From The Editor's Memo Pad:

An issue currently developing on the horizon has to do with establishing a balance between the individual's right to privacy with regard to his health records and the society's need for information to keep insurance costs down, to guard against fraud, to pursue criminal justice, and to conduct epidemiological research (Science, Oct. 28, 1977, p. 361.) Currently, many employers, insurance companies and money lenders routinely make decisions about employees and clients on the basis of medical records to which they have been freely given access. Certainly, the individual has a right to control over the information about his health. He should know what is in his health records, where are they kept and who has access to them. The prospect of national insurance will increase the pressure for access to these records. On the other hand, there is important knowledge for the common good in those records. Consequently, there is a need for a balance between the individual's rights and societal needs. Some of the information could be distributed in anonymous fashion but other, which require follow-up, would need to be identifiable as to person. Most people are becoming rapidly aware that our society is moving into a new phase of relationship between individuals and society. As our civilization gets more complex and technological, there is a greater interdependence upon its component parts and there is also a reduction in privacy. Obviously, there is no simple answer to this type of question. However, if one retains the applicable basic principles in mind, then various options could be tried and tested until what would appear to be the best compromise available in the circumstances could be reached. We must always recall the basic principle that an individual has the right to make decisions regarding his life and health. He has a right to privacy. He has a right to determine with whom he shall share personal information. This may require that informed consent may be obtained more widely in order to get access to these records or it may be that data only obtained from publications could be used. The presumption would be that the investigator publishing the results of his research would have obtained the permission of his patients to publish the material in an anonymous fashion. Should particular follow-up be needed, it could be done through the physician who would then make the necessary contact with his patient.

FACT: A group of clinical pharmacologists representing 16 countries has worked out what they believe to be the minimum information the lay public would need to know for the reasonable use of six medicines widely self-prescribed: aspirin, paracetamol (acetaminophen; Tylenol), ferrous sulphate, aluminum hydroxide, senna; and a multivitamin preparation. The information is expressed in simple, nontechnical language. For each substance it is presented in four categories: Nature and uses; Dosage (allowing for a variety of dosage forms); Unwanted effects; Storage. (“Minimum Information for Sensible Use of Self-prescribed Medicines,” Report by an Ad-Hoc Working-Group, The Lancet, November 12, 1977, pp. 1017-1019.)

COMMENTARY: This appears to be the first step in responding to a long existing need for the general public to have access to correct information about drugs which are frequently self-administered. As the authors point out, presently available information is one or a mixture of the following: absent; mixed with advertising; couched in medical jargon; excessive. As a consequence, the lay individual is less able to discharge his responsibility to care for his health in a reasonable manner. For a variety of reasons, there will probably be an increase of self-treatment in the immediate future. Consequently, professionals in the health field have the responsibility to assist the non-medical public in the proper use of those medications available to them. In general, persons living in European nations have easier access to medications for self-treatment than those in the United States. What impact this difference has had on the health of the various populations has yet to be adequately studied. But it seems evident that as a rule, whether the medication is prescribed by an appropriate professional or by the individual, the human dignity of the person is better served when he has an intelligent understanding of the medications he is consuming.

BioNews-An Ethical Focus

Conjoined Twins Separated

FACT: Conjoined twins were reported in the Chicago Sun Times of July 12, 1977 to have been separated. Apparently, at the upper end were two heads, four arms, and shoulders all apparently perfect; at the lower were a single pair of perfect hips and two perfect legs. The insides were entirely mixed up. These twins were reminiscent of another pair of conjoined twins in Houston who were separated a few years ago. The principal problem then was that there was only one heart between the two of them. They were separated but since the one heart could go only to one of the twins, the other unfortunately but necessarily died.

COMMENTARY: There is no question that these are agonizing problems, extremely difficult decisions to make. It has been a constant basic principle of the Church that one innocent person, that is, a person not guilty of any crime cannot be slain or sacrificed for another. In the case of the conjoined twins with the one heart, such currently would be the situation. However, if an artificial heart were available that could maintain life adequately in that individual for a suitable length of time, then the ethical problem would be of a different kind. But as it stands at present the saving of one involves necessarily the death of the other. Can this ever be justified? It is probably true in the case of the twins having the one heart that they could exist for some time in that condition, perhaps until age three or four. However, at some point, the one heart would be inadequate for the two bodies and both would die. Should, then, one do nothing or should one then try to save the life of one even though it may

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