



**IDEALS**

International Dental Ethics  
And Law Society

8th International Dental Ethics and Law Congress  
August 18-20, 2010, Helsinki, Finland

**PROGRAMME & ABSTRACT BOOK**





**IDEALS**  
International Dental Ethics  
And Law Society

**International Dental Ethics and Law Society**

**University of Helsinki**

**Finnish Dental Association**

**8th International Dental Ethics and Law Congress  
August 18-20, 2010, Helsinki, Finland**

## **Programme**

**Day 1: Wednesday August 18**

### **Auditorium 1**

**12:00–17:00 Registration and information desk open**

**14:00 Opening and Welcome**

Klaas-Jan Bakker, President, IDEALS

Kimmo Kontula, Vice Rector, University of Helsinki

**THEME I: Health ICT – Plenary Session**

### **Auditorium 1**

Chair: Matti Pöyry

**14.30 Keynote:** The Role of the European Union in eHealth,  
Jaakko Aarnio, Research Programme Officer,  
European Commission

**15:15 Coffee Break**

**15:45** The challenges of health ICT and vulnerable people  
Dr. Samuli Saarni

**16:15** Ethical aspects of health promotion and advertising via the  
Internet, Professor Jos Welie

**16:45** Forum

**17:15 Closing of the first day**

**19:00** Reception by City of Helsinki (Old Court House)





**Day 2: Thursday August 19**

**Auditorium 1**

**08:15** Opening Remarks, Professor Heikki Murto

**THEME II: Information technology in dental education – Plenary Session**

**Auditorium 1**

Chair: Heikki Murto

**08:30 Keynote:** Privacy and Student Portfolios,  
Professor Richard Oliver

**09:00** Teaching ethics – what should the students learn about ICT?,  
Docent Ritva Halila

**09:45 Coffee Break**

**10:15 Breakout Sessions**

**Auditorium 1**

Chair: Helena Ranta

**Break-out session 1.1** – Information technology in dental education  
(Submitted papers)

1. Meeting ICT challenges when teaching professionalism,  
Wolter Brands, Netherlands

2. Evaluating the Introduction of a Patient's Voice in Dental Education  
Through Reflective Experiential Learning and Self Reported Changes in  
Empathy, Barry Schwartz, Canada

3. Dental ethics education in Turkey: reflections from a 16-year  
experience, Sefik Gorkey, Gurkan Sert, Tolga Guven, Turkey

4. Doctor of Dental Medicine Advertising in Croatia,  
Zvonimir Kaic, Croatia

**Auditorium 2**

Chair: David A. Frenkel

**Break-out session 1.2** – Discussion session, Professional ethics in  
dentistry

1. The Professional Ethics Initiative in Dentistry,  
Donald Patthoff, United States, et al (Discussion)

2. Ethical Issues Surrounding International Dental Outreach Initiatives,  
Shafik Dharamsi, Canada, Jos Welie, USA, et al (Discussion)

**11:45 Lunch**



**THEME III: Patient Safety and Dental Liability Insurance Systems – Plenary Session**

**Auditorium 1**  
Chair: Yvo Vermynen

**13:15** Patient Safety and Dental Liability Insurance systems in different countries,  
Italy – Dr. Vilma Pinchi  
Netherlands – Dr. Bart Admiraal  
Scandinavia – Mr Reima Palonen  
Great Britain – Dr. Greg Waldron

**14:45 Coffee Break**

**15:15 Breakout Sessions**

**Auditorium 1**  
Chair: Yvo Vermynen

**Break-out session 2.1** Patient Safety and Dental Liability Insurance Systems – Round table based on plenary session presentations

**Lounge**  
Chair: Sinikka Salo

**Break-out session 2.2** Poster Session

1. Informed Consent and other Ethical Considerations for Clinical Photography in Teaching, Research and Publication in Dentistry, Sudeshni Naidoo, South Africa
2. The consent in dentistry: ethical and deontological topics with reference to Italian laws, Corrado Paganelli, Francesco De Ferrari, Adelaide Conti, Paola Delbon, Italy
3. Malpractice in dentistry and Turkey, Murat Nergiz, Gurkan Sert, Sefik Gorkey, Turkey
4. The property of medical records in Turkey's dental practice, Murat Nergiz, Gurkan Sert, Sefik Gorkey, Turkey
5. HIV seropositive status data collection in dental patients in Italy - Garante for the personal data protection recent opinion, Corrado Paganelli, Adelaide Conti, Paola Delbon, Laura Laffranchi, Francesco De Ferrari, Italy
6. Ethical and legal issues on mental restarted children who had been treated by general anesthesia at Marmara University Faculty of Dentistry, Department of Pediatric Dentistry Evaluation of 6 month data, Sevi Akgun, Turkey
7. Ethical aspects of stem cell researches in the field of dentistry in Turkey, Seda Mete, Turkey
8. Do Croatian dentists respect patients' confidentiality and privacy?, Gordana Cerjan-Letica, Vice Budimir, Croatia



9. Psychological care for maxillofacial trauma patients: A preliminary survey of oral and maxillofacial surgeons, Poramate Pitak-Arnnop, Christian Hervé, Jean-Christophe Coffin, Kittipong Dhanuthai, Jacques-Charles Bertrand, Jean-Paul Meningaud, Germany
10. Complaints against dentists of various specialities in Poland, Jerzy Marcinkowski, Ryszard Koczorowski, Kinga Jakubowska-Blonko, Poland
11. Analysis of complaints against dentist posted on the Internet in Poland, Jerzy Marcinkowski, Poland
12. The specificity of complaints against dentists in Poland, Jerzy Marcinkowski, Poland

**Auditorium 2**  
Chair: Anthony Vernillo

**Break-out session 2.3** Panel Discussion, Property and Privacy Paradigms of "Marketable Spit". An Ethical and Legal Counterpart to Blood? Anthony Vernillo, USA, Jos Welie, USA, Sudeshni Naidoo, South Africa, Daniel Malamud, USA (via skype)

**16:15 Break**

**Auditorium 1**

**16.30 IDEALS General Assembly Meeting**  
(open to members and non-members)

**19.30 DINNER** at Suomenlinna sea fortress, restaurant Tenalji von Fersen Special Speech: Professor Helena Ranta





**Auditorium 1**  
Puheenjohtaja:  
Ilpo Pietilä

**Break-out session 3.2 – Suomenkielinen rinnakkaisohjelma**

**Potilastietojärjestelmät potilaan ja lääkärin tukena**  
Yhteistyössä Suomen Hammaslääkäriseura Apollonian  
Kansanterveysjaoston kanssa

- 10:30** Uudet sähköiset työkalut ja niiden ongelmat,  
kehittämispäällikkö Anne Kallio, STM
- 11:15** eKatselun vaikutus lääkärin työhön ja potilaan asemaan,  
LL Tinja Lääveri, Lääkäriliiton e-Health-valiokunta

**12:00 Lunch**

Apollonian Kansanterveysjaoston lounaskokous, Faculty Club 6. krs

**THEME V: Right to Health and Health Information**

**13:30 Breakout Sessions**

**Auditorium 2**  
Chair:  
Shafik Dharamsi

**Break-out session 4.1** Ethical issues in dental practice II (Submitted papers)

1. Considerations on collection, utilization and storage of postmortem dental data in the aftermath of mass disasters: Current situation in Turkey, Elif Gunce, Turkey
2. Ethical Issues in the Dental Care Pathway of the Working Poor in Canada, Diego Ardenghi, Christophe Bedos, Rosario Rodriguez, Canada
3. Problems of DVI missions in failed states, Hans Kirsch, Germany

**Auditorium 1**  
Puheenjohtaja:  
Juhani Liikala

**Break-out session 4.2 – Suomenkielinen rinnakkaisohjelma jatkuu**

- 13:30** Hoitosuosittelun rooli, vaikutukset ja etiikka lääkärin työssä, dosentti, yleislääketieteen erikoislääkäri Ilkka Kunnamo, Kustannus Oy Duodecim
- 14:15** Potilaan asema ja muuttuva rooli, professori Veikko Launis, Turun yliopisto

**15:00 Coffee Break**



**IDEALS**  
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## Auditorium 1

Chair: Klaas-Jan Bakker

## Plenary Session

**15:30 Keynote:** Information and the relationship between individual and group good, David W. Chambers, Professor of Dental Education, San Francisco

**16:15 Closing Remarks**  
Klaas-Jan Bakker, President, IDEALS

## Organizers



Suomen Hammaslääkäriliitto  
Finlands Tandläkarförbund



HELSINGIN YLIOPISTO

International Dental Ethics and Law Society

University of Helsinki – Institute of Dentistry

Finnish Dental Association

In collaboration with:

Finnish Association of Forensic Odontology

Division of Public Health – Finnish Dental Society Apollonia



Klaas-Jan Bakker, the President of IDEALS

Dear colleagues,

With great pleasure I welcome you to the beautiful city of Helsinki which is the scenery of the 8th International Dental Ethics and Law Congress. This 8th international congress, organized by IDEALS, the University of Helsinki and the Finnish Dental Association in collaboration with the Finnish Association of Forensic Odontology and the Finnish Dental Society Apollonia, has without a doubt a challenging theme: "Dentistry and Information Technology - Ethical and Legal Considerations. A challenging theme because it touches many areas of today's dental practice and the field of dental education. Privacy and protection of data, health promotion on the internet and the impact of webbased sources on oral healthcare are examples of the many interesting topics which are part of the congress program. Excellent speakers will guide us on our journey to explore the legal and ethical aspects and complexities concerning oral healthcare and the dental profession.

This congress follows the succesful previous congresses which turned out to be excellent forums that offered dentist and legal experts the possibility to exchange views with colleagues from all over the world. It is part of the mission of IDEALS to foster an international dialogue on the values guiding the practice of oral healthcare and more specifically to advance the level of academic education and scholarly activities as well as to promote the development of public policies that respect the rights of patients and that will contribute to the professional character of the healthcare disciplines. In view hereof I am grateful that the Finnish Dental Association was willing to follow up Toronto 2007 and has organized the 8th international congress on Dental Law and Ethics. I am confident that the congress will meet your professional expectations and will make your stay in Helsinki worthwhile and a good thing to remember.

Klaas-Jan Bakker JD President IDEALS



Dear colleagues,

Welcome to Finland and to Biomedicum Helsinki, the centre for medical research and training. The centre provides working facilities for 1800 researchers, graduate students, and support staff of the University of Helsinki and Helsinki University Central Hospital. The first two years of the undergraduate medical and dental curriculum of the Faculty of Medicine are taught here. More than 300 medical and dental students are in residence at the centre.

Each doctor and dentist makes ethical choices in their daily work, and it is our duty to present and discuss these choices. There is not always a single correct answer or solution, but recognising an ethical problem is an important step in the right direction. The aim of IDEALS is to foster exchange of ideas, experiences and knowledge in the fields of dental ethics and dental law. Moreover, it wants to advance understanding and consideration of the values, patient rights and professional duties that guide the clinical practice of dentistry and oral health care.

This is also the key objective of the Finnish Dental Association in Finland. With a view to promoting ethics and collegiality, the Association is encouraging ethical thinking among its members – and not only through formal speeches. The website of the Dental Association publishes ethically problematic cases with comments from members, and a summary is published in the Finnish Dental Journal. According to a readership survey, the published cases were considered the most interesting of all articles in the Journal. In addition, a dental ethics conference has been organized on an annual basis, and dentists have the opportunity to participate in a free ethics course that is arranged in various cities across the country.

We hope you find the congress useful and that it meets your expectations. It is important for all of us to adopt new insights and perspectives. Hopefully this event also provides our foreign guests with a glimpse of Finland and Finnish culture.

Matti Pöyry

Chair, local organizing committee

Executive Director, Finnish Dental Association



Jaakko Aarnio

Nationality: Finnish

Studies: Doctor of Technology, Helsinki University of Technology, 1992

Professional experiences and responsibilities:

Research Programme Officer at ICT for Health Unit, Information Society and Media (DG INFSO), European Commission, Brussels, 2003 onwards – focus area Personal Health Systems (PHS), Administration of projects in EC Framework and Competition and Innovation Programmes related to PHS, Virtual physiological human, patient safety and risk management; EC policy contributions including public procurement studies in the areas of PHS, telemedicine, eHealth business models and mobile eHealth.

Principal scientist and senior researcher at Nokia Research Centre, Communication Systems Lab., Helsinki 1995-2003 - concept development for high speed cellular and fixed networks; strategy and vision work at corporate and research centre levels; corporate and EC policy contributions; various project management and expert tasks in the areas of photonic technologies and broadband communications.

Post-Doc position at Alcatel SEL, Forschungszentrum, Stuttgart, Germany, 1994-1995

Researcher at VTT Electronics, Electronic materials and components, Finland, 1988-1994

**Jaakko Aarnio**

Abstract

## **The role of the European Union in eHealth**

In an ageing Europe, where more and more citizens live with chronic diseases, eHealth can help to make the difference in facing the global challenge posed to health systems by an increasingly heavy burden of demand for service. The European Commission (EC) realises this potential and intends to exercise leadership in fostering the deployment of eHealth applications on a large scale.

Acting in the structured framework of several policy initiatives started in 2004 with the eHealth Action Plan (COM(2004)356), the EC addressed in its Communication on Telemedicine (COM(2008)689) the main barriers that need to be overcome in order to facilitate greater deployment: (1) increasing confidence and acceptance of Telemedicine services; (2) gaining legal clarity; (3) overcoming unsolved technical issues and supporting market development. In the communication "a Digital Agenda for Europe" (COM(2010)245, May 19th 2010) the EC has recently presented Europe's strategy for a flourishing digital economy by 2020, outlining policies and actions to maximise the benefit of the Digital Revolution for all. Commitment to eHealth is confirmed and key actions are defined, as well as clear deadlines for delivery of results. Moreover, a joint action (2010-2012) between the EC and Member States will reinforce coordination between eHealth initiatives. Finally, the Directive for patients' rights in cross-border healthcare, likely to be adopted early 2011, will mark the first time eHealth appears in EU-level legislation. Arguably, the policy momentum for eHealth at present is stronger than ever.

The presentation will outline the initiatives the Commission has adopted. Complementary views of "ICT for Health Unit" in Directorate General for Information Society and Media (DG INFSO) and "Health strategy and Health systems Unit" in Directorate General for Health and Consumer Affairs (DG SANCO) will be presented. The topics include EC policy development, Public Health Objectives and instruments at EU-level and funding instruments for pertinent research and piloting in eHealth.



Samuli Saarni

Samuli Saarni got his MD and M.Soc.Sc (philosophy) degrees from the University of Helsinki years 2001 and 2002. After that he has worked at research positions at the National Institute for Health and Welfare (previously National Public Health Institute) and at clinical positions at the Department of Psychiatry, Helsinki University Central Hospital. Dr Saarni's research interests in ethics are in clinical ethics, evidence-based medicine and health technology assessment. He is currently adjunct professor of social psychiatry at the University of Helsinki, vice-president of the board and chairman of the ethics committee of the Finnish Medical Association, general secretary of the Finnish Physicians Ethics Forum and a consultant ethicist at the Finnish Office for Health Technology Assessment. His recent work includes the development and testing of an international EUnetHTA model for integrating ethical analysis into health technology assessment.

### **The challenges of health ICT and vulnerable people**

Developing and introducing medical technologies, especially pharmacological treatments, is guided and guarded by rigorous processes and safeguards. Thus the effects of new treatments are reasonably well known when they enter the market. This is not usually true of information and communication technologies in health care (Health ICT) or health information technologies (HIT). The result is less-than-perfect systems and the challenge to try to differentiate the value and consequences of HITs working as they should, from situations where they do not work as they should. In other words, there is often less-than-perfect information about the implications of HITs when decisions about implementation are made.

Different HIT systems have obviously different ethical implications and few generalisations are warranted. Assessing the value-issues of HITs requires a wide scope of considerations going beyond a utilitarian maximisation of health benefits or minimisation of costs. These may include the following:

- 1) HITs may be totally novel technologies, opening up previously unimaginable possibilities and processes, the value-consequences of which can be difficult to analyse
- 2) Novel technologies may influence and conflict with peoples deeply held values and convictions. They may also disrupt existing practices and organisational structures, creating important but often unintended or hidden consequences for major stakeholders
- 3) The expected benefits of HITs should always be clearly defined and estimated – being “new” or “computer-based” is not a benefit. How reliable information of benefits should be required?
- 4) The consequences for vulnerable people should be considered separately. Increasing personal responsibility for health with HITs generally risks unequal uptake, i.e. the people most competent for using HITs are rarely those in most health need and visa versa.
- 5) Equality and justice are important in health care. HIT may improve equality of opportunity, but it may also require positive actions and safeguards in order to benefit also the most needy, and not in practice increase socioeconomic differences in health.
- 6) HITs may change the roles of health professionals and patients, requiring shifts in attitudes, values and work-practices. These may be challenging in a the deeply professionalistic culture of medicine.
- 7) Data safety and information ownership issues are important. Even if the theoretical issues do not change, the practical ease of spreading information might change much.
- 8) Human dignity and integrity may need special attention and safeguarding, so that individual values can be respected, and patients not reduced to information especially when HIT is increasingly used for management and health policy.
- 9) What kind of legal frameworks are needed to safeguard the ethical use of HITs?

In sum, HITs can have complex and large creative or disruptive potential for health care systems. We should assess and take these into account with similar seriousness that we use when deciding to implement new medical or surgical interventions.



Jos V.M. Welie, M.A., M.Med.S., J.D., Ph.D.

Professor, Center for Health Policy and Ethics

Creighton University Medical Center; Omaha, Nebraska - USA

Jos V.M. Welie is a native of The Netherlands where he attained degrees in medicine, law, and philosophy. A Fulbright grant brought him to Loyola University of Chicago's Department of Medical Humanities. Subsequently, he started specializing in medical ethics. He obtained his doctorate in medical ethics from the Radboud University of Nijmegen School of Medical Sciences. Areas of primary interest include ethical issues in chronic and terminal care, dental ethics, Jesuit involvement in health sciences education, the philosophical foundations of health care ethics, the human body and person, and the relationships between law and ethics. He came to Creighton University 14 years ago, attaining the rank of full professor in the Center for Health Policy and Ethics in 2004.

In addition to teaching medical ethics at Creighton's School of Medicine, Dr. Welie is also a Professor in the Graduate School and the School of Dentistry's Department of Community and Preventive Dentistry, where he co-directs the main dental ethics course. He has authored some 170 publications, including many chapters and articles on dental ethics. One of the eight books he has produced is an edited volume entitled "Justice in Oral Health Care. Ethical and Educational Perspectives" (Marquette University Press 2006). He served as the Secretary of the International Dental Ethics and Law Society from its inception in 2000 until 2009, was an editorial consultant for the FDI's Dental Ethics Manual (2007), and has lectured on dental ethics topics in a variety of countries besides the USA, including The Netherlands, Germany, Sweden, Croatia, Italy, Turkey, Canada, Australia, and Brazil.

**Jos Welie**

Abstract

### **Ethical aspects of health promotion and advertising via the Internet**

Advertising has been a contentious topic in the world of oral health care ever since the first codes of dental ethics were issued. Forces guiding the regulatory developments have included the (1) profession's desire to restrain the rather outlandish marketing practices of quacks; (2) public health initiatives to increase the populations' knowledge about and use of oral health care services; (3) ethical concerns about the spread of misleading information, (4) and governmental efforts to foster commercial competition among oral health care providers. These competing interests underscore the power of information. Regulations on advertising have ranged from overly detailed rules on the exact font type and size of a dentist's name on his or her business card, to vague and largely ineffective general guidelines, or even the complete absence of any regulations. The emergence and extremely rapid expansion of the internet has further complicated the regulation of the information stream from dentists to patients.

This presentation will begin by reviewing the ethics of advertising. I will then argue that the impact of the internet has primarily been one of scope, not of kind. That is to say, most of the ethical concerns raised by PR via the internet are similar to those of print media, except at a much expanded scale. There are, however, some concerns that are particularly pertinent to the internet. These are raised by the dual direction of internet communications. Even if the patient may not be aware of this, there is a constant stream of information going back from the patient to the internet provider about the patient's internet searches. This, in turn, allows for targeted, patient-specific



Richard Oliver

Richard Oliver is Professor in Dental Education and honorary consultant in orthodontics in the School of Dentistry, Cardiff University, UK. He is actively involved in dental education within the UK and in Europe. He has published articles on undergraduate orthodontic education across Europe and has visited several European dental schools as part of a quality assurance programme managed by the Association for Dental Education in Europe. He is actively involved in research into the Erasmus experience, both at a strategic level and also at an individual student level. He is responsible for the management and delivery of the undergraduate orthodontic programme at Cardiff University, he introduced a reflective portfolio to the dental undergraduate course in 2001 and is an active teacher on the 3-year postgraduate training programme for specialist training. He is a Fellow of the Higher Education Academy and institutional representative to the Association for the Study of Medical Education. He is co-author of a best-selling undergraduate orthodontic textbook, and a textbook on Ethics and Law for the Dental Team.

**Richard Oliver**

Abstract

### **Privacy and Portfolio**

The presentation covers a brief history of portfolios (or personal development planning - PDP) in higher education in the UK, and the use of portfolios in postgraduate dentistry in the UK. This will be followed by a description of the reflective portfolio currently in use by the dental undergraduates in Cardiff University.

The conflict between a reflective portfolio maintained by the student in the form of a personal diary, and a reflective portfolio that is subject to formative and/or summative assessment, and the purpose of that assessment, is discussed. The implications of the inclusion of a clinical log-book as part of a portfolio and issues of patient confidentiality are also discussed.

The presentation will conclude with the findings of a questionnaire distributed to Year 4 and Year 5 students at the School of Dentistry in Cardiff seeking their views on the privacy of their portfolio and concerns in relation to the development of an e-portfolio.



Ritva Halila

Born	Sept. 28, 1958 Kemijärvi, Finland
M.D.	1982, University of Oulu, Finland
Ph.D.	1985, University of Oulu, Finland
Specialist in Paediatrics	1997, University of Helsinki, Finland
Docent of Medical Ethics	2007, University of Helsinki, Finland
MBA	2009, Technological University of Tampere, Finland
Present position	Department Director, Hjelt Institute, University of Helsinki

Previous positions:

Ph.D. Student. Dept. of Anatomy, University of Oulu, 1982-1984  
Research Fellow. Recombinant DNA Laboratory, University of Helsinki, 1984-1987  
Fogarty Fellow. Thomas Jefferson University, Philadelphia, PA, U.S.A. , 1987-1989  
Senior researcher. National Public Health Institute, Helsinki, Finland, 1989-1991  
University teacher. Dept. of Medical Genetics, University of Helsinki, 1991-1992  
Resident. Dept. of Paediatrics, Helsinki University Central Hospital, 1993-1997  
Specialist in Paediatrics. Dept. of Paediatrics, University of Helsinki and Helsinki University Central Hospital, 1998  
General Secretary. National Advisory Board on Health Care Ethics, Ministry of Social Affairs and Health, Finland, 1999-2008  
University lecturer, field: medical ethics. Department of Public Health, University of Helsinki, 2009.

**Teaching ethics – what should medical students know about ICT**

Ethics is a branch of philosophy that raises and weighs questions about morality such as good and evil, right and wrong. Medical ethics is considered as one specific field of applied ethics. The classical four principles of medical ethics are beneficence (doing good), maleficence (avoiding harm), autonomy (right to self determination), and justice (Beauchamp and Childress). Later these four principles were amended by maximization of benefits and respect of human dignity. Health care professionals can use ethical principles as tools when making choices in difficult and complex situations. Ethics provides no ready-made solutions, but tools for thinking and weighing balances between benefit and harm, good and bad, well-being and suffering. Conceptions of good and evil or right and wrong are universal, but their emphasis and interpretations vary from one culture to another and according to political circumstances.

From 1980's medical ethics have been a part of educational curriculum of the Finnish medical schools, but its extent has varied widely in different medical faculties. In some medical schools ethics issues have been integrated into different specialties – sometimes even hidden behind general items, so that ethics have not been easily recognized as a separate discipline.

Information and Communications Technology (ICT) has completely changed the context and working environment of health care professionals. A lot that previously could not be dreamed about is now possible, more and also more sophisticated diagnostics can be made, data about advancement of science can be used for the benefit of patients, information about the patient is easily reached and easily available, and technical development has also contributed directly to better care of patients. Information can also be used for the harm of individuals – and lack of information about health and disease can be harmful. The development has set requirements for the protection of privacy of patients but also for safe and adequate access to personal health information of persons.

Teaching of ethical issues can improve the awareness of medical students on different aspects of ICT. Different actors in the health care sector have different interests. How will the rights of the patient be considered and respected in circumstances where some actors' interests are in conflict with the rights of patients? How to protect the right not to know in situations where the well-being of the patient or his next of kin would be in danger? How to respect the patient's choices if they are other than what the health care professional would have chosen? Does the patient still have right to self-determination also about his/her privacy? Or does the patient really have choices to informed consent in respect to his/her health information? These will be discussed during the presentation.



Vilma Pinchi

Diplomate Dentist

PhD in Medical Forensic Science

Associate Professor of Legal Medicine at University of Florence

Secretary of the Forensic Odontologist Project (Pro.O.F.)

Author of National and International publications dealing with: dental liability, evaluation of dental damage, professional insurance and personal identification

Direct involvement in professional liability matters in various jurisdictions in Italy

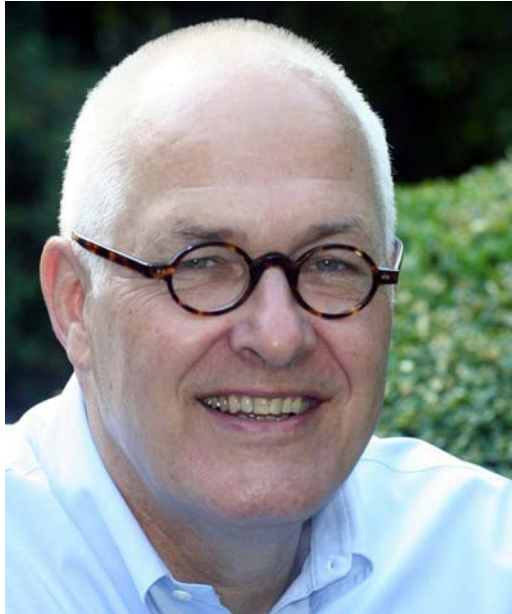
Wide experience in dealing with issues facing the dental profession from regulators, corporate third parties and the legal profession

**Vilma Pinchi**

Abstract

**Dental Claims and professional liability insurance of dentists in Italy**

The speech deals with questions of professional insurance of the dentist in particular discussing about the recent intervention of National Dentist Association that has granted more suitable contracts at lower costs than in the past. The most relevant aspects of the insurance contracts (coverage, exclusion conditions such as those for implantology, aesthetic damage, etc), and the insurance managing of claims will be analyzed. Some points will concern both out-of-court settlement of dental claims and civil judicial procedure of dental suits. The presentation will show the malpractice claim data filed by an important insurance company and by the most important Civil Court and Appeal Court in Italy



W. J. Admiraal

Dentistry at Utrecht University 1966-1974

Dentist Royal Navy 1974-1976

Assistant Professor Utrecht University dep Prosthodontics 1976- 1982

Assistant Professor Utrecht University dep Preventive & Social Dentistry 1982-1986

Combined University, General Practice and Law study till 1983 Thesis (Health Law) : Delegation in dentistry.

Guest teacher Health Law, Academic Dental Center Amsterdam (ACTA) 1986-2003

Personal dental injury consultant in Liability cases.

Legal assistance

**W. J. Admiraal**

Abstract

**Complaining about dentists. The Dutch Paradise.**

This presentation aims to give an insight in the dutch system of filing complaints about dentists. The dutch tripartite system consists of civil procedure, disciplinary jurisdiction and professional mediation. Different cases and examples illustrate the unique emphasis of the dutch system on mediation and professional arbitration. The insights in the way this system works and its consequences will offer plenty of material to think about ways of handling and communicating about complaints in professional, medical practices.

Paradise for the patient or the dentist or Paradise lost?



Reima Palonen

Mr. Reima Palonen is a lawyer, and he has been working as a Claims manager in Finnish Patient Insurance Centre since 2000.

**Patient Safety and Dental Liability Insurance systems in different countries - The Nordic model**

All the Nordic countries – Denmark, Finland, Iceland, Norway and Sweden – have a statutory system for compensating patient injuries sustained in connection with health care and medical treatment. The main purpose of these systems is to improve the patient's position by guaranteeing that he or she has the possibility to receive compensation without legal proceedings for an injury sustained in connection with health care and medical treatment. At the same time the systems also ensure that health care personnel are protected in case of claims for compensation. Although the administrative and financing models vary from country to country, their main features are similar. In Sweden and Finland the systems are based on private insurance policies while in Denmark and Norway a Government authority is responsible for handling compensation claims. Annually the number of claims varies within the countries from 0.36 to 1.4 per thousand inhabitants.

In all five countries compensation and administrative costs are financed by contributions collected from medical and health care practitioners. Every health and medical care practitioner has the statutory obligation to take out an insurance. The amount of public health care contributions is determined primarily on the absorption principle, while private sector contributions, at least in insurance-based systems are priced on commercial principles. Public health care insurance premiums in Finland are currently about EUR 6–7 per inhabitant annually.

The Nordic model is often called the no-fault model. However, the name does not give a correct picture as the main basis of compensation in all the countries is whether the patient injury was avoidable or not, as opposed to objective liability for the injury. The appropriateness of examination and treatment – and thus also the avoidability of the injury – are assessed using as a criterion the competence of an experienced health care professional. If this level of competence is not reached and the injury could probably have been avoided by appropriate action, it will be compensated. In addition to avoidability, there are other grounds for compensation; these include an infection contracted in connection with care, or other serious non-avoidable consequences, and accidents and patient injuries caused by faults in equipment. The percentage of compensable injuries of all injury notifications in the different countries varies between 30 and 45 per cent.

In the case of a compensable injury, it is assessed how the injury affects the development of the patient's health and the need for care. Only extra costs and losses are compensated. The amounts of compensation are in all five countries determined on the basis of tort liability law. Compensation can be paid, among other things, for extra medical treatment costs, pain and suffering, permanent functional or cosmetic incapacity, loss of earnings and in cases of loss of life, funeral expenses and loss of maintenance. The average compensation paid varies by country, between EUR 10,500 and EUR 68,000.



Greg Waldron

Greg qualified as a dentist in 1986 from University of Newcastle upon Tyne and practised as a general dentist from 1986 until 1997.

He then qualified as a solicitor in 1997 from Nottingham Law School. Initially he trained in clinical negligence law firms gaining experience of representing both patients and dentists.

In 2000 he founded the Dental Law Partnership ('DLP') with another dentally qualified solicitor and is now one of the 4 directors of the firm. DLP is a specialist firm of solicitors which only acts for dental patients in dental negligence claims and does not carry out any other type of legal work. The firm now has around 40 employees and is attributed with dealing with around 70% of the UK's dental claims.

Greg was a founding committee member of IDEALS and also a founding member of the UK Dental Ethics and Law Forum.

## **Greg Waldron**

### Abstract

Health care and medical practitioners may make use of information they have acquired in connection with the handling of patient injuries, such as decisions on compensation, to help them develop their own activities. In addition they are regularly supplied with statistical information on the basis of which it is possible to make peer assessments. Information acquired during claims handling can also be used in a medical research investigating the causes leading to injuries and the possibilities of avoiding them in the future, and also in general in developing different forms of medical and health care. In addition to the parties involved in claims handling, the research material commissioned by them is also available to other researchers. The use of patient injury information for research purposes has increased in all the Nordic countries during recent years at the same time as interest in patient safety work has grown.



Helena Ranta

Professor Helena Ranta works at the Department of Forensic Medicine, Hjelt Institute, University of Helsinki and Pontificia Universidad Católica del Perú (bioarchaeology and forensic anthropology). Since 1991, she has been the member of the Finnish DVI Team and from 1996, the Leader of the Finnish Forensic Expert Team. She has participated in the identification of M/S Estonia in 1994, Tsunami in 2004-5 and school shootings in Jokela and Kauhajoki, in addition to repatriation of Finnish soldiers killed in action during the WW2 since 1992.

Professor Ranta has led forensic investigations in Srebrenica and Tuzla, BiH (1996-7) and in Kosovo (1998-2000). The evidence has been submitted to the International Criminal Tribunal for The Former Yugoslavia and national courts. She appeared as a Chamber Witness at the Milosević trial. She has conducted investigations in Cameroon, Iraq and Nepal. In 2005, she was invited to Chechnya as a representative of the Council of Europe.

In 2002-3, Professor Ranta assisted the Peruvian Truth and Reconciliation Commission, and has since been involved in MSc training in Lima. Preliminary plans for training have been completed also in Columbia.

**Helena Ranta**

Abstract

### **Privacy and protection of personal data in disaster victim identification**

The Sumatra-Andaman earthquake on 24 Dec 2004, resulting in extensive material destruction and over 200 000 victims, required an immediate response of national and international rescue and disaster victim identification (DVI) teams. In Thailand, the total death toll exceeded 8000, including over 1000 tourists from Finland, Germany, Sweden and UK.

The identification operation was carried out under the Thai Ministry of the Interior in collaboration with Interpol and national DVI Teams. Medical and dental ante mortem (AM) information was collected in Finland and submitted to the Thai authorities for comparison. There are no exhaustive regulations in relation to the publication of names of missing individuals in disasters. In Finland, the directive 95/46/EC on personal data and free exchange of information is incorporated into the Personal Act (523/1999). After the Ombudsman was consulted, the legality of the publication was confirmed, based on the Act of Rescue Service (561/1999). The list was distributed via the Finnish Dental Association net to practicing dentists and health centers and within two weeks, AM data including x-rays was sent via the protected police net to Thailand, where PM information was collected by multinational DVI Teams. Some confusion was caused by the request of Thai authorities of the original x-rays to be submitted.

International police organization (Interpol) has developed and published guidelines for accident investigation and disaster victim identification. It has also recommended to the members an establishment of a national DVI Team, including police officers and forensic experts. The Finnish DVI Team was established in 1991 under the National Bureau of Investigation (NBI). The guidelines are currently under review, partly as a consequence of experiences in Thailand. The new guidelines and recommendations, including eventually professional requirements and qualifications of forensic odontologists, will hopefully be accepted in the next DVI meeting in Lyon in 2011.



Lasse Lehtonen

Dr. Lasse Lehtonen works as the administrative chief physician of the Helsinki University Central Hospital in Helsinki, Finland. After graduating from medical school he made his Ph.D. in transplantation immunology in the University of Turku and specialized for clinical pharmacology. In addition of medical training he has a doctor's degree in law from the University of Helsinki. He is teaching medical law in several universities in Finland. Dr. Lehtonen has authored or co-authored some 190 publications in immunology, clinical pharmacology or medical law with special interest on data protection and privacy issues in health care. Recently he has been heavily involved in EU funded projects concerning the regulation of the use of human tissues and DNA samples. He has served as a board member in several national and international societies in the field of medical ethics and law.

**Lasse Lehtonen**

Abstract

## **PRIVACY AND DATA PROTECTION**

The right to privacy includes aspects on self-determination (e.g. consent to treatment), on maintenance of confidentiality, and on data protection. Medical data has been considered confidential since the times of Hippocrates. Breach of medical confidentiality is sanctioned in the criminal code. In addition of national laws there are several binding international conventions that require respect for privacy. The article 8 of the European convention on human rights includes regulations both on the protection of privacy and on its restrictions. These regulations were established before electronic data processing became possible. The data protection convention of the Council of Europe from 1981 includes more specific regulations on sensitive data and on the safe guards of data processing.

The EU Directive (95/46/EU/24.10.95) on the Protection of Personal Data is based on the principles of the conventions of the Council of Europe. It mandates member states to maintain adequate level of data protection. It prohibits the processing of sensitive health data with some exemptions. Article 8 of the directive states that registration of sensitive health data is allowed, if the registry is necessary for preventive medicine, medical diagnostics or treatment, or for the administration of health care services. Even when the processing of health data is allowed on the basis of exemptions, the processing of data must follow data protection principles.

Data protection principles require that personal data is processed fairly and lawfully and that the processing is in line with the rights of the individual data subjects. The data can only be processed for a specific purpose and may not be further processed in any way that is incompatible with the original purpose. The data must be adequate, relevant and not excessive for the purpose it is collected for. The data must be accurate and kept up to date, where necessary. The data should not be stored longer than it is necessary for the purpose for which it is used. The processor of the data must keep the data secure with appropriate technical and organisational measures.

The European Court of Human Rights has in several recent decisions assessed, if restrictions of privacy issued in national laws have been compatible with the article 8 of the human rights convention. In the case of *I v Finland* (2008) the court concluded that a person's right to respect for their private life may be breached where the state fails to take appropriate steps to secure medical data, so that it cannot be accessed improperly. This decision puts specific demands on electronic health records. It has an impact also on the way any national health registry may be constructed



Richard (Dick) Speers

Graduated from the University of Toronto, Faculty of Dentistry, in 1975 and has been in private practice since that time. He has chaired the Practice Advisory Committee of the Ontario Dental Association and the Ethics Committee of the Canadian Dental Association. He has held positions in Complaints, Quality Assurance and Professional Liability at the Royal College of Dental Surgeons of Ontario.

Since his own health records were compromised, he has been actively involved in lecturing internationally and writing on personal health information protection and its implications on the delivery of care.

He is a founding member and past President of IDEALS.

**Richard Speers**

Abstract

**Electronic health records and patient data protection: Legislative and ethical issues from the Canadian experience.**

For successful health care interventions, many providers with specialized skills are involved in patient care, from physicians, dentists, lab technicians, pharmacists, nurses and a myriad of therapists.

Each has his or her own need for access to patient information and legislative requirements to document observations, diagnoses and interventions.

Electronic records are necessary for efficient, seamless and appropriate care.

Personal health information, in the wrong hands can, however, lead to loss of self esteem, embarrassment, prejudicial care, loss of job opportunities and more insidiously, blackmail. Even as this is being written, new issues of medical identity theft are being reported as a new and emerging threat.

Can electronic records, designed for ease of access, allow for patient privacy protection?

Is the ethical requirement for patient confidentiality and privacy a concept that is foreign to electronic health records and now 'obsolete'? Have engineers decided that access to information renders patient dignity and privacy as road kill on the information highway?

This presentation intends to present a review of where Canadians are heading with a single payer health care system and some of the problems already encountered with electronic health records.



Anne Kallio

Kehittämispäällikkö

Sosiaali- ja terveysministeriö

Anne Kallio on koulutukseltaan hallinnon pätevyyden omaava KNK-erikoislääkäri, joka on työskennellyt erikoissairaanhoidossa korvalääkärinä. Viimeiset 10 vuotta hän on toiminut terveydenhuollon tietohallintotehtävissä Kaakkois-Suomessa. Vuodesta 2009 lähtien hän on toiminut Sosiaali- ja terveysministeriössä kehittämispäällikkönä vastuualueenaan sosiaali- ja terveydenhuollon tiedonhallinnan kansallisten palveluiden kehittäminen, keihäänkärkenä KanTa-hanke.

Anne Kallio

Head of Development

Ministry of Social Affairs and Health

Anne Kallio is an ENT doctor and has worked within specialised care. Last ten years she has worked with eHealth in South East Finland and national projects. Since 2009 she has worked in the Ministry of Social Affairs and Health tasked to develop and direct social and healthcare data management and the implementation of national services supporting them.

## Anne Kallio

### Abstract

## KanTa – mikä muuttuu?

### Kansalaisen kannalta - eKatselu

- pääsy omiin tietoihin
- luovutusten seuranta lokitietojen avulla
- suostumusten ja kieltojen hallinta
- omien tietojen (elinluovutus, hoitotahto) hallinta

### Terveydenhuollon ammattilaisten kannalta

- potilastiedot käytössä (julkinen, yksityissektori ja työterveyshuolto) potilaan suostumuksella
- suostumusten kysely vähenee potilaiden hoitaessa asian itse
- tiedon standardointi luo mahdollisuuksia
  - päätöksenteon tuki
  - riskitiedot
  - älykkäät haut (esim rokotustiedot)

### Terveydenhuollon johtamisen kannalta

- organisaatiokohtaisesta kokonaisvaltaiseen tarkasteluun
- lonkkapotilaan palvelukokonaisuus
  - kauanko kesti, mitä maksoi pth:ssa, esh:ssa, yksityispuolella, menetettynä työaikana, hoidon lopputulos
  - vertailu muihin alueisiin
- yksittäisistä tutkimuksista on line –tilastointiin
- yksittäisistä tiedonsiirroista valtakunnalliseen ratkaisuun
- uudet toimintamallit mahdollisiksi
  - tiedonkulku ei ole uusien toimintojen esteenä
  - ostopalvelut, palveluseteli
  - potilaan valinnanvapaus
  - yhteispäivystykset
  - järjestelmävaihdot, kuntaliitokset...

## Yhteenveto

- Rakennetaan kansallista terveydenhuollon tietohallinnon infrastruktuuria
- KanTa on tietovarasto, joka mahdollistaa terveydenhuollon palvelujen kehittämisen ja tehostamisen
  - tiedot käytössä palvelurakenteen muutoksessa ja kaikilla hoitavilla tahoilla
- kyseessä ei ole hanke, vaan pysyvä toiminta
  - vaatii riittävän organisoinnin ja resursoinnin
- pääasia ei ole tietotekniikka vaan sen mahdollistamat uudet toimintatavat



Tinja Lääveri

LL, sisätautien erikoislääkäri, infektioatauteihin erikoistuva lääkäri HUS infektioosion kehittäjä  
Kehittämispäällikkö HUS tietotekniikka  
Suomen Lääkäriliitto eHealth valiokunnan puheenjohtaja

## eKatselun vaikutus lääkärin työhön ja potilaan asemaan

Potilaalla on lain mukaan katselu-oikeus kaikkiin häntä koskeviin terveydenhuollon asiakirjoihin – siis myös paperisiin. Tästä voidaan poiketa vain jos siitä voidaan katsoa olevan erityistä haittaa potilaan terveydelle. Uusi laki (ehdotus tätä kirjoittaessa) potilastietojen sähköisestä käsittelystä takaa tämän oikeuden myös sähköisiin potilasasiakirjoihin. Potilas pystyy eKatseluyhteyden avulla hallinnoimaan myös suostumuksia ja kieltoja tietojen katseluun ja seuraamaan, kuka tietoja on katsellut. Suostumus on voimassa toistaiseksi ja lähtökohtaisesti kaikkiin tietoihin eikä, kuten tähän asti, rajattu palvelutapahtumiin. Potilaan katseltaviksi päätyvät läheteet, yhteenvedot annetusta hoidosta, hoidon loppulausunnot, laboratoriotulokset, lääkärintodistukset ja –lausunnot sekä reseptikeskuksen kautta tiedot kirjoitetuista resepteistä.

Ammattilainen kirjaa terveydenhuollon asiakirjoihin tekstiä ensisijaisesti välittääkseen tiedot toiselle ammattilaiselle, perustellakseen hoitoratkaisunsa ja turvatakseen jatkohoidon. Ilmaisujen kuuluu olla yksiselitteisiä ennen kaikkea toiselle ammattilaiselle, jolloin kieli varsin väistämättä muuttuu ilman lääkäritilinaakin lääkärisuomeksi eikä potilassuomeksi. Potilaan kykyä ymmärtää tätä tekstiä voi luonnollisesti haitata myös tietämättömyys diagnostiikan ja hoidon lääketieteellisistä perusteista. Lääkärille täysin looginen päätelmäketju hiuksianostattavine poissulkudiagnooseineen saattaa olla potilaalle ihan käsittämätön. Tähän tarvitaan väliin tulkki. Tähän ei riitä sanojen kääntäminen vaan kokonaisuuden tulkkaminen eli potilas tarvitsee oman päätöksenteon tuen kertomaan, mitä kaikki oikeasti tarkoittaa ja miten tähän on päädytty.

Jopa 60%:ssa sähköisistä potilasasiakirjoista on Weirin (2006) selvityksen mukaan virheellisiä kirjauksia, usein vielä kopioituna myöhempiinkin merkintöihin. Poikkeavista laboratoriotutkimustuloksista jää kertomatta potilaalle 5% (Casalino 2009). Potilasta voidaankin jopa pitää ”viimeisenä turvavarmistustarkistuspisteenä”.

Asia erikseen on, jos asiakirjatekstin sisältö ei miellytä. Potilas ei voi määrätä, mitä hänestä kirjataan. Ammattilaisen velvollisuus on kirjata asiat ja ennen kaikkea päätöksiinsä vaikuttaneet seikat. Jo nyt terveydenhuoltohenkilöstö joutuu jättämään kirjaamatta olennaisia asioita pelätessään turvallisuutensa puolesta joko uhkaavasti käyttäytyvän potilaan tai omaisten takia.

Jatkohoitosuunnitelma ei koske kuitenkaan vain terveydenhuollon ammattilaisia. Potilas on olennainen osa jatkohoidon suunnittelua ja ennen kaikkea sen toteutusta. Potilasasiakirjat tuleekin tulevaisuudessa nähdä myös tapana kommunikoida potilaan kanssa.

Lääkäri on harvoin enää sellainen auktoriteetti, joka määrää hoidosta neuvottelematta potilaan kanssa. Toisaalta lääkäriä, toisin kuin muulla terveydenhuollon henkilökunnalla, on lakisääteinen vastuu diagnostiikasta ja hoidosta päättämisestä. Potilaan ”voimaantumisen” ei saa olla pakoilua tästä vastuusta. Potilaan on entistä helpompi saada second opinion, ja tämä asettaa ammattilaiselle haasteen tietotaidon ajan tasalla pysymisestä. Potilaalle on avoimena myös lähes kaikki sama tutkimustieto, mikä lääkärikin. Tämäkin asettaa ammattilaiselle haasteen pysytellä ajan hermolla.

”Valtaistuminenkaan” ei saa olla heitteillejättöä. Kaikilla ei ole kykyä tai halua valtaistua. Sekin on hyväksyttävä. On rakennettava turvaverkko niille, joille elämä sähköisessä verkossa ei ole itsestäänselvyys. Heitä on keskuudessamme vielä kymmeniä vuosia. On luotava turvaverkko myös niille, jotka ovat pudonneet nykyisen terveydenhuollon verkon läpi. Suuri haaste on löytää ne avainasiakkaat, joita ennen terveystalveluiden suurkuluttajiksi kutsuttiin, ne, joihin kuuluu ne kuuluisat 80% terveydenhuollon resursseista? Tunnetustihan varsinkin perusterveydenhuollon vastaanotoilla käyvät usein aivan ”väärät” henkilöt.

”Katselu” on jo sanana passiivinen, ja näenkin pelkän potilasasiakirjojen katseluyhteyden ilman minkäänlaista potilasopastusta suorastaan heitteillejättönä. Internet pursua epäasiallista terveysdisinformaatiota, jossa asiantuntijoiksi itsensä julistaneet kertovat lääketieteen ”oikeasta” diagnostiikasta. Meidän velvollisuutemme on ohjata potilas asiallisen informaation luo. Jos potilas asiallisen informaation saatuaan valitsee uskomushoidot, niin se on hänen oma valintansa, mutta hänellä tulee olla mahdollisuus tehdä tietoisia päätöksiä.

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David W. Chambers

Dr. Chambers is professor of dental education and former associate dean for academic affairs and scholarship at the University of the Pacific, Arthur A. Dugoni School of Dentistry in San Francisco. He is also the editor of the American College of Dentists and a member of the board of directors of the Sonoma Valley Healthcare District. He has served as a consultant to most national dental organizations and dental schools in the United States and Canada, as well as being an examiner for the Malcolm Baldrige National Quality Award and on the Commission on Dental Accreditation. He has earned the EdM, MBA, and PhD degrees. He has published over 400 papers in his areas of interest, which include competency-based education, ethics, evaluation, and critical thinking.

**Dr. David W. Chambers**

Abstract

**Information, Privacy, and the Individual and Public Good [abstract] David W. Chambers**

I will explore the proposition that individual privacy of information in health care is an inadequately defined and false issue. Instead, a second-person perspective, mutual satisfaction approach where patients and providers choose what information to share in a context generally set by relevant bodies, is a more useful and robust framework.

The ethics of information privacy have traditionally been cast as studying the conditions under which the default principle of individual patients' autonomy might be abridged. This approach has difficulty managing the mutual symmetry of information needs and cases where providing information is an imposition on others. The underdetermination and indeterminacy of ethical principles relative to specific moral behavior predictably leads to unsatisfactory dilemmas.

Information has value in a different sense from personal property or even bodily capacity. It can be given away and still kept, its duplication and transmission costs are nil compared with the labor of acquiring it, getting more of the same information is almost never of value, and it cannot be inspected or previewed. Thus, "violation of information privacy" per se has almost no effect on increasing or decreasing one's personal value.

In the primal sense of violated privacy, one is outraged at being discovered. An image designed for public consumption has been torn (even if the image was a lie). In the primal sense, invasion of does not involve what, if any, use is made of the information gained, but one must be aware that the invasion has taken place or it is not an invasion.

In the general sense of violation of privacy, the concerns are fair use by both parties. This is fundamentally a concern over not using information beyond agreed or necessary purposes, confidentiality (unauthorized disclosure), and security (protection against accidental misuse). Both the primal and the general senses of information privacy are inescapably multiparty ethical situations, not matters of individual acts and principles.

Information privacy thus concerns pairs of individuals (such as dentists and patients) negotiating the kinds of information that must be shared, and sometimes the terms and conditions of that use. If a mutually satisfactory understanding cannot be reached, care is not provided. There is no presumption that the arrangement is ideal or even "principled," but the understanding must be one which both parties agree could not be improved on given the circumstances; neither party would choose to change, even if given further information. This is a game theory equilibrium, and Nobel laureate John Nash proved that there is always such an equilibrium in the case of pairs such as dentists and patients. This is the criterion I propose for the act of ethical sharing of private information, as long as there is no coercion, deception, or renegeing involved

Where do the circumstances that provide the context for ethical practice come from? Called "practice," these are provided by law, policy, custom, and codes developed in the community. Unfortunately, it has been proven by another Nobel laureate, Kenneth Arrow, that that there can never be a generally satisfactory solution for the so-called social welfare function: it is impossible to identify a set of rules that will be acceptable to all parties. There is one exception to Arrow's Theorem. A dictator can be appointed to decide. But I would be suspicious of any philosopher who volunteered for such a position.

## Abstracts Scientific Presentations

**Day 2: Thursday August 19**

### **Break-out session 1.1 Information technology in dental education**

Chair: Suzette Porter

#### **1. Meeting ICT challenges when teaching professionalism**

**Dr. Wolter G. Brands, Vaassen, Gelderland, Netherlands**

In many dental schools professionalism is becoming an important part of the curriculum. Teaching professionalism brings other challenges than for instance teaching periodontology or other clinical aspects of dentistry. Professionalism is seen as an attitude that is gradually acquired. Contrary to clinical aspects, it is not enough to simply provide the student with adequate skills by training certain procedures. A second challenge is the competition for the available hours. Clinicians have a point when they argue that a dentist without clinical skills cannot treat patients adequately. Consequently the greater part of curriculum will be used to teach clinical skills.

In the UMC Nijmegen these factors led to little hours for professionalism, spread throughout the 6 years curriculum. This spread allows us to work with a port folio, thus monitoring the professional development of the student. As we have about 400 students and a limited staff, it was a challenge to reduce the paperwork. Our experiments with a digital port folio may be useful to other faculty teaching professionalism. As we try to improve our curriculum we hope to learn from the experience of others schools. So we are highly interested in discussing this topic with other faculties.

#### **2. Evaluating the Introduction of a Patient's Voice in Dental Education Through Reflective Experiential Learning and Self Reported Changes in Empathy**

**Dr. Barry Schwartz, London, Ontario, Canada**

At the Schulich School of Medicine and Dentistry, the University of Western Ontario, Canada, a study was conducted entitled; "Evaluating the Introduction of a Patient's Voice in Dental Education Through Reflective Experiential Learning and Self Reported Changes in Empathy."

Barry Schwartz, as Principal Investigator, along with Richard Bohay and Judy McCormick as Co-Investigators, were the recipient of the 2009 Fellowship in Teaching Innovation at the University of Western Ontario for this project.

It is believed that optimum inter-personal relationships in a dentist-patient relationship are central to enhanced patient care and development of a trusting professional relationship. In order to enhance such relationships, dentists must see patients as more than an illness or a treatment. Understanding the whole patient is also related to assisting dentists in becoming reflective practitioners. Integrating a patient's voice into dental education attempts to develop a more humanistic approach towards the dental education journey.

In our study, we filmed a series of patients who shared their dental experiences in order that they can be shared with Schulich Dentistry students as part of classroom discussions regarding topics such as access to care, dentists in society, dental treatment error and medically/socio-economically marginalized patients. This will hopefully enhance courses already offered in ethics and communications training at Schulich Dentistry.

The students involved in this study were asked to fill out a survey pre- and post-intervention. These were analyzed quantitatively along with a qualitative analysis of reflective journals prepared by the students, and the interviews conducted with the patient volunteers, to determine the overall impact of this educational intervention on students' levels of empathy for patients.

Information technology was integrated throughout this study with online surveys and via allowing the students to review the videos on a secure WebCT website. Early findings of this research will be presented.

### **3. DENTAL ETHICS EDUCATION IN TURKEY: REFLECTIONS FROM A 16-YEAR EXPERIENCE.**

**Prof. Sefik Gorkey, ISTANBUL, Turkey**

Establishing a specific curriculum for dental ethics lectures can be a significant challenge. The number of specific texts on dental ethics in the international literature is very limited in comparison to the vast number of sources on medical ethics, and scholars of ethics very rarely specialize in this field. This is an important problem in Turkey, where there are currently no departments of dental ethics in universities. Generally, lecturers employed in schools of medicine are also responsible for conducting dental ethics lectures. As a result, the content of dental ethics lectures do not usually differ than those provided to medicine students and to other future health care workers. Unfortunately, such a generalized approach to ethics curriculum in dentistry education can not adequately cover the ethical aspects of topics that are specific for dental practice. Consequently, these lectures can not be expected to provide guidance for ethical dilemmas and problems which dentistry students may face in their future practice.

In order to avoid this problem, Marmara University's Department of Medical Ethics and History of Medicine has been using a curriculum designed to meet the requirements of dental ethics education. For this purpose, the curriculum classifies the main topics of bioethics in three different groups: Issues specific for medical ethics (Group 1), overlapping issues of medical and dental ethics (Group 2) and issues specific for dental ethics (Group 3). This classification plays a significant role in determining the scope of the dental ethics lectures. For instance; since topics in Group 1 are remotely related with dental practice, only general information about these issues are presented in the lectures. On the other hand, topics in Group 3 are covered in detailed in the lectures and these lectures are given by a department member who has a background in dentistry.

It should be noted that topics in group 2 are further divided into 3 groups according to their significance for dental practice. Among those; informed consent, biomedical research, ethics committees and patient rights (subgroup A) are considered to be equally important for both medical and dental practice and therefore, the content of these lectures do not differ significantly than those provided in the faculty of medicine curriculum. Oncology ethics (subgroup B) are considered to be more closely related with medical practice and this topic is usually not covered in detail for dentistry students. On the other hand, ethical aspects of advertising and ethical issues in HIV infection and AIDS (subgroup C) are treated in the same manner with the topics in Group 3, since these issues are particularly important for the practice of dentistry.

We believe that this method of classification for organizing the large number of topics in bioethics in accordance with their significance for dental practice can be an important and beneficial approach for dental ethics education, particularly for providing practical and relevant information for dentistry students.

#### **4. Doctor of Dental Medicine Advertising in Croatia**

**Prof. Zvonimir Kaic, Zagreb, Croatia,**

Advertising by dentists is old as the profession itself; it happens all around the globe and in Croatia too. The current Regulations Governing Professional Advertising by Dentists (RGPAD) in Croatia is based on the Dental Medicine Law and the Croatian Dental Chamber Statutes. This by-law was passed by the Administrative Council of the Croatian Dental Chamber on 2nd June 2009 and came into force on 11th June 2009.

These rules are binding on the 4200 licensed and registered doctors of dental medicine (DDM) in Croatia which are practising as individuals, group practices partnerships, the concessionaire, the founder or the owner of a dental office or professional corporations, associations or the trade company.

##### Advertising Manner

A DDM has the right to advertise in newspapers (daily, weekly or monthly), in professional journals, at the Internet by the web sites or at the other ways in accordance with the Croatian Chamber of Dental Medicine (CCDM) Code of Dental Ethics and Deontology and RGPAD dispositions respectively (Article 3). Actually 57 percent of the Croatian households have the access to the broadband Internet. Moreover, roughly 50 percent Croatian inhabitants elder of 15 years have been using the Internet. Unfortunately, the current Croatian guidelines do not contain any specific instruction relating to the Internet. Furthermore, if a DDM publishes a professional article on dentistry, the DDM should include his/her full name, but the title and address of the private or group practice, the healthcare institution or the trade company where treatment can be done must not be pointed out. The previous rule does not apply to members working for any of the Croatian universities (Article 4).

A DDM may not be advertised via radio, TV or similar means (Article 5). A DDM does have the right to actively take part in a radio broadcast or TV shows related to the dentistry, provided the DDM does not pointing out his/her place of work. Again, this rule does not pertain to the employees of the Croatian universities. Advertising of the dental services that exceed the DDM's level of knowledge, experience and competences, that would tempt patients to switch dentists without due cause, or that encroaches on the practice of other specialties is forbidden (Article 7).

##### Permission issuing

A DDM who wants to advertise his practice is obliged to follow the various procedures that have been put in place by the CCDM. Among others, the DDM has to submit the proposal of the advertisement, including the draft.

#### **CONCLUSIONS**

Advertising by dental professionals appears increasingly necessary to sustain a dental practice economically. However, regulations of advertising by dentists are ever more necessary as well. The new Croatian Regulations Governing Professional Advertising by Dentists are intended to improve and harmonise the scope and manner of advertising by Croatian DDMs in order to protect the public against misleading ads.

Only real life will tell whether these new regulations will be effective.

## **Break-out session 1.2 Discussion session, Professional ethics in dentistry**

Chair: David A. Frenkel

### **1. The Professional Ethics Initiative in Dentistry**

**Dr. Donald E. Patthoff, Martinsburg, WV, United States**

This presentation aims to describe and expand the Professional Ethics Initiative in Dentistry which is being developed to help professionals and society regain their professional voice. This presentation/ discussion will explore and develop the role of professionalism as a third voice along side that of the market and bureaucracy. Eliot Friedson's work, in "Professionalism: the Third Logic" offers an Ideal of Professionalism; Base on this Ideal, he, others, and current local to global experiences have demonstrated why professionals and society should not adopt the competitive language of business and politics if they need to preserve the collaborative voice of professions. The internal damage that professionals do when they adopt language that is not native to their professional mission and core values, is as threatening, if not more threatening, than the discourse of a business/government hegemony aimed at influencing or controlling professionally guided social interests such as health care. The professional ethics Initiative was initially developed as a collaborative of the American College of Dentists, The American Dental Association, The American Dental Association, and the American Society of Dental Ethics. It is currently working with several other national and global organizations to further its strategic partnerships based on prioritizing the partnership models of professionalism rather than only business or political relationships. The actualization of this initiative is currently being developed through four general projects: 1) building a literature clearing house devoted to the scholarly collection of theoretical and applied professional ethics in dentistry, 2) developing a core cadre of professional dental ethicists from DDS/facilitators to DDS/PhDs, 3) developing and implementing professional ethics qualitative self assessment tools for individual dental practices, and 4) developing and implementing professional ethics qualitative self assessment tools for dental organizations such as dental schools, dental societies, specialty dental organizations etc. Dr. Don Patthoff will introduce the theme for the session, coordinate the preparations for this session, and lead the discussion during the actual session. Several of the PEI steering committee members will be available to co-present and facilitate.

### **2. Ethical Issues Surrounding International Dental Outreach Initiatives**

**Dr. Shafik Dharamsi, British Columbia, Canada**

International dental outreach is seen as an effective way to foster a sense of global citizenship and social responsibility. Dental students are participating in increasing numbers in both formally established and self-arranged outreach projects. Outreach activities generally have the potential to offer students the opportunity to learn about their role as global citizens, community engagement, leadership, and social responsibility. Opportunities are often set in vulnerable communities in resource poor settings where there are pronounced disparities in health and healthcare.

There is a growing concern, however, around undesirable impacts of outreach activities. Student motivations range from a positive desire to respond to disparities in oral health, inequities in healthcare, and to promote social justice, as well as, and sometimes primarily to practice clinical skills, enhance a résumé, opportunities for travel and experience different cultures in far-away and exotic places. Outreach activities can easily create dependency relationships if they take an exclusively charity based approach rather than enabling an equal and collaborative partnership with communities for developing capacity to address the root causes of systemic social inequity and disparity. A one week stint in a developing country extracting hundreds of teeth followed by sightseeing and cultural excursions can be seen as nothing more than voluntourism or dental tourism – used pejoratively to describe dentists who travel internationally to provide healthcare in impoverished settings, and at times providing care that is of questionable quality and outside one's area of expertise. Vulnerable communities can easily become a means to the volunteers' ends

instead of serving first the community identified needs and empowerment interests. The undesirable impact (the potential for harm and exploitation) of international outreach activities has not been adequately considered.

## **Break-out session 2.2 Poster session**

Chair: Sinikka Salo

### **1. Informed Consent and other Ethical Considerations for Clinical Photography in Teaching, Research and Publication in Dentistry**

**Prof.dr. Sudeshni Naidoo, Cape Town, Western Cape, South Africa**

The art of representing and reproducing medical subjects dates back to 1500 BC and has encompassed a range of techniques including stone carvings, painting, woodwork, copper engraving, sketching, drawing, anatomical models, photography, medical imaging and computer-generated images. Photography can be traced back to 1839 and in its infancy was described as “half art, half science”, and indeed the former often became the tool for the latter. Photography, new as it was in those early years helped to make sense of the world. It provided evidence of imperceptible phenomena in discipline ranging from geology to biology and astronomy. In the last decade of the 19th century, Wilhelm Röntgen’s discovery of X-rays extended human vision. The question persisted: was it art or science?

The photograph generates an ambiguous relationship with the idea of identity. It can lay it bare, exploit it, reveal and embody it. The American Indians believed that the photographer could steal their soul. Historically, the clinical photograph or image has offered a powerful medium for research. Photography in research, as a method of data collection has its roots in social anthropology ethnographic observation in which photographs were seen as an undeniable, static record of the truth. Photography also made the world feel a smaller place. It was simply a visual notebook used by anthropologists to establish and identify the ‘body types’ of criminals and to explore the ‘otherness’ of foreign tribes and cultures.

The introduction of photography was intended to add reliability and credibility to the images represented, although it has become increasingly evident that photographs can be manipulated. Guidelines have been developed in North America and Europe insisting on patient consent for clinical photography; however, they have failed to protect the identities of all patients because they are applied only loosely in developing countries.

Photographs of patients and disease entities are used for many purposes in dentistry. They are incorporated into the dental record as an adjunct to clinical care, displayed to colleagues, students and other audiences in educational settings, and published in scientific journals or other media as part of dental research. In each case it is not only prudent, but necessary for the patients’ protection and interest that appropriate and valid consent be obtained. While dental journals invariably require written consent for photographs that may identify the patient, the format of the photograph consent form is usually not specified, nor is it always clear which images require consent. With the advancement of information technology and the proliferation of published images on the Internet it has become particularly important to obtain permission for all uses that will be made of dental images, including worldwide distribution through various electronic media.

This presentation will explore Informed Consent and other Ethical Considerations for Clinical Photography with view to establishing clinical photography guidelines that are sensitive to the privacy and dignities of patients and research subjects alike.

## **2. The consent in dentistry: ethical and deontological topics with reference to Italian laws. Prof. corrado Paganelli, Brescia, Italy**

The exercise of professional activity of a dentist or dental hygienist, toward the patient, cannot be carried out without obtaining the patient's consensus and providing adequate information.

In Italy, the consensus for health treatment, other than representing an ethical and deontological obligation, constitutes an essential requirement for any medical treatment according to article 13 and 23 of "Carta Costituzionale", further more in accordance with the article 5 of European Council Convention on Human Rights and Biomedicine" (Oviedo 1997), signed by Italy and subject of the law on authorization for approval n. 145/ 2001".

An essential requirement for the validity of consensus is clear, exhaustive and adequate information to the patient himself: this is the reason why the practice of informed consent is not only a patient's signature on a preprinted form, but, instead, it is an informational process, as in a communicative relationship in which the patient can express doubts, perplexities and clarifications demand to the dentist or dental hygienist.

Furthermore dentist and hygienist treatment, and their related professional figures, show some peculiarities: the relationship between dentistry and esthetics, the idea of pain often automatically associated with dental care, the concomitant presence of some pathologies, requiring different treatment, the elongated (months or even years) care process and the establishment of a trustworthy relationship and almost familiarity with the patient (with the risk towards a paternalistic unbalance of the therapeutic relationship), the preventive and therapeutic function of the dentist and hygienist represent important aspects in the configuration of the relationship with the patient and in the process of acquiring an informed consent.

The dentist cannot avoid offering correct information on the diagnosis, the prognosis, the therapeutic prospective, the likely consequences of therapy of alternative therapy and refusal of therapy and in relation to eventual commitments for the period after treatment (e.g. control appointment, hygiene rules, the need of other eventual interventions, ect.)

Particular considerations must be carried out for patients of unsound mind, minors and elderly: the approach to this type of patients by the dentist and hygienist needs to be clear, compatible to the age and understanding ability, even if the decisional power for sanitary treatment may be of a third person

## **3. MALPRACTICE IN DENTISTRY AND TURKEY**

### **Mr. Murat Nergiz, ISTANBUL, Turkey**

According to the World Medical Association, malpractice "involves the physician's failure to conform to the standard of care for treatment of the patient's condition, or a lack of skill, or negligence in providing care to the patient, which is the direct cause of an injury to the patient." (44th World Medical Assembly, 1992).

The concept of malpractice is also significant for dentistry, particularly because dental practice involves interventions of surgical nature and these interventions have a direct effect on the quality of life and the health of the individual. Malpractice may ensue as a result of different factors such as negligence, wrongful intention or professional incompetence. Under such conditions, the dentist will be professionally and legally liable.

Medical Deontology Regulation's Article 2 states that "The primary duty of the physician and the dentist is to show respect and to care for the health, the life and the personality of the human being". Therefore, the Regulation does not emphasize a distinction between the professional responsibility of the physician and the dentist. Article 10 of the same regulation (amended in February 27, 2001) states that dentists are responsible for the medical interventions they perform, (as well as) the completeness of patient records, the recording of procedures and interventions in patient files, the sterilization and disinfection of equipment and for ensuring that the employed health care personnel are periodically examined with regard to contagious diseases". However, despite these provisions aiming to define the scope of the professional liability of dentists, it

accepted that there are deficits in the legislation addressing the concept of malpractice in Turkey. Nevertheless, it should also be noted that efforts to issue new regulations for malpractice problems have been intensified, particularly in the last decade.

Private practice in the field of dentistry in Turkey is very common. This means that the dentist uses her own resources to diagnose and treat the dental problem in her own office. Under these circumstances, aspects regarding the adequacy of medical equipment and other physical conditions become significant. Considering the fact that determination of the “standards of medical treatment” is one of the key aspects in the detection of malpractice, it is essential to establish and implement such standards in the practice of dentistry. Although there may be deficits in the content of the current legislation with regard to malpractice issues, it is clear that there is no difference between the legal and ethical aspects of the practices of a physician and a dentist. For this reason, it should be emphasized that legal liability issues in the practice of health care should be considered for dentists as well as for physicians.

#### **4. THE PROPERTY OF MEDICAL RECORDS IN TURKEY’S DENTAL PRACTICE**

##### **Mr. Murat Nergiz, ISTANBUL, Turkey**

Providers of health care service are under an obligation to maintain the medical records of patients. This obligation is also closely related with the concept of informed consent. Complete and organized maintenance of medical records are also important in case of potential legal conflicts that may arise between the patient and the health care provider.

Turkey’s “Law on the Practice of Medicine and Related Arts (LPOMRA)”, dating from 1928, has a dedicated article on this issue, which states that health care professionals including physicians, dentists and midwives have a duty to record patient information. It is important to note that the article explicitly includes dentists as a part of the health care professionals who have a duty to maintain patient records. In addition, Medical Deontology Regulation’s (issued in 1960) Article 19 states that “...upon leaving the patient (to some other health care professional’s care), the notes regarding the treatment process are to be provided to the patient if the physician or the dentist think it is necessary, or if the patient requests them”. However, since the approaches defined in these regulations are not sufficiently detailed, different approaches to the issue have ensued. This issue has been a subject of controversy for many years until the Regulation on Patient Rights (RPR, issued in 1998), whose Articles 16 (entitled “Examining the records”) and 17 (Entitled “Demanding the correction of records”) finally addressed the issue in more detail. These articles clearly define the nature and the scope of the records that should be maintained, helping to partially eliminate the confusion about the topic.

On the other hand, the answer to the question on whether medical records are the property of the patient, the health care professional or the health care institution still remains controversial. Article 16 of RPR has addressed the issue as in the following: “The patient can examine the records and the files containing information about her medical situation directly, or through her legal representative and can obtain a copy of them. These records can only be seen by those who are directly related with the treatment of the patient.” However, although the provision on the issue defined the right to obtain a copy of the records, it has also implied that these records are the property of the health care institution. Therefore, the question on the property of these records – and particularly whether they belong to the patient herself- still remains controversial.

## **5. HIV seropositive status data collection in dental patients in Italy - Garante for the personal data protection recent opinion**

**Prof. Corrado Paganelli, Brescia, Italy**

The processing of sensitive information in health field is subjected to rigorous discipline to guarantee the protection of information confidentiality pertaining to inner personal sphere. Recently in Italy, the Garante for the personal data protection code has expressed a formal opinion regarding the standard procedure of dental offices to submit a form concerning the patient's health status, before the first check-up, with the request to declare whether suffering from HIV infection or not.

The Garante has underlined as all health data collection must be in accordance with the current Italian normative framework for the personal data protection and therefore with due respect of the patient's freedom. This freedom allows patient to decide, in a conscious and responsible way, of not sharing some health information with health personnel without, hence, suffering any prejudice in the provision of health care requested. Moreover the data collection must be relevant and not-exceed principles of treatment goals having reference to specific care to the concerned person. On the other hand, the need of recording information about of the eventual HIV infection at the first appointment, regardless of whatever clinical intervention or therapeutic plan has to be carried out, could not alter the standard specific protection measures for health staff. In fact these measures have to be adopted for every patient.

## **6. Ethical and legal issues on mental retarded children who had been treated by general anesthesia at Marmara University Faculty of Dentistry, Department of Pediatric Dentistry Evaluation of 6 month data.**

**Ms. Sevi Akgun, İstanbul, Şişli, Turkey**

This retrospective study shows ethical circumstances of a fact in health care for children undergoing general anesthesia to dental treatment in Marmara University, Department of Pediatric Dentistry.

The aim of the study: It is not always possible to perform effective clinical dental treatment even to have a comprehensive examination on patients mentally and/or physically challenged. In selected circumstances, general anesthesia may be the only option for dental treatment. When these situations occur, the dentist 's responsible for administering the general anesthesia should be documented by informed consent form . This form designed to provide general information to patient and to guide parents or legal presentatives in fully and clearly explaining risks, benefits and treatment alternatives to patient. But an ethical dilemma may arise between the person who give permission and the limited effects of the dental team on the decision. Due to incompetence of the patients, the parents or legal representatives should have signed the informed consent form. In this study we tried the evaluate the auotonomy of parents or legal representatives. In case of a decision againts the benefit of the mental retarded patients what can dentists do in the legal ground.

Material and Method : Parents of the disabled children been receiving general anestesias in the first six month in 2009, had been filled in questionnaire which consist of age, gender, socioeconomic status and dental situation of the brothers /sisters in the family, etc.

Conclusion : None of the parents object to practitioner' decision. We thought that (Because of the fact that) Marmara University Hospital last alternative on general anestesias procedure in İstanbul. We believe this is an important problem in principle of auotonomy in dental ethics.

If the dentist believes that child would be harmed irreversibly without the treatment and this treatment is refused by parents and legal representatives, dentist has droit to follow legal procedures. These procedures are to file a complaint report with the child services of competent authorities and these authorities may make a decision to abolish or limit the law guardianship if they certain about child's neglecting .

## **7. Ethical aspects of stem cell researches in the field of dentistry in Turkey**

**Dr. Seda Mete, İstanbul, Turkey**

Stem cells are found in the early embryo, in the foetus and the umbilical cord blood, and in many tissues of the body after birth and in the adult. These stem cells are the source for tissues and organs of the foetus and for growth and repair in the new born and adult body. Human stem cells are classified as human embryonic stem cells, human embryonic germ cells and human somatic stem cells.

Stem cell based therapies (often called regenerative medicine or cell based therapies) are being investigated to develop new methods to repair or replace tissues or cells damaged by injuries or diseases and to treat serious chronic diseases.

For the characterization of BMSCs (Bone marrow stromal cells), researchers have reported the isolation of stem cells from the pulp of deciduous and permanent teeth and from the periodontal ligament (PDL). Dental pulp cells were shown to form dentin when transplanted in vivo, and cells derived from PDL formed cementum and a PDL-like structure. Deciduous teeth and third molars with attached PDL are available routinely and these tissues represent another source of autologous cells that would be of interest to the dental community for restorative procedures. The goals to be reached in dentistry with the researches on stem cells are; recreation of a tooth bud, regeneration of bone/marrow organ, restoring dentally relevant tissues such as dentin, cementum and PDL.

The stem cell researches are based on two kinds of stem cell lines: embryonic and adult stem cell lines. Even both methods have bioethical dilemmas, it seems that embryonic stem cells seem more problematic.

One of the main ethical dilemma regarding ethics on stem cell research is caused by different moral statuses attributed to the embryo. Because the process of embryonic stem cell extraction end the "life" of embryo this intervention is unacceptable for those regarding the beginning of life from insemination.

Due to European Union's pluralistic point of view, European Union decision makers left the final decision to member countries on researches of stem cells using embryos.

In Turkey there isn't a legal regulation specific to stem cell researches in the country. There is only a legal regulation on human experimentation since 1993.

On account of stem cell researches both in dental and medical field, Turkish Ministry of Health has taken the initiative in the country and banned stem cell researches temporarily until announcement of national guidelines.

In 2006, Turkish Ministry of Health announced a guideline on clinically used non-embryonic stem cell researches and they organised a scientific consultation committee for the transportation of stem cells. In 1979 Turkish Parliament enacted the legislation called "The Law of Donating, Preserving, Grafting and Transplantation of Organs and Tissues" and by now in the country organ and tissue transplantation services are organised according to the notice announced by the Ministry of Health in 2000. As well as the guideline on clinically used non-embryonic stem cell researches doesn't include any specific explanation about the regulation of researches in the field of dentistry; the guideline on organ and tissue transportation services doesn't include a regulation on "Tooth Banks" specifically.

## **8. DO CROATIAN DENTISTS RESPECT PATIENTS' CONFIDENTIALITY AND PRIVACY**

**Prof. Gordana Cerjan Cerjan-Letica, Vice Budimir, ZAGREB, Croatia**

Confidentiality of what the dentists learn about their patients and the patient's right to privacy about their information and personal data is build into respective national laws and the Code of ethics in the Croatian dentistry – as one of the key components of the professional duties. Nevertheless from clinical experience, i.e. daily practice, it appears that dentists are insufficiently informed about obligation of professional confidentiality and privacy of patients and that they consequently do not apply in practice the Croatian legislation regulating this issue. There is no relevant scientific data to what extent health professionals in general and dentists in particular employ their obligation to

protect patients' confidentiality in Croatia. The purpose of this study is to explore how dentist understand their professional duty to protect patients' privacy, the level of awareness and the dominant attitudes on the subject.

We plan to include 840 dentists in our survey and ask them to fill out a questionnaire. We hope for a response rate of 70% which, according to data from the registry of the Croatian Chamber of Dentists, makes 15% of the total number of dentists. The research will be designed as cross-sectional observational study. Statistical analysis of the obtained data will be made using the statistical program SPSS 10.0 - analysis of variance, analysis of Covariance, multiple regression and discriminatory analysis. Canonical discrimination function analysis will be used to assess the attitudes of 3 different strata (dentist in the public health institutions, dentists in private sector without active third party, dentist in private sector with third-party payers)

We expect our survey results to demonstrate that in daily dental care practice the right to patients' confidentiality and privacy of data is not fully accepted standard and that Croatian dentist do not completely understand ethical reasons for protection. Besides we hope that research results may indicate the direction of future dental education bearing in mind that good communication between patient and dentist strongly depends on confidentiality. We would like to propose specific training patterns on the matter and to set strict educational commitment to dentists' obligations. Without obligation to respect the patients' confidentiality and privacy of information and personal data, diagnosis and appropriate treatment can not be properly established.

## **9. Psychological care for maxillofacial trauma patients: A preliminary survey of oral and maxillofacial surgeons**

**Dr. Poramate Pitak-Arnnop, Leipzig, Germany**

Introduction: Psychological morbidities are major complications following maxillofacial injuries. Most studies focused on nature of the posttraumatic psychological problems. However, self-evaluation of treating surgeons has not been studied before.

Subjects and Methods: A cross-sectional design in the form of a self-administered e-mail questionnaire was sent to 398 surgeons sampled from 261 oral and maxillofacial surgery (OMFS) services in the USA, UK, and France. It evaluated self-assessed knowledge, attitude and practice of the surgeons with regard to psychological problems in facial injury patients, and their collaboration with psychological personnel. Descriptive statistics was computed as appropriate.

Results: The response rate was 28.1%, and 100 respondents practising in 107 OMFS units were included. A moderate or high level of relevant knowledge was disclosed by 60% of the surgeons. Intra-service psychological staff was reported in 28 departments (26.2%), whereas 5 surgeons revealed considerable deficits in access to psychological care. Frequent reasons for patient referral to psychological staff were depression, body dysmorphic disorder, posttraumatic stress disorder, suicidal idea, anxiety and behavioural changes. Eighty-eight surgeons stated that non-compliance of patients causes practice changes or difficulties, and 58 surgeons experienced it already.

Conclusions: Despite several limitations, the results of this study suggested that the surgeons had a great interest and experience of posttraumatic psychological problems. However, surgeons should not neglect psychosocial aspects of the patients. Psychological professionals in charge may help deliver high-quality surgical care. Well-designed studies with larger sample size are encouraged to confirm our results. Ethical issues of maxillofacial trauma care were also discussed.

## **10. Complaints against dentists of various specialities in Poland**

**Jerzy T. Marcinkowski, Ryszard Koczorowski, Kinga Jakubowski-Błonk**

**Introduction.** The number of complaints against doctors and dentists is growing and this is seen mainly in highly developed countries. This is a result of many factors among which a greater awareness of patients' rights and the role played by the media seem to be the most important. Regarding Poland, three phenomena may be of crucial importance: the transformation from socialism to capitalism initiated in 1989, a crisis in the health care system continuing for decades, a significant migration of medical personnel to highly developed countries.

**Objective.** Assessment of complaints against dentists of various specialities in Poland.

**Material.** Documentation of the District Commissioner of Professional Responsibility of the Wielkopolska Chamber of Physicians on the complaints against dentists in the years 1990-2010.

**Results.** Before the reactivation of the Chamber of Physicians (1989) a very low number of complaints were voiced against physicians. From 1990 the number of complaints against medical doctors increased rapidly, reaching a peak in 2002, while the number of complaints against dentists was significantly lower and remained in each year at a similar level. However, allegations against dentists became more serious and some of them were put on trial. Complaints against dentists in Poland . since 2000 have involved: general dentistry - 59.6%, dental prosthetics - 10.1%, dental surgery - 8.7%, paedodontics - 8.0%, restorative dentistry - 5.9%, orthodontics - 3.5%, maxillo-facial surgery - 3.1% of all the complaints made. The same situation was in Wielkopolska, where 56.1% of general dentistry complaints were investigated by the District Commissioner of Professional Responsibility. Further reasons were: idleness of patient's plea (dental procedure was not in accordance with current medical knowledge), withdrawal of the complaint by the patient, the patient's absence on interview, the lack of relevant data concerning the material provided by the patient. Most complaints were filed because patients in their 60s and 70s were not satisfied with dental prosthetics. Male dentists had a worse rapport with their patients than the female dentists. Complaints were more frequently submitted by women living in towns with a population of over 100,000. The main concern was discomfort (local) and/or lack of aesthetic satisfaction. 10% of the complaints were lodged by the parents of under-aged children and regarded orthodontics.

**Conclusions.** Bracket and dental materials quality limits of National Health Fund services increased the number of complaints. The financial aspect is also a frequent problem. The highest number of complaints concerned dental prosthetics. Many complaints is a result of inappropriate communication with patients, so this issue requires very clear-sighted interference into pre- and postgraduate education system. Dentists should be adequately insured.

## **11. Analysis of complaints against dentist posted on the Internet in Poland**

**Jerzy T. Marcinkowski, Ryszard Koczorowski, Kinga Jakubowski-Błonko**

**Introduction:** Complaints against dentists are frequently publicized in mass media and on the Internet. They grow in numbers and are directed to numerous institutions, which negatively influences the image of the dental profession. Therefore an analysis of that undesired phenomenon would be advisable in order to recognize its background and causes.

**Aim.** By analyzing the problem-related internet information to recognize the causes of the patients' dissatisfaction with dental services – and subsequently to analyze them with the focus on the possibilities of improvement of the health care system in order to minimize the number of the patients' complaints against dentists in the future.

**Material and methods.** Websites were analyzed quantitatively and qualitatively in the period from 2007 to 2010 by introducing keywords associated with complaints against dentists, such as claims, doctors /dentists, bad dentist, bad dental care, etc. into the following search engines:

[www.google.com](http://www.google.com), [www.wp.pl](http://www.wp.pl), [www.onet.pl](http://www.onet.pl). In quantitative analysis, after entering these keywords each of the search engines showed the total number of websites that each of them found in connection with the keywords. A large number of such sites were given. In qualitative analysis the content of these sites was analyzed with regard to types of complaints. Results: The most sites were found in response to the expression "dissatisfied with the dentist " (1232) and the word "dentist" (770). Complaints against dentists are present in Internet users' conversations (chat

rooms, blogs) and are discussed on the websites of many institutions, such as the Chamber of Physicians (the professional responsibility representative), the National Healthcare Fund (the patients' representative), the Agricultural Social Insurance Fund, mass media, courts of law, the Patients' Rights Office at the Ministry of Health and Welfare, the Prime Minister's Office, both chambers of the Polish Parliament, the ombudsman, the European Court of Human Rights. Conclusions. Dentists should be aware of Internet comments and discussions concerning their profession, conduct and ethical standards.

The scope of information on dental treatment is surprisingly wide among the Internet users who, generally, are not dentists. There has been a rapid development of Internet communication between patients, physicians and health care institutions (e.g. through e-mail messages).

## **12. The specificity of complaints against dentists in Poland**

### **Jerzy Marcinkowski, Poland**

Introduction. The number of complaints against doctors and dentists is growing and this is seen mainly in highly developed countries. This causes the growth of many factors, among which most likely is important to raise awareness about rights, to which mainly contribute to the media. What is unique about the issues analysed the situation in Poland? Three factors seem to be of crucial importance: 1) the transformation from a socialist to a capitalist system initiated in 1989 with an increase in public awareness, 2) health care crisis going on for decades, despite attempts to fundamental reforms, 3) a significant emigration of medical personnel to highly developed countries.

Objective. Assessment of complaints against dentists.

Material. Documentation of the District Commissioner of Professional Responsibility of the Wielkopolska Chamber of Physicians on the complaints of dentists covering the years 1990-2010.

Results. Prior to the reactivation of the Chamber of Physicians (which before 1989 in Poland did not exist) were only isolated cases of complaints against doctors. Since 1990 the number of complaints against doctors has increased rapidly, reaching a peak in 2002, while the number of complaints against dentists were significantly lower and remained in each year at a similar level. However, allegations that dentists have become increasingly serious and increasingly the courts were directed to doctors.

Complaints against dentists were in Poland, since 2000, as follows: general dentistry - 59.6%, dental prosthetics - 10.1%, dental surgery - 8.7%, dentistry for children - 8.0%, restorative dentistry - 5.9%, orthodontics - 3.5%, maxillo-facial surgery - 3.1% of all applications. The same was in Wielkopolska, where as many as 56.1% has been a refusal to initiate the investigation by the District Commissioner of Professional Responsibility, which - acting as a mediator between the complainant to blame the patient and the dentist - often achieved a favourable solution to both parties. Further reasons for refusal to initiate the investigation were: the patient's plea statement groundlessness (dental procedure was in accordance with current medical knowledge), withdrawal of the complaint by the patient, failing to submit the patient to be interviewed, the lack of relevant data concerning the material provided by the patient. The majority of complaints filed, patients in the sixth and seventh decade of life, this was mainly dissatisfaction with prosthetic services.

Dentists - men have a worse relationship with their patients than the dentists – women.

Complaints were more frequently by women and residents of major cities. Mainly concerned discomfort (local) and/or lack of aesthetic satisfaction. 10% of complaints were lodged by parents of minor children, mainly related to orthodontics.

Conclusions. 1) limits on the scope of free dental services and quality used dental materials that exist in the contracts with the National Health Fund, increase the number of complaints. 2) The financial aspect is one of the important themes. 3) Complaints about services from dental prosthetics that were the most frequent. 4) At the root of many complaints lying inappropriate communication with patients, so this issue requires the widest possible integration into the education of pre- and postgraduate. 5) Dentists must be adequately insured.

## **Break-out session 2.3 Panel discussion**

### **Property and Privacy Paradigms of "Marketable Spit": An Ethical and Legal Counterpart to Blood?,**

**Anthony Vernillo, USA, Jos Welie, USA, Sudeshni Naidoo, South Africa, Daniel Malamud, USA (via skype)**

Major advances in the testing of oral fluid (e.g., saliva) may lead to the diagnosis and treatment of previously undiagnosed conditions and may enable dentists to manage oral disease more effectively. Such use of another body fluid, blood, is already well established. Blood is a complex tissue that has been extensively researched and is now used for a wide variety of diagnostic tests. It is also regarded as a form of property with ethical and legal dimensions. If saliva is to fulfill a similar role, it should perhaps be granted those same protections. This paper advances the concept that saliva should be considered a form of property, possibly within personal biological materials law. The emerging potential for the development of marketable products from oral fluids raises the issue of protecting the research participant's ethical and legal rights. In particular, violation of privacy and genetic discrimination may arise from the testing of salivary DNA. Respect for autonomy requires that the clinician inform a patient or research participant about his or her rights to property and privacy as these may pertain to oral fluid.

## **Day 3: Friday 20 August**

### **Break-out session 3.1 Ethical issues in dental practice I**

Chair: Sefik Gorkey

#### **1. Research ethics and surgeons: A survey of oral and maxillofacial surgeon**

**Dr. Poramate Pitak-Arnnop, Leipzig, Germany**

**INTRODUCTION:** Ethics and oral-maxillofacial (OMF) surgeons remain understudied. Our previous studies revealed the lack of ethical documentation and conflicts of interest (Col) disclosures in most oral and maxillofacial surgery (OMS) publications. Ethical issues in the OMS journals' instructions to authors were incomplete, albeit comparable with those in plastic surgery and otolaryngologic journals.

**AIM:** To explore backgrounds and opinions of OMF surgeon-authors on biomedical ethics and their understanding of research ethics standards.

**METHODS:** This was a cross-sectional study using an e-mail questionnaire. We enrolled a sample of 324 OMF authors and 2 Editors-in-Chiefs of the leading OMS journals in 2007. The main predictor variables were types of practice, interests and educational backgrounds in bioethics, and support from an ethical committee. The main outcome variable was the understanding of human subject protection (HSP) statement, Col disclosures, and duplicate publications. Appropriate descriptive and univariate statistics were computed, and a P-value of < 0.05 was considered statistically significant.

**RESULTS:** A 52.8% response rate was obtained from 172 surgeons, 154 of which met the inclusion criteria: OMF surgeons only. One hundred and forty-five responders (94.2%) were males. Although 146 surgeons (94.8%) revealed their interest in bioethics, only 48 surgeons (31.2%) understood the ethics standards correctly. Types of practice, interests in bioethics and ethical support were not individually associated with the surgeon's comprehension of the research ethics guidance ( $P > 0.05$ ). Continuing education improved surgeons' knowledge with regard to research ethics ( $P = 0.001$ ).

**CONCLUSIONS:** Our results suggest that OMF surgeon-authors are interested in bioethics. However, there are vast differences in their understanding of the research ethics standards, deserving more awareness of the journal editors and reviewers. Continuing education on research ethics for OMF surgeons is urgently needed.

#### **2. The Need for Explicit Informed Consent for N2O Sedation**

**Dr. Nicholas J Levering, Omaha, NE, United States**

Informed consent is an integral component of patient autonomy in the decision to administer nitrous oxide in the dental treatment of the pediatric patient. It is a right and responsibility shared by the dental provider and patient as a necessary condition of any dental intervention and underscored by the elevated status of nitrous oxide as a routine intervention in contemporary American dental practice. However, routine usage may result in overconfidence such that issues of side-effects, administration and polypharmacy are insufficiently acknowledged. With respect to nitrous oxide as both a dental and medical intervention in children, this paper will (1) address the necessity of explicit consent and (2) that such consent should be written.

## Explicit vs Implied Consent

The issue of consent to specific dental and/or medical treatment always becomes more complex with respect to the pediatric patient which requires reliance on a surrogate decision-maker, usually the parent. It will be argued that the consent cannot be implied by reasonable inference of the actions of both parties but must be explicit. Hence, a provider-caretaker dialogue becomes a prerequisite to clarify treatment goals and how those are to be achieved. A parent may present with a pre-conceived notion or even "demand" regarding those goals, whereas the dental provider may present a counter treatment or rationale as "this is what I always do". Treatment cannot proceed until there is resolution of consent which must be obtained through parental education and professional justification based on objective, scientific methods. The consent must additionally reflect the current trend in the law toward the expansion of patient's rights with the shift from the "professional community standard" of consent toward the "reasonable patient standard".

## Oral vs Written Consent

Although there is general agreement that nitrous consent for the minor patient is required, British standards of conscious sedation for dentistry for written consent are more demanding than those of the US. The guidelines of the American Academy of Pediatric Dentistry do not distinguish between written and oral consent, only that consent is required. Although written consent (endorsed with a signature) can elicit and facilitate a streamlined discussion between parties, it does not necessarily constitute an "informed" consent. This is especially true in the case of "blanket" consent, common in the US, used to obtain consent for a variety of dissimilar interventions and where discussion, disclosure and deliberation may be limited. Oral consent can be similarly critiqued, but is additionally problematic in that it provides no documented evidence in the dental record or physical copy given to the custodial caretaker to the depth and nature of the pre-treatment dialogue, nor address the expanded legal rights of today's surrogate decision-maker.

The act of both explicit and written informed consent of nitrous oxide usage documents and reinforces a comprehensive discussion, understanding, and assent as paramount to the best interests of the child, while at the same time reducing practitioner liability.

### **3. Important organizational aspects to assess a general dental practice**

**Mr. Rutger E Sonneveld, Nijmegen, Netherlands**

#### Background

Nowadays, in health care patients are more and more seen as emancipated consumers. Internet is an important source for consumers to gain information about a large diversity of subjects but information on management of primary health care is scarce. Information on practice management would enable consumers and providers of care to assess and improve practice management and to compare practices.

#### Aim of the study

The present study focused on the question: which organizational aspects are most important for patients and dentists to assess a general dental practice?

#### Method

A framework of over 60 aspects within five domains was developed consisting of: (1) infrastructure; (2) information; (3) people; (4) finance; and (5) quality & safety. These indicators were rated on usefulness and clarity in consensus rounds with patients and general dental practitioners separately. The result was a set of 41 aspects and was made ready for use into 39 questions on organizational aspects of general dental practices.

#### Material; sampling

The study population consisted of 5000 patients, recruited from 150 randomly chosen general dental practices in the Netherlands. The participating dentists were asked to give a questionnaire to the first 50 patients they treated in the third week of January 2009. Two weeks after the last handed out questionnaire reminders were sent. The patients were asked to send the completed questionnaires back to the practice.

#### Dentists

In addition to the participating dentists selected in the patient sample procedure, a random sample of 400 dentists was drawn out of all the dentists (aged  $\leq 65$  yrs) registered in the Netherlands. In a covering letter the dentists were asked to participate in the study and to fill in the dentist questionnaire. The response rate was 54% after two reminders.

#### Results

The overall response rate was 63% and 61%, respectively for patients and dentists. The most important aspects mentioned by more than 50% of the dentists and patients were accessibility of the dental practice by telephone, refreshment courses for dentists, native speaking dentist, waiting times, and information about treatments.

#### Conclusion

If dental patients are seen as emancipated health consumers, dentists should provide them at least information concerning the above mentioned organizational aspects of their practice.

#### **4. The Effect of Communication of Medical Errors on Liability Exposure**

##### **Dr. Michael R Ragan, Miami, Fl, United States**

Since the publication of the IOM Report, "To Err is Human" in 1999 and the solvency crisis of the US Professional Liability insurance market there has been significant discussion of the communication of clinical errors in the dental medicine setting. This case-based oral presentation will outline the potential effect of the communication of medical errors on liability exposure from both the perspective of the USA litigation system as well as the USA Dental Professional Liability insurance companies.

#### **5. SECURITY CAMERAS AND PRIVACY IN HOSPITAL**

##### **Dr. MEHMET KARATAS, ISTANBUL, Turkey**

Hospital security cameras in the prevention of theft, any judicial event lighting, hospital staff in the hospital with many benefits such as keeping track of the performance is an application. This is to get health care as well as patients who were admitted to hospital because of the privacy of security cameras may cause ethical problems.

Body in the provision of health services respect the privacy of private life is an important part of the right to privacy. A person's body, his most intimate aspects of private life forms. The solution of health problems for people who came to the hospital, the security cameras because of its record in the social life of people do not want to know about the body can be damaged due to an issue.

## **Break-out session 4.1 Ethical issues in dental practice II**

Chair: Shafik Dharamsi

### **1. Considerations on collection, utilization and storage of postmortem dental data in the aftermath of mass disasters: Current situation in Turkey**

**Dr. Elif M. Gunce, Istanbul, Turkey**

Forensic odontology is a relatively new discipline in Turkey. Dental data was first used for identification purposes following an airplane accident in January 2003. After this incident, dental identification has gradually gained weight in mass disasters. Turkish forensic odontologists, currently only two in the Council of Forensic Medicine, an expert institution linked to the Ministry of Justice, have been employed in more than 15 DVI operations since 2003. Although no statistics are available on how many of the around 500 victims of these disasters were identified by their dental characteristics, a significant rise in the awareness about dental identification as a reliable and useful tool of human identification is clearly observed. Inevitably, this has brought up concerns regarding the confidentiality of personal data. So far, there are no guidelines available how to collect, use and store the obtained postmortem findings. To avoid adverse outcomes and as a part of the quality system implemented in the Council of Forensic Medicine, forensic odontologists are in the process of establishing standards to ensure the confidential handling of postmortem dental data.

Questions arising in this aspect include at least the following:

1. Who should perform the intraoral autopsy?
2. Which dental findings are relevant for identification?
3. How should these findings be documented?
4. How should the documented findings be archived?
5. Who should have access to the data?
6. How should the data be stored and for how long?

Guidelines should give clear answers to the abovementioned questions and emphasize the real purpose of obtaining postmortem data. In a country where forensic disciplines are still in progress, establishing guidelines concerning ethical issues mean a real big step towards best practice.

Keywords: confidentiality, postmortem data, identification

### **2. Ethical Issues in the Dental Care Pathway of the Working Poor in Canada**

**Dr. Diego M. Ardenghi, Montreal, QC, Canada**

Canada has universal public medical insurance for the population. However, there is no coverage for oral health care, except for a few specific groups; in fact, the majority of Canadian youth, adult and elderly populations do not have free access to general oral health care. This situation might bring questions of social justice and ethics. In Canada, as well as in many developed countries, the most privileged social classes have better oral health than underprivileged groups. This contributes to a strong social gradient in oral health: the poorer one is, the poorer is her oral health. Several studies have focused on the determinants of access to dental services and have shown the importance of financial, cultural, and social factors to oral health care access. However, very little research has been conducted on the working poor population. **OBJECTIVE:** This research aims to describe, understand and explain the dental care pathway of the Canadian working poor exploring the social justice and ethical issues related to that. **METHODOLOGY/METHODS:** This qualitative research uses constructivist grounded theory. Face-to face, 60 minutes, semi-structured interviews with working poor people were audio-recorded. **RESULTS:** We found two different dental care pathways for the working poor (a) when experiencing dental pain and (b) when not experiencing dental pain. When suffering dental pain they visit the dentist and usually make the treatment necessary to relieve their suffering; they follow the dentist's recommendation and might exit the pathway when the pain is over. In the second situation, when they do not have pain, participants might not complete the dental treatment and might exit the dental care pathway due to many

motives, such as, bad experience with dentists, financial issues and lack of working benefits. The ethical implications of this pathway will be explored in this presentation and the final findings of this study might help policy-makers to develop more reliable and ethical programs to improve access to dental care services for the working poor, ultimately improving their oral health. This research is funded by: Canadian Institutes of Health Research (CIHR), CIHR Strategic Training Program in Applied Oral Health Research and Fonds de la Recherche en Santé du Québec (FRSQ).

### **3. Problems of DVI missions in failed states**

#### **Dr. Hans P. Kirsch, Saarbruecken, Saarland, Germany**

My oral presentation was encouraged by Prof. John Clement Chair of Forensic Odontology, Head, Oral Anatomy Medicine and Surgery Unit, Melbourne Dental School.

I know that this theme doesn't meet the core themes of the congress but it is highly topical.

My presentation would like to set the starting point to an internationally led discussion about the ethics in DVI, confronted with a largest scale and very complex internationally responded disaster scenario.

The Haiti scenario is unprecedented.

Haiti can be described as a failed state as it was listed on the failed state index on rank number 12 in 2009. Haiti could not take care of the DVI process as there was neither a functional legislative nor a functional jurisdiction left after the devastating earthquake occurred. It is even not known if Haiti sent out the Major Disaster Assessment Form to ask Interpol for help.

The overall responsibility for Haiti was legally in the hands of the UN mission MINUSTAH, who lost many lives and many of their head management level as well.

Additionally, foreign troops came into the country, controlling the International airport and doubling MINUSTAH functions.

The first question in such a scenario is: Who is in charge of the DVI process?

Further questions are: Who takes responsibility? Who has the ability to respond quickly and sufficiently at that scale?

The MINUSTAH is obliged to prevent that the human remains of their personnel are dug into mass graves together with the debris, as shown in the media. The Major Disaster Assessment Form describes some aspects of a possible and legally performed DVI triage.

Overall, the international community cannot accept human remains treated like rubbish. This holds far reaching implications. For me as a Christian, this is an absolutely unacceptable procedure.

In a disaster scenario like this, it is legal, legitimate and highly ethical to perform a quick and fast (first-) response by a professional disaster management company. Should we wait until about 20 nations DVI teams are coordinated in all their sensitivities? Should the embassies personnel deploy in the disaster area searching for the human remains of their nationals?

Why did Interpol not respond? Why did the international DVI teams not respond? Why did no one take responsibility?

What will be in the future? What shall we do if a civilian airplane crashes in the area of a nation in combat with each other? And this country won't accept national DVI teams, won't accept national flags? Start a military campaign?

Or hire a neutral company in blue berets accepted by both combatants?

What we need is international cooperation, collaboration and partnership of all protagonists Governmental-NGO-Public-Private, embedded in an ethical codex under the UN flag and the UN resolutions.



