorganisms. At the same time, they condemn scientists when they try to breed plants with recombinant DNA technology, and they accept the fact that the production of insulin and somatostatin

> is achieved using genetically modified bacteria, that GP microorganisms are used in the purification of industrial wastewater before it is released into the environment. (2006, p. 15)

Despite all of the above, one should be realistic.

> In today's world of population growth, limited and unevenly distributed resources for growing food, GP plants seem to us to be an inevitable future. It is impossible to deny the advantages of such plants over conventional varieties. However, it is equally true that every advancement in technology, in addition to numerous benefits, also brings a certain danger. In the case of GP plants, it could affect human health and the environment that surrounds us. In order to minimise all potential dangers, it is necessary to adopt understandable and well-worded legal regulations related to the production, cultivation, transportation and placement of genetically modified organisms on the market. It is necessary to ensure the unquestioning implementation of these regulations. In order to preserve human health, before releasing new GP organisms on the market, it is necessary to carry out comprehensive toxicological and allergy tests on them and ensure an independent assessment of their risk to the environment and humans based on scientific facts. (Želježić, 2006, p. 15)

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1.3.

Ethics in Genetics

In 1986, a project began whereby it was planned to reconstruct the complete human genome in 10 years. It was predicted that it would be necessary to determine the sequence of about three billion nucleotides containing all the genetic information. This would enable the identification, localisation and research of the expression of 50-100,000 genes, which represent the complete human inheritance. The advantages are the possibility of diagnosing and treating (gene therapy) various hereditary diseases (Host, 1995b; Adon, 2021j; Pozaić, 2001). Transgenics, addition, replacement or inactivation of genes in the genome can be applied in food production, production of animals with organs suitable for human transplantation, experimental animals and others (Richter, 2000). Chastand-Maillard claims that

> potential risks also exist for both the transgenic animals themselves (short life span) and for humans; for example, the danger that some pathogenic agent will be transferred with the transplant. The danger of transgenic food is negligible in practice. However, there is a danger that transgenic species will spread from cultivation into the wild, where the consequences cannot be monitored. (acc. to Richter, 2000, p. 41)

The risks concern the reliability and availability of tests, their imposition under certain conditions, the individual's autonomy and rights, and the right of access to such personal data as the genetic code (Pozaić, 2001). Some issues concerning genetic testing arise: will it be a *service* or a *judgment*; the question of hereditary diseases; the role of gene therapy in forensic medicine and criminology, and with insurers; the issue of genome patenting and the right to information; genetic manipulation; the possibility of "genetic racism" (eugenics) and others (Švajger, 1999; Brkljačić, 2006; Adon, 2005a). According to Ružička (2000), Mattei cites marginalisation, more challenging conditions for obtaining a job and difficulties in health and life insurance, while Švajger warns us about the application of genetic tests in the judiciary, the protection of privacy and human dignity (e.g. proving inheritance rights), and insufficient legislation on that area. The Ethics Commission of the USA warns of the possibility of misuse of genetic information and the necessity of a guarantee to preserve patients' privacy. They believe that information about genetic predispositions can negatively affect offspring (Adon, 2013c). Along with the research on the human genome, Osswald (1999) points out the challenges of genetic engineering, which can significantly change the inheritance and establish an already embedded inequality among people. According to Vrsalović (1999), Bolund also points to the danger of genetic engineering. The fear of preimplantation genetic diagnosis of embryos created by *in vitro* fertilisation to remove those with a genetic defect has been expressed (Adon, 2004).

Reviewing the ethics in molecular diagnostics, Božina (2009) claims that genetic testing and screening are used more and more significantly in health care and occupational medicine, which contributes to the improvement of general health. Significant ethical, legislative and social questions also arise:

> Should genetic testing or screening be permitted in any situation without consent? Should genetic screening be performed without reliable and accurate diagnostic tests? Should genetic testing or screening programs be mandatory or voluntary? How can health professionals obtain, use or publish genetic test results without violating the privacy rights of an individual or a group of test subjects? Is the genetic information obtained by a

> test 'special' or in any way different from other health data, and therefore, does it require increased privacy protection? (Božina, 2008, p. 10)

Božina also cautions us about the limitations of genetic testing: the impossibility of identifying every gene change or determining a complex interaction of genes and the interaction of genes and the environment. Genetic tests detect certain tendencies in an individual, while genetic screening identifies the degree of genetic diseases or conditions within a specific subpopulation. With the availability of a reliable test as a precondition, it is necessary to clearly define the criteria for carrying out genetic screening regarding:

> **1)** accurate definition of the risk population for targeted testing, **2)** the choice of mandatory or optional methods, **3)** the access to the screening program, **4)** an effective and available treatment procedure for the condition under investigation, **5)** a well-designed screening program to achieve the set goals and **6)** the public's desire and debatable obligation to accept the program. (Božina, 2008, p. 12)

Božina reiterates by drawing our attention to genetic exclusivity, which suggests that genetic information is unique and requires protection: genetic information remains mostly permanent throughout life; the genetic imprint is recognisable; genetic traits are inherited and can be compromising for family members and offspring; genetic information can also reveal some predispositions and personality traits.

According to Pozaić, ethics will have to pay more attention to the achievements of positive sciences, while scientists will have to pay more attention to the whole of man: "All human endeavours and achievements have their justification in the authentic well-being of man" (2001, p. 17). Ratzinger (2006a) points out that human dignity cannot be identified with the genes of human DNA nor diminished by the possible presence of physical differences or genetic defects. In order to avoid abuses, efforts were made to protect the human genome legally, which was already at the end of the 20th century. Personal genetic code is sought to be protected from misuse in personal insurance and employment procedures. This data is not protected in the family environment (discussions about paternity and the like), except when it concerns a third person as a gamete donor, where the principle of anonymity applies. Any manipulation of human genes to alter the offspring is prohibited, except for medical purposes (Richter, 1995). In America, a law was passed in 2009 that protects workers from coercion by employers or health insurance to undergo genetic testing (Adon, 2009l).

Eugenics includes methods of eliminating unwanted and improving desired hereditary traits of human and animal individuals. The subjects of discussion are the concepts and practices of eugenics, the possibilities of genetic intervention, the improvement of the individual and the species and the scientific basis of pathology with a genetic component. According to some opinions, "selective" eugenics and "improvement" eugenics can question human dignity, contradict ethical and cultural concepts, and, as a social orientation, represent a risk. Lombardo claims that eugenics is generally a pejorative term today (acc. to Zurak, 2009). What is the term eugenics today, and whose behaviour can be safely qualified as "eugenic"? How does the development of science, medicine and technology, which is both promising and frightening, force us to ask ourselves if the new practices are similar to those done in the name of eugenics years ago?

> Fitzgerald points out a tendency in which genetic selection and/or genetic engineering programmes aimed at potential benefit in the spirit of negative eugenics (removing the genetic basis of disease) predominate, and a less positive eugenics approach aimed towards genetic improvement or the selection of certain human characteristics based on community expectations. Health care experts firmly believe that the future is in the so-called 'personalised medicine', where the adjective 'personal' includes unique genetic and molecular aspects of individual physiology starting from the molecular biological levels to the levels of interaction of the individual with the community and the surrounding environment. By analysing the genome, it will be possible to predict the tendency towards certain diseases for their prevention, while determining chemical markers for diseases will

> enable rapid medical interventions. In this vision of a ‘happy’ health future, there will be a system of electronically stored health data for each person, thus enabling the necessary personalised treatment. Regarding this concept’s social, political, economic, ethical and theological implications, Fitzgerald points to the need for an anthropological and philosophical approach and correction. (Zurak, 2009, p. 51)

Regarding the same problem, Keown states that although today eugenics is justified more by emphasising free individual choice than through state intervention, the distinction between individual choice and state intervention is, in any case, problematic (Zurak, 2009). Ratzinger (2009) praises the outstanding achievements in genetics, especially in the prevention and treatment of diseases:

> The efforts of researchers in these most enigmatic and valuable areas require special support; for this reason, collaboration between different sciences must be present at all times in order to achieve effective results and, at the same time, authentic progress for all of humanity. This complementarity makes it possible to avoid the risks of widespread genetic reductionism, which tends to identify a person exclusively within the framework of genetic information and interaction with the environment. (2009, p. 27)

He emphasises that a person is always more than the sum of their parts, more than a unique combination of genetic information passed down from their parents. He warns of the possibility of eugenics and the tendency to prioritise effectiveness, efficiency, perfection and physical beauty at the expense of other life dimensions that are considered unworthy.

> Equal dignity of every human being derived from the very fact of being born must be strongly affirmed. A person’s biological, mental and cultural development or state of health must never become a discriminating factor. In contrast, it is necessary to strengthen the culture of acceptance and love by showing real solidarity towards those who suffer and thus break down the

> barriers that society often erects by discriminating against those who are helpless or afflicted with disease or, worse, by choosing or rejecting life in the name of an abstract ideal of health and physical perfection. If the human being was reduced to an object of experimental manipulation from the earliest stages of their development, it would mean that biotechnological medicine has surrendered to the will of the stronger. Trust in science must not be a reason to forget the primacy of ethics when it comes to human life. (2009, p. 28)

The patenting of the human genome is being questioned (Richter, 1997). Patenting itself will encourage the development of therapeutic and diagnostic procedures in the private sector and the emergence of commercial research in the basic sciences. On the other hand, some fears are also related to patenting: patent royalties will raise the prices of genetic material; interest gathering of producers and monopolisation of production will occur; public health laboratories and non-profit laboratories will be left behind; the free exchange of scientific knowledge and discoveries will be limited; "ownership" of the common good will appear; commercial companies will possibly hijack the last stage in the research chain and apply for a patent without mentioning previous contributions, etc.

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Cloning

1.4.

The authors who present on this topic define the term *cloning* as the identical reproduction, generation or creation of one or more cells genetically identical to the original individual. The American Presidential Council on Bioethics defines the related terminology:

> *Cloning*: a form of reproduction that does not arise from the accidental joining of an egg and a sperm cell but by the conscious repetition of the genetic content of another individual; *human cloning*: asexual reproduction of a new human organism that is always genetically identical to another existing or previously existing human being – this human organism is created by the transfer of the nuclei of somatic cells; *reproductive cloning*: the production of a human cloned embryo to achieve pregnancy; *biomedical research cloning* [refers to: *therapeutic cloning*]: the production of a human embryo for research purposes; *cloned human embryo*: a) human embryo created by somatic cell nuclear transfer (SCNT), b) immediate product created by the cloning process. (Lochner, 2005, p. 25)

Similar to the above, Pacholczyk (2005) defines reproductive cloning as a procedure by which the nucleus of a body cell is introduced into an egg cell, and the cloned embryo is identical to the body cell donor.

Therapeutic cloning is defined as a procedure identical to reproductive cloning, except that instead of embryo implantation, it serves to collect stem cells for donor therapy.

1.4.1. Human Cloning Attempts Cloning of the Sheep Dolly (Dolly the Sheep)

At the end of 1993, it was announced that a human embryo had been cloned for the first time. It was done by a team of scientists led by Jerry Hall, director of the Laboratory for In Vitro Fertilization and Andrology at the George Washington University School of Medicine in Washington. Švajger (1994a) claims that the news became a sensation at the same time the media began to analyse the ethical implications of experiments on human embryos. From the point of view of the biology of reproduction and embryonic development, Švajger recalls the results of research from the 1960s when it was possible to separate mouse blastomeres and obtain healthy cubs. Applying this knowledge to humans only required improving technology (and putting the conscience to sleep). Švajger adds that Hall and his team repeated the described procedure, only they used human embryos. This experiment is not actual cloning because actual cloning involves growing a cell isolated from an adult organism. This experiment does not involve the transfer of a cell nucleus into an unfertilised egg cell nor introducing new genes into the existing genome ("genetic engineering").

Švajger (1994a) does not deny the value of scientific knowledge about the developmental omnipotence of the first blastomeres in human embryonic development. This should satisfy true and positive scientific curiosity. From the point of view of medical practice, the existence of many blastomeres for which it is not known how they will develop is of little practical benefit. Establishing a "bank of identical twins for the mass production of genetically identical persons" is morbid towards the individuals that will be subsequently bred as a reserve of biological material or to satisfy various human whims.

> That is why the artificial production of identical twins in humans has no justification even as a search for scientific truth. It is not scientific research but a scientific-technocratic fad with problematic prospects for valuable medical applicaton in practice, which offends the dignity of human life and whose unethicality rests on the conscience of the researcher. Concealment of conscience is reflected not only in the procedure but also in the thought, intention and decision to carry it out! (Švajger, 1994a, p. 8)

Švajger and Pozaić react to the news about the cloning of a human embryo in an American private biotechnology company.

> Nothing from reproductive cloning, not even close to stem cells for therapeutic cloning! There is no real scientific contribution. That is the whole and only basis of the great media sensation, along with the unfounded enumeration of several various diseases that could be cured by therapeutic cloning. (2001, p. 29)

They explained that the technicians from that company had no intention of performing reproductive cloning, but they wanted to obtain embryonic stem cells for autotransplantation after "tissue engineering". For this purpose, they transplanted a fibroblast nucleus from the skin and stimulated the cell to divide (*artificial parthenogenesis*).

Švajger (1997) also referred to the cloning of Dolly the sheep. In the first attempt (1996), an egg cell without a nucleus was fused with a cell from another individual. Cores were taken from three sources in the second attempt (1997). All series' results were qualitatively equal to the first attempt's (lambs with phenotypic features of the core donor strain). However, the quantitative efficiency of the procedure was much lower. Out of 277 reconstructed embryos in which the nucleus from an adult animal's cell was transferred to the egg cell, only Dolly was successfully born. She was the first mammal obtained by transplanting a differentiated cell's nucleus from an adult's tissue.

Švajger (1997) claims that cloning is an identical replication of a single original "entity". In the literal sense of the word, cloning is neither the transfer of genes from cell to cell (*gene cloning*) nor the fusion or hybridisation of two cells, nor it is the transplantation of the nucleus of one cell into another. In the true sense of the word, cloning occurs in unicellular organisms, while in higher organisms, it is successful only in plants. The method of sexual reproduction (procreation) is more productive and biologically valuable. This form of reproduction enables variability, resistance to minor mutations and unfavourable external factors, and adaptability to changes in living conditions. The carriers of the inheritance are found not only in the cell nucleus but also in the cell cytoplasm (mitochondria), which is Švajger's primary claim. Mitochondrial genes in the egg cell suggest that Dolly is not genetically identical to the nucleus donor. Furthermore, sheep udder cells are "weakly differentiated pluripotent cells" that cannot be called "differentiated cells of an adult organism".

Švajger concludes:

> Thus, the whole sensation surrounding Dolly as the first cloned mammal obtained from a differentiated cell of an adult organism comes down to three ruthless facts with a negative sign: 1) The applied procedure is not cloning at all, 2) The source cell – the donor of the genome nucleus is of an unknown species and 3) It is not certain that it is a differentiated ('adult') cell! (1997, p. 15)

Another aggravating circumstance is that the nucleus is taken from an already old cell that has gone through many division cycles. This always entails the possibility of damage to the genetic content of the core. Finally, environmental factors also influence new/old organisms.

Švajger (1997) finds the scientific contribution of the Dolly Experiment in the study of age-related changes in the genome (cellular ageing) and in the possibility of obtaining a large number of cells of larger organisms for experiments. The application of genetic engineering and cloning in biotechnology would enable the creation of pure strains of genetically altered animals. Among other things, such animals could be used for laboratory experiments, and application in the field of xenotransplantation is also possible. As far as humans are concerned, there is little need for their eventual cloning from the medical indication alone. Therefore, Švajger concludes that most of the announced applications of cloning fall into fantasy, uncriticalness and obscenity categories. Referring to Hill's, Wilmut's and Campbell's achievements, Correa and Sgreccia claim:

> Indeed, research is acceptable, even cloning, in the field of animal and plant life whenever it represents a response to needs or a great benefit to man and other living beings on the assumption that the rules of protection of the animal itself and preservation of specific biological diversity are respected. (1998, p. 17)

Regarding human cloning, they are much more reserved. They indicate some ethical problems regarding human cloning and the conflict between human rights and freedom of research. Finally, psychological development, culture and environment, in their own way, influence the formation of always different individuals, although perhaps genetically identical, which can be seen in twins.

Švajger explains that

> there is a general reason for concern and fear not because of this latest achievement but because of the overall current 'trend' of manipulating the human embryo, supported by the unsuspected rapid development of technology and devoid of a sense of measure or limits, scruples, morality and a fundamental natural sense of the value of human life. That is why the stormy reaction to the recent 'cloning' of mammals is nothing more than one of the occasional outbreaks of permanently accumulated charge, which burdens our collective conscience and does not find many nice words for our future. (1997, p. 18)

He adds in another place:

> Although predictions about such monstrous possibilities are still in the realm of imagination (partially due to the already mentioned low efficiency of in vitro fertilisation), they are still terrifying because today's improvement of scientific and medical technology is swift, and the humanity's ethical awareness and conscience is lagging far behind. (1994a, p. 6)

Švajger also reiterates on the mood in large laboratories:

> Attempts to predict the ultimate range and possibility of the results' misuse and their ethical evaluation are often seen as aggravating circumstances that hinder and inhibit progress in this heated industry of scientific results. That is why they are offered strong, sometimes guild-organized resistance, especially when there are threats to the commercial interests of strong companies that produce scientific and technological aids or biochemical and pharmaceutical preparations. (1994a, p. 8)

1.4.2. For/Against Cloning

Human wishes concerning cloning are real and present:

> reproduction of persons gifted with genius and extraordinary beauty, reproduction of the image of the 'dear deceased', selection of individuals who are healthy and resistant to hereditary diseases, the possibility of choosing sex, freezing selected embryos for subsequent transferral to the uterus as a reserve organ, etc., the procreation of a child in a family where the father has no sperm or the compensation of a dying child to a widow... (Correa & Sgreccia, 1998, p. 14)

The American Presidential Council on Bioethics presents these arguments for reproductive cloning: an infertile couple would be enabled to have genetically related children; the birth of a sick child could be avoided; a child obtained in this way could be "planned" as an ideal organ donor; there would be a possibility of preserving a connection with someone who died, that is, a prominent person's further replication (Lochner, 2005). The principles underlying the mentioned advantages are the good of improving health through cloning, the good of the human person and his/her freedom and the good of existence (of the cloned human) in the face of no existence. Solbakk states the following in favour of cloning: *therapeutic argument* (prevention of vertical transmission of mitochondrial diseases, infertile parents who already have one child and want more children, prevention of anonymous donors), and *extinction argument* (the mother takes a clone of her child because her husband died and her child is dying) (acc. to Smoljan, 1998).

On the other hand, Solbakk also presents the following arguments against reproductive cloning: *the argument of human dignity* (a clone is an identical twin born later), *the argument of family integrity* (the clone is not the child of the person from whom the cell was taken but the child of the donor's parents), and *the argument of human copies* (not even the fingerprints of identical twins are equal, and clones are less similar than twins) (Smoljan, 1998). The aforementioned Council for Bioethics puts in the foreground a legal-terminological approach that necessarily limits fertilisation as such because either sexual or asexual fertilisation produces a new human being that, regardless of how it was "produced", has the right to life and protection. The Council reminds of the dignity and rights of the object of research, points out the risks related to the potentially obtained child, the egg donor and the (surrogate) mother.

> If, as in the Nuremberg Code from 1947, the Helsinki Declaration from 1964 and the Belmont report from 1978, it is determined as the most urgent that the safety, consent and rights of the object of research have the highest priority and that the inviolability and dignity of all people should be protected from danger and abuse, then the question is not in which special cases of cloning this or that right is violated, but how much cloning violates the spirit of those codes. (Lochner, 2005, p. 26)

The Council's third objection considers the impact of current genetic manipulation on future generations. The reach cannot be seen for now: "With the help of the market as a dehumanising power, reproductive cloning could lead to the industrialisation and commercialisation of human fertilisation. The resulting positive eugenics could try to change the human race" (Lochner, 2005, p. 29). Moretti elaborates on

> four possible reasons: **1)** birth: if only one embryo is created during in vitro fertilisation, attempts are made in the early stage in order to obtain two embryos and implant them both in the uterus, which increases the probability of successful implantation

> and then birth; **2)** reproduction: if the husband is sterile, mother's oocyte is taken and enucleated, and then the nucleus of the husband's somatic cell is introduced into it; **3)** the 'production' of the elite (eugenics) and **4)** the production of 'spare' organ donors for transplantation. The technology is very unreliable, while the ethical motives are unacceptable, so human cloning was already condemned in 1997 by the European Parliament, the World Health Organization, the European Council and the French Medical Academy as a manipulation of the human being. (acc. to Richter, 2000, p. 41)

Gigli (2004) asserts that it is immoral to spend substantial financial resources at a time when the AIDS, malaria and malnutrition pandemics are ongoing; it is immoral to ask for public support for cloning for the treatment of some diseases (Parkinson's, Alzheimer's, diabetes), whose successful realisation is still nowhere in hand; it is immoral to present the future results as a gift to humanity even though it is clear that the treatment will be costly and the participating industry will make a huge profit; it is immoral that scientists must kill a cloned human embryo to obtain stem cells; it is immoral to overlook the considerable risk of subsequent uncontrolled growth of embryonic stem cells and a high risk of malignancy.

Correa and Sgreccia draw attention to the logic of industrially manufacturing people to best suit the needs of the market, relativising parentage and blood kinship and treatment of clones after they have come to life as independent individuals, i.e. the dignity of the clone as a copied person after birth, the instrumentalisation of a woman for obtaining an egg cell and carrying a fetus for nine months and the functional understanding of bisexuality.

> With human cloning, the necessary prerequisite for any coexistence begins to disappear. This prerequisite is reflected in the fact that a human being is always and unconditionally considered a goal and a value, as opposed to a mere means or an ordinary object. (Correa & Sgreccia, 1998, p. 16)

Correa and Sgreccia conclude that the principle of egalitarianism and fairness is negated by cloning, which rests on the possibility of one man's supremacy over another and discrimination realised through the entire selective-eugenic approach inherent to the cloning logic.

From a biological point of view, reproductive human cloning is dangerous for the human species. From an anthropological point of view, it is an insult to a "clone", i.e. a "copy" (Santa Sedes, 2014). Volarić-Mršić (1998) asserts that cloning a person deprives them of their natural right to be an original, at least at the cellular level. We should avoid fleeting technology, scientism and the utopian project of recreating the human species in our own image (Lochner, 2005). Pozaić (1996) also writes about attempts to change hereditary characteristics in the genetic record and points to genetic engineering, predetermination and selection of human species and subspecies, either by gender or characteristics. Švajger (1994a) claims that manipulating human genes is gross violence against the dignity of a person and natural human rights (1994a). He asserts that every human being carries his or her personality in their genes and therefore shares the right to respect that personality with all living people. The psychological and anthropological aspects of cloning are reviewed in various collections (Švajger, 1999). Some ask why there is such a fear of biological cloning when we live in a time of social cloning through social networks (Smoljan, 1998).

As for therapeutic cloning (cloning for biomedical research), its proponents emphasise improving the understanding of human diseases, finding new means of treatment and opening up the possibility of creating immune-resistant tissues. Possible moral dilemmas are related to research cloning procedures:

> the possibility of experimenting with embryos after the blastocyst stage, the exploitation of women, opening the way to reproductive cloning without the possibility of final control as well as the general weakening of respect for life. Both the conscious production and use of a cloned human embryo until its destruction are considered completely controversial and lead to the question of whether its production can be justified only for research purposes. (Lochner, 2005, p. 28)

The same Council reminds us that the evaluation of research cloning should not be based on intentions but on the moral status of a human being. The lack of the possibility to recognise the human in a human certainly cannot be a decisive reason for challenging humanity. A being that will become a human in the future deserves special treatment guided by "specific respect". Proponents of research cloning do not acknowledge the existence of moral problems in these experiments. No "special moral status" can be attributed to the embryo itself because the mere possibility of becoming someone is not the same as the reality of being someone. Implantation, necessary for human development, is not integral to research cloning.

Therapeutic cloning – technically and morally – is no different from ordinary cloning. Reproductive cloning is usually considered ethically unacceptable because it is inherently dehumanising, and it enables genetic engineering and manipulation of the clone. Therapeutic cloning is even worse because it seeks to create an identical twin with the predetermined purpose of ending its life in order to harvest its tissues. Pacholczyk (2005) writes that although the goal in itself is positive (treatment of disease), it presupposes the direct and explicit exploitation of one human being for the benefit of another. The manipulation of embryonic stem cells is usually problematic. There are no ethical objections to the use of stem cells from the organs of an adult. Švajger and Pozaić persist:

> Since there is a scientific and ethical alternative to the dubious proposed 'therapeutic' cloning, it is unacceptable. Until there is a clear and satisfactory answer to the question of the human embryo's status and obtaining stem cells from an adult organism, the least that can be asked for in the name of ethics and morality is a moratorium on the 'therapeutic' cloning of human embryos. (2001, p. 32)

Opponents of the use of embryonic stem cells for therapeutic cloning warn of the absence of therapeutic success, potential carcinogenicity and the possibility of genetic disorders (Santa Sedes, 2004). The benefit of therapeutic cloning for health and the method itself are still hypothetical, with embryo cloning far from effecting the progress in treatment (Migliore, 2004). Others say:

> It was found with satisfaction that more and more people in the world are accepting the scientifically-grounded point of view that there is no place for the use of stem cells of embryonic origin, regardless of therapeutic indications, because the destruction of the embryo is unethical, and there is no evidence that their use is more successful than the application of adult cells, i.e. stem cells from umbilical cord blood. (Zurak, 2011, p. 47)

The same legal treatment for the newly conceived and the born individual, protection of women from unfair harm and supervision of assisted reproduction are all being insisted upon. The rights of the child are being questioned: protection from a deliberate attack, the right to a stable identity, the right to access genetic parents and the possibility of later termination of pregnancy in case of severe "damage" to the child (Linacre, 2005). There is much room for manipulating the results (Ćelić, 2006c).

The question of whether human cloning should be prohibited by law, that is, all cloning experiments on human cells for any purpose, is answered in this way:

> The authors conclude that the ban on research with the purpose of human cloning is justified, but it should not be extended to the entire area of cloning human cells for distinct medical benefit. They especially emphasise that an ethical assessment of how justified it is to apply new technology can be made only with complete knowledge of all relevant scientific facts. (Švajger, 1998, p. 33)

Referring to the already adopted documents, the resolution of the European Parliament on human cloning from 2000 once again emphasises the comprehensive prohibition of cloning at any level:

> ... 'therapeutic cloning', which involves the creation of human embryos solely for research, raises a deep ethical question and represents a point of no return as far as the rules of research are concerned, and it is contrary to the assumptions of public order accepted by the European Community. (EP, 2001, p. 34)

At one time, some countries supported the ban on therapeutic and reproductive cloning. Others supported only therapeutic cloning (Belgium) or opposed any legal restriction of cloning (Great Britain) (Markljević, 2004b). There are discussions about stem cell research, such as the one in Italy (Ćelić, 2006a). In some countries, the law on medically assisted fertilisation is seen as a legal license to clone human beings: "The law will open the door to 'reproductive cloning', i.e. the future production of cloned children as well as the so-called "medicine babies", that is, children who will be born to serve the treatment of another brother or sister and sacrificed in the first days of their existence" (Ćelić, 2006c, p. 46).

The UN Declaration on Human Cloning issues the following recommendations to member states: (a) adopting measures to protect human life in the application of natural sciences; (b) prohibiting any form of human cloning because it is incompatible with human dignity and the protection of human life; (c) adopting measures necessary to prohibit the implementation of genetic engineering techniques that could be contrary to human dignity; (d) taking measures to prevent the exploitation of women in the application of natural sciences; (e) adopting and implementing national legislation taking into account subparagraphs a and d above; (f) taking into account global issues such as HIV/AIDS, tuberculosis and malaria in funding medical research, including natural sciences (UN, 2005). Regardless of the opinions of proponents or opponents of cloning, the American Council for Bioethics suggests the future establishment of specific legal frameworks and obligation for researchers to carry out their work based on the highest scientific standards. In any case, it would be more beneficial to encourage research into non-embryonic stem cells and put the trade in live, cloned human embryos under the supervision of government bodies specially established for this purpose (Lochner, 2005).

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1.5.

Human Stem Cell Research

Wuerl (2005) defines a stem cell as an undifferentiated cell that can self-renew and, depending on the circumstances, become another, more differentiated cell type. Pacholczyk (2005) mentions tissue (adult) and embryonic (stem and germ) cells. Tissue stem cells originate from the umbilical cord, placenta and amniotic fluid, as well as from adult bodies or cadavers. The following is regarded as the advantages of tissue stem cells: they are not immunogenic nor oncogenic, they may have already been somewhat differentiated, they have a certain flexibility, they are relatively readily available and present no harm to the donor. On the other hand, these are the disadvantages: they are limited in number and short-lived, i.e. they cannot live as long as embryonic cells, and they are less flexible than embryonic cells, that is, more challenging to reprogram for other types of cells. Embryonic stem cells are often collected from embryos three to five days old. Their advantages are flexibility (they have potency for any cell), immortality (one line of embryonic stem cells provides an endless supply of cells with specific characteristics) and availability (remaining embryos from in vitro fertilisation). Disadvantages of embryonic stem cells include them being immunogenic (likely to be rejected after transplantation), carcinogenic (capable of forming tumours) and challenging to grow uniformly and homogeneously in the target tissue.

When asked why tissue stem cells should be preferred over embryonic stem cells, Pacholczyk (2005) first pointed out that they belong to the microenvironment of an adult organism. Therefore, there should be no rejection; they do not cause tumours; they are available in the umbilical cord and placenta; they are valid in the treatment of spinal cord injuries, leukaemia, Krebbe's disease and Parkinson's disease; their use excludes possible moral dilemmas. Along these lines, Vescovi states:

> As an example, somatic stem cells are not endowed with the innate ability to create tumours and are already specialised in the direction of cell production of the tissue in which they are located, but in some cases, it is tough to grow them in large numbers. In contrast, embryonic cells multiply rapidly, but they are intrinsically carcinogenic, and it is difficult to produce the specific cell type we desire for use. (2009, p. 12)

The greater use of tissue stem cells is facilitated by the fact that new techniques for reprogramming these cells do not pertain to the patents that currently cover the use of embryonic cells. Vescovi (2009) writes that for this reason, groups that previously worked on embryonic stem cells are switching to techniques that enable the production of cells analogous to embryonic stem cells, but without creating embryos. He also warns about the right of the sick to access possible future treatment methods.

Possible moral debates surrounding stem cells are not concerned with the technical method but their origin.

> First, it should be explained that these are not totipotent cells, as often mistakenly described, because they cannot create an embryo by themselves. They are pluripotent, meaning they can create all the cell types in the body except the embryonic appendages needed for life in the womb. The difference seems subtle, but it is significant for ethical problems in this field. Indeed, no ethical problem intrinsically relates to embryonic stem cells' nature and biological identity. In other words, an embryonic stem cell is not an embryo but a part of an embryo. The problem concerns how these cells are isolated. As they are only temporarily

> present during in-utero development and only at an early stage, at the moment, there is no other way to isolate them from the embryo than to create an embryo in the laboratory in order to later extract the stem cells from it in a process that leads to its death. (Vescovi, 2009, p. 12)

According to the circles representing Catholic teaching, the destruction of human embryos is not compatible with human dignity (COMECE, 2007). Catholics in the USA financially support adult stem cell research for therapeutic purposes (Adon, 2010c). The Adult Stem Cell Institute is launching an ambitious campaign for drugs derived from adult stem cell research (Adon, 2011b).

Stem cells isolated from the human placenta (amniotic epithelial cells) were found to be very similar to embryonic stem cells and should not cause tumours or be immunologically rejected. They show differentiation potential for all three germ layers – endoderm (liver, pancreas), mesoderm (cardiomyocyte) and ectoderm (neurons) in vitro (Ertelt, 2005). O'Brien claims that cord blood stem cells and tissue stem cells are curing people of a multitude of severe conditions and diseases: "Ironically, we are on the verge of systematically turning medical waste – umbilical cord and placenta – into medical miracles" (O'Brien, 2005, p. 82). The organs grown from umbilical cord blood could be used to test drugs to repair damaged or diseased organs. The first umbilical cord blood bank was established in France, with the ability to collect up to eight thousand samples a year (Ćelić, 2006a). Some studies show that stem cells obtained from adult breasts are pluripotent and can become most other cell types (Adon, 2013). Research has been done on reprogramming human skin cells (fibroblasts) to create pluripotent stem cells with the characteristics of human embryo stem cells (Adon, 2007a,d,e,f).

Adult stem cell researchers promise a significant advancement in treatment procedures (FEAMC, 2004). Vescovi (2009) writes about the importance of stem cells for tissue reconstruction and in pharmacological and biotechnological research of new substances. The possibility of using adult stem cells in cardiology, neurology and regenerative medicine has been proven (Znidarčić, 2006), i.e. their use in preclinical, clinical and therapeutic medicine (Prskalo, 2009). Experiments show that stem cells obtained from umbilical cord blood could be used to produce insulin and possibly treat diabetes (Adon, 2007c). Adult stem cells can be effective in the treatment of alcoholic liver cirrhosis (Adon, 2008d) and then in the treatment of side effects of radiotherapy (Adon, 2006b). Furthermore, experiments with stem cells in connection with Parkinson's disease were also performed (Adon, 2010). It has been shown how these cells can become dopamine-producing neurons (Adon, 2008n), how they improve the microenvironment of the ageing brain (Adon, 2008i), and how treatment with one's brain stem cells taken from the brain before the advanced stage of the disease can be achieved (Adon, 2009d). Moreover, adult stem cells have been effective in treating motor neuron disease (Adon, 2013i), and stem cell therapy in patients with multiple sclerosis improves the quality of life (Adon, 2008e, 2009k). Experiments with adult heart stem cells hint at the possibility of growing new heart tissue (Adon, 2009a) and successful recovery of existing heart damage (Adon, 2011f). Also, stem cells from the nose can prevent deafness in children (Adon, 2011d).

Progress has also been made in converting adult cells into so-called induced pluripotent stem cells (IPS) (Adon, 2008l). A group of researchers managed to increase the efficiency of reprogramming adult cells taken from human hair into IPS cells by more than a hundred times (Adon, 2008j). Japanese researchers discovered wisdom teeth contain soft pulp with mesenchymal stromal cells similar to bone marrow cells. Previously, IPS cells were mainly obtained from skin cells (Adon, 2010b, 2008h). A Japanese research group will begin a clinical trial using induced pluripotent cells (IPS) (Adon, 2013f). Stem/progenitor cells were extracted from the testes and successfully converted back into pluripotent stem cells similar to embryonic ones (Adon, 2009h). Scientists have created functional neurons from fibroblasts without needing an intermediate pluripotent stage. A significant advantage of skipping the pluripotent stage is avoiding tumour formation (Adon, 2010e). Abdominal fat tissue has been found to be rich in stem cells (Adon, 2008c). The upper jaw of a 65-year-old patient was grown from stem cells taken from the fat tissue of the abdomen (Adon, 2008m).

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1.6.

Pharmaceutical Industry and Pharmacists

Gross explained that experiments on animals, volunteers and clinical trials in hospital wards are carried out respectively to test the effectiveness and harmlessness of a new drug (acc. to Ružička, 2001a). These tests should be documented, examiners educated and patients, employees and the environment protected from the effects of toxic substances. When researching new drugs, manipulations might occur of/in the following: choosing study participants, clinical trials, selective publication of results, changing the definitions of diseases for a drug to be administered to as many patients as possible, expanding the indications for use, inventing new diseases and introducing new vaccines, which are often of questionable effectiveness. According to Grbac Gredelj (2010), Gajski pointed out the heightened consumption of certain types of drugs and the spread of expensive therapy to an increasing number of people over many years as possible indirect consequences of the guidelines for the treatment and prevention of chronic diseases. Therefore, the fact that the pharmaceutical industry once financed 70% of drug research can challenge medical science, health policy and medical education (sponsored lectures dominate permanent medical education). Some companies support legislation on disclosing pharmaceutical gifts to physicians (Adon, 2008r).

Bradamante (2005) writes that preclinical drug testing broadly includes pharmacological and toxicological experiments on animals. This area has been well-regulated since the nineties of the last century. This allows careful monitoring of the new drug development programme and ensures the quality of preclinical testing of a new drug, reduces the unnecessary use of animals, promotes safe and ethical development of a new drug and accelerates the time course of clinical trials.

> Preclinical trials wherein the safety and tolerability of a potential drug are tested (nonclinical safety studies) entail acute toxicity trials, subacute and chronic (repeated administration) trials, trials testing the impact on fertility and reproduction, genotoxicity tests, local tolerability tests and if there is a special reason or the drug is expected to be used for a long period, carcinogenicity tests. It is important to add that carefully selected statistical methods are used to assess the significance of the results obtained on animals. (Bradamante, 2005, p. 13)

With regard to the ethical aspects of animal research, Šalković-Petrišić (2008) mentions that experiments on animals have led to knowledge that has improved human health, which is reflected in medicines and vaccines as well as in diagnostic, therapeutic and surgical procedures, and more. Previous restrictions on animal research were technical, while more recently, questions have arisen about the ethical acceptability of animal experiments. The author states that the (ethical) sense of using animals in biomedical and psychopharmacological research is determined by the degree of usefulness for humans. In experiments on animals, it is necessary to: 1) evaluate the scientific benefit of stress, pain and discomfort in animals; 2) properly plan the experiment from a scientific and moral point of view; 3) evaluate the validity of experimental animal models; 4) adhere to the “3R model” and 5) follow existing legal regulations. It is also essential to educate everyone who participates in biomedical research on animals as soon as acceptable conditions for conducting research are guaranteed by the rules of the profession, science and ethics.

Clinical research of new drugs also includes human trials. Bradamante (2008) writes that it is necessary to implement them according to the accepted ethical principles and rules of the profession. The subject is the crucial person in every clinical trial. Nevertheless, consideration is also due to the physician-researcher who closely cooperates with the subject, other staff, the institution where the research is performed, pharmaceutical company, research sponsor and other interested parties. The author affirms that each research participant enters a personal conflict of interest. Therefore, she underlines that in order to avoid the conflict of interest during a clinical trial, the rules of ethical behaviour must apply equally to all its participants while respecting the rules of the profession. It is necessary to abide by international recommendations and standards of clinical testing of a new drug from the Nuremberg Declaration (1947) onwards, with particular attention to the ICH Guidelines (International Conference on Harmonisation) from the nineties of the previous century.

Rumboldt (2005) states that the credibility of a modern clinical trial rests on: a) a good and clear hypothesis, i.e. searching for an answer to a relevant question; b) comparison of therapeutic effects; c) appropriate selection of respondents and purposeful measurements; d) ensuring impartiality; e) appropriate statistical processing to assess the consistency or significance of the obtained data and f) ethical issues. Regarding ethical issues in clinical research, the author emphasises the specific relationship between doctor and patient, which is both scientific and professional and, first of all, humane. All medical research should rest precisely on scientificity and humanity.

> Horrifying examples of abuse of ‘scientific’ curiosity from the Second World War (several such procedures were recorded earlier, and unfortunately also in recent past) led to the adoption of the so-called Nuremberg Code in 1947 and subsequently the so-called Declaration of Helsinki (1964, with a series of follow-up amendments; the last (fifth) was adopted in Edinburgh in 2000), and several codes of medical societies, legal regulations and regulations on good clinical practice, in order to protect the subjects’ interests and dignity and at the same time not lose the

> scientific credibility of human experiments. The process was significantly accelerated by the well-known affair with teratogenic side effects of thalidomide (although it was neither the first nor the only). (Rumboldt, 2005, p. 24)

The stated regulations have the task: a) ensure the relevance of the research and its scientific validity, and b) protect research results and the autonomy, dignity and health interests of both respondents and potential users, with particular emphasis on the role of ethics commissions and informed consent.

In the application of medicines, the awareness of rationalisation in clinical application is awakened (Adon, 2005b; Ružička, 2005). Jukić (2005) poses a question about what "rational use of drugs" means. Is it short-term and effective medication administration, prescribing medication with the most minor side effects, using the cheapest medication, the smallest possible number of different medications, medication that will prevent disease, prescribing medication that will improve the quality of patients' lives, and so on? Pharmacoeconomics is a medical-economic term that has been coined due to increasing healthcare costs. Today, a drug is not placed on the market without the support from pharmacoeconomic analyses that justify its use. Jukić (2005) claims doctors should also choose a more irrational drug through pharmacoeconomic analyses. As Kolarić (2011) has reported, Antolić wonders whether pharmacoeconomics is a myth or a reality. For doctors, pharmacists and payers of health services, assessing the relationship between treatment costs and the effects of the drug and treatment is essential. Hence, the mandatory application of pharmacoeconomic studies before introducing new drugs on the market is necessary. In the example of Western European countries, it is possible to observe the differences in pharmacoeconomic approaches and drug pricing methods. Pulanić writes that rational pharmacotherapy is the application of the right medicine at the right time, for a long enough time and in an appropriate dose, while the key reasons for an irrational approach to treatment entail: "… doctors' orientation to making a diagnosis, insufficient doctor's education on therapy approach, pressure from the pharmaceutical industry and the lack of a comparative approach to the selection of drugs" (2005, p. 40). Pulanić emphasises the importance of continuous literature review and the use of new data from practice. In his article on the rational use of drugs in neurology, Poljaković claims:

> It is tough, if not impossible, to show what the ‘rational’ use of drugs is in a particular area, since – regardless of knowing the facts, research results and characteristics of certain drugs (including their prices) – we often approach our patients irrationally, driven solely by the desire to help them and ease their illness... However, even though our daily practice must be founded on the so-called evidence-based medicine, we must not forget that at certain times neither the price nor scientific evidence matters but our patients’ individual uniqueness and their illness. (2005, p. 55)

Mimica Matanović asserts that the increased use of antibiotics and hypersensitivity to antibiotics present a challenge for the rational use of medicines (Ilić, 2019). Malčić states (2005) that more than 50% of medicines used among children have never been evaluated with regard to the age specificities and points to the difficulties in over- and under-dosing of medicines in children. Bagatin pays special attention to the prescription of drugs for the elderly.

> Thus, side effects and interactions of drugs play a significant role in patient morbidity. Caution is necessary in the use of drugs, especially in elderly patients and in patients with impaired kidney and liver function. Medicinal and herbal products can cause side effects. Special attention must be paid to monitoring the effect of new drugs that appear on the market. Intensive monitoring of each drug after formal registration and appearance on the market is necessary, and any suspicion of a side effect must be reported. (2005, p. 21)

The importance of drug interactions in elderly patients is emphasised by Falamić, according to Miškulin (2009) and Kaćera (2009). He warns about the importance of knowing drug interactions from the clinical and pharmacoeconomic side and stresses the need for cooperation between doctors and pharmacists in their daily work. Gobov-Prstačić (2020) points to biological drugs as a revolutionary medical achievement, and Tomić (2021) writes about some folk pharmacies in Bosnia and Herzegovina at the beginning of the 20th century.

Peraica (2008a) claims that the use of toxic substances depends on the user's ethical principles, and it is assumed that a person will use poisons in such a way as to ensure a benefit or to prevent some evil. Toxicologists are under pressure from the chemical industry, often driven by profit interests. That is why the general principles of behaviour should guide toxicologists in the scientific community (availability, independence and verifiability). Toxicologists also have a great responsibility towards the environment. In the Republic of Croatia, all tests on humans that do not benefit the subject are prohibited. Research into the effects of toxic substances on human health is permitted under special conditions and with the approval of ethics committees. For approval, it is necessary to show: a) that the research can only be carried out on humans, b) an informed consent to research participation, c) anonymity of the obtained results, d) the possibility for subjects to withdraw from the research and e) disposal of biological material after completion of the tests.

Vukušić (2013a) states that pharmacists play a significant role in the case of side effects, drug abuse, interactions, overdose/underdose and counterfeit prescriptions and drugs. From the point of view of ethics in the pharmacy profession, the following questions can be asked: How to reconcile serving people with economic logic? How to approach the challenges in the production and distribution of medicines from a moral and ethical aspect? What is solidarity in the profession and how to achieve cooperation with other health professions? What is pharmacovigilance and should side effects be reported? Furthermore, there are questions about ethics in approaching the patient, difficulties and moral dilemmas in dispensing medicines, legal and deontological aspects in the pharmaceutical profession, communication with the patient and medication errors. As reported by Vukušić (2011b), Falamić claims that in everyday practice pharmacists often make mistakes in prescribing and dosing medicine and other preparations. It is helpful for pharmacists to act preventively, as in the case of identifying risk groups of patients (e.g. women of reproductive age who are planning pregnancy, pregnant women, vulnerable groups of chronic patients and drug addicts). It would also be helpful for the pharmacist to have insight into the patient's medication history, recognise drug interactions and their contraindications and be aware of possible medication errors (Falamić, acc. to Umiljanović, 2011).

Falamić (2009b) points out that almost all preparations found in pharmacies can be bought in specialised stores, that pharmacies deal less and less with magistral and galenic prescriptions, and that the growing purchase of drugs over the Internet is worrying. Thus, at the beginning of this millennium, the supply of counterfeit medicines (thanks to the Internet) quadrupled compared to the previous period. It has been warned that counterfeit medicines, and not only those purchased over the Internet (among which erectile dysfunction medicines were leading), can harm health (Adon, 2010d). At the congress Drug Safety: Ethics and Conscience of Pharmacists, it was warned that half of all the drugs sold in Africa at that time could likely be fake (Falamić, 2009a). On the other hand, tens of millions of people around the world are prevented from having access to cheap drugs for severe pain, according to the findings of Human Rights Watch. The advertising of drugs and the related promotional material are problematic. As reported by Vukušić (2012a), Dujnić-Špoljarević claims that all principles of drug advertising are based on sound legal regulations; namely, in the Republic of Croatia, these documents are the Law on Medicines, the Rulebook on the Advertising of Medicines and Homeopathic Products, the Code of Pharmacy Ethics and Deontology and the Agreement on Ethical Advertising from May 2010. As quoted by Vukušić (2014), Marković has asserted that the quite aggressive marketing of herbal medicines has caused a stir in the medical profession, so the question arises of an ethical approach to quality control and marketing of herbal preparations. When thinking about phytotherapy and quality control of herbal preparations, several factors should be taken into account:

> **1)** unprofitability – which is why there are few clinical studies on their effectiveness; **2)** knowledge – today the study of medicine, and even the study of pharmacy, does not educate about medicinal plants; **3)** the patient's rights – knowing the possibilities and limitations; **4)** the neglect of some herbal medicines with clear indications; **5)** dosage – many of today's preparations are underdosed; **6)** marketing – herbal preparations with a very low dose as a means of treatment; **7)** quality control – herbal preparations

> – dietary supplements are not subject to such extensive quality control as medicine; **8)** adding synthetic compounds – as was the case with preparations for potency, corticosteroids in cosmetics; **9)** price – some preparations are too expensive, and **10)** legality. (Vukšić, 2014, p. 45)

According to Hildegard of Bingen, Juričev-Sudac pointed to some herbal preparations (Benković, 2019; Adon, 2021b).

Jukić (2019) states that the ethical activity and deontology of pharmacists is regulated by the Code of the Croatian Chamber of Pharmacists and the Law on Pharmacy, and the pharmacist's right to call of conscience also has its legal aspect. Pharmacists are the link between doctor and patient. They have the task of showing patients how to use medicines well and understand the ethical meaning of using some medicines. Ratzinger states: "It is not possible to anaesthetise the conscience," and continues:

> Biomedical science is at the service of man, and if it were not, it would be cold and inhuman. Every science in the healthcare field and therapeutic intervention is at the service of the sick person, who should be accepted in their integrity, be an active collaborator in the treatment and respected in their autonomy. (2007a, p. 22)

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1.7. Review of the Chapter "Ecoetical Topics"

First, *care for the environment* implies sustainable management of natural resources. Various measures that could improve environmental protection, including ecological food production, are listed. Human population growth was overlooked. At the micro level, the problem of medical waste disposal, the danger of drug and plastic pollution were observed. It is stated that the ecological crisis exposes man as a ruthless exploiter.

Genetically modified plant organisms (GMOs) seem inevitable at a time of population growth and limited natural resources. Genetically improved plants are more resistant to herbicides, insects and stress; they have improved nutritional composition and industrial properties; they are used in the pharmaceutical industry and for wastewater treatment, etc. Possible difficulties in their application are toxicity and allergic reactions of other organisms, narrowing of biodiversity in the diet of only a few economically profitable genetically modified species (maize, rapeseed, potatoes and soybeans), the appearance of super-insects and super-weeds, possible ecological imbalance, etc. Establishing clear legal regulations for producing and cultivating genetically modified plants worldwide is necessary. Unfortunately, despite significantly higher food production, its fair distribution has not yet been resolved, so (it seems) the goal of higher food production is only higher profits.

Eugenics includes methods of eliminating unwanted and improving desired hereditary traits of human and animal individuals. The subjects of discussion are the concepts and practices of eugenics, the possibilities of genetic intervention, the improvement of the individual and the species, and the scientific basis of pathology with a genetic component. Genetically modified animal organisms can contribute to food production and serve as a source of organs suitable for human transplantation in the production of experimental animals and others. On the other hand, there is the possibility of spreading unwanted transgenic species and transferring pathogenic agents to humans during transplantation. Human genetic testing is becoming more and more important in health care as well as in occupational medicine. The following issues are also raised: gene testing as a "service" or a "judgment", protecting one's genetic information from the point of view of the individual, employer's rights, hereditary diseases and the related issues with insurers, gene therapy in forensic medicine and criminology, genome patenting and rights to information, genetic manipulation, the possibility of "genetic racism" and others. We should not lose sight of the fact that human dignity goes beyond the unique combination of genetic information in DNA. The possible presence of physical differences or genetic defects does not diminish the dignity of a human being.

As the reproduction of cells genetically identical to the original individual, *cloning* encourages human desires for the reproduction of individuals gifted with genius and extraordinary beauty, the selection of individuals who are healthy and resistant to hereditary diseases, the possibility of choosing sex, the existence of individuals as organ reserves, reproduction of the image of the dear deceased, etc. On the other hand, a legal-terminological approach is inevitably present because either sexual or asexual fertilisation "produces" a new human being who, regardless of how it was obtained, has the right to life and protection; the logic of industrial production of people according to market needs is introduced; parentage and blood kinship are relativised; the dignity of the clone as a copied person is questioned; woman is instrumentalised and bisexuality is understood functionally. From the point of view of medical practice, it seems that there is little benefit from the existence of a large number of blastomeres for which it is not known how they will develop, and the mere establishment of an "identical twin bank for the mass production of genetically identical persons" is morbid towards the individuals who will grow and exist as a reserve of biological material.

Stem cells are used in the treatment of some diseases. They appear as tissue and embryonic stem cells. Both types have advantages and disadvantages in application. When asked why tissue stem cells should be preferred over embryonic stem cells, the emphasis lies on an adult organism's belonging to the microenvironment, which alone should exclude the possibility of rejection; they do not cause tumours; they are available in the umbilical cord and placenta; they are helpful in the treatment of spinal cord injuries, leukaemia, Krebbe's disease and Parkinson's disease, and their use excludes possible moral dilemmas. Likely moral debates surrounding stem cells are not concerned with the technical method but their origin. The greater use of tissue stem cells is facilitated by the fact that new techniques for reprogramming these cells are not covered by patents that currently cover the use of embryonic cells.

When researching *new drugs*, manipulations could occur in/of the following: selection of study participants, clinical trials, selective publication of results, changing the definitions of diseases in order to cover as many patients as possible, expanding the indications for drug use, inventing new diseases, introducing new vaccines often of questionable effectiveness and manipulating guidelines for the treatment and prevention of chronic diseases, which could directly lead to an increase in the consumption of certain types of drugs and spread of expensive therapy to a growing number of people over many years. The credibility of modern clinical drug testing should be based on a good and clear hypothesis, comparison of therapeutic effects, appropriate selection of subjects and purposeful measurements, impartiality, appropriate statistical processing and ethical issues. It is necessary to protect the autonomy of research results and dignity and health interests of subjects and potential drug users, as well as emphasise the role of ethics committees and informed consent. Pharmacoeconomic analyses are increasingly important, which entail the application of the right medicine at the right time, in the appropriate dose and for the optimal duration. The increased use of antibiotics was observed.

2.

PSYCHO-ETHICAL TOPICS

Kocijan Hercigonja (2008) claims that a scientific-ethical approach to a person with impaired mental health implies three directions: 1) ethics in psychiatry considering the specifics of psychiatry, 2) ethics of society in relation to psychiatric patients and 3) ethics and morality regarding mental health.

2.1.

Ethics in Psychiatry Considering the Specifics of Psychiatry

Jukić (2003) claims that the unknown cause of many psychological disorders can be the source of errors in working with psychiatric patients. Is mental illness biologically conditioned and should be treated with biological methods or is it psychogenically conditioned (as a result of childhood trauma or bad habits...)? Perhaps mental illness does not even exist, but mentally ill people are victims of society, which has labelled them as such and tries to remove them? Errors in the psychiatric procedure can also be a result of the attitude towards some therapeutic procedures, insisting on the latest psychopharmaceuticals, attempts to save money on medicines and others.

Kocijan Hercigonja (2008) claims that the patient's condition and way of functioning in psychiatry require a very high level of ethics on the part of psychiatrists. A psychiatric patient does not often have the capacity or possibility to understand that he or she is ill, which often excludes the relationship of agreement and joint decision-making and sometimes implies coercion. Rosenberg points out, as stated by Smoljan (1998), that the forced hospitalisation of non-psychiatric patients, such as alcoholics, drug addicts and others, is a challenge. She adds that it would be appropriate to respect the patient's wish that after forced hospitalisation (later), electroshocks and the relevant drugs should not be administered if he/she refused these procedures in a healthy state. Bilić also dealt with forced hospitalisation (Adon, 2021h; similar: Grković, 2021). Clinical trials in psychiatry are very challenging: "If the patient is psychotic or mentally retarded and cannot understand informed consent, such a patient is not included in the study, even though he or she could theoretically benefit from such treatment" (Kocijan Hercigonja, 2008, p. 17). Children and persons with mental difficulties also enjoy special legal protection (Korać, 2002). For children, deciding on treatment, type of therapy and hospitalisation is the exclusive right of parents or guardians, who must give written consent for every doctor's decision and procedure (SOO, 1999; Znidarčić, 1999).

2.2.

Ethics of Society in Relation to Psychiatric Patients

Kocijan Hercigonja (2008) claims that psychiatric patients are stigmatised, lose their right to work or do not have adequate jobs, education, housing conditions and more. It is precisely the stigmatisation and misunderstanding of people with a mental health condition that makes their treatment and socialisation difficult. Mental problems affect as much as a fifth of humanity, so due to such a large share, society needs to adopt a proper attitude towards these vulnerable groups (Majdančić, 2006). Rowell (2008) claims that mental illnesses are among the leading causes of prolonged disability. She claims that income and social status, social support system, education, employment and working conditions, social environment, physical environment, personal health habits and ability to deal with problems, healthy development of children and health services are crucial for psychological stability. Primary social conditions in which people with mental difficulties live should not be overlooked during their medication. Rowell (2008) concludes that bioethics can promote the appropriate social context of health and illness, improve care around the physical domain of the sick person and transform the perception and care of mental health.

Barreto (1996) claims that psychopathological syndromes develop and change in accordance with changes in social relations and cultural atmosphere. Thus, psychosocial factors are pushed into the background, and the individualistic and hedonistic mentality impoverishes the person seeking help. According to Grbac Gredelj (2011), Dodig claims that psychopathology in a globalised society is fuelled by repressed aggression. Globalisation promotes unlimited progress and encourages egoism, selfishness and greed.

> In globalisation, man has become a bottleneck. In globalisation, we are all in a bad mood and depressed. This becomes a problem in the diagnostic sense. Doctors recognise the same symptoms of a depressed patient in themselves, but they deny them and no longer diagnose the condition as depression. Globalisation in the context of therapeutic problems: an increasing number of therapists are being sought, but one does not ask about the cause or why selfishness and egocentricity are encouraged. The background is political because a group cannot be organised from selfish individuals. (Grbac Gredelj, 2011, p. 26)

Furthermore, Ratzinger (2006b) points to some additional reasons for the deterioration of mental health: armed conflicts, natural disasters, terrorism, the negative impact of the crisis of moral values and abandoning the traditional form of social cohesion.

There is an "epidemic of mental disorders". The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* contains the most significant diagnostic conditions. According to one estimate, half of Americans will be diagnosed with a mental disorder in their lifetime. In this sense, Frances, the editor of the fourth edition, expresses fear that the new edition "includes new diagnoses and lowers the threshold for old ones, which increases the already stretched boundaries of psychiatry and threatens to turn diagnostic inflation into hyperinflation" (Adon, 2013h). Professor Jukić (in Radić, 2010) claims that patients with PTSD occupy 10-13% of hospital beds in psychiatric institutions, while according to his estimates, they should be 2-3%. The percentage of hospital capacity occupied by patients with addictions and alcoholism is growing; now, it is over 30%. Considering Croatian society, Radić reports on Jukić:

> First, he notices texts in the Croatian media that could contaminate readers with fear and paranoia. This effects the rational component, and later people start functioning on a level that was not usual for us, says professor Jukić. Secondly, it seems that the phenomenon of antisocial personality disorders has 'spread' to the wider social stage. Everyone wants to fulfil their wishes without delay, and they are not interested in others. (Radić, 2010, p. 51)

Depression is the tribute to globalisation, the loss of social ties, total social anomie and the uneven relationship between knowledge and capital. It marked the end of the last and the beginning of this millennium. It is a disease of the elderly and the youngest, which requires an interdisciplinary approach (Vidović, 2003; similar: Šendula Jengić, 2003). Jakovljević claims that the culture in which people are immersed today favours the development of depression (Radić, 2005). Dealing with depression in oncology patients, Braš states that psychosocial interventions, family support, open conversation, socialising and preferably practising religiosity are essential for the prevention of depression. The course of the disease may depend precisely on the psychological state of these patients because optimal psychological balance strengthens immunoreactivity and antitumor immunity (Ružička, 2009).

2.3. Ethics and Morality Regarding Mental Health

Mandić (1996) claims that psychiatric ethics investigates and directs morality in psychiatric practice and harmonises psychiatric activities with favourable legal regulations, behavioural psychology and education. He briefly overviews the development of interest in psychiatric ethics. He explicitly mentions the "Supplement to the Principles of Medical Ethics" of the American Psychiatric Association from 1973, which is applied in psychiatry. He also mentions the Hawaiian Declaration from 1977. Moreover, he discusses the doctor-patient relationship, diagnosis and therapeutic procedures, hospitalisation, education and research in psychiatry, laws concerning psychiatry (medical secrecy, informing patients about the patient, medical psychiatric documentation and sanity). Nikić (2010) lists the duties of a psychiatrist according to the Hippocratic Oath: ethical and moral behaviour, professional training, respect for human dignity, medical secrecy and acquiring life wisdom.

Mandić claims (2002) that ethical doubts in psychiatry arise due to the following: the exposure of psychiatric practice to the progressive influences of biological, psychological, psychosocial and behavioural concepts, as well as the influence of modern neurobiology and molecular genetics; frequent psycho-traumatic disorders caused by stress in a competitive and aggressive environment; under-capacity and high standards; isolation and rejection of the psychiatric patient by his environment; inadequate organisation and relatively low standard of mental health care; false humanism and incomplete treatment of psychiatric patients, which results in insufficient integration of personality.

Mandić (2002) also points out that today's psychotherapy is burdened with psychologism and technicism, which ignore the integrity and complexity of a person who, at every moment of existence, is not only a mental but also a physical, social and spiritual being – *unitas multiplex*. Writing about the rehumanization of psychotherapy, Gismondi (1996) warns of the danger of psychologism and technicism in psychotherapy. The first is a consequence of overestimating the value of the psychological interpretation of human action: "The psychological attitude ultimately creates a wrong image of man, makes a psychotherapist with such an attitude ridiculous, and – worst of all – does a disservice to the patient who needs help" (Gismondi, 1996, p. 26). Technicism implies a frantic search for technical perfection that places the human relationship essential for the success of psychotherapy in the background. Gismondi believes that "logotherapy and existential analysis", i.e. Viktor Frankl's theoretical-critical model, is a proper "antidote" to psychologism and technician in psychiatry.

Religiosity and spirituality are generally considered a positive influence on coping with illness, the outcome of treatment and the related decisions (Fabijanić et al. 2005). Jakovljević points to the possibilities provided by spirituality in the treatment of depression, and in this context, he also mentions some psychosomatic phenomena in those who attend religious ceremonies (Radić, 2005). Similarly, Brečić points to the role of faith in the treatment of depression insofar as patients are encouraged to forgive, think positively, bring more love into mutual relationships, do good, rejoice in other people's success and encourage each other to love (Skorupski, 2008). Salajpal (2004; similar: Peraica, 2008b) refers to the importance of forgiveness as a means of liberation from feelings of guilt and fear. According to Pavesi (2008b), it is necessary to get rid of human fixations, which can lead to a person's maturation and understanding the transient nature of all that exists. Ivančić gives some practical advice on how to remain spiritually healthy despite illness (Skorupski, 2009).

An attempt has been made to draw a parallel between psychotherapy and confession. Jukić claims that although one does not exclude the other (namely, it is possible to visit both a psychotherapist and a confessor simultaneously), both psychotherapists and confessors are well aware of the difference between psychotherapy and confession, which lies foremost in the "indication". For psychotherapy, these are mental disorders of a neurotic nature, mild depression, reactive states and the like, and for confession, it is a committed sin. The primary effect of confession is the forgiveness of sins and reconciliation with God, while psychotherapy provides relief from neurotic or other symptoms, or at least their mitigation (Ćelić, 2006b; Žagar, 2008; Atalić, 2009). Confession is a one-time act performed by different ministers, while psychotherapy is repeated and performed by the same specialist; confession is intended for believers and psychotherapy for all patients; confession entails an established pattern of preparation, the very act of confession and accompanying actions, while psychotherapy does not have a solid pattern; confession can sometimes have a psychotherapeutic effect, while psychiatry cannot have the effect of confession (Grbić, 2007; similar: Ratzinger, 2012).

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Review of the Chapter “Psycho-Ethical Topics”

In society, psychiatric patients are stigmatised; they lose the right to work or do not have adequate jobs, education, living conditions, etc. In a psychiatric institution, the patient’s condition and way of functioning require a very high level of ethics on the part of the psychiatrist because such a patient is unable to understand that he or she is sick, which often excludes the relationship of agreement and joint decision-making, and sometimes the whole process implies coercion. Errors in the psychiatric procedure can occur as a result of attitude towards some therapeutic procedures or insisting on the latest psychopharmaceuticals, attempts to save money on drugs, etc. The primary social conditions in which people with mental difficulties live should not be overlooked. Clinical trials in psychiatry are incredibly challenging. Children and people with mental difficulties should also enjoy special legal protection. It is pointed out that ethical doubts in psychiatry arise due to the exposure of psychiatric practice to the progressive influences of modern neurobiology and molecular genetics, as well as biological, psychological, psychosocial and behavioural concepts; frequent psycho-traumatic disorders caused by stress in a competitive and aggressive environment; under-capacity and high standards; isolation and rejection of the psychiatric patient by his or her environment; inadequate organisation and relatively low standard of mental health care; false humanism and incomplete treatment of psychiatric patients, which results in insufficient integration of personality. Today's psychotherapy may be burdened with psychologism and technicalism, which ignore the integrity and complexity of a person who is not only a mental but also a physical, social and spiritual being throughout the entirety of their existence.

3.

THANATO-ETHICAL TOPICS

3.1.

Death as Brain Death

In the context of ethnological, cultural, religious and other understandings of death, Zurak states:

> Death is regularly defined in a negative context, namely as the absence or negation of life functions. Emphasising the need to distinguish death from the process of dying and accepting the knowledge that death is an active physiological process could be the contribution of today's medics to the dialogue about the cosmic problem of human existence with philosophers, theologians and other intellectuals of a humanist orientation. (1998, p. 11)

Considering the simplified philosophical-theological point of view, according to which the soul (joined with the body) is the one that makes the bodily substance an organic whole, Richter concludes:

> Based on such deductions, the question could be raised that if the brain is not completely the seat of all superior functions of the human organism, can then brain death be considered the

> death of a human? At first, it seems that the answer is negative. However, let us consider that the brain is an organ that enables a person to think and love. It must at least be assumed that after brain death, an organism can no longer maintain all functions and perform all the procedures and actions that we consider inherent to a human being. It can therefore be concluded that with brain death, the person also dies. (1994a, p. 28)

The basic definition of death for any living being is "... the complete and irreversible loss of all abilities essential for the integration and coordination of an organism's functions into a functional whole" (Richter, 1994a, p. 26). Bergovec (2001) mentions *clinical death*, *cardiac death*, *cortical death*, *brainstem death*, *brain death* and *biological death*. Richter (194a) claims that the brain performs a function of central organisation and integration in a more organised living being. When, for any reason, the brain irreversibly loses its ability to integrate, it is dead, and at that moment, the organism ceases to be an organism, i.e. it becomes a transient set of tissues and organs that can no longer represent a living human being, concludes Richter. Pozaić (2008) writes about the *criterion of death* as the complete disintegration of a unique and integrated whole – the personal self, life's principle, the physical reality of a person. That is, the complete and irreversible cessation of the entire brain's activity.

Richter writes that (1994a) the problematisation of the moment of brain death is a consequence of achievements in the fields of intensive care medicine (sustaining life in the so-called vegetative state), transplantation technology (the need for an earlier and safer decision on the occurrence of a potential donor's death), and criminal and civil law (forced termination of life for therapeutic or research purposes, ownership and inheritance issues). Zurak (1998) also notes that the need to establish generally accepted criteria for diagnosing the "point of no return" has been updated with the progress of resuscitation technology and transplantation medicine. Richter conveys Plumer and Posner's (1994a) definition that brain death is a state where all brain functions – cortical, subcortical and brainstem – are irretrievably lost. Zurak (1998) adheres to the opinion that brain death is also the death of a human being, and there is no brain death without the death of the brain stem. According to Zurak's thoughts:

> Brain death is the death of the brain stem when the centres for breathing and blood flow in the medulla oblongata cease to work irreversibly. It is of crucial importance to assess whether a person is dead and can only be kept alive with the help of a respirator. Only when a person's death is objectively proven can their organs be taken for transplantation to another person. Some tests and criteria are considered to prove that death has occurred objectively: diseases or conditions incompatible with life, irreversibility of the condition, cessation of cerebral blood flow proven by cerebral angiography, electroencephalography, apnea test, etc. (acc. to Ružička, 1997b, p. 38)

Zurak (1998) lists the Harvard (1968) and Minnesotta criteria (1971) and the UK Code as criteria for proving cerebral death. He also states the criteria of the so-called President's Commission (1981) along with the similar Swedish (1984) and Japanese (1987) criteria. He then presents the apnea test, which he marks as an indicator of crucial importance because it includes clinical criteria (the so-called bedside tests) and measures strictly quantified, objective parameters. (For more information about explantation and clinical and instrumental tests for determining brain death, see Vučić, acc. to Ćelić 2009.) Richter elaborates on the protocols for determining death:

> If there is reasonable doubt about a person's life, they must be considered alive until death is undoubtedly established. Furthermore, although there are some objections to the neurological criteria for determining death, much valid evidence leads to the conclusion that brain death is also a person's death. If the established death criteria are carried out – which should be emphasised – conscientiously and correctly, they are a safe and reliable basis for the doctor's decision. (1994a, p. 28)

Stoić-Brezak explains brain death as a prerequisite for organ harvesting in more detail (acc. to IKA, 2010). A case from Denmark is cited in Adon (2013b), where the public was shocked by the recovery of a patient diagnosed with brain death.

The doctor's activity regarding death can be problematised from an anthropological and ethical point of view as well as from the perspective of the dying themselves and their relatives (Maučević, 1992). Salajpal claims that death is always an unpleasant experience for both the doctor and the nursing staff, accompanied by irrational guilt (real or imagined, or both), so everything connected with it is avoided.

> Guilt can stem from several sources: our unconscious hostility towards the patient or the deceased, 'inappropriate' behaviour during the illness, our too strict conscience (archaic superego), projected superego onto the professional group (in doctors), fear of punishment (judgment and criticism), violation of ethical-moral principles, failure to fulfil our mission, refusal to create relationships with others as well as religious beliefs about a strict all-punishing God, which belongs to an immature type of religiosity. (Salajpal, 2004, p. 37)

By looking at one's shortcomings, weaknesses and imperfections, doctors will more easily cope with guilt and gradually learn to forgive themselves.

Salajpal (2010) writes about messages from the unconscious (dreams, visions and images) at the end of life's journey. She claims that in addition to striking physical signs of the end of life, the patient's inner wisdom warns them of the approach of death with symbolic messages. The doctors' task is to relieve the companion's inner discomfort caused by the impending death of the loved one and to ease anticipated mourning.

> Doctors do not often notice the described phenomena nor attach importance to them because the dying person is isolated and hidden by a psychological screen. Because of their vulnerability, doctors avoid a more intimate relationship with the dying, whose death they perceive as additional stress and failure. (Salajpal, 2010, p. 25)

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3.2. Hydration and Nutrition of Patients in a Vegetative State

Maintaining the life of a patient who lives in a *permanent vegetative state* (PVS) without life support equipment is related to the issue of *artificial hydration and nutrition* (AHN). Švajger (1994b) asks whether AHN is a treatment or patient care, if a PVS patient is incurable, and he questions the ways we evaluate the benefit of the treatment compared to inconvenience and suffering it brings. In addition, he discusses the rights of patients and their relatives not to agree to AHN. Markeljević (2004a) points out the principled position on the value of human life as an unquestionable given and the necessity to protect human dignity and ensure the right to life and health protection without discrimination and regardless of socio-economic status. The author promotes solidarity care for patients and spiritual, moral and material help. She emphasises the importance of families, volunteers and professional staff, health and social institutions and society. Moreover, she stresses the principled moral unacceptability of euthanasia and research into the pathophysiology of the vegetative state.

American Terri Schindler-Schiavo, who was in a vegetative state throughout her life, declared that she did not want to be artificially fed, so she stopped being fed and hydrated according to a court ruling (Gigli, 2005; Adon, 2005c). The case attracted a lot of media attention (Adon, 2005d). Also notable is the case of Eluana Englaro, an Italian girl who stated in 1991 that she was not going to be kept alive in the event of critical physical trauma and unconsciousness. After a severe car accident, she was left lying motionless in a permanent coma. She was utterly dependent on someone else's care, which included feeding, hydration and hygiene. The patient's father started the initiative to stop feeding and hydrating the patient. The case was handled in Italian courts for ten years (Paštar, 2009). The related topic of euthanasia is further discussed in Tomić (2024).

Wojtyla (2004) interprets that a person in a vegetative state does not show any signs of self-awareness or recognition of the environment and does not seem to be able to communicate with loved ones or react to appropriate stimuli. He points to some cases of at least partial recovery even after many years of "vegetation". He calls to mind that even a person who vegetates is a human whose inner value and personal honour do not change. He advocates these patients' right to primary health care and prevention of complications that result from being tied to the bed, their right to targeted rehabilitation and monitoring clinical signs of eventual recovery. He believes that even "vegetating" for more than a year cannot ethically justify abandoning or ceasing to provide minimal care to the patient, which includes nutrition and hydration (Wojtyla, 2004). In the literature, there is an example of a Canadian who spent more than ten years in a vegetative state and, with the help of advanced technology, said that he did not suffer any pain (Adon, 2013a).

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3.3.

Palliative Care of Terminal Patients

Palliative medicine is an extension of curative medicine and involves care for terminally ill patients. Jušić (2011) states that palliative care is the care provided by a group of doctors, nurses, physical therapists, social workers, priests and volunteers. He (2001) lists the three tasks of palliative care: differential diagnosis and treatment of symptoms, psychosocial support for the patient and their family, and resolving some ethical doubts related to the end of life and the dying person's dignity. Brkljačić lists the forms of palliative care: home hospice care, hospice, palliative wards, day hospice stay, pain clinic and bereavement services (Pilipović, 2009; Sudar, 2013). It is argued that palliative care integrates treatment, nursing and psychological, social and spiritual assistance while respecting human dignity at the end of life (FEAMC, 2004). Petković writes:

> Experience has shown that palliative medical care is most expediently performed by a team of experts consisting of medical staff (doctors, nurses) and social workers who work to calm the symptoms of the disease, provide psychosocial support to residents and their relatives, and resolve ethical problems that arise in the last phase of life. (2003, p. 68)

It is insisted that patients on their deathbed have the right to the best possible palliative care. Families must also receive adequate assistance and respect for each individual's religious beliefs (FEAMC, 1996). Lončar (2011) warns about the importance of better management. High acute and chronic pain in severe and incurable patients interferes with physical functioning and social interaction and is strongly associated with increased psychological stress.

> In analgesia and sedation, the doctrines of double effect are now generally accepted. Despite the awareness of possible side effects of varying and unpredictable intensity, the goal must be freedom from pain and other symptoms, and an increased quality of life – life to the end. It should be emphasised that relief from pain is a fundamental element of human existence and homeostasis... The right to die without the suffering caused by pain is the right of every seriously terminal patient. At the same time, relief from pain must respect the patient's autonomy. Pain therapy must never cause dangerous side effects that would accelerate the death outcome. On the other hand, the risk of pain therapy must not result in restrictive analgesia, and chronic pain must be prevented by effective treatment of acute pain. (Lončar, 2011, p. 16)

Jušić (2001) points out that the phenomenon of hospice (inn, "house of dying") is closely related to palliative care. The first modern hospices appeared in London. Hospice care does not prolong life, but it does not hasten death either. According to the writings of Pilipović (2009) and Sudar (2013), Brkljačić explains that a hospice is a healthcare institution that provides help at the end of life, to both the patient and his family. Brkljačić Žagrović states:

> An established and proven model of palliative care at the end of life is hospice care. It begins when the classical methods of treatment have been exhausted or when the signs of the spread of malignant disease can no longer be tolerated by the patient. In palliative medicine, the goal is the relief of suffering, and the death that occurs after the patient's suffering is relieved is a success. (2009, p. 39)

Jušić believes that hospice is primarily an elaboration of an ethical philosophy:

> Hospice care accepts death as a normal process, as the last phase of life in which the dying person should live fully, proudly and tolerably, without rushing or postponing death. The success of the hospice philosophy does not depend on technology or luxurious space but on the skills and attitudes of the staff and helpers. Work with the terminally ill can take place in the hospice department of a hospital, in a non-hospital hospice, in daycare facilities or in patients' homes. (acc. to Ružička, 1997a, p. 25)

Palliative care used to be mainly related to oncology patients in the terminal phase of the disease. Now, more and more older adults are in the terminal stages of chronic degenerative and especially neurodegenerative diseases. Hence, the Belgian Model, i.e. the so-called "integrative palliative care" emerged within the framework of palliative care, entailing the possibility and practice of euthanasia, which contradicts the recommendation of the World Association of Doctors on palliative care as a procedure whose purpose is neither to prolong life nor accelerate the dying process (Zurak, 2019). Others advocate original palliative care (Adon, 2009). Some aspects of palliative medicine are also present in nursing homes. They represent an additional challenge for family medicine doctors (Ružička, 2011).

Efforts are being made to sensitise the public and educate experts about the problem of dying (Ružička, 1997a). Education includes mastering the ways of overcoming pain and the accompanying symptoms of illness and dying, practising how to approach people who are sick and dying, taking into account psychosocial aspects of care (primarily relationships with family members), familiarisation with the ethical principles of palliative care, engagement of volunteers and more (Ružička, 1997c; Marušić, 2014). The role of families and volunteers is emphasised (Ružička, 2004a). Volunteers should be altruistic, self-sacrificing and even well-off. Radinger has shared her experiences working in a hospice in Edmonton (Ružička, 2001b). The experience of volunteering in palliative care is also expressed by Franinović Marković: "We are aware of the fact that we cannot cover the needs of everyone who needs palliative care, but new members are joining us, and we are preparing volunteer education in cooperation with the Croatian Society for Palliative/Hospice Care" (2006, p. 42). Nikić (2021) claims that cooperation between priests and medical staff in palliative care is desirable and necessary. Medical staff should provide the necessary conditions for the priest to distribute the sacraments and help terminal patients make sense of the suffering by encouraging them to believe in another life. Brkljačić (2014), Babić (2014) and Rimac (Adon, 2021g) also write about the role of spirituality, attention and love in palliative care. The role of pharmacists in implementing quality palliative care is also significant, as Buhač claims:

> As part of teams, pharmacists can help with the procurement, storage and dispensing of medicines, advice on their proper use and the manufacture of medicines and dispensers. With an individual approach to the patient, treatment costs can be reduced. The possibility of interactions and side effects is reduced by preventing the simultaneous use of the same or similar drugs. Finally, pharmacists must cooperate and communicate well with other team members. (acc. to Vukušić, 2011a, p. 27)

Ružička (2004a) finds that much has been done in the Republic of Croatia regarding palliative care, especially education and integrating palliative care into the organised health service.

> In our country, there is also the Croatian Society for Hospice and Palliative Care. According to the recommendation of the Council of Europe to the Government of the Republic of Croatia, palliative care should be available to everyone who needs it. For this reason, palliative medicine should be implemented in the health system of the Republic of Croatia, centres for palliative care should be organised, at least four hospices should be built along with at least one children's hospice, and health personnel and citizens should be educated. It is also necessary to further educate doctors and nurses. (Pilipović, 2009, p. 37; Sudar, 2013, p. 44)

The Centre for Palliative Medicine, Medical Ethics and Communication Skills was established at the Faculty of Medicine of the University of Zagreb (Vukušić, 2011a).

Moreover, others are calling on social authorities to rise to the occasion of improving care for the dying and those without a cure. Such conditions should be created so humans can endure incurable illness and death dignifiedly (Ratzinger, 2007b). In this sense, individual, often pathetic cases are presented that lead to the popularisation of dying in the family environment (Aston, 2005) or self-sacrifice (Pinjatela, 2005). Aspects of palliative care for children have been written about elsewhere (Tomić et al., 2022).

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3.4.

Organ Donation and Transplantation

Fuček answers the question of a young man on whether it is morally permissible to donate a kidney to his mother: "... it is morally permissible and a good decision to manage our body in this way if it does not violate one's essential personal integrity" (1999, p. 15). He explains that when donating/receiving organs, one should bear in mind two bioethical principles: the principle of integrity or totality (therapeutic principle – a person is not accessible to dispose of their body except for the benefit of the greater good) and the principle of sociability or social principle (each person should realise themselves by participating in the community for the benefit of others). Thus, the mentioned kidney transplant is a morally permissible action if the donor is aware of the act and will be able to continue living normally with one kidney, the possibility of success of the transplanted kidney is guaranteed in the recipient, the transplant results in an actual extension of the recipient's life and both the donor and the recipient are informed about the consequences for health and future working ability. Brkljačić names four fundamental principles that should be respected in the field of transplant medicine: beneficence, harmlessness, autonomy and justice (acc. to Ćelić, 2009). Mateljan notes that organ donation is a decision of high ethical value – namely, a part of oneself is donated for the health and well-being of another person. He recalls the importance of notification, possible abuses, waiting lists, etc. (acc. to Strujuć Vladanović, 2013). Pozaić (2008) claims that the culture of giving is a recognisable feature of the culture of life.

Vrsalović (1999) asks if organ donation is a universal human obligation or organ donation and transplantation are cannibalism, and whether there are any obligations for organ recipients. The prevailing opinion among the public is that vital organs should not be taken as long as the potential donor is alive. On the other hand, emphasis falls on the importance of informed consent to transplantation by the donor or his guardian, irreversible state of the donor without hope of significant recovery, painless explantation of the organ into the donor and fulfilment of the donor's intention through successful transplantation. Observing these requirements and taking into account the great need for organs, it is less important whether the death of the donor has been declared (Adon, 2013j). On the example of an anencephalic whose organs could be used to sustain the life of healthy individuals, Pozaić expresses his point of view:

> The idea that one individual can kill another due to his or her lack of health is frightening and calls into question the entire culture and civilisation. Accepting the sacrifice of an anencephalic for the supply of spare parts in the form of transplantation exposes us to two dangers. First, medicine would give up its essential mark of always re-investigating and trying to cure every disease – in medicine, there is no such thing as an incurable disease. Second, crude utilitarianism would win over man, reducing the person to a function. (1996, p. 7)

There are different experiences in different countries regarding organ donation. Israel gives priority to transplantation to people who have signed a donor card and their first relatives (Adon, 2010f). In China, there is allegedly a practice of using the organs of executed prisoners for transplantation (Adon, 2011a). A study based on the data on organ donation in Australia, the Netherlands, Canada, Germany, Great Britain and the USA shows that from 1995 to 2007, the number of donations from living donors increased by 250%, while the donation of organs from people after their death increased by only 7%. It is believed that new social trends that tend less and less towards altruism could lead to problems related to the availability of organs (Adon, 2011c). The Erasmus Medical Center in the Netherlands intends to conduct a three-year study on the international black market in human organs for the European Commission (Adon, 2013e).

Transplantation of organs is closely related to the determination of death and disposal of the dead body. Because of this connection with law and ethics, organ transplantation must be regulated by law (GK, 1993). Richter (1994a) presents the Regulation from 1982 on the detailed medical criteria and method of determining the cause of death of a person whose body parts can be taken for medical transplantation. He (1995) states that France passed a law on corneal transplantation already in 1949 and later, in 1975, the law on tissue and organ transplantation. Both laws assume the donor's consent. According to the law from 1994, the establishment of an automated register of those who, during their lifetime, expressly refuse to donate parts of their body after death is foreseen, and in the absence of a donation statement, the deceased's attitude can be witnessed by relatives. The law above established the French Institute for Transplantation with the aims of: a) maintaining a list of patients who need a transplant and determining priorities; b) standardising procedures for taking, processing, storing and transferring transplants; c) monitoring the correctness of institutional procedures; d) promoting solidarity among the population in favour of organ donation and e) coordinating cooperation with international organisations in that area. Anonymity, complete information about possible dangers, inconveniences and prospects for success are guaranteed, according to Richter (1995).

Čelić (2009) mentions the association Transplant that operates in the Republic of Croatia. Bušić adds (acc. to Ružička, 2007) that Transplant is a part of Eurotransplant and is in charge of national coordination in cases of emergency transplants. Lipovac writes: "The association [Transplant] helps its members become aware of how important it is to protect their health and informs them about their rights and duties. It also helps them with other life needs" (2009, p. 45). Experiences in liver transplantation (alcoholic liver cirrhosis being the most common cause of failure) are presented of the Merkur Clinical Hospital with a survival rate of 85-87% and a price of HRK 200,000, while in Padova, the price of the same operation is 120-140 thousand euros (Naumovski-Mihalić, acc. to Šeparović, 2005). Simultaneous kidney and pancreas transplantation (most often in diabetics) is performed with a survival rate of 80-100% and a price of up to HRK 350,000 (while the price of just one dialysis is HRK 1,000) (Knotek, acc. to Šeparović, 2005). The availability of kidney transplantation in the Republic of Croatia (Ružička, 2007) and the role of general hospitals in the transplantation process (Mustač, acc. to IKA, 2010) present special topics. Bušić pointed to the well-developed Croatian legislation on this topic. In 2009, 265 transplants were performed in the Republic of Croatia (acc. to Pandžić, 2010). Vlašić-Matas claims that in 2011, the Republic of Croatia was the first in the world in the number of kidney and liver transplants and second in the number of organ donors (acc. to Strujić-Vladanović, 2013). In addition, the Republic of Croatia was the most successful country in Eurotransplant and received the status of a regional health centre for developing the donor and transplant program in Southeast Europe. Brezak states the similar (Adon, 2021e). Kocman has pointed out the challenges of transplant medicine in the Republic of Croatia. He presents data on the state of transplantation medicine in Croatia, organ donation, donor cards and Eurotransplant (Celiščak-Koštarić, 2010; Čušek Samec, 2010). In order to sensitise the public and educate the professional staff, a workshop on the explantation-transplantation programme of Clinical Hospital Centre Zagreb was held (Adon, 2021c).

Organ donation and *transplantation* inevitably involve ethical questions (Pandžić, 2010). For this reason, the Eurotransplant association has its own ethics subcommittee (Ćelić, 2009). Namely, every intervention on a human person is subject not only to technical possibilities but also to limits determined by respect for human dignity (Wojtyla, 2002; PAV, 2002; Švajger, 2002). Wojtyla (2001) reminds us that the protection and promotion of the integral good of the human being should be the guidance. For this reason, he states: 1) trade in human organs is unacceptable, which therefore includes the necessity of informed consent; 2) individual vital organs cannot be taken, except from individuals whose death is certain, for which the criteria should be complete and irreversible cessation of the entire brain's activity; 3) waiting lists for transplants should be compiled based on clear and reasonable criteria, immunological and clinical facts; 4) xenotransplantation must not impair the recipient's psychological or genetic identity – there must be a confirmed biological possibility of a successful transplant that will not expose the recipient to excessive risks. Similarly, Pozaić (2008) states three conditions for the ethical and moral correctness of donating body parts: 1) the necessity of mutual informed consent, 2) fair distribution of available donated organs, 3) sources of organs for transplantation: own or another organism (in the case of another living organism, the principles of wholeness, love and solidarity must be respected; if it is another dead organism, death must be established), or artificial organs as temporary or permanent replacements. Grbac claims the similar: "Organ transplantation has a multifaceted value and is morally grounded in several postulates that must be respected: solidarity, finality and altruism (acc. to Vlah, 2010, p. 47).

Ratzinger (2008a) reminds us that an organ can be donated only if it does not call into question personal health and identity. He insists on informed consent as a prerequisite for a transplant to be characterised as a gift and condemns possible abuses in transplantation or organ trading. The same source reminds us of possible doubts about the moment of the donor's death and encourages additional interdisciplinary research on the anthropological, social, ethical and legal implications of transplantation. On other occasions, the organ trade was condemned, and education was insistent on promoting the culture of organ donation and the role of the media in sensitising the public to these possibilities (Zurak, 2008). UN and EU bodies emphasise the need to harmonise international legislation to stop the trade in human organs, tissues and cells. Namely, human trafficking is already well regulated by international conventions, but not organ trafficking (Adon, 2009i). From the point of view of law and justice, Hlača emphasised that in transplantation, there should be no conflict of interest between man and medical ethics (acc. to Vlah, 2010). Ethics in organ transplantation, the history of transplantation and bioethical principles in organ transplantation have been discussed on other occasions (Adon, 2021f).

In addition to all of the above, it is essential to perform organ transplantation in appropriately equipped centres. Besides, ethical commissions for organ transplantation should include not only surgeons but also experts from other relevant medical professions, as well as non-medical occupations (lawyers, philosophers and theologians) (Ružička, 2003). Pavlović points to the complexity of the transplant problem, especially the psychophysical and physiological situation in which the recipient and the donor find themselves (Vlah, 2010). Xenotransplantation is being developed, and a very (both time- and technically) demanding method of transporting organs from the donor to the recipient is being improved (Adon, 2008p).

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3.5.

Review of the Chapter “Thanatoethical Topics”

Death is defined as the complete and irreversible loss of abilities essential for the integration and coordination of the organism into a functional whole. In humans, it is the death of the brain, more precisely, the brain stem. The problematisation of the moment of brain death is conditioned by achievements in intensive care medicine (sustaining life in the so-called vegetative state), in transplantation technology (the need for an early and sure decision on the occurrence of death of a potential donor), in the field of criminal and civil law (forcible termination of life in therapeutic or research purposes, issues concerning ownership and inheritance).

A person in a *vegetative state* does not show any signs of self-awareness or recognition of the environment nor seems to be able to communicate or react to appropriate stimuli. The question arises of maintaining the life of such a patient and their care (hygiene, hydration and feeding). It is said that even a patient who vegetates without the help of a life support machine is a human being whose inner value and personal honour do not change.

Palliative care is the care provided for terminal patients in specialised institutions or their homes by doctors, nurses, physiotherapists, social workers, priests and volunteers. The tasks of palliative care are differential diagnosis and treatment of symptoms, psychosocial support for the patients and their family and circumventing some ethical doubts related to the end of life. The importance of better management was emphasised. The phenomenon of hospice is closely related to palliative care.

Donation and *transplantation* of living persons' organs is recommended if it does not violate personal integrity. The principles of beneficence, harmlessness, autonomy and justice should be respected in transplant medicine. Informed consent to transplantation is essential both on the part of the recipient and organ donor. Organ transplantation is closely related to the determination of death and disposal of the dead body. Trade in human organs is unacceptable, and vital organs may only be taken from an indeed deceased donor. Waiting lists should be drawn up based on clear and reasonable criteria. Xenotransplantation should not violate the identity of the recipient. Organ transplantation should be carried out in appropriately equipped centres, and, in addition to surgeons, experts from other relevant medical and non-medical professions (lawyers, philosophers, theologians) should be appointed to ethical commissions.

4.

BIOETHICAL MISCELLANY

4.1.

Addiction in Financially Situated Democracies

Thanks to the high standard of living and unlimited offers, different forms of addiction can be more frequent in modern societies. When approaching addiction, emphasis should be placed on prevention and work with young people (Ružička, 1998). Working with addicts is a challenge not only for forensic psychiatric institutions but also has economic, social and other repercussions (Peraica, 2001). Although a person with an addiction, such a patient also has his/her place in society (FEAMC, 2004). Pozaić (2003) claims that personal asceticism in the environment of a hedonistic consumer society remains the only possibility for personality development and moral maturation of the human person and their expression of the culture of life. On the other hand, Balaban claims that any renunciation in a consumer society becomes a big problem (2003). Man, who should give up something occasionally, is constantly invited to consume and enjoy.

According to Strujić Vladanović (2010), Vidović asserts that gambling addiction is more present in recent times. A pathological gambler is a person who has frequently gambled in the last 18 months and has five or more of the listed gambling-related symptoms:

preoccupation with gambling, the need for ever-increasing stakes and risks, frequent efforts to control gambling, restlessness or irritability when trying to reduce gambling, gambling as escape from problems and unpleasant moods or an attempt to make up the lost money, lying to friends and family, financial and other malfeasance to finance gambling, jeopardising or losing a meaningful relationship/job/educational or business opportunity due to gambling and relying on others for money. Vidović presents these data:

> In Croatia [in 2009], there are 2,600 betting shops and 250 slot machines, 50,000 pathological gamblers and 200,000-300,000 at-risk people, which is much more than drug addicts and the same as alcoholics – about 250,000. In the first four months of 2009, the state earned over HRK 85 million from slot clubs, over HRK 78 million from betting shops and HRK 14 million from casinos. On the other hand, insignificant resources are invested in treating this dangerous addiction that destroys young people, families and the whole of society. On the contrary, gambling is constantly promoted in the media as a standard form of behaviour. (acc. to Strujić Vladanović, 2010, p. 45)

Smoking addiction has been labelled as the biggest epidemic of the 20th century, with severe consequences for people's health. Approximately one billion people are expected to die as a result of smoking in the 21st century (Adon, 2013d). According to a survey conducted in Zagreb, approximately one-third of medical workers are smokers. This percentage is slightly higher among nurses and medical technicians (36.7%) and somewhat lower among doctors (31.5%) (Šimunović, 2003). Popović-Grle (2003) claims that smoking is causally related to many serious diseases. Just a few days after quitting smoking, circulation improves, difficulty breathing disappears after a month or two, and the risk of cardiovascular diseases drops to the level of a non-smoker after a year. The risk of lung cancer is halved after ten years. Čivljak states that prevention and quitting smoking are the two main strategies in the fight against smoking.

> It is estimated that education and public health interventions that point out the consequences of smoking, especially if the

> media support them, can greatly contribute to changing the attitudes and behaviour of individuals and the community. However, although providing information and education increases knowledge, these activities are not effective if they are not combined with activities that change the environment and create conditions in which it is possible to accept a behaviour change more easily. Likewise, intersectoral cooperation and the mobilisation of civil society are essential in promoting health. (Čivljak, 2003, p. 10)

Jozić (2003) names three levels that require regulatory and educational intervention by society: the subjective level (violation of generally accepted values of one’s own life and health), the intersubjective level (violation of the fundamental rights of “passive smokers”) and the socio-political level (threatening public health, work efficiency, quality of life, traffic, safety, etc.).

Efforts to liberalise the use of soft drugs have been observed. Referring to the White Paper (2012) of the American Society of Addiction Medicine (ASAM), Pavesi (2019) states the reasons why he believes that legalising cannabis for therapeutic use is not particularly beneficial: the use of marijuana is neither safe nor harmless due to the psychoactive cannabinoids that act on the brain in a similar way to other opiates; disturbances caused by marijuana are severe and frequent problems, and damage to specific organs and tissues is possible as well as changes in behavioural and neurological function; marijuana consumption increases the risk of traffic accidents and is associated with an increased incidence of psychosis and its worsening symptoms; legalisation would create the impression that marijuana is less dangerous than it is, and the number of its users would increase; tax revenues for legal marijuana would be far less than the costs that would be caused by its greater consumption.

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4.2.

Suicide and Its Reasons

Suicide can be related to psychological difficulties, socioeconomic status, special health conditions, age (in minors), PTSD or addictions (alcoholism, drugs, gambling, etc.). Suicide has its psychodynamics; it requires a unique approach by doctors and even the police (Editorial Office of the *Journal of the Croatian Medical Society*, 2000). According to Vučić Peitl (2009), Pavlović claims that suicide can be associated with psychological disorders (bipolar affective disorder, depression, schizophrenia and personality disorders) and disease (primarily neurological, epilepsy and multiple sclerosis). Pavlović also points to different causes and motives of suicide (lack of help, unbearable living situation, psychological pain, loss of control, desire to die, etc.), various types of suicide (teenagers, kamikazes, guerrillas, terrorists, mass suicides, Internet suicides and others), and different ways of suicide (self-immolation, causing car accidents, drowning in water, hanging, poisoning, suffocation and others). In the prevention of suicide, Pavlović underlines the importance of coping skills, plans for the future, family engagement, religiosity, cultural factors and more. There is no harmless suicide attempt, suicide is always part of broader suicidal behaviour, the announcement of suicide is always a call for help (including professional psychological and social help) and the physical and resuscitation assistance of suicide should always be accompanied by psychological aid (Jerbić, 2001). Salajpal describes the pre-suicidal syndrome.

> The pre-suicidal syndrome can turn into a suicidal crisis, and on the other hand, a pre-suicidal syndrome can grow out of a crisis if a critical situation hits a vulnerable point of personality (we judge the traumatic experience from the point of view of the affected)... (2001, p. 31).

Brečić asserted that the suicide rate has increased in the last 50 years and amounts to about one million people per year (acc. to Radić, 2012). The number of suicides among young people has increased. In most European countries, suicide is among the ten most common causes of death. Brečić claims that 90% of suicide cases are related to some psychopathology. Valković writes that the media can also contribute to the increase in the number of suicides with their reckless, inadequate, populist attitude and writing: "The media, with its power of communication, can reveal and conceal (cover up) suicide, whether they reveal it as if on an open stage or cover it up if it is political and socially dubious" (Vlah, 2011, p. 34). Kocijan-Hercigonja noticed that more than ever before, children have suicidal urges (Radić, 2010). The fact of a large number of suicides among financially advantaged young people bothered Frankl. Štengel claims (IKA, 2013) that for a person to transcend themselves and their problems, they must be aware that they and their needs are not at the centre of the world but only a part of it (KA, 2013).

A scientific guide containing instructions on the fastest and most painless ways to commit suicide has been published in the Netherlands. The manual also contains possible ethical and legal issues for those who assist in suicides (Adon, 2008k). The British government has noticed that websites about suicide are more informative than websites that provide support against suicide, so it intends to extend the scope of the suicide law to websites as well (Adon, 2008b). Kusch designed a "suicide machine" so that terminally ill patients would not have to travel from Germany to Switzerland, where assisted suicide is legal (Adon, 2008a).

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4.3.

Human Immunodeficiency Virus

At one time, the subject of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) had all the hallmarks of dealing with an infection of a pandemic nature. Barragan (2005) provided statistics of about 40 million patients in 2005 in a message for World AIDS Day (1st December). He advocates removing the stigma from the sick. Moreover, he emphasises education about the already known way of transmitting the disease (through blood and sex) and prevention measures to reduce the accelerated spread of diseases, especially those related to sexual intercourse. On a practical level, he has suggested awareness campaigns, prevention and health education programmes, support for orphans, distribution of medicine and food, home care, foundation of hospitals, centres and therapeutic communities that care for and help HIV/AIDS patients, work with governments, care in prisons, related courses, creating a help system via the Internet and establishment of support groups for sick people. Barragan has provided guidelines for governments (to promote population health and care for AIDS patients based on the principles of responsibility, solidarity, justice and integrity), the pharmaceutical industry (to secure antiviral drugs to treat HIV/AIDS and opportunistic infections), scientists and health workers (for solidarity and progress of biomedical research related to HIV/AIDS), the media (to ensure transparent, correct and truthful information about this phenomenon and methods of prevention), and finally to Christian communities (to promote family stability and children's education about sexual activity). Among other things, he reminded us that a quarter of the centres for the care of HIV-AIDS patients are owned by the Catholic Church (Baragan, 2004, 2006). Wojtyla (1999) touched on AIDS on the 13th World Day of the Sick.

In a lecture on World AIDS Day (1st December), Miletić-Medved (Adon, 2014) stated that 10-15 years could pass from the moment of HIV infection to the appearance of AIDS. Testing in the Republic of Croatia is anonymous and free of charge in counselling and testing centres. She dealt with data for Brod-Posavina County, where 26 patients were registered from 1993 to 2013. In 2013, 1,713 tests were performed in the Republic of Croatia, during which 22 HIV-positive persons were detected. It is assumed that there are three to five times more patients. The disease causes stigma and discrimination as a result of misunderstanding and ignorance about the disease, the consequences of myths about the transmission of the virus and irresponsible media coverage of the epidemic. On an individual level, sufferers feel shame, guilt and isolation. Miletić-Medved advocates testing in communities, introducing and implementing needle exchange programs, encouraging infected people to reveal their status, improving care for the sick, promoting the human rights of people infected with HIV, striving for individual and social protection and the availability of drugs that can delay the onset of AIDS (Adon, 2014). Others have also disclosed data on those infected in the Republic of Croatia and the world, interpreted models and approaches to AIDS prevention and advocated for educating the population and doctors to develop awareness of responsible behaviour (Ćelić, 2005; Nađ, 2006).

The results of some research studies have been published that indicate that HIV can be dormant in a small number of cells, even in just one cell, and become active at a given moment. This is a good indicator because it shows that anti-HIV drugs are precisely what they should be: they entirely block viral replication and cell-to-cell transmission (Adon, 2008g). A synthetic protein was found that interferes with the entry of HIV into healthy cells (Adon, 2009j). Two immune system antibodies were isolated in the blood of an African infected with HIV, which could have resulted in the patenting of a vaccine against HIV (Adon, 2009f). According to some research in Germany, targeted bone marrow transplantation, which is used in cases of leukaemia, can also cure AIDS patients (Adon, 2008o). Gene therapy offers new hope for HIV patients (Adon, 2009b, 2011e). The incidence of HIV in some population groups in the urban centres of the USA is even higher than in the countries of the sub-Saharan region (Rwanda, Nigeria, Ethiopia) (Adon, 2010a).

Some researchers are convinced that HIV passed from primates to humans. It is claimed that the human virus HIV-type 2 and the simian virus SIV are the same. According to Richter (1996), dilemmas about disease transmission cut into medical practice and, as such, may have bioethical implications. Some claim that the transplantation of animal organs to humans played a role in this. Namely, in 1992, a primate liver was successfully transplanted. Outraged by the surgeon's mechanistic approach, virologists and infectious disease experts warned of a possible danger. They indicated the possibility of transmission of viruses from primates to humans, including the AIDS virus. Another (probably unfounded) claim refers to Hilary Koprowski's anti-polio vaccine against a polio epidemic in the Congo in the middle of the 20th century. The culture of the kidney tissue of a green guinea pig was used to grow the antigen, an attenuated poliovirus. Doubts about the transmission of the infection arose later when it was determined that all African monkeys carry strains of the virus that can potentially be fatal for other species of animals. Richter concludes:

> Much remains to be elucidated, but something is becoming clear: rushing to achieve spectacular results in medicine without reflecting on the possible consequences is full of dangers and may be contrary to bioethical principles in research and practice. Progress will always be necessary and even inevitable, but such progress will rest on the conscientious cooperation of all relevant professions. (1996, p. 38)

Different associations question the moral and ethical challenges of AIDS from their positions (Host, 1992). The Community of Sant'Egidio, founded in Rome by a high school girl, received a personal gift from Bill Gates of USD 200,000 annually for three years to finance an AIDS prevention programme in Africa (Ćelić, 2006c). The Vatican administration is accused of being responsible for the deaths of millions of people due to its opposition to the use of condoms. The accused, however, claim that African countries with a higher proportion of Catholics have a lower percentage of patients due to abstinence (Adon, 2007b).

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Population Aeging and Demographic Challenges

Mateljan (1999) observes that the entire social system has intensified efforts to improve living conditions, which, with the help of medicine, has prolonged human life. The increase in the number of older adults and the longer life expectancy of people with disabilities and chronic diseases has become a significant challenge in the field of economy and social policy in this century in the EU, which can also affect some decisions. Possible solutions to the disparity between available money and needs can be a significant challenge in the 21st century for both solidarity and sensibility. Hence, it is essential to clearly define the conditions appropriate for an active relationship with the most sensitive groups of people (Markeljević, 2012). Ratzinger (2008b) does not accept the mentality that the old and the sick are a burden or a problem for society. He supports palliative measures, reminds us of the necessity of understanding, comfort, encouragement and friendliness; moreover, he insists on the fact that life should continue to be protected even when the challenge of old age and illness becomes dramatic because human life is worthy of the most tremendous respect in every period and even more so in old age and disease. Richter

(1999) points out that the prevention of the exclusion of older people from social events implies systematic education of the population and health and social workers according to specific elaborated programmes, even at the levels of postgraduate and permanent professional education. The possibility of intergenerational cooperation is worth pointing out. Richter (1999) concludes that it is believed the majority of the population will grow old, so it would be helpful to educate them about preventive measures for the happiest possible last phase of human life, which brings with it visible changes in tissues, diseases of the cardiovascular, respiratory and osteomuscular systems. It is essential to make a transition from the state of homeostasis of an adult towards senescence, multiple clinical pathologies, various acute, chronic and progressive neurological, neuromuscular, cardiovascular and systemic diseases, psychological specificities and possible disability (Zurak, 2014; Bergoglio, 2014). Although the riches of the Third Age are emphasised, Mateljan points out the possibility of old people being placed in particular institutions and in this way isolated from their social (family) environment and usual activities, that is, treated as chronic patients who should be cured from their old age.

Specific *demographic challenges* are observed. The question arises whether the country is overpopulated. In developed countries, both infant mortality and the number of newborns have decreased, life expectancy has increased, and the number of older adults in the total population is also on the rise. According to Host (1995b, a), the question of the sustainability of such a socio-economic situation is raised, and the right to health needs to be revised. Wooster (2008) writes about limiting population growth, especially in India and China. Pell (2008) reports a letter to the *Medical Journal of Australia* stating that anyone with children "acts like they like the greenhouse effect". Any family with more than two children should be charged a tax to plant and maintain four hectares of forest as compensation for each child's CO2 emissions. Under this recommendation, parents would be charged a carbon tax, while family planning clinics and hospitals could receive benefits by providing "greenhouse-friendly services" such as hormonal contraception, IUDs, diaphragms, condoms and sterilisation.

On the other hand, Eurostat predicted that by 2015, there would be more deaths than births in the EU (Adon, 2008f). The problem of "demographic winter" and no danger of a "demographic explosion" are rumours created by economic interests (Volarić-Mršić, 1995). Depopulation in developed countries also contributes to the later childbearing age (Adon, 2009e). One of the three researchers who mastered the critical step in the creation of the oral contraceptive, 85-year-old Carl Djerassi, claims that contraceptives may have partly contributed to the demographic imbalance in Europe (Adon, 2009c). Already in the mid-20th century, Wilson pointed to the possible substitution of the indigenous European population (Zurak, 2019).

Significant depopulation has been noted in the Republic of Croatia since the middle of the 20th century and in some Croatian regions even before, where the "white plague" occurred. Švel (1994) cites modern reasons for the low birth rate: efforts to increase the standard of living, more significant investment in each child, the desire for greater child safety and the consequences of migration mainly to big cities or abroad. Here, too, the disproportion between those who earn and those who spend is pointed out, i.e. the problem of a predominantly old population.

> Demographic extinction inevitably causes an economic crisis. There is an inadequate reflection on the fact that the ageing generation leads to negative trends in society, not only economic – where do pensions come from? – but also social and human, caused by disproportions between the elderly and the young. (Župan, 2007, p. 43)

Various initiatives call for the design and implementation of an improved population policy: three-year maternity leave, stimulating child allowances, tax and other benefits, assistance in securing housing, health care, pedagogical assistance, the title of mother-educator and introduction of half-time work for mothers with three or more children (Richter, 1994b). On the other hand, indignation was caused by announcements of reduction in maternity benefits of up to 40%.

> Savings in the budget, which was the main motive for the adoption of these measures, will turn into increased costs in health care and further accelerate the extinction of the nation, thus also

> the loss of workforce and collapse of autochthonous economy. (Švajger, 2001, p. 89).

On this occasion, the authorities are called upon to reconsider the decision on the reduction of maternity benefits and implement the already devised population policy, doctors are expected to support the population policy and everyone to promote the culture of life, basic rights of women and children's rights to a healthy upbringing in happy families. Along these lines is an open letter from "astonished, shocked, offended, confused and worried" parents of three or more children whereby they reacted to the remark about parents who have children and cannot feed them. The parents called upon refer to the Constitution of the Republic of Croatia (Articles 61 and 62), the National Program of Demographic Development and some international documents. They remind us of the greater number of deaths than births, possible difficulties regarding pension and health funds, social solidarity and equality before the law in the Republic of Croatia.

> That is why we demand that you and everyone who has been involved in dishonourable and humiliating statements in recent days publicly apologise and acknowledge that the Constitution was violated and many parents and children were offended with such statements. (Adon, 2001, p. 40)

Pozaić believes that the devastating demographic picture in the Republic of Croatia is caused by, among other, the environment permeated by the "civilisation of death" mentality (Fureš, 2006; similarly: Bubalo, 1998). As an alternative, he proposes a "civilisation of love" and strict adherence to the achievements of Christian civilisation. A special concept of reproductive health emerges from demographic strategies, which, in the opinion of some, does not derive from jurisprudence and human rights law (review of the Cairo Conference) (PVPZ, 2007). Župan appeals:

> Let us not let the fear of being labelled as backward discourage us and keep us silent in the face of those who put people to sleep with money and pleasures and numb them with empty slogans.

> The indifference and inability to see that entire nations are being quietly extinguished are a consequence of such campaigns, from which we are not spared in Croatia. Year by year, our schools have fewer and fewer classes. (2007, p. 43)

Župan (2008) reminds us that children are the nation's wealth; they ensure the future, and it is essential to encourage them and provide decent living conditions. Meetings of families with several children were also organised in this sense (Adon, 1999). Smoljanović, Šperanda and De Micheli Vitturi assert that doctors also have their role in the demographic renewal of the Republic of Croatia (Adon, 2021a; Adon, 2021i; PB, 2021).

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Understanding the State of Illness and Health and the Hippocratic Tradition

The perception of *illness* as a result of breaking some order or law is an ancient view. Pavesi (2004) writes that over time, the opinion prevailed that illness is not always the result of individual human guilt that could lead to moral condemnation of the patient, but it is an integral part of human existence and, as such, cannot be eradicated. In the second half of the 18th century, the opinion appeared according to which disease is caused by social injustice. The disease becomes a sociopolitical problem. In a more radical sense, the concept of the right to health appears; therefore, not only the right of individuals to their physical integrity but also the right to live healthily, without illness. According to the writings of Murgić (2006), Pavesi concludes that adequate occupation of society and political power could ensure good health for everyone. Feytor and Vitor (1997) claim that the reproduction of individuals carrying diseases and unwanted traits is unacceptable for advocates of social Darwinism. The *biological* *current* in modern medicine perceives disease as a biological deficiency or damage that should be treated with the methods of natural sciences, whereas the *psychological current* puts psychological pathology in the foreground as the cause of psychosomatic disorders. The *socio-political current* views the disease as the result of social contradictions, so medicine and psychiatry should help with diagnosing pathological conditions and their removal. On the other hand, the *spiritual current* perceives the disease as dependent on some deficiency of a spiritual nature. Each of these approaches is one-sided when viewed separately.

PAV (2005) argues that *health*, defined as a state of complete physical, mental and social well-being (WHO, 1946), is a utopian and hedonistic ideal. It is pointed out that over time, the terms "quality of life" and "health ethics" have become an expression of a kind of "health religion", which justifies violence against (powerless) human life. Sgreccia (2005) claims that a program based on the quality of life becomes an ethical obligation. Ethical good is identified with pleasure and the removal of pain. A human being who does not possess the minimum quality should not live. There lies the seed of eugenic parameters for selection ("quantity is the enemy of quality"). Sgreccia (2005) claims that highlighting health as the highest human value can result in the marginalisation and elimination of those who do not have these values: the disabled, the terminally ill, those with special needs and the poor who are treated as "organ banks". This is indicated by the limited funds for health care (and unlimited funds for weapons) as a system of admission to hospital care, as well as the constant identification and definition of excess expenditures in health care. From such actions, the question of the quality of life and the ideal of health follows.

The Hippocratic Oath, created in the 5th century, is often taken as the origin of doctors' ethical behaviour. Švajger writes: "The text of the Hippocratic Oath should be viewed through the lense of the place and time of its creation, but it nevertheless remained a permanent model of ethical thinking about the medical profession and a template for all later codes of medical ethics" (1996, p. 12). A significant part of the article "From Medical Ethics to Bioethics" by Pavesi (2008a; similar: Adon, 2021k) is dedicated precisely to the Hippocratic Oath, wanting to place it in the context of the time it was created.

This position is also supported by Mandić (1996), who adds that the Hippocratic Oath determines doctors' moral framework, rights and duties. Zurak (2021) believes that the Hippocratic Oath should be protected in time as an intangible cultural heritage. Pozaić (2004) reflects on the aspects of protecting human life before birth in the light of the Hippocratic Oath. As contemporary research shows, few doctors believe that taking the oath significantly impacts their sense of professionalism (Adon, 2011f). Ninety percent of doctors rely on their "personal sense of good and bad" to perform their duties and run their practice.

Švajger (1996) writes that the *Formula Comitis Archiatrorum* from the beginning of the 6th century of our era and the *Prayer of Maimonides* from the 12th century are also two well-known codes of medical ethics. In addition to the elements of medical ethics, Maimonides' text also reviews the difficulties and inconveniences encountered in medical practice. The texts of Hippocrates and Maimonides influenced the medical oath of Amatus Lusitanus from the 16th century. Švajger concludes:

> Suffice it to say that, although they [the mentioned patterns] reflect the spirit of the time in which they were created, all the principles stated in them are still valid today. For some of them (attitude towards the end of life, the obligation to constantly expand and improve professional knowledge, consult with other doctors and pass on knowledge to younger ones), we can only regret that they are not explicitly mentioned in the Geneva formulation of the Hippocratic Oath, which our students also take when they are promoted to the medical profession. (1995, p.17)

Mandić (1996) also mentions a couple of old codes of medical ethics and the more recent code of the American Medical Association from 1847. An overview of medical ethics from the Hippocratic Oath to the Code of Medical Ethics and Deontology was provided by Brkljačić Žagrović:

> They [chapters of the Code of Medical Ethics and Deontology] highlight biomedical principles that every medical worker

should adhere to: autonomy (respecting the wishes and decision-making ability of independent persons), non-maleficence (not harming others), beneficence (preventing harm, enabling welfare) and equity (equal and fair distribution of welfare). (acc. to Vukičević, 2011, p. 46)

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4.6.

Appeal of Conscience in Health Professionals

This chapter presents reflections on the appeal to conscience in healthcare workers as a reaction to the incompatibility of their values and work tasks. Health workers (health personnel) perform healthcare tasks and have medical qualifications determined by law and other regulations. Healthcare professions include doctors, nurses, dentists, pharmacists, medical biochemists and others. In their work, healthcare professionals are obliged to invest their professional abilities to the greatest extent, respect the human person and the personal dignity of man and act according to social norms and ethical principles of healthcare. Also, they have the right and duty to receive professional training during their employment. Here, we want to point out some aspects of the activities of healthcare workers with a Catholic worldview, i.e. those medically qualified persons in the healthcare system who apply some specific instructions of the Catholic Church to their professional work. From everything published in the *Journal of the Croatian Catholic Medical Society* until 2021, slightly more than 850 bibliographic items (i.e. 40% of everything written) can be marked as bioethical material. Of these “bioethical bibliographic units”, 5% (43 items) deal entirely or at least partially with an appeal to conscience, namely 14 articles and 29 reports from lectures, symposia, round tables and other events. The magazine dealt with the appeal of conscience more intensively in 2005, 2013 and 2021.

Looking at the current state of the institute of conscience in the medical profession and biomedical research, Zurak (2021) asserts that the institute of conscience in the medical profession is most often actualised in the context of termination of pregnancy, euthanasia, assisted suicide, participation in capital punishment, artificial fertilisation and sterilisation and some other procedures.

> Increasingly free legislation and increasing pressure on the medical code of ethics in terms of its change... will tighten the institute of appeal of conscience, but probably force legislators to limit its application, with arguments of the fear of anarchy. (Zurak, 2021, p. 16).

Here, Zurak reminds us of the Hippocratic tradition, which at one time pointed out some moral dilemmas, and the difference, compared to today, is only found in the amount of technical aid, so in this sense, he wonders whether the laws sufficiently protect medical workers and whether one day laws will appear that will not protect life (Zurak, 2021; similar: Richter, 2020). In addition to this and several other authors, the topic of conscience and the appeal of conscience has come to the fore several times through statements in the media, lectures, forums, public debates, webinars, reviews and others, as well as on the occasion of marking International Conscientious Objectors Day on 15 May (Adon, 2013k; 2021o,p,m,n,r; hr.n1info.com., 2021; Šegović, 2021; IKA, 2021a,b; Katanić, 2021; Galešić Ljubanović, 2020; Bodrožić, 2020; Tomić, 2021; Iustitia et pax, 2013). Zurak writes: "Conscience is a complex psychological instantiation that contains elements of thinking, emotional and intuitive, therefore rational and irrational, with their mutual interaction on the unconscious and conscious level" (2008, p. 13).

Markeljević (2014) also defines conscience as a complex category of the human mind in an interactive relationship with the human will. The author in question defines the right to appeal to conscience, or conscientious objection, as an integral part of the freedom of opinion of an individual or a group, expressed most often as a reaction to some challenges of contemporary civilisation. Zurak (2008) states that an appeal to conscience protects individual freedom and resolves value controversies. It is a way of disobeying the law, but not an instrument of the so-called civil disobedience.

> It is a civil right, but also the right of doctors and health workers to refuse to participate in scientific research, diagnostic and therapeutic procedures and interventions if these procedures and their purposes, as well as collateral effects, conflict with their conscience. (Zurak, 2008, p. 13)

Castellvi states: “Conscientious objection is the last refuge, a human right and obligation not to get involved in acts that are deeply incompatible with the human person” (acc. to Adon, 2007, p. 57). Miličić, as interpreted by Brkljačić (2013), also lists the right to appeal to conscience as one of the critical predictors whose removal may call into question the doctor’s moral integrity. The right to appeal to conscience must be respected because the opposite would mean discrimination against doctors, which is against the constitutions of most countries. In contrast, doctors’ appeal to conscience should be motivated primarily by professional reasons (Host, 1996). The doctor and his conscience see the patient as a suffering person, and, in that case, the patient is not just an object (Dogan, 2004).

Justice requires the healthcare worker to be equal to his patient in at least one fundamental right, i.e. the right to conscientious objection to a review of healthcare laws (Adon, 1993). Healthcare workers should be explicitly allowed to refuse to participate in procedures against their conscience and determine the conditions under which this right can be used. Pozaić (2005) warns of the *phenomenon of the adult patient* as a demand for the patient’s autonomy and respect for their will, which, on the other hand, can call into question the professional and moral integrity of the doctor. He states that in order to guarantee a minimum of morality, the state must allow doctors, health workers and those responsible in hospital institutions, clinics and nursing homes the possibility of refusing to participate in the advisory, preparatory and executive phase in acts against life.

> No one should be forced to participate in the evil act of another. Besides: 'Whoever invokes conscientious objection must be protected not only from punitive measures but also any damage on the legal, disciplinary, economic and professional level' (No. 74). Every individual has the right to physical integrity, no less to moral integrity: to act freely by their conviction, by the dictates of their conscience as the last norm of action. (Pozaić, 1995, p. 14)

Looking at the relationship between the power of the state and the rights of the free individual, Pavesi refers to some public law experts (Kagi) who emphasise

> that laws are needed that are before and above the state, which can protect the individual from the state: How one wants to call these limiting norms – 'legal principles' or 'basic norms' or 'natural law' or 'eternal norms' – is less important. (Pavesi, 2011, p. 31)

Pavesi (2011) considers that the state and the individual should accept limiting norms and their binding character. Freedom of conscience and the appeal of conscience are not based on the absolute autonomy of the individual but on the right/duty/obligation to act by the supreme norm that transcends both the state and the individual. Korać Graovac (2020) discusses the topics of conscience as a necessary corrective to laws passed in postmodern society, the need for legal recognition of the right to appeal to conscience and the thesis that this right stems from the right to dignity. In the conclusions of the Congress on conscience, it is stated that the cultural context of the individual and the legislation in force present great temptations for individual conscience: "We would like to emphasise that it is tough for healthcare workers to express a conscientious objection because this right is usually accepted as a person's right, and not as a right of hospital structures and associations" (Pavesi, 2007; Zurak, 2007).

The resolution of the Parliamentary Assembly of the Council of Europe (1763/2010) on the right to appeal to conscience in medicine states that no natural or legal person shall be subjected to coercion, held responsible or discriminated against in any way for refusing to do, allow the termination of pregnancy to happen, or carry out the termination of pregnancy or euthanasia. At the same time, the state's responsibility to ensure patients' access to timely health care, especially in emergency cases, was emphasised; it was stated that in a large number of European countries, the implementation of appeals of conscience is well regulated in the sense that there is a comprehensive and transparent legal and political framework for appeals of conscience of healthcare workers with respect, protection and fulfilment of the interests and rights of individuals seeking medical services (VE, 2014). Several other legal acts ensure the right to appeal to conscience as a fundamental human right and an integral part of freedom of opinion: the Convention on the Protection of Human Rights and Fundamental Freedoms (Art. 9.1) defends the right to freedom of opinion, conscience and religion; the Constitution of the Republic of Croatia (Art. 40) guarantees freedom of conscience and religion; the Law on Medicine of the Republic of Croatia (Art. 20) guarantees the right to appeal to conscience, as well as the Code of Medical Ethics and Deontology (Art. 2.15) (Turalija, Balta, 2013; HKLD, 2013; HKLD, 2014; Matulić, 2020).

In the review of the proposal by the Code of Ethics of the Croatian Medical Association (CMA), the doctor is asked to recognise the right to the conscientious objection about possible provisions of the law; that is, doctors can refuse "participation in procedures that are contrary to their ethical conviction" if this does not jeopardise the patient's life (Richter, 1994). Zurak claims that according to the Law on Medicine of the Republic of Croatia, doctors have the right to appeal to conscience if a request is made against their ethical, religious or moral beliefs (acc. to Marušić, 2011). He does not overlook that there are countries, such as the Netherlands, where doctors do not have this right. Zurak also presents a real danger:

> Although the appeal to conscience is a praiseworthy mechanism for the protection of human rights, there is an increasingly real danger that its existence becomes an excuse for enacting laws

> of dubious ethics based on the argument that then the appeal of conscience becomes the corrective of those laws. (acc. to Marušić, 2011, p. 40)

One should ask about the rights of medical students who are not allowed to refuse participation in parts of their medical training by citing the right to appeal to conscience, as well as of those whose religious beliefs prevent them from examining a patient of the opposite sex (Adon, 2013l).

The issue of appeal to conscience can also be brought up among pharmacists (Mihaljević, 2011; Planinc-Peraica, Benković, 2021; Adon, 2021l). Prusak (2021) claims that the appeal to the conscience of a modern pharmacist will have a prophetic dimension if it is not an arbitrary choice but becomes a kind of internal duty that stems from the responsibility towards oneself and the patient. Pozaić (2021; similar: Šaler, 2021) writes that when faced with a prescription and a client, pharmacists cannot act mechanically and automatically, but they must pay due attention to both the prescribed medicine and the patient.

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4.7.

Review of the Chapter “Bioethical Miscellany”

Addictions are a challenge for forensic psychiatric institutions; they have economic, social and other repercussions. In recent times, gambling addiction has become more present, while smoking addiction has been labelled as the biggest epidemic of the 20th century, with severe consequences for people’s health. Efforts to liberalise the use of soft drugs have been observed. In liberal democracies and the environment of a hedonistic consumer society, personal asceticism remains the only possibility for personality development, moral maturation and improvement of the human person’s social dimension. Although a person with an addiction, such a patient also has a place in society.

In most European countries, *suicide* is among the ten most common causes of death. Suicide has different causes and motives, types and ways. It can be related to psychological difficulties, socio-economic status, special health conditions, age (in minors), PTSD and addictions (alcoholism, drugs, gambling, etc.). In the prevention of suicide, it is essential to adopt the skill of overcoming problems, have plans for the future, achieve family involvement, practice religiosity and take into account cultural factors and others.

The *human immunodeficiency virus* (HIV) once took on an almost pandemic character. It seemed essential to advocate for removing the stigma from the sick and emphasise education regarding the already known way of transmitting the disease and preventive measures. Experts came up with awareness campaigns, prevention and health education programmes, support for orphans, distribution of medicine and food, home care, creation of hospitals, centres and therapeutic communities that care for and help people with HIV/AIDS, work with governments, care in prisons, courses, creation of a help system via the Internet and establishment of support groups for sick people.

Population ageing and *demographic challenges* are present in Western European countries. The increasing number of older adults and the longer life expectancy of people with disabilities and chronic diseases have become a significant challenge in the field of economics and social policy. The right to health is being questioned. Therefore, clearly defining the relationship parameters between these social groups is essential. Specific demographic challenges can also be observed: parts of the country are overpopulated, while depopulation and even population substitution have occurred in others. In developed countries, infant mortality has decreased. However, the number of newborns has also decreased, life expectancy is significantly longer, and the share of older adults in the population is also on the rise. The question of the permanent sustainability of such a social and economic situation comes to the fore. Significant depopulation has been noted in the Republic of Croatia since the middle of the 20th century.

Understanding the *state of illness* and *health* and the *Hippocratic tradition*. The view of illness as a result of breaking some order or law is an ancient perspective. Over time, the opinion prevailed that disease is an integral part of human existence and that, as such, it cannot be eradicated. The concept of the right to health and a disease-free life is also emerging. Health, defined as a state of complete physical, mental and social well-being, is a utopian and hedonistic ideal. The terms quality of life and ethics of health have become expressions of a kind of health religion. The Hippocratic Oath, created in the 5th century, is often taken as the origin of doctors’ ethical behaviour. It highlights that every medical worker should adhere to autonomy, harmlessness, beneficence and justice, and it should be protected in time as an intangible cultural heritage.

In the section on *appeal to conscience*, some principled requirements are emphasised that are placed before the conscience of healthcare workers, who, in addition to their professional obligations and principles of general humanism, also take on some principles suggested by the Catholic Church (*magisterium*). A few less prominent moments by the quoted authors should also be pointed out: *Declarative level* – the cases under the guidelines of the *magisterium* intended for healthcare workers in each state are strictly regulated by law in their own way, primarily because of their delicacy. Although ethically sensitive, these cases are not among the most numerous in the healthcare system in terms of their frequency: the majority of healthcare workers will never experience a challenge of conscience in their professional practice when terminating a pregnancy or euthanasia. Thus, the agreement of healthcare workers with the teaching of the *magisterium* in these matters is at the declarative level. However, what healthcare workers constantly encounter at their workplaces are endless waiting lists of suffering patients in which those with a Catholic worldview would have to recognise the figure of their “suffering Christ”. *Professional reasons* – the *magisterium*, for its part, offers relatively convincing theological-moral-ethical explanations as to why a health worker should remove some of the procedures or procedures in medicine. An essential contribution of a healthcare worker with a Catholic worldview would be to offer the profession and the interested public strong professional and biomedically relevant arguments about controversial cases so as not to create the appearance of endangering professional integrity due to the (uncritical) acceptance of some doctrine. Appeal to conscience is a means of resolving controversies regarding value, not professional ones. (Let us leave aside the question of how something incompatible with Catholicism and tradition can even become a controversy in a highly Catholic and traditionalist environment.) *Pluralism of values* – in a dynamic world with a pronounced pluralism of value systems, in a world where the phenomenon of the adult patient’s autonomy is present, which is favoured by legislation and public opinion, it is to be expected that in some medical fields, health workers of the Catholic worldview will encounter demands that are against their conscience. There may be more and more such requests, which can put the Catholic healthcare worker in an ungrateful position regarding clients who ask for something that is against their conscience, as well as fellow doctors who have or do not have these fences of conscience, not to leave out the health care system and legal regulation. From this perspective, it is understandable to comment on how advisable it is for someone with an unshakable Catholic conscience to accept a specialisation for which they already know contains a challenge to their conscience (e.g. gynaecology). *Revaluation of values* – the difference between the time of Hippocrates and the modern era is not only in the amount of technical aids (thus, in the amount of knowledge) that are available to man but also in the value scale now containing some different priorities than in Hippocrates' or any other time. In practice, it is always possible to discern the course of value revaluation by which some aspect of any human science is finished. Every human teaching contains a certain amount of manipulation that can significantly affect the professional engagement of an individual whose conscience conflicts with legislation and worldview. Experience shows that phenomena once incompatible with anyone's conscience, a matter of life and death, are now *passé*. With the development of society, the improvement of technology and the progress of science, ethically dubious actions in medicine will probably be able to be performed in a way acceptable to every worldview. However, as of now, it is prudent in the light of common sense to try as much as possible for *the human to be humane*.

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