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EDITORIAL – BUILDING THE SCIENTIFIC PROGRAM FOR THE  
24TH WORLD CONGRESS ON MEDICAL LAW AND BIOETHICS, TEL  
AVIV 2-6 SEPTEMBER, 2018

The Scientific Committee of the 24<sup>th</sup> World Congress on Medical Law and Bioethics reviewed over 220 abstracts from about 40 countries. The program contains about 110 oral presentations and 50 posters from 33 countries.

Main themes covered in the Congress:

- Liability, Risk Management and Patient Safety, tort law and health
- Health professions law and ethics
- Forensic Medicine
- Disability Studies, Law and Ethics
- Old Age, End of Life Issues and Ethics
- Mental Health, Law and Ethics
- Public Health Ethics and Law, Right to Health, Health Care Systems.
- Humanitarian Medicine
- Religious Medical Ethics, Research Ethics and the Law
- Organ Transplantation
- Genetics, Ethics and Law

All accepted abstracts also went through language and content editing. Authors received the committees editorial and academic comments for their consideration and revision in some cases.

Accepted abstracts are included in this special issue of Medicine and Law which amounts to Part 2 of the June Issue.

Just before the Congress, a sub-committee for the Davies Awards will review the full articles submitted by authors and grade those as a basis for the selection of the Davies Awards winners for the year of 2018. These will be announced and awarded their prizes during the closing awards session on September 5. During this session they will also present their papers.

We are very excited about the high academic level and the diversity of speakers for this year's Annual Congress. The prominence of the speakers in their fields and the multicultural and multinational nature of the scientific program reflects the great importance of the World Association for Medical Law as a unique platform for deliberation and shared learning in the fields of Bioethics, Health Law and Legal and Forensic Medicine.

On this Occasion, I would like to acknowledge the generous support of the following for the successful planning and organization of this Congress: The Israeli Ministry of Health, The Tel Aviv University Sackler Faculty of Medicine, the Department of Nursing and the School of Health Professions, The Schlesinger Institute for Medical-Halachic Research, The Tel Aviv Municipality, The Thomas Noguchi Foundation, Adv. Jonathan Davies, Mr. Adam Neumann.

I am also indebted to many devoted professionals and volunteers, which I would like to acknowledge:

Members of the Scientific Committee: Yechiel Michael Barilan, Liat Kishon-Rabin, Michael Ashley Stein, Tal Bergman-Levy, Thierry Vanswevelt, Silvia Koton, Chen Kugel, Vardit Rispler-Chaim, Alexander Capron;

Members of the Planning and Organizing Committee: Adi Liberty, Denise McNally, Doris Sheynfeld, Sarah Demsitz, Yehoshua Weisinger.

Members of the Scientific Advisory Board: Thomas T. Noguchi, Vardit Ravitsky, Sivia Bar-Noy, Cécile Bensimon, Nili Tabak, Roy Beran, Avivit Neuman, Regis Anthony de Silva, Svetlana Pospelova, Jonathan Davies

I am especially indebted to Professor Ehud Grossman, Dean of the Sackler Faculty of Medicine, Tel Aviv University, for encouraging me to pursue the task of Program Chair.

Looking forward to welcoming you in our World Congress,

Oren Asman, LL.D.,  
Scientific Committee Chair,  
24<sup>th</sup> World Congress on Medical Law and Bioethics  
Executive Director, Bioethics and Law Initiative,  
Tel Aviv University, Israel

## **OPENING PLENARY SESSION**

### **Ethics at the Horizon: A Proposal for a Future-Facing Global Bioethics**

#### **Jeffrey Kahn**

*Andreas C Dracopoulos Director, Johns Hopkins Berman Institute of Bioethics, Maryland United States*

What do we mean by “global bioethics” and how should we be thinking about issues, research, and scholarship in this territory? In this presentation, I will examine the various understandings of the term and the territory it is intended to cover, and then propose a topography and framework for how to describe and categorize the territory of global bioethics with some examples for future attention. Through this discussion I hope to sharpen the focus of our discussions of global bioethics, with implications for scholars, research groups, and funders.

### **The Medicalization of International Humanitarian and Human Rights Law**

#### **Yechiel Michael Barilan**

Professor of Medical Education, Academic Director, Bioethics and Law Initiative, Sackler Faculty of Medicine, Tel Aviv University, Israel

Contemporary humanitarian law is comprised of three bodies: international humanitarian law, human rights law and the activities and rulings of the international criminal tribunals. In the past few decades, these bodies have been converging towards the unified framework of human rights. In the same period, biomedical law and ethics have taken a similar turn. A rights conceptual world has become dominant in bioethics. This turn has led to a “new kind of bioethics”, and, perhaps, to a new vision of common human identity and values, or at least, a globalized language of normativity. The advent of “expert status”, “epistemic communities”, and professional organizations during the second half of the 19th century and in the aftermath of World War I, paralleled the creation of the International Commission of the Red Cross and the drafting of the Geneva Conventions.

The rise of both HR and “expert opinion” has created a mixed scientific and HR / moral expertise. For example, the UN Committee on the Rights of the Child is comprised of “18 independent experts who are persons of high moral character and recognized competence in the field of human rights” (the

Committee's website). Another case in point is the Declaration of Istanbul Custodian Group, and its Board of Councilors, established in 2010, monitoring the efforts to ban international trafficking in organs.

The turn to HR articulates a normative shift in the international legal order from prioritization of state sovereignty to protection of human security. The turn to "human security" is also a turn to the physical and mental health, to the embodied human individual, which is conceived at the level of a concrete "interval" between birth (or: conception) and death. Medicine monopolizes the instruments, authority and vocabulary reigning over the limits of this "interval" – prenatal existence and "brain-death".

The search for a universal, basic and comprehensive set of "humanity" norms has landed on the supposedly firm ground of HR. In this odd alliance of medicine and HR, each party resolves inherent normative, epistemic and structural weaknesses by relying on the other's reputation for probity, certainty and efficiency. This situation is further problematized by the expectations of medicine to arbitrate HR issues, and of HR to restrain medicine, even more so, in relation to vulnerable persons.

### **Medical Law and Bioethics - Connecting the Dots Internationally**

#### **Oren Asman**

*Faculty at the Nursing Department, Executive Director, Bioethics and Law Initiative, Sackler Faculty of Medicine, Tel Aviv University, Israel*

Bioethical reasoning may be done from a principlist (generalist) perspective or a situationist (specific) one. Principlism assumes that normativity is captured by generalizable abstract rules; while situationism may very well capture the small nuances of sickness and healthcare and may use casuistic reasoning. These competing notions will be reviewed from my perspective as the Scientific program Chair of the 24th World Congress on Medical Law and Bioethics. The topics, contents and attributes of over 220 abstracts received and more specifically those of the 170 abstracts from 33 countries accepted will be the basis of this presentation. It will include a content analysis and provide an overview of the Congress Scientific Program: connecting principlism in Bioethics with International Conventions and national constitutional law ; connecting Situationism in Bioethics with various landmark cases and pointing to the common thread of the Congress themes and sessions.

In conclusions, some ideas about the role of an international platform for deliberation and allowing a comparative discussion will be presented, with an emphasis of the role of the Annual meeting of the World Association for Medical Law in furthering the promotion of human rights from a critical yet constructive standpoint.

## **PLENARY SESSION 1 – DISABILITY RIGHTS, MENTAL HEALTH POLICY**

### **Recent Advances in the Genetics and Neurobiology of Mental Health – Social and Ethical Implications**

#### **Steven Kushner**

*Professor of Neurobiological Psychiatry, Department of Psychiatry, Erasmus MC: University Medical Center Rotterdam, The Netherlands*

The history of mental health research is largely defined by valiant efforts to understand some of the most consequential and enigmatic diseases of humankind. However, there are a number of very significant examples which are deeply instructive of the ease with which such endeavors, if not carefully considered, can lead to dangerous medical, ethical and legal scenarios. The breathtaking pace at which neuroscience and genetics are currently advancing has been widely lauded for its potential to unlock the secrets of the human brain, and finally reveal clinically-relevant insights into the nature of mental health disorders. But how can we learn from the lessons of the past to avoid repeating similar mistakes in the future? What issues are already foreseeable, and what emerging technologies should be giving us pause for deeper consideration?

### **Finding the Yellow Brick Road – Highlights of Ethical Dilemmas in Setting Mental Health Services -Ethics of Public Policy**

#### **Tal Bergman Levy**

*Head of Mental Health Division, Medical Directorate, Ministry of Health, Israel*

How do we plan health systems? How do we plan mental health systems? Who are the major stakeholders in this game, what are their interests and what are the tensions, shared interests and motivations in navigating the system? The mental health systems has been in the past three years in the center of a robust public discussion unveiling various dilemmas clinical, political and ethical.

Highlights of these complex dilemmas will be presented in the lecture. We shall discuss the Mental Health Reform that formally began on July 2012 and has mended a severe distortion when finally after more than two decades the responsibility of treatment of the citizens mental health was transferred from the government to the sick funds- the HMO's that provide health services by a specific legislation to the public – creating mind- body cohesive treatment by integration. We shall then turn and inspect the process of reducing the usage of restriction measurements ( mechanical restrains and seclusion ) in the treatment of hospitalized acute psychiatric patients in mental health wards the its implication on the services and subsequently we shall challenge all mental health “hospitalization” systems by exploring the test case of the model of social balancing houses for acute exacerbation of mental illness within the domain of community care.

### **Not Guilty By Reason of Insanity in Neurodevelopmental Disability**

#### **Anthony Kearns**

*Consultant Forensic Psychiatrist, Senior Clinical Lecturer Academic  
Department of Psychiatry Trinity College Dublin, Central Mental Hospital,  
Ireland*

People with intellectual disability and other neurodevelopmental disorders are now part of mainstream society. Therefore such individuals' ability to make decisions and take responsibility for their actions has been receiving increasing attention from service-providing agencies and the law. For service providers, consideration has to be given to the tension between the person's right to have freedom of movement and action and, for the law, to participation in variety of legal proceedings, including consideration of responsibility for putatively criminal acts. I will be exploring these issues and focusing on the areas of decision-making competence with reference to deprivation of liberty, fitness to stand trial and criminal responsibility, with particular as applying to persons with intellectual disability and autism disorders. I will be reviewing a 2-year cohort of referrals to a national forensic intellectual and developmental disability service and review our advising on these issues. I will refer to legislative provisions in other jurisdictions for comparative purposes. I will discuss recent work in our forensic service on the devising of a capacity assessment instrument, the DUNDRUM capacity ladders. I will provide anonymised illustrative case histories. I will consider possible future developments.

## **MENTAL HEALTH**

### **Standard of Protection of Human Rights of Patients in Psychiatric Hospitals**

**Tomasz Sroka**

*Jagiellonian University, Krakow, Poland*

Deprivation of liberty may be a measure of preventive nature, being a reaction to the danger threatening from the part of a person. Several institutions are examples of preventive detention and one of them is placing a patient in a psychiatric hospital or social care home without his consent.

Due to the fact that a compulsory placement in a psychiatric hospital constitutes a far-reaching interference with important legal value of human freedom, guaranteed under Article. 5 of the Convention for the Protection of Human Rights and Fundamental Freedoms, there must be strict compliance with the principle of proportionality in determining the situations allowing for deprivation of liberty in a psychiatric hospital and with the conditions for its usage.

Numerous problems associated with the use of preventive imprisonment were pointed out by the ECHR in cases concerning placing patients in psychiatric institution without their consent (eg. Case: Shtukaturv v. Russia, Application No. 44009/05; Storck v. Germany, Application No. 61603/00; HL v. United Kingdom, Application No. 45508/99; Stanev v. Bulgaria Application No. 36760/06).

During my presentation I want to present a minimum standard of protection of human rights of patients in psychiatric hospitals resulted from the judgments of ECHR, especially in terms of proportional restriction of personal liberty in relation to the danger posed by the person, ensuring the realization of his right to have the case heard by the court of law, his right to respect of his private life etc.

## **Please Let Mentally Ill Patients Make True Self-Decision Under the Macau Law**

### **Man Teng Iong**

*Macau Health Bureau, Macau, China*

According to the mental health law in Macau, patients with mental disorder have a right to accept or refuse diagnostic and therapeutic intervention, except for cases of compulsive hospitalization or in emergency situation, where non-intervention is likely to create serious risks to patients or the others. As those patients do not necessary have sufficient discernment to make healthcare decisions, the mentioned right is eventually exercised by guardians appointed by court. This paper indicates a problem of current procedure: a potential risk of guardians making a wrong decision against the true will of mental disorder patients, if the will were presented by patients when capable. In other words, such decisions made by guardians may not fully express the true willingness of mental disorder patients, which also have significant impact on making their self-decisions and reduction in their autonomy.

This paper intends to propose the usage of Psychiatric Advance Directives in Macau to resolve the existing problem, as well as a binding nature of prior will in Macau since the prior will is only taken into account and may not be respected in actual circumstances. Those two proposals are very important to enhance the autonomy of patients with mental disorder as they can make their own healthcare decisions according to their true prior will. Furthermore, the proposal of implementation with facilitation, education and legal support, of which Macau Health Bureau plays an important role, is also critical for practical use in Psychiatric Advance Directives.

## **Mental Health Legal Representation in Israel**

### **Advocate Daniel Raz**

*National Supervisor (involuntary commitments) Legal Aid, Ministry of Justice, Center, Israel*

The issue of legal representation for mental health patient has dramatically changed during the recent years.

We will outline the history of mental health legal representation in Israel

We will discuss the requirements for involuntary commitment which are both legal and medical. In order to hospitalize a person, one need to prove that this person is dangerous to himself or to other person immediately prior to his hospitalization.

We will elaborate the work of the psychiatric committees and the jurisprudence of the Israeli court regarding that issue.

We will further discuss the physical restrictions on patient especially regarding the solitary confinement and physical restraint and the ECT treatment

The lawyers representing the patients are fully qualified and receive an extensive program which enable them to understand legal and medical terms in mental health law.

The legal aid representation is an essential instrument for improving human rights of person and our duty is to find a way to challenge that.

### **Psychiatric Patient Restraint In Israel - Between Medicine and law**

#### **Sharon Primor**

*Legal Counselor; Bizchut. ,PhD candidate Hebrew University, Jerusalem, Israel*

The use of mechanical restraints in mental health hospitals has long been a pervasive practice in Israel and is explicitly authorized by its mental health law. Only recently has this long-established practice been criticized as a human-rights violation in Israel. Further, despite its legal implications, it has never been legally scrutinized or discussed locally.

Although restraint is viewed as a clinical tool, this study exposes the role of the law in its establishment and systematic reinforcement. Through an investigation of its 600-year history in England, I show that restraint was socially accepted long before it was embedded into psychiatric practice. Furthermore, law was pivotal in modelling this otherwise aggressive act into an accepted mode of care. This study reveals a pattern, evident both in England and in Israel, in which the legal authority to restraint follows the changing entities and professionals who were entrusted by society to care for people with psycho-social disability: first family members, then asylum managers and lastly psychiatrists. Through this I contend that law, not only medicine, has shaped the attitudes of both the public and mental health professional towards psychiatric patients.

This article uses a critical legal lens tinted with disability studies and “mad studies” perspectives to expose mechanical restraint as a legal and social phenomenon. The recent public out-cry in Israel against restraining psychiatric patients holds great promise for a systematic change. Yet this study shows that a deep-set understanding of its social and legal roots is needed to make a lasting reform.

## **Compulsory Admission Based on Public Authority in Japan**

### **Shigeki Takahashi**

*Hamani-Takahashi Law Office, Tokyo, Japan*

In Japan, compulsory admission on the authorization of the Governor has been legal since 1950, when it was adopted in the case of the mentally disabled who were considered a danger to themselves or others. The purpose of admission is the protection of the public by the police. However, it requires a confirmation of the diagnosis by a psychiatrist who has been assigned by the Minister of Health, Labor and Welfare. In addition, if the director of the hospital reports that the detention of the patient is no longer appropriate, the Governor must allow the patient to be discharged from the hospital, following assessment by a designated psychiatrist. Recently, this revocation of the admission order has been applied to minimize the duration of hospital stays. However, in cases where patients who have been discharged and have later gone on to cause an injury to themselves or others, we cannot help but be preoccupied by the offence. In 2003, the Act on the Medical Services and Observations of Persons who have committed serious other injuring behaviors in the state of Insanity was established. In this Act, the first article explains that the Act aims to provide continuous medical services to the mentally disabled as well as to prevent repeated offences in society. This Act was criticized for entrusting too much power to the police. Following this criticism, the act has been applied deliberately by now. However, we should remain cautious and observant about the potential for the abuse of police power.

## **Coping with Refusals and Consents of Psychotic Patients to Medical Procedures**

### **Uriel Levinger**

*Ianiado hospital, rebecca reicher atir PhD, Clinical and Medical Psychologist, Israel*

What tools are at the disposal of the medical system which is challenged by patients who are recognized as suffering from psychosis and on the one hand demand the proper and the best treatment, but on the other hand refuse the proffered medical procedure by which that treatment is achieved? On one hand albeit those patients are diagnosed as dealing with psychosis, regarding the optimal treatment their claim is compatible with the rules of law and common sense. On the other hand, their refusal is considered to be uninformed and unreasonable. The unreasonableness is embedded in the contradiction between a patient's agreement to the proper treatment and the refusal of an examination or treatment intended to realize this treatment.

Cases in which the treating physicians consulted the Ethics Committee will be presented. Tactics of the Ethics Committee at the Patient's Bedside, which serves as an extension of the Ethics Committee will be represented. We will show that sometimes usage of the psychotic way of thinking is the only available way to achieve consent not only to the best treatment but also to the necessary procedure enabling that treatment. We will argue that that kind of consultations and the interventions of the Ethics Committee enable open dialogues with those patients, express the respect for them and reinforce their cooperation. and. We will evoke the question if "Surfing with psychosis", where physicians join in the patient's idiosyncratic language and delusions in order to obtain consent indeed comply with the spirit of informed consent?

## **PRIVACY AND LIABILITY IN THE INFORMATION AGE**

### **Electronic Medical Records (EMR) and the Patient in the Hard Drive**

#### **Regis Desilva**

*Harvard Medical School, Massachusetts, United States*

The EMR facilitates recording and retrieval of medical data. There are two potential problems with ethical and legal implications discussed below:

Case 1. A 54y old hospital patient was told he was taking propranolol. He denied being on the drug and refuses it. The admitting clerk had flagged the wrong EMR with an identical name. The admitting doctors had not checked directly with the patient as they copied verbatim from the previous EMR.

Case 2. A cardiology trainee presents a case in detail to the consultant, who is puzzled as he obtained a different history. The fellow reveals he cut and pasted the record from the wrong patient. Much of the history, physical examination and laboratory data were thus incorrect.

Comment: An electronic record creates a simulacrum of a "person" as all clinical and demographic data and tests are stored as a "Virtual Patient". Caregivers are increasingly interacting with the simulacrum and treating the "patient in the hard drive", thus interacting less and less with the real patient. This raises serious ethical and legal questions: (1) Is appropriating another physician's work and passing it off as one's own medical plagiarism and ethically or legally permissible? (2) Are doctors discharging their moral responsibility of caregiving if they are "treating" a simulacrum instead of a patient? (3) Can a physician be sued for errors in diagnosis and treatment that so result? Patients have the right to expect a direct and thorough evaluation by their physicians based on an independent evaluation.

## **Telemedicine and Liability – Legal Framework**

### **Raf Van Goethem**

*Dewallens & Partners, Vlaams-Brabant, Belgium*

Telemedicine is now mainstream: the numbers speak for themselves. According to a recent industry report, the global telemedicine market is expected to be a \$ 35 billion industry by 2020. As patient care is provided on a 24-hour basis accessible from virtually any location, telemedicine can be optimal for many who may prefer to seek healthcare services on an alternative basis to traditional physician office or facility settings, or more importantly, for those unable to access in-person services due to factors such as distance from providers.

There are many legal and regulatory issues implicated with the use of telehealth, including cross-border licensure, prescribing and cybersecurity. One issue discussed less by telehealth stakeholders concerns potential liability exposure. In general there are two legal systems. There is a strict liability for defective products, which holds manufacturers liable for injuries caused by a defect, regardless of fault. Can that theory be applied in cases of telemedicine given the uniqueness of the technology and the fact that numerous actors are involved in the production chain. Telemedicine does turn the traditional manufacturing process on its head. Is the “manufacturer” the person that designs the program for the product? The person who delivers the hardware? Or is it the hospital or the doctor? These are the questions lawmakers have to tackle.

That does not mean that we have to scrap the existing product liability regimes. Negligence based liability, which does not require the designation of a specific manufacturer, can operate as the general liability theory.

## **Legal Risk Analysis of Remote Consultation**

### **Lu Yiguang**

*Shanghai United Law Firm, Huangpu District, China*

With the continuous development of Internet technology, the remote consultation will become the norm in diagnosis and treatment activity. proximal medical institutions should carefully choose partners, including technical service providers, and the remote medical institutions or medical personnel, objective evaluate consultation opinion, concerning obviously violates the rule of medical knowledge, and properly handle the occurrence of medical damage, prevent the expansion of damage; The technical service organization shall abide by the legal obligations and agreed obligations, ensure the quality of consultation and communication, and keep the data secret; Remote medical institutions should properly arrange consultation, fulfill the duty of expert, once

it appear medical damage, should be actively processing with the proximal medical institutions, and keep patient privacy, data security maintenance.

### **The Freedom of Medical Information Vs. The Freedom From Medical Information**

#### **Olaolu Osanyin**

*First Counsel Solicitors (Medical Law Consultants), Lagos, Nigeria*

The Freedom of Medical Information Vs. The Freedom From Medical Information.

There are approximately 80 million Nigerians who are internet and social media users and with this raising on line population there are bound to be varying robust and educative contents on line. Most of these contents are educational and beneficial to the general public.

Hence on social media networks a varying number of issues are posted and discussed, some from the mundane to the extra-ordinary.

Accounts and footages of medical procedures, treatments and discoveries are found on social media posted by health workers.

This paper is borne out of this rather recent trend of Health workers posting patient's information to the general public on social media. This paper attempts to examine the medicolegal issues surrounding this act which at times is regarded as a public enlightenment initiative, however these acts are also prone to the violation of patients' rights.

### **Confidentiality of Personal Information in an Era of Big Data - The Rights of the Individual Versus The Rights of Society**

#### **Orly Toren**

*Nurith Wagner, Israel*

In the era of Big Data, crucial ethical questions exist regarding the level of confidentiality and anonymity versus the process of data collection and data maintenance. Issues of informed consent, privacy and ownership of the information arise prior to data collection and data transferring to large databases. This process requires reexamination and formation of principles for the proper use of information management, while protecting the rights of both the individual and society.

Confidentiality is a fundamental concept to all medical professions. This professional obligation to keep health information confidential is a basic ethical principle. On the legal level, there are two laws in Israel relating to confidentiality issues. The Public Health Ordinance specifies conditions of which removal of confidentiality is essential, and reporting of identified data is mandatory. These conditions are related to infectious diseases, published in the Medical Administration circular (2011, from which one can assume that information disclosure is permitted only in these circumstances. The Patient's Rights Law requires every caregiver or employee of a medical institution to keep all information relating to the patient confidential. This law also specifies conditions under which a caregiver or medical institution may provide medical information to another, most of which relates to the transfer of information to other therapists/institutions, or for a condition that the patient has given his consent. Professional codes as well, such as the Code of Ethics for Nurses (2018) emphasize the obligation of a caretaker to take all means to protect patients' confidentiality and to refrain from providing information to non-staff members.

Notwithstanding, data are transferred for the purpose of research, for creating medical databases (registrars, and for quality indicators. Often such data transfers identified, without the consent of the patient.

This paper will discuss the dilemmas and principles emerging between the right of the individual to confidentiality and the need to preserve the health of the people.

## **Managing Libel against Health Care Professionals - The Israeli Example**

**Shlomi Weinberg**

*Weinberg Law Offices, Israel*

Shaming in Israel has increased over the past years, mainly due to the development of social media including Facebook, Twitter, Google Plus, Instagram, telegram etc.

It is harmful to many professionals, particularly health care professionals.

Three levels of defamation regarding health care professionals will be presented. Each with its unique traits: False factual statements regarding the conduct of the medical staff or serious exaggerations that are meant to severely harm the staff; negative publications that include expression of an opinion about the medical treatment and the comportment of the staff; publications that are reflecting subjective experiences related to interpersonal connection with the treating staff.

We will refer to several legal mechanisms in such cases and exemplify each from real life shaming cases of health professionals I Israel:

1. Order to immediate remove of the publication
2. Order to publish a corrective publication or an apology publication
3. Damages payment, including of high amounts

Finally, the practical matters of such cases will be discussed, including the use of expert opinions in health care professionals shaming cases.

## **DISABILITIES**

### **Nothing About Us Without Us: A Disability Challenge to Bioethics**

#### **Sagit Mor**

*University of Haifa, Israel*

Disability theory and disability activism pose a fundamental challenge to bioethics. Bioethics has historically endorsed an individual-medical approach to disability under which life with a disability was portrayed as life of misery and suffering and disabled people's knowledge and experience were devalued and marginalized. The disability challenge to bioethics involves not only a new understanding of disability but also a new place for disabled people in society – as active participants in decision-making processes. This new understanding is encapsulated in the disability rights movement's slogan: Nothing about us without us, which captures the essence of the disability struggle: to be part of society and to take an active role in individual and collective decision-making processes in all aspects of life. However, the meaning of this slogan as a framework of analysis was not clarified so far. My talk will introduce a reading of this slogan as a call for individual and collective voice and representation in personal and public decision-making processes in bioethics in the Israeli context. I suggest that a nothing about us without us approach entails both an individual dimension that concerns personal decisions regarding one's own life, and a collective dimension that concerns the involvement of disabled people as a group in all public deliberation processes. I also call to create formal channels that institutionalize the incorporation of disabled people individual and collective voices and perspectives into personal and public deliberation processes. The inclusion of disabled people voices and perspectives – both as individuals and as a collective – has both procedural and substantive implications as it eventually changes both the process and the outcome.

## **Desiring Motherhood Despite Severe Disability**

### **Esther-Lee Marcus**

*Herzog Medical Center, Jerusalem, Israel, Eliezer Beeri Alyn Hospital, Jerusalem, Israel Marina Dackman Alyn Hospital Mauritz Beeri Alyn Hospital, Israel*

In our contemporary healthcare environment, people with severe disabilities can survive while maintaining total dependence on others for their basic daily activities and with dependence on mechanical ventilation, well into their reproductive years and beyond.

Despite severe disabilities, some people, who live independent-dependent lives long for relationships and family life.

We would like to present a case study of a woman with muscular dystrophy who requested assistance from her health care providers to obtain fertility treatment. The woman, in her late twenties, is completely dependent on the care of others and on a ventilator 24 hour a day.

The question was brought to a multidisciplinary ethics committee of the institution where she lives, comprising a gynecologist, a rabbi, a social worker, a nurse, a lawyer, and her primary care physicians.

The focus of the discussion was on: the health risk of fertility treatment and resulting pregnancy for a woman in her condition; the short and long term risk of premature birth for the baby; the physical and emotional parental capacity; the moral obligation of healthcare providers to weigh the risks and benefits of fertility treatment and to respect the woman's wishes and autonomy; the health care costs and burden for society in caring for the prospective mother and child, and the well-being of the child.

The questions that the committee faced were not simple and required balancing personal opinions, values, and beliefs with the unique values and wishes of the woman in this case. To finalize, we will offer some normative reflections on the matter that might have general implications on the disability discourse in bioethics.

## **Patient's Rights in Mental Health: Problems of Residential Care in Serbia**

**Hajrija Mujovic**

*Institute of Social Sciences, Belgrade, Serbia*

The area of mental health care in Serbia points to all complexity and specialty of this branch of medical practice and the diversity of nursing care in the cases of residential accommodation. Considering the Serbian legislation in this area and the aim to implement the UN Convention on the Rights of Persons with Disabilities, it is necessary to make more defined position for patients-users' rights in the practice of residential services. Most important issues are use of patient's advanced directives as well as support to the patient's mental capacity during different way of decision making process. Both aspects of these rights should have a positive attitude and such practice should be further developed in the sense of comparative law and contemporary standards of mental health care. That means in the same time the full affirmation of the Patients' rights Act. In the course of 2017. a large research was carried out in Serbia on the topic - "Securing health care in line with the human rights standards for persons with disabilities in residential institutions in Serbia". The project is realized to make further improve: more accessibility to health care services that residents receive, their availability and quality, and more support to the position of residents who are deprived of their legal capacity or that struggle with a label of mental disability and facing social stigmatization.

Key words: mental health, residential care, human rights, health and social protection

## **Application of Eugenic Practices to People with Disabilities in Israel**

**Chaya Gershuni**

*Advocate, Israel*

The eugenic approach strove to reduce the proportion of persons with disabilities in society. The characteristics of eugenic principles and the bioethical outlook are derived from the socio-cultural representation and the nature of the time and place. In totalitarian regimes, an authoritarian eugenic policy of rigid immigration laws, control of marriage and procreation, and the sterilization of persons with disabilities were adopted. The liberal discourse of rights addresses the individual's choices, through genetic planning, abortions and legitimization to prevent medical treatment for people with disabilities.

In ultra-Orthodox society, a practice based on the continuum between liberal and authoritarian eugenics is accepted through the genetic tests of Dor

Yeshurim that are designed to prevent a marriage that has the potential to give birth to a disabled person. These tests, which are not enforced by law, are part of the Haredi norm and constitute a kind of condition for marriage. This principle is based on the value of “the duty of intervention” and it reinforces the tenet of creating a healthy generation.

The criticism of disability challenges these eugenics, arguing that eugenics affect the status and rights of people with disabilities. And there were those who argued that the conduct practiced in Dor Yeshurim affects people with disabilities even more than liberal eugenics, which allows every person to act as he chooses.

### **Significance of Natural Will Relating to Sexual Health**

#### **Özge Yücel**

*Ufuk University Faculty of Law, Ankara, Turkey*

The purpose of this paper is to discuss the significance of incompetent patients’ natural will in respect of medical decisions concerning sexual health and rights. It is reviewed, in which cases natural will should be considered binding in terms of the right to autonomy. The European Convention on Human Rights and Biomedicine, the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child include guiding principles regarding this.

In order to protect the right to autonomy of persons lacking capacity due to age or mental disability, their natural will must be taken into consideration to the extent necessary. Natural will means emotional reactions and opinions of an incapacitated person.

When patient’s natural will conflict with her assumed best interests, “natural will” should be preferred within sexual health interventions. In the context of bodily integrity related to sexuality, genital surgery of intersexual child, circumcision, abortion and sterilisation can be regarded. It is difficult to argue that there is a reasonable ground for someone else to make a decision on this issue. The aim of considering capacity necessary to give validity to declaration of intention is just to prevent exploitation of incompetent individuals. As the urgency and medical necessity of medical intervention decreases, the right to consent to intervention becomes more strictly personally. Considering that children’s mental incapacity is temporary, in order not to violate their expected autonomy, whether the intervention is an irreversible or a difficultly reversible surgical operation should be taken into consideration.

## **PROCEDURES RELATED TO MEDICAL LIABILITY**

### **Is there an Alternative Medical Liability for Alternative Medicine?**

#### **Vera Lúcia Raposo**

*University of Macau, China*

The so-called alternative medicine intends to provide health care through a holistic view of the human being, in interaction with the physical and social environment. In this presentation we will use the designation alternative medicine, to present it as another form of medicine, complementary to conventional medicine, thus refusing the thesis that only the latter is “real medicine”.

Lawsuits against practitioners of alternative medicine are not common, but its increased used of alternative medicine requires further attention in order to provide patient’s adequate protection. A proper regulation, a clear definition of its standard of care and the analysis of the elements composing its liability – maybe an alternative form of medical liability - is crucial for imposing accountability.

For instance, practitioners of alternative medicine have been held liable for not referring the patient to a doctor of conventional medicine, thus failing to identify that the patient’s condition required treatments only provided by western medicine (it remains to be seen if a conventional doctor can also be held liable for not referring a patient to alternative medicine).

There are obvious particularities in the liability of these practitioners, related with their specific duty of care and the respective breaches, the identification of precise *leges artis* and the definition of causation in this domain, just to name a few. In sum, there are certainly elements of an “alternative medical liability”, to be developed in this presentation.

### **Medical Arbitration in Peru: Proposals for Changes**

#### **Giancarlo Jiménez Bazán**

*(1) Peruvian Affiliate of the Latin American Association for Medical Law – Asolademe Peru, Lima, Peru, (2) Meza & Jiménez Attorneys, Lima, Peru*

In Peru the medical disputes has definitely increased and mainly related about damage compensation. The ordinary courts often do not satisfy the expectations of the parties because the prolonged waiting time for the resolution of their disputes and the lack of specialization of the judges about Medical Law.

This explains the development of medical arbitration because the parties declaim ordinary courts and arbitration clauses are incorporated in health insurance agreement because parties believe that this kind of procedure is faster and specialized.

The General Arbitration Act - Law N° 26572, approved in 1996 and the current Arbitration Act Legislative Decree 1071, approved in 2008, together with the Center for Conciliation and Arbitration - in Health (and its regulation and rules), provide the legal framework for the parties to resolve certain medical disputes

This study focuses on the discussion of proposals for change in arbitration proceedings related to medical disputes because the reality of arbitration in Peru about payment of medical damages does not necessarily mean a specialized resolution.

## **State Control Over the Medical Services of Citizens in the Republic of Bulgaria**

### **Neli Gradinarova**

*Department of Medical Ethics and Law, Faculty of Public Health, Medical University-Sofia, Magdalena Aleksandrova Department of Medical Ethics and Law, Faculty of Public Health, Medical University-Sofia, Bulgaria*

Improving the quality of medical education and guaranteeing the rights of citizens in the healthcare sector is a particularly pressing issue in recent years. The Constitution of the Republic of Bulgaria guarantees equal access to high-quality medical assistance, timeliness and efficiency of the medical service in the country. In order to guarantee the quality and control of the provided medical services in January 2010, a Medical Audit Executive Agency was established in Bulgaria. The Agency is a budget-dependent legal entity that carries out permanent state control over the medical care of citizens, adherence to established medical standards and patients' rights and to the activities related to mandatory and voluntary health insurance in the country. The goal of the Medical Audit Executive Agency is to improve the quality of citizens' healthcare by stimulating legal entities and health care providers to quality, workplace improvements and increased professionalism.

In Bulgaria, there is still no register of medical errors at national level, there is no definition at national level of the term "medical mistake". It is also necessary to regulate the justified medical risk, ie. to indicate the extent of this risk that should not be sanctioned despite the damage occurring during treatment. These and other inadequacies in the country's health legislation make it difficult for the agency to do its work and make judgments and acts

that are available to it in court. Legislative omissions are a matter of work for both the agency and judiciary authorities in the country. It is necessary to introduce a number of legislative changes to ensure the control and quality of the medical care in the country.

### **Disciplinary Liability of Physicians in Romania. What can be Learned?**

#### **Beatrice Gabriela Ioan**

*“Grigore T. Popa” University of Medicine and Pharmacy, Institute of Legal Medicine, Iasi, Romania*

In Romania, there are main types of medical liability: civil, criminal and disciplinary. Each of them has its own analysis procedure and consequences.

The basis of disciplinary liability lies in the obligations of physicians, provided by the laws and regulations of the medical profession. The analysis of disciplinary liability is carried out by the disciplinary commissions of the County Medical Colleges and the Superior Discipline Commission of the Romanian College of Physicians.

The author reviewed the decisions taken by the Superior Discipline Commission over the course of 12 years (2006-2018) to identify the most common deficiencies that can harm the patients and may lead to the reclamation of physicians by the patients.

During the 12 years of the study, the Superior Discipline Commission issued over 1,800 decisions. The specialties with the highest risk of complaints are surgery and obstetrics-gynecology. Reasons for complaints and identified issues can be grouped into three categories: non-compliance with ethical principles in current medical practice (e.g. lack of patient's informed consent for a diagnostic or therapeutic act, breach of confidentiality), negligence of medical staff (e.g. non-request of interdisciplinary consultations, lack of transfer of the patient to a clinic with superior endowments, superficial management of the case) and organizational deficiencies at the hospital level or at the level of the medical system in Romania.

The results of this study allow to draw valuable conclusions for improving the quality of the physician-patient relationship and of the organizational framework of the medical profession in Romania.

## **Chief Medical Officer: Judge or Mediator?**

### **Diego Fornaciari**

*Legal Counsel, General Hospital AZ Delta, Oost-Vlaanderen, Belgium*

The Chief Medical Officer (CMO) is a key member of a hospital's executive team, leading the overall clinical vision for the organization. His or her responsibilities are, however, not only related to hospital policy. The CMO also bears end responsibility for the quality of medical care in the hospital. This will require a CMO to take action when he or she believes that, for example, a medical professional endangers patient safety. Although the CMO bears this responsibility, national legislation not always provides the necessary tools for the CMO to take proper actions.

In Belgium, for example, a CMO has no authority to take disciplinary measures against a medical professional. Only the hospital board has this authority and before a decision can be made one often has to go through a long and formal procedure.

This is a remarkable observation as the protection of patient safety often requires quick decision making. If a CMO and by extension the hospital cannot take proper actions, they can even be held liable if a patient suffers damages.

The CMO should have the authority to act as a "judge" in the hospital and thus be able to take (temporary) measures against medical professionals in order to protect patient safety. When national legislation does not provide this authority, hospitals should grant these competences to the CMO through the hospital staff regulations.

## **MENTAL HEALTH**

### **Advanced Directives and Mental Health in Czech Law**

#### **Tomáš Holčapek**

*Charles University in Prague, Faculty of Law, Petr Šustek Charles University in Prague, Faculty of Law, Praha, Czech Republic*

The interests in protection of a patient's health and respect for her personal integrity may sometimes contradict each other. An additional layer of difficult considerations comes into play when the patient's mental capacity is impaired, limiting or preventing her from exercising her decision-making autonomy. The impairment may last for a short period of time or be permanent, and the consequences may differ. The law may call upon substitute decisions-makers, such as close relatives, legal guardians or courts, to decide in the patient's

stead, utilizing physicians' recommendations to a various degree. However, if the patient gave an advanced directive, it may take precedence over any such substitute decision. The issue is complicated by the fact that the patient's will may not have been entirely clear, it may not correspond optimally to new information which was unavailable at the time when the patient gave the directive etc. Czech law attempts to reconcile these tensions in line with the Convention on Biomedicine, by requiring respect for advanced directives but without making them absolutely binding. This approach has its advantages but also significant problematic implications, which need to be discussed in more detail. A separate but related topic is the issue of termination of life supporting treatment of patients who, for whatever reason, do not have sufficient mental capacity to decide on their own at the critical time. The role of advanced directives and substitute decision-making – and their mutual relation – may have decisive effect on the actual outcome in such cases.

## **The Obligations and Rights of a Psychiatrist**

### **Tugce Oral**

*Ankara University, Çankaya, Turkey*

Treatment contracts including psychological treatment have a special character, since it is possible that the patient, in other words one of the parties of this contract, has a mental incapacity.

In this presentation, I will first begin by discussing the legal nature of the relationship between the patient and the psychiatrist.

Secondly and on the basis of conclusion reached under the first question, I will deal with the question of how it is possible to conclude a contract or enter into a legal relationship with a person having mental disability.

The third and final question posed will be if there are any specific obligations or rights of a psychiatrist and hospitals or changes in the scope of their duties to inform and take informed consent.

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## **Prisoners' Competence to Die: Hunger Strike and Cognitive Competence**

### **Zohar Lederman**

*Assuta Ashdod Hospital, Emergency Department, Israel*

Several Bioethicists have recently advocated the force feeding of prisoners, based on the assumption that said prisoners have reduced or no autonomy. This assumed lack of autonomy follows from a decrease in cognitive competence that is in turn supposedly due to their imprisonment and/or being on a hunger strike. In brief, causal links are made between imprisonment or voluntary total fasting (VTF) and mental disorders, and between mental disorders and lack of cognitive competence. We engage with these bioethicists by severing both of these links. Specifically, I refute the claims that VTF automatically and necessarily causes mental disorders such as depression, and that these mental disorders necessarily or commonly entail cognitive impairment. Instead, I critically review more nuanced approaches to assessing mental competence in hunger strikes, urging that a diagnosis of incompetence should be made on a case-by-case basis- an assertion that is widely shared by the medical community. I thus make a case against force feeding of prisoners.

## **Homicide While Asleep and Israeli Law**

### **Jean Askenasy**

*Sackler School of Medicine & Faculty of Law TAU, Haran Feinstein Bar Ilan University, Israel*

There is no scientific definition of consciousness and there is no clear answer regarding consciousness during sleep. The premeditation of a murder does not occur during sleepwalking. However, knowledge of a wake state conscious intent involvement to commit an actus reus (an act that is a constituent element of a crime) during sleepwalking cannot be excluded. That an actus reus which occurs during sleepwalking was performed with mens rea (conscious intent and knowledge that it is an antisocial act) is a matter of probability both for the law and for neuroscience. It is mandatory to establish a permanent commission of jurists and medics who will endeavor to create semantic harmony between these two professional disciplines.

## **Capacity and Self-Determination in Mental Health - The Portuguese Law**

### **Carla Barbosa**

*Biomedical Law Center (Law Faculty/ Coimbra University); Health Parliament Portugal; Lawyer, Coimbra, Portugal*

One of the problems often faced by health professionals working with people with mental illness is their inability to make decisions about their health. In 2012, Law n.º 25/2012, of July 16, was approved in Portugal, which regulates the advance directives of will. One of the novelties that brought us this law was the creation of a figure already known in the legal doctrine and other legal systems: the health care prosecutor - who is given representative powers to decide on health care when the grantor is unable to express their will personally and autonomously. However, this is a figure that is still rarely used. To that extent, we are legally obliged to find other solutions which justify the representation of people with mental illness and the taking of decisions regarding their health by third parties. Legal instruments which, however, have not been created specifically to think about representation in health. Legally it is possible to judicially declare someone disabled or interdicted by naming him, respectively, either a conservator or a guardian. However, this representation is dependent on a judicial process that in the vast majority of situations is too slow. Failing the legal instruments of representation, whether they were created for the particular situations of health or for a general representation, with the necessary adaptations for the representation in the health we resort to the figure of the business management a singular institute in the scope of civil law, whose borders have been under discussion.

## **Legal (or Illegal) Denial of Micro Trauma in Mental Injuries**

### **Samuel Wolfman**

*Haifa University Law Faculty, Tali Shaked Wolfman, Shaled & Co. - Law Offices, Israel*

Micro Trauma is recognized by many legal systems as a cause for major injuries which develop gradually along extensive periods of exposure to mini/micro traumatic events. The Israeli labor law may grant social security compensation to workers who have been exposed to minor orthopedic back injuries and developed, with years of working, major back injuries with significant disability. Micro Trauma is recognized also in other areas of medicine, such as in deafness after continues exposure to high level of noise or in lung injuries after exposures to toxic inhaled materials.

The only medical field where Micro Trauma is not recognized as a cause for illness is in mental diseases. Continues stress in work or military service has

been denied by the Israeli courts, including the Supreme Court, as a cause for major depression, psychotic disorders or any other type of mental disorders defined by the DSM.

The presentation will discuss this denial of rights of mentally ill people to be recognized as being injured by harsh and stressing work conditions, military service or even accidental life events which may be a cause for tort claims. The presentation will also suggest a review of the present legal standing with a possible suggestion to change the law.

### **Pain and Suffering in Tort law**

#### **Natali Levin**

*PhD Student, Adam Mickiewicz University in Poznan, Israel*

As of today, there are no well-defined legal standards on the evaluation of no pecuniary harm in general and of the type of pain and suffering in particular. Consequently, we find rulings of damages that are significantly different between the harmed parties, even in circumstances under which the harms are similar. The purpose of tort law is to restore the harmed party to the situation that preceded the harm and thus the power of torts cannot punish the person accused of harm. The matter of every harmed party are individual, and the betterment of the question of bettering is harm is unique to his/her lifestyle. The economic approach to law teaches that the guiding principle in torts is justice that remedies the harm in an equal manner, and thus certainty in law is obtained. However, in the absence of well defined legal standards ,the economic approach is unachievable. One possible solution to this situation is that the types of harms and the types of harmed people could be deciding factor in amount of compensation, therefore it is necessary to estimate, evaluate, and quantify this in numerical financial terms.

In current reality, the lack of defined standards which indicate uniformity in the ruling of damages for the head of tort of physical pain and suffering explains to a large extent the reason why these harms have been and will continue to be a focus for discussion.

## **HEALTH, BIOETHICS AND LAW – INTERDISCIPLINARY SESSION**

### **Law, Spirituality and Health: A ‘Three Body Problem’?**

**Rostam J. Neuwirth**

*University of Macau, Macau, China*

“Health”, like “life”, remains one of the most important essentially contested concepts, because it knows no final and objective definition. The distinction between subjective and objective elements is but one of the principal dichotomies applied to the human understanding of reality. Dichotomies are a profound expression of a dualistic mode of thinking and binary logic, which dominate the present conception of science and law. Dualistic thinking also plays a crucial role in health, which is often contrasted with disease. Even though the WHO definition of health understands health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, the WHO still fails to follow-up on it in its various public health policies. Generally, health policies are often fragmented into separate medical fields, such as conventional medicine, traditional medicine, alternative medicine and mental health medicine. Moreover, they often contradict each other.

What is thus urgently needed is a more integrated approach to health, which may depend on a better understanding of another dichotomy, the one of law and spirituality. The relationship between law and spirituality is one that was considered an emerging interdisciplinary relation that has “much to contribute to the understanding and improvement of law” (Blomquist 2003). It was also said that while spirituality is subjective and law objective, both are necessary (Lamm 1998). In sum, the present article attempts to examine the relationship between law and spirituality as a means to enhance the coherence of health law and policymaking.

## **Multiculturalism and Informed Consent in Peru: Bioethical Perspective**

### **Rosa Teresa Meza Vásquez**

*(1) Peruvian Affiliate of the Latin American Association for Medical Law – Asolademe Peru, Lima, Peru, (2) Meza & Jiménez Attorneys, Lima, Peru, Giancarlo Jiménez Bazán (1) Peruvian Affiliate of the Latin American Association for Medical Law – Asolademe Peru, Lima, Peru, (2) Meza & Jiménez Attorneys, Lima, Peru*

Peruvian Constitution recognized as official languages besides Spanish to Quechua, Aymara and other 47 aboriginal languages especially from the jungle of Peru and constitute the way of communication of 55 indigenous peoples of Peru.

Aboriginal communities have resided in the region of the Andes of Peru and in the Jungle for many centuries, and still preserve their language, customs and way of life. This multicultural framework enforces changes in content and methodology of informed consent procedures.

In these cases respecting autonomy related to tradition and beliefs of the communities. Some require the consent of community leaders, or the head of family, husband and others. This study shows an approach to the situation and provide some considerations to handle that from a Bioethical perspective.

## **Doctors as Businessmen: The Ethical Implications**

### **Coralie Herijgers**

*University of Antwerp - Antwerp Health Law and Ethic Chair, Antwerp, Belgium*

Traditionally, doctors have been seen as professionals who treat their patients from a purely altruistic point of view. In contrast, both the Court of Justice in Europe and the Supreme Court in the United States have treated medicine for antitrust law purposes as not only a profession but also as an economic activity. Doctors therefore are businessmen who have certain rights and freedoms in performing their profession. For example, they can advertise their services and lower their prices in order to attract patients. However, medicine can't be fully equated with an ordinary business venture. The qualitative care of patients, not profit, must always come first. Physicians can have a financial interest but it always has to be a secondary concern.

This dual role as professional and businessman can be a positive incentive to create a more innovative, efficient and qualitative healthcare. On the other

hand, however, there is a danger of conflicts of interest. A key problem is possible impairment to doctors' necessary professional independence.

Medical and ethical regulations therefore have to find a balance between this necessary freedom of physicians on the one hand and the necessary protection of patients on the other hand. This presentation explains what type of balance is desirable and what implications this will have for the content of ethical rules. To take a comprehensive approach, the (ethical) rules in France, Belgium, the UK and the United States will be analyzed functionally. Hence, the research aims to provide concrete guidance for further necessary regulatory changes.

### **Exploring the Ethical Foundations of Medicine: The Canadian Medical Association Code of Ethics at 150**

#### **Cécile Bensimon**

*Director, Ethics and Professional Affairs, Canadian Medical Association*

Adjunct Professor, Faculty of Health Sciences, University of Ottawa, Canada

A Code of Ethics is an explicit articulation of values to which a profession aspires and norms of conduct that are expected of professionals. The Canadian Medical Association's (CMA) Code of Ethics was introduced in 1868 and has since been revised 19 times to reflect professional, societal, and technological changes. It is presently under revision.

In this presentation, we trace the changes in the CMA Code of Ethics over its 150-year history to contextualize the proposed revisions to the Code. We draw particular attention to the ways in which obligations to society and populations are articulated in the Code and further contextualize these findings within a broader ethical debate concerning societal obligations in medicine.

A historical analysis of the CMA Code of Ethics provides important insight into the nature and evolution of the ethical foundations of medicine. One notable shift in the Code's history has been a move away from a virtue-based ethic, emphasizing the characteristics that physicians ought to embody, to a principle-based ethic, which is consistent with the rise of principlism in modern bioethics. Another shift concerns the nature and importance of the profession's obligations to society. Early iterations of the Code recognized physicians' obligations to society, especially in matters of public health, while later iterations emphasized the primacy of obligations to patients. More recently, the Code has seen a return to more-explicitly articulated obligations to society and has expanded them to include notions of resource stewardship and health care advocacy as part of the evolving role of the physician in the changing landscape of medicine.

## **Physicians in the Field of Occupational Health and Ethical Problems**

### **Elif Ekmekci**

*TOBB ETU Medical School, Alper Bulut, Gulhane Training and Research Hospital Uluslararası Hasta Birimi, Berna Arda Ankara University Faculty of Medicine, Turkey*

Occupational health has been a concern for centuries. History goes back to Hippocrates. Today occupational health and safety is considered as risk management and proactive measures. Expectations and legislations for physicians working in occupational health area differ from usual physician routine in some ways, so different issues arise. The existing academic literature reveals the scarce of research in this field compared to the extent of the ethical issues.

**Aim:** To find out major ethical issues of occupational health physicians as the first step of a chain study concerning occupational health and safety.

**Method:** 44-question survey, consisting of multiple choice and commentary questions was conducted and sent to 53 physicians actively working in occupational health area via an online survey program. Thirty-six filled surveys were received. Answers were grouped as themes and analyzed accordingly.

**Results:** Themes were; issues concerning relationship between occupational health physicians and employers, the relations with employees and the issues of physicians' own. Most reported issue was physicians' not being free to point out the deficiencies and force the employer to take protective measures for occupational health while they are paid by employer even when the legislations tell them to do so. Issues concerning employees were mostly about lack of privacy and loyalty and the physicians' own issues were mostly about insufficient salaries, incompetency in occupational health practice and lack of trustworthy certification trainings.

**Conclusion:** Our study revealed that there were major ethical issues in occupational health area to be solved with governmental, NGOs and scientific involvement.

## **Recording a Doctor-Patient Conversation**

### **Evelien Delbeke**

*University of Antwerp, Antwerp, Belgium*

With our high-tech smartphones it is possible to record almost any conversation, not in the least a conversation between patient and doctor. Recording such conversation can help a patient to improve his recall and understanding of medical information and allows him to share the information with family members. On the other hand, these recordings could also be used as proof in complaints and lawsuits against doctors, e.g. when a patient claims his doctor didn't inform him about a specific risk of the medical procedure and uses the recording to prove the doctor's misinformation.

This paper explores if and to what extent it is allowed to record a conversation between a doctor and a patient. Are patient and doctor both allowed to record the conversation and if so, are there specific conditions and do they apply for both of them? Is permission needed to make these recordings or can it be done secretly? Can these (secretly made) recordings be used in court as proof of medical negligence or are they considered inadmissible evidence?

This paper approaches these questions from different angles: Belgian law, the new European General Data Protection Regulation, jurisprudence from Belgium, the Netherlands and the US as well as guidelines and rulings of different professional associations.

## **Representation and Rehabilitation of Health Professionals with Substance Abuse Disorders**

### **C. William Hinnant**

*Adjunct Associate Professor of Public Health Sciences, Clemson University, Clemson, SC, Hinnant Medical & Law Offices, LLC, Anderson, South Carolina, United States*

The United States is in the midst of an Opioid Epidemic wherein the ready availability of those and similar drugs to Health Professionals frequently leads to professional licensure actions. Such matters implicate criminal, civil and administrative liability pitting the professional's liberty and property interests against the state's police power and need to protect its citizen-patients. Health Professional Recovery Programs are now commonplace and allow respondents to continue to work under strict scrutiny and oversight by addiction specialists. First-time criminal defendants may be offered diversion programs while federal offenders face stiffer sentencing. Prescriptive authority is dually regulated at the state and federal level and may be revoked or limited by

licensure boards. Mentors may be required for the impacted professional to reenter practice, sometimes in more controlled environments. Interaction with probations professionals may be necessary and pardons may be available long-term for those that recover. Health Professional Data Banks memorialize such matters in virtually all cases and impact their employability and credentialing throughout their careers. This presentation will address the criminal, civil and administrative representation of these professionals and how to shepherd them from the pit of despair back to unimpeded professional practice. Techniques for salvaging employability and pardons for the restoration of any impacted civil rights will be discussed as will specific case hypotheticals.

## **PLENARY SESSION 2**

### **Living with Advanced Dementia and the Law: Lessons from Practice and Philosophy**

#### **Julian Hughes**

*RICE Professor of Old Age Psychiatry, University of Bristol, England*

In this paper, I particularly wish to focus on the relevance of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and ask what relevance it might have for people living with advanced dementia. In order to do this, I shall draw on clinical experience, some aspects of neuroscience and philosophy. There is a general background point about the juridification of clinical practice. This has been much in evidence in the UK context recently. I shall discuss this and the tensions that it seems to raise. The UNCRPD pushes a particular conception of human rights, seemingly to the limits when it is applied to the rights of persons living with severe dementia. I shall use clinical and neuroscientific data to suggest that the direction of travel in the UNCRPD is exactly right, despite the obvious difficulties. But I shall use some philosophical arguments to suggest the difficulties should not be so obvious. Perhaps there are no solutions because there are no problems!

### **Elder Law - What the Future Holds**

#### **Israel (Issi) Doron**

*Professor of Gerontology, University of Haifa, Israel*

Twenty five years have gone since the day I was first exposed to the field of “elder law”. From a “young” masters student I have become a law professor and a gerontologist, who specializes in law and aging. The journey I have personally overcome in the last quarter of a century, provided me with some perspective regarding the field of elder law (or as I rather call it: law and aging).

In this presentation, I will try to summarize my experience and share some personal insights on the field. This is naturally a personal and subjective experience, however, it may be constructive to others, in shaping the next coming 25 years of the field. Hence, the goal of this presentation is to provide both an integrative description of the developments in the field as well as some attempts to provide future directions.

In trying to meet this goal, this presentation will be divided into three parts: The first part will describe what were for me the formative years, i.e. the 1990s, especially my personal introduction to American Elder Law, which I view as the foundation to the field. The second part will describe the developments in the field during the early 2000s until today; The third and last part will try to provide some insights and point to current and future developments in the field.

### **Legal Capacity and Mental Disability: A Need for Cross-Disciplinary Dialogue**

#### **Michael Stein**

*Harvard Project on Disability. Harvard Law School, United States*

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is the first human rights treaty of the twenty-first century, and the first one to specifically protect the rights of the world's one billion persons with disabilities. One of the fundamental rights contained in the CRPD, and one that is emblematic of the paradigm shift intended by the treaty, is that of legal capacity: the equal right of persons with disabilities to make their own decisions in all aspects of life, including health care provision. At the same time, this right is also the least understood in terms of practice, and the most controversial. The speaker was privileged to have participated in the CRPD's drafting and to have worked on implementing the treaty in over 40 countries. This talk will investigate and provoke discussions around involuntary confinement and treatment, a topic currently dominated by rights advocates but without consultation.

## **END-OF-LIFE**

### **End-of-Life Care Decision-Making in Japan: Past, Present & Future Perspectives**

#### **Takeshi Miyashita**

*Bunkyo University, Tokyo, Japan*

This presentation will address the issues on end-of-life care and decision-making process in Japan. The number of people dying a year was about 700,000 in 1980 and then steadily increases by aging population. According to the latest demographic statistics, it will reach a peak at about 1,700,000 in 2040. It is obvious that the substantial number of people will be faced with the problem of end-of-life decision making. Some judicial cases dealt with euthanasia as a matter of the criminal liability of a doctor and the Yokohama District Court set up the requirements for active or passive euthanasia. In 2007, the Ministry of Health, Labour and Welfare formulated guidelines for decision-making process on terminal care as a soft law in the view of fact that the issues remained controversial. The guidelines mainly targeted at patients and medical professions, and provided basic consensus on decision-making process. March 2018, the guidelines were revised on the grounds that, in the course of a decade, the issues on end-of-life care has involved not only medical professions, but also care providers who work in nursing-care facilities and that it is necessary to add the concept of advance care planning to the decision-making process. I will make the outline of end-of-life care and decision-making process that is formed from the revised guideline and other judicial opinions, and analyze matters of concern about the guideline.

### **The Belgian Case of the 'Deacon of Death': Ending the Life of the Patient Without Their Consent**

#### **Thierry Vanswevelt**

*University of Antwerp, Belgium*

In 2002 Belgium introduced a Law on Euthanasia. In this law euthanasia is defined as intentionally terminating life by a physician at the (written) request of the patient. This law determines that euthanasia is a crime unless specific conditions have been fulfilled, including a serious and incurable disease and a condition of unbearable physical or mental suffering.

Recently, the Belgian society was shocked by the trial of a former nurse/deacon who had admitted to have ended the life of approximately 20 persons, and maybe more, in a hospital between 1978 and 2012. This case involved a discussion on the boundaries of the current euthanasia law and its interpretation.

The deacon had serious sleeping problems and consulted a psychiatrist. During these sessions the deacon confessed what he had done. The psychiatrist was of the opinion that his patient was still a danger for society and alarmed the police, violating his professional secrecy.

The accused argued that he had acted out of compassion, because the patients were terminally ill and suffered severe pain. At the trial he admitted to have ended the life of 4 people, his own family members, which he could identify, but he could not remember the name of the other people.

The Assize court convicted the former deacon because he violated the right of self determination of the victims, hence there was no euthanasia. Neither was there a gentle death, since the injection of air causes a death struggle of several minutes. The former deacon was convicted to 27 years imprisonment for the murder of five people.

The trial did not question the Belgian Law on Euthanasia. The Assize court stressed that several legal conditions of the law were not fulfilled: only a physician and not a nurse can perform euthanasia; and the law requires the (written) request of the patient. The deacon violated essential conditions and abused the law on Euthanasia. That's why the criminal conviction for multiple murder was accepted as logic, by both the advocates and the opponents of the law. The judgment confirmed that euthanasia is an exception to the principle that murder is a crime and can only be allowed if all the legal conditions are fulfilled.

## **Ethics and the Patient's Religious Beliefs in Physician Assisted Death**

### **Richard Wilbur**

*American Medical Foundation for Peer Review, Illinois United States*

When patients desiring physician aid in dying are evaluated by a second physician as to the rationality (sanity) of the request, an often overlooked aspect is the patients' belief as to what will happen to them after death. Where do they believe they will be next? Will they be in a glorious Heaven surrounded by their loved ones who have gone before? Do they expect go to a Hell for punishment of the crime of suicide? Will it be a new life on Earth in a different form? Are we like butterflies which simply change their state, but not their nature? Or will it be oblivion? The rationality of a person's desire to end his/her present life situation and go on to the next rests may rest upon their belief as to what that "next" will be. This belief may vary considerably from that of the consulting ethicist and of the culture in which they reside.

This presentation compares the afterlife as visualized by various religions and their various attitudes toward suicide. It will denote the shift in public attitudes over time. These beliefs affect the rationality of the patients' decision and therefore the consulting ethicist's judgement as to the ethical correctness of the attending physician's decision to aid in terminating a patient's present life state.

### **Euthanasia for Psychiatric Patients in the Benelux: Reasons for Concern?**

**Sylvie Tack**

*Ghent University - University of Antwerp, East-Flanders, Belgium*

Physician assistance to help people end their lives by prescribing or directly administering medication is now legal in a few American states, Canada, and five European countries (Switzerland, Germany, Luxembourg, Belgium and the Netherlands). In most of these countries, laws permitting physicians to write prescriptions for medications intended to end patients' lives are limited to patients with terminal conditions and preclude physician administration of the medication.

Belgium, the Netherlands and Luxembourg also allow direct physician involvement and expanded the criteria to include patients with irremediable suffering, whatever the cause. In these countries, non-terminally ill patients with severe mentally disorders can request for euthanasia, though only under strict conditions. However, data show the number of euthanasia cases with a psychiatric disorder has increased significantly since 2008. The majority concerned female patients with a mood disorder.

Due to the rise of euthanasia for non-terminally ill patients with mental disorders over the last decade, the objections against this controversial practice have grown as well. Local professional organizations have developed guidelines containing stricter due care criteria and a large number of psychiatric health institutions still prohibit euthanasia. Some political parties even want to curb the rights of psychiatric patients.

This study analyses whether these concerns are legitimate and if an adaptation of the Belgian, Dutch and Luxembourg law on euthanasia is desirable.

## **Cost-Benefit Model for Antibiotic Treatment at End of Life**

### **Yael Dishon-Benattar**

*1. The Cheryl Spencer Department of Nursing, University of Haifa, Israel. 2. Division of Infectious Diseases, Rambam Health Care Campus, Israel*

Antibiotic resistance became a global concern and threat in the past two decades. The use of antibiotics is considered futile when conferring no benefit to patients in terms of life expectancy (LE or quality of life (QOL), yet it is frequent at end of life (EOL and in presence of poor QOL, evoking ethical dilemmas concerning distribution of this nonrenewable resource. Futile treatment is neglected by the attempts to promote judicious antibiotic use. We developed a cost-benefit model for antibiotic treatment that addresses EOL and ecological costs, to avoid futile antibiotic use. Benefit is expressed as the expected reduction in mortality and hospital days with antibiotic treatment. EOL considerations, as curtailed LE, based on a 30-day mortality prediction score and poor QOL for bedridden patients with advanced dementia. Antibiotics' costs comprise of pharmacy cost; adverse event costs and the dominant component, ecological antibiotic costs, representing the potential of antibiotic treatment to promote resistance in the individual treated and in society. At EOL, ecological costs are higher due to the higher risk for recurrent infections and larger potential for spread of resistance. The model, developed using a causal probabilistic network, was incorporated to a previously developed computerized decision support system for antibiotic treatment, and tested on cohorts of patients suspected or diagnosed with infections. The model recommends less futile antibiotic treatment than clinicians in the acute care hospital setting, without compromising the appropriateness of antibiotic prescription in other cases and may reconcile ethical dilemmas involved, according to theories of distributive justice.

## **A Legal Appraisal of End of Life Issues in Nigeria**

### **Matthew Godfree**

*Pwajok, Ikowe&CO.NO.28 Ahmadu Bello Way, Jos, Nigerian Bar Association Jos, North Central Nigeria*

Life is the navel of humanity. That is why it enjoys priority over other facets of civilization. Life is so valuable that man explores the earth, sea, sky and space in order to safeguard it. Thus, whenever life conflicts with anything, preference is usually given to life. In Nigeria, belief in the sanctity of life is an interesting aspect of existence from cradle to grave. Hence, reverence for human lives continues even after death. Therefore, Nigerians are naturally conservative towards end of life issues. This prompts the following questions: Is patient's right to die recognized by Nigerian law? Is it justifiable to kill a

new born baby with incurable illness? Does Nigerian laws recognized post-humous rights of patients? Is it rational under Nigerian laws to dig out a corpse in order to establish a fact?

Nigeria adopts a ‘Hybrid Approach’ to end of life issues-where some aspects are permissible and others are prohibited. Thus, this paper seeks to:

- a. Identify instances of end of life issues under Nigerian laws.
- b. Examine end of life issues that are permissible and prohibited in Nigeria.
- c. Examine the challenges facing end of life issues in Nigeria.
- d. Suggest ways that will bolster quality practice of end of life issues in Nigeria.

It is the hope of the writer that this work will be an asset to the treasury of knowledge.

## **RESEARCH ETHICS AND LAW, GENERAL: BIOETHICS AND LAW**

### **Ethics of Research on Vulnerable Population: Sexual Abuse Among Inpatients**

#### **Alexander Shestipero**

*Be'er Ya'akov-Ness Ziona Mental Health Center, Israel., Ronit Kigli Be'er Ya'akov-Ness Ziona Mental Health Center, Israel. Hilik Levkovitz Be'er Ya'akov-Ness Ziona Mental Health Center, Israel. Orli Grinstein-Cohen Department of Nursing, Recanati School for Community Health Professions, Faculty of Health Sciences, Ben Gurion University of the Negev, Israel. Southern Israel*

As the awareness for childhood sexual abuse [CSA] raised in the recent years, recent studies have shown the negative influence of CSA on health of the victims. Yet, in Israel, our review concluded that the connection between the abuse and mental health has never been studied before.

One of the main ethical dilemmas in clinical research related to the interpersonal boundaries between the researcher who might be perceived as knowledgeable, paternalistic, and objective and the patient who might be perceived as subjective and less knowledgeable. It seems to us, that the researcher is supposed to relate to patient's inner world while providing information with this in mind.

While conducting a research to identify inpatients inside psychiatric hospital who had CSA, several dilemmas were faced:

- The transition from social relationships to care giver-patient and researcher-researched relationships.
- Disclosure a latent topic in patient's life can cause a negative influence and refusal to cooperate with the research.
- The need for placing boundaries for keeping the safety and caring of patients while dealing with multiple professional roles of the care giver as researcher and case manager on other hand, can interfere the research process.
- The blurred boundaries of written informed consent: Integration of information to secure the competency of the patient.

The main dilemmas, ways of processing, and keeping the balance between the safety and the needs of the inpatients to the aims of the research and for the need in expanding the knowledge to help care givers in their work will be discussed.

## **Harmonising Medical Research with GDPR Requirements**

### **Iryna Lishchuk**

*Leibniz Universität Hannover, Deutschland Germany*

HarmonicSS is a H2020 medical research project investigating primary Sjögren's Syndrome (pSS). The idea is to harmonize well-characterized multi-national cohorts of pSS patients into an integrative structure on the cloud and facilitate cross-border data sharing and research. The legal issues of General Data Protection Regulation (GDPR) compliance come into play: How partners share the roles and data protection obligations, when all partners process the data, decide the purposes and means of processing and thus act as controllers in terms of the GDPR? Who bears responsibility to conduct the data protection impact assessment (DPIA)? How to handle data transfers to non-EU partners, e.g. UK and USA?

Contractual arrangement, namely the Data Protection Memorandum, has been proposed to settle the data protection issues and allocate responsibilities for GDPR compliance among the partners. Accordingly, the partners, categorized into data providers, developers and researchers as per the tasks, are vested with corresponding data protection obligations. The legitimacy and accuracy of data (Article 5(1)(a,c)); pseudonymisation (Article 89(1)); information duties (Article 13) lie with the data providers; developers and researchers share the security obligations and data protection by design and by default (Articles 32,

25). Profiling and de-identification are no-go. The Data Control Committee is to take over the DPIA and monitor data protection in the project. Organisation of legal background behind potential data transfers to non-EU partners is under way. Whereas the task of the research team is to harmonize the data, the legal task is to harmonize medical research with the GDPR.

### **Compassionate Care or Subsequent Research on Unproven Intervention in Disaster Situation: Reflections on International Guidelines and the Development of the EBOLA Vaccine**

**Shlomit Zuckerman**

*Israel*

The use of unproven intervention is relatively common in disaster situation. Coping with overwhelming public health challenges in either natural or human made disasters is oftentimes impossible unless using medications, which has not yet been specifically proven for the treatment or prevention of certain pathologies in clinical trials.

International guidelines emphasize the compassionate use scenario over the need for research in those settings. Specifically, paragraph 37 of the Declaration of Helsinki (2013) states that “...the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician’s judgement it offers hope of saving life, re-establishing health or alleviating suffering.” In addition, CIOMS Guideline 20- Research in disaster situations (2017) states that “the conduct of research must not unduly compromise the response to the victims of a disaster”.

In this paper I argue that the guidelines does not necessarily imply that research should be conducted throughout the disaster situation itself or that it ought to be prospectively designed. In other words, the compassionate use of unproven interventions, as opposed to the subsequent research requirement, tends to be easier to justify in a disaster setting. This claim can be substantiated by the scarcity of medications available at the disaster and post-disaster situations, as well as an urgent need to save lives by all existing means. Indeed, the more serious a medical condition in a disaster setting is, the more compelling is the compassionate use scenario over the research use. More so, according to the declaration, a wide discretion is assigned to the physician in this context.

Finally, I will investigate whether or not throughout developing the Ebola vaccine following the outbreak of the epidemic in Africa in 2014, the dominant compassionate care scenario set the stage for modified and less restrictive principles of biomedical research and the ethical implications of such modification.

## **Patients' Rights or Human Rights - Is it the Same?**

### **Jasna Karacic**

*Croatian Association for the Promotion of Patients' Rights, Croatia*

Health authorities do accept that a minimal number of the immunized children can be injured by a vaccination-related encephalopathic process. Once a child is injured by this way, what is required in order to get court agreement to this connection? Who is the one responsible for the injury if at all? Do the governmental health authorities, those who instituted the vaccination policy, take full responsibility for covering vaccination related injury?

## **Learning from Charlie and Alfie - Parent's Decision Making Regarding Their Young Babies Medical Care**

### **Ian Freckelton**

*Melbourne University, Victoria, Australia*

The Charlie Gard and Alfie Evans legal sagas have preoccupied the common law world as their parents have fought for unorthodox measures to be taken to provide Charlie and Alfie with a chance for life. This paper analyses the decisions of the courts and reflects upon the campaigns fought on the behalf of the children's parents and the consequences that the sad cases have for medical practitioners, hospitals, courts, the media, legal principle and children's families. It particularly considers issues of dignity, autonomy and parental rights, arguing that a way needs to be found to avoid the unsatisfactory confrontation between law and medicine that has been portrayed by the media as lying at the heart of these cases.

## **OLD AGE AND LEGAL RIGHTS**

### **Age Discrimination of Doctors Versus Quality Care**

#### **Filip Dewallens**

*KU Leuven, UAntwerpen & Dewallens & Partners Law Firm, Vlaams-Brabant, Belgium*

The prohibition of age discrimination is a general principle of European Union Law that must be applied by national judges. This prohibition affects any form of direct or indirect discrimination based on age, and therefore also in relation to healthcare providers. This means that an agreement with a healthcare provider can't be terminated due to the only fact that he has reached a certain age. Nevertheless, a distinction in age is allowed: (1 if age is an essential and

determinative occupational requirement for the profession, and (2 if the age distinction is serving a legitimate aim.

We will make clear that although European, national and non-European judges use different criteria for this assessment, they still come to the same decision. Notwithstanding the fact that “quality” isn’t always included as a justification in national legislations of EU member states, hospital directors can actually still invoke this justification when making an age distinction. This means that on the one hand, an agreement with a healthcare provider can’t be terminated just because he has reached the age of 65, but that, on the other hand, the agreement can yet be terminated when a healthcare provider is no longer able to provide enough guarantees for patientcare according to the current state of scientific knowledge because of his age. In that case the burden of proof will be for the one who invokes the argument of quality.

### **Cause Lawyering in Representation of Older Persons**

#### **Meytal Segal-Reich**

*Elderly Representation and Competence, The Legal Aid Administration, Ministry of Justice, Israel.*

Representation of older persons in legal capacity procedures in Family courts in Israel is a new innovative advocacy practice, carried out by a unique state department, and very challenging for various reasons. Throughout the years, Stereotypes of older persons and ageism, and not being heard in court as a routine since Guardianship Law was regulated in 1962, made it almost impossible for older persons to succeed in objecting guardianships, and avoid what can be described as “civil death”. More than 90% of the cases ended without the older person being part of the procedure, and with a verdict “as requested”, appointing a guardian for all of the person’s affairs, for life. Knowing this reality, from practice and research, a new department was established, of lawyers specializing in Elder Law and in Disability Studies, in the Legal Aid of the Israeli Ministry of Justice, for representing in legal capacity procedures. The representation is accomodated to the person, fit to their measures, striving to find less restrictive options, to find and create facilities and services for assistance at home, and implement supported decision making instead. There has been great success, and in 2017 we had 2400 legal capacity cases in which we represented in court, creating a balanced procedure, in which the older person is seen and heard after neutralizing prejudice around age or Dementia. Supporters for decision making were appointed, guardianships were canceled, and wills and preferences were advocated for and heard, leading great precedents regarding rights in old age.

## **Challenges for Public Health in a Fast-Aging Society**

### **Eduardo Dantas**

*University of Coimbra, Pernambuco, Brazil*

For years, Brazil had a reputation of being a young nation, with a very young population. Statistically, the social pyramid was indeed formed with a strong, solid base of young people, and a reduced number of elderly citizens. Improvements in quality of life, medicine and technology, associated with a lower demographic rate has changed the scenario that had been around for centuries.

It is expected that the country will lose the status of a nation of young citizens, and become more similar to developed countries and their representative percentage of elderly people. And it is happening faster than public authorities are able to plan and design a new health system to adjust to this new reality.

The purpose of this paper is to study the ethical, economic and legal challenges for the public health system, in order to adapt and become effective for a growing number of elderly citizens that are changing the face, the needs and the way of living in the Brazilian society, and to establish propositions and reflections on what needs to be done to shift the paradigms in law and health public policies, before it is too late to avoid social disaster.

## **The Older Patient with Dementia as a Sexual Offender**

### **Tzvi Dwolatzky**

*Rambam Health Care Campus, Ella Holtzman Consultant Neuropsychologist  
Eliezer Witztum Faculty of Health Sciences, Ben-Gurion University of the  
Negev, North Israel*

#### **Background**

The rise in life expectancy has resulted in an increasing number of older people suffering from age-related comorbidities. Cognitive impairment and dementia, which are especially prevalent in this population, are associated with behavioral disturbances in up to 90% of patients. Sexually inappropriate behaviors are particularly disturbing, occurring in approximately 8% of patients with dementia. The most common manifestations include an increased sexual drive, sexual disinhibition, and sexual molesting and assault. In certain instances, these behaviors may lead to criminal charges being brought against the patient with dementia. Apart from the human tragedy resulting from such situations, the legal system is inadequately prepared to face the complex legal, medical and ethical challenges involved. There is thus an increasing need to raise awareness of this important issue.

### Case presentations

We will present three distinct cases of older people with dementia who were charged for sexually molesting minors. The medical history and evaluation, relevant neuropsychological assessment, and neuroimaging findings will be presented. We will discuss the medical and ethical ramifications of therapeutic pharmacological approaches used to inhibit sexual drive. In addition, we will relate to the dilemmas faced by the court in its deliberations.

### Conclusion

This presentation serves to highlight a complex medical, legal and ethical issue of increasing importance as the population ages. An increased awareness by health care providers, policy makers and law enforcement authorities, will help to alleviate unnecessary human suffering and inappropriate incarceration.

## **Using Humor Intelligently in Interactions Between Doctor and Elderly Patient**

**Edna**

**Katzenelson**

*Ph.D., Tel Aviv, Israel*

Humor can provide many benefits in doctor-patient relations. However, its use in interactions with elderly patients requires caution, prior knowledge of the patient, self-awareness, and careful judgement.

#### 1. From the doctor's perspective:

- Humorous 'venting' between doctors about elderly patients (in a sarcastic or condescending manner) is liable to seep into direct interactions with the patient.
- Humor that reflects ageism.
- 'Black humor' that reflects the doctor's own death anxiety.
- Humor that is perceived as disinclination on the part of the doctor to make serious efforts, as avoidance of difficult news, or as giving up, due to the age of the patient.

#### 2. From the elderly patient's perspective:

- Elderly patients who are liable to be harmed by doctors' humor: patients with depression; patients with neurological injury; patients sensitive to contact due to loneliness.
- Elderly patients who relate to themselves humorously in order to prevent the doctor from doing so (implicit ageism).

3. Even humor directed at the person accompanying the patient is harmful to the elderly patient.

## **HEALTH CARE SYSTEMS**

### **Medical Reform in Ukraine**

#### **Sibilla Buletsa**

*State Higher Educational Institution “Uzhhorod National University”, Head of Civil Law and Civil Procedure Law Department, Transcarpathia, Ukraine*

The medical reform of the health care system in Ukraine starts from the beginning of 2018, although serious transformations in it began earlier due to the reform. The law “On State Financial Guarantees for Medical Care of the Population”, adopted by the Parliament on October 19, 2017, introduces the practice of establishing health care guarantees in Ukraine.

The main reform measures are defined in the Program of Activities of the Cabinet Ministers of Ukraine, they include: 1) changing the concept of financing; 2) the formation of hospital districts; 3) the transformation of health facilities from budget institutions into communal non-profit enterprises; 4) other changes related to new principles of public procurements and other anti-corruption measures.

Within of the medical reform, the following measures have already been taken: 1) the number of hospital beds decreases in the regions due to the reduction of the number of inpatient patients in the regions; 2) the cost of utilities in all hospitals from January 1, 2018 is placed on the local authorities; 3) the formation of hospital districts began in the country; 4) since April 2017, the state program “Available medicines” has begun; 5) On April 25, 2017, the decision was made to introduce new standards of clinical protocols in Ukraine which basis on international standards; 6) since June 19, 2017, the first service of the electronic healthcare system eHealth operates in the pilot mode - “registration of primary care institutions”; 7) September 20, 2017, the eHealth system has been working in test mode.

## **China's Legislation on Health China**

### **Yanlin Cao**

*Institute of Medical Information, Chinese Academy of Medical Sciences  
& Peking Union Medical College, Xueqian Zheng Chinese Hospital  
Association, Chaoyang, China*

The proposal of the Healthy China Initiative is a milestone in China's health policy and health reform. It is also the largest public health movement in the world today. China's top legislature hopes to promote public health development and ensure health fairness through legislation. They have been trying for the past three years to provide legal grounds to the health reform and the implementation of the Healthy China Initiative by drafting China's Law on Basic Health Service and Health Promotion. This draft was submitted to the Standing Committee of the National People's Congress for the first reading by the end of 2017. The draft is publicized on the website of the NPC for public comments. This Draft was submitted to the Standing Committee of the NPC, it evoked tremendous debates not only in the congress but also among various governmental branches and different interest groups and stakeholder in the society.

The Draft of China's Basic Health Service and Health Promotion comprises 10 Chapters and 102 articles. The basic starting point of this legislation is to promote the development of public health undertakings and secure health fairness, which is also main content of the law. The draft made provisions on legislative principles, health rights and interests protection, free public health services, national health education, and non-profit public medical institutions.

## **Health Care Services to Non Brazilians in Brazil – Legal Aspects**

### **Washington Fonseca**

*São Paulo, Brazil*

This study aims to approach aspects of patients' migratory process in South America who seek health treatment in Brazil. Brazil (the largest country in the continent) has an Unified Health System called SUS (Sistema Único de Saúde). The Brazilian Constitution honors important principles such as human dignity, isonomy, universal access to health. The Constitution provides equal treatment to Brazilian citizens and foreigners despite of the status of these people in its territory. This leads to the occurrence of a phenomenon of people migrating from other countries seeking for medical treatment at no cost (all held by the Brazilian government). In addition, it shall be mentioned that Brazilian citizens migrate to big urban metropolitan areas seeking for medical treatment, which makes these places reference centers. Public hospitals became crowded and its

financial resources exhausted. Another problem to be discussed is the unequal distribution of financial resources and the lack of a plan for the patients' co-participation in the cost of their treatment (as it happens in many countries in Europe. Another recurring problem is the public health judicialization. Since public health care is free of cost, patients with severe diseases who need expensive treatment file suits against SUS in order to get provision for medical services (even for experimental treatment abroad. The purpose of this study is to discuss possible solutions under the perspective of comparative law.

### **China's Progress in Achieving UHC and Related Legislative Proposals**

#### **Xueqian Zheng**

*Chinese Society of Health Law Beijing Huawei Law Firm, China Hospital Association, Xicheng Region China*

UHC is intended to improve public health and promote health equity. In response to WHO's call, China has made great efforts to achieve UHC in China, including the establishment of universal medical insurance system and continuous enhancement of its support capabilities; focusing on strong basic level organizations, promoting the establishment of a hierarchical diagnosis and treatment system; advancing comprehensive reform of public hospitals, establishing modern hospital management systems; implement full-process reforming and improving the drug supply guarantee systems. In order to effectively implement the UHC policy, three legislative proposals are proposed: firstly, to ensure fairness and access to quality and efficient medical and health service systems; secondly, strengthening the protection of disease risks and integrating the universal health insurance system; thirdly, improving the performance of health systems and strengthening the service capacity of basic level medical and health institutions.

### **Taking Patients' Rights Seriously in a Developing Economy an Appraisal of Patients Rights Regime in Ghana**

#### **Ernest Owusu-Dapaa,**

*Kwame Nkrumah University of Science and Technology, Ghana*

The resources challenge of developing countries is a major obstacle towards meaningful development of health care law and ethics in those countries. Ghana is no exception. In this paper it is postulated that the quest to empower patients by adoption of various frameworks on patient rights including the patients charter would remain a mirage unless other supporting mechanism for public awareness creation and enforcements have been put in place. The paper first explores the preliminary theoretical issue as to whether a country must

develop first prior to being concerned with development of a field of health care law and ethics or such an enterprise could be undertaken regardless of the economic development level of a country. Secondly, the paper presents an overview of the bleak situation of patients in the hands of health care professionals and health facilities in Ghana. The paper then embark upon a survey of legal frameworks in Ghana that have elaborated or enshrined rights of patients. A critical examination is made of these legal frameworks with respects to the prospects and challenges in securing rights of patients in Ghana. The paper concludes by making pertinent recommendations that draw upon best practices in other jurisdictions.

Keywords: health profession, law and medicine, health care law, Patients' rights, bioethics

## **HUMANITARIAN MEDICINE – HISTORICAL, ETHICAL AND LEGAL ASPECTS**

### **Treatment of Syrian Patients in Israel – Care takers' Perceptions and Attitudes**

#### **Tanya Kronus**

*Galilee Medical Center, Abeer Dabbah, Galilee Medical Center, Maya Peled-Raz, University of Haifa, Ohad Ronen, Galilee Medical Center, Israel*

#### Background

Since March 2013, following the collapse of civic and medical Infrastructure amidst the civil war in Syria, over 2,260 Syrian patients – men, women and children, have been treated in the Galilee Medical Center in the north of Israel.

The difficulty and challenges of dealing with the treatment of Syrian patients is clear, as it is set against the background of a culture that is perceived as hostile to Israel, as well as against social, cultural and organizational constraints.

#### Methods

127 Israeli physicians and nurses from the Galilee Medical Center have thus far been surveyed anonymously (data collection is on-going. 45 of them serve on units and departments that frequently treat Syrian patients. The other 82 participants serve on units where they have infrequent or no encounters with Syrian patients. Participants in both groups were asked about demographic background and their general attitudes regarding the treatment of Syrian patients in Israel. Participants in the “Syrian group” were also asked about their personal perception of the treatment of Syrian Patients, while participants

in the “Israeli Group” were asked about their personal perception of the treatment of Israeli-nationals.

### Results

Significant differences were found between departmental-groups, as well as between physicians and nurses, in regards to their general attitudes regarding Israel’s involvement in the treatment of Syrian patients as well as regarding their personal perception of patient-treatment.

### Discussion

The treatment of patients from war-torn regions in general, and from “hostile nations” in particular, poses unique ethical and professional challenges.

## **70 years of the Geneva Conventions – A Timely Re-Appraisal of their Impact on Medical Personnel and Human Rights**

### **Roy Beran**

*University of New South Wales; Griffith University, John Devereux, NSW Australia*

### Background

The modern Geneva Conventions were signed in 1949, though the laws of war date back as far as the Mahabharata and the Torah. The Geneva Conventions came into force in the shadows of the horror of two world wars, the use of chemical weapons, carpet bombing of civilian towns, mass extermination and medical experimentation on vulnerable groups.

Times have changed. Wars are no longer fought on a global scale. Regional conflicts, non-international armed conflicts and peacekeeping missions dominate the landscape. Modern challenges include the use of human shields, the impact in war of non state actors and civilians taking intermittent direct parts in hostility.

In light of the above changes, it is timely to review the Geneva Conventions – particularly as they impact on medical procedures and practitioners. We need to revisit humanitarian principles to preserve life and dignity.

### What are the Geneva Conventions?

The Geneva Conventions protect those no longer acting in hostilities (those “hors de combat”), civilians, sick, wounded and shipwrecked and prisoners of war (PWs). The Geneva Conventions and Hague Conventions are a subset of ‘international humanitarian law’ – jus in bello. Breaches of the laws of war are war crimes - wilful killing, torture, genocide and inhumane treatment.

### How do the Geneva Conventions Affect Medical Personnel?

Medical personnel may carry arms for self-defence and patient protection. They can remove weapons or ammunition from wounded and sick. Medical transport, displaying protective insignia, cannot have mounted weaponry but can have armed escorts. Patient consent is expected for medical care. Medical Personnel can be charged if they violate the laws of war, including: injuring or killing non-combatants; failing to provide essential care; exposing sick or injured to infection or contagion; affronting dignity; and subjecting protected people to humiliation, intimidation or degrading treatment.

### Conflict of Duties

Doctors in uniform have divergent responsibilities: (1) whom to treat and when; (2) harmful interrogations; (3) respecting ethical codes of conduct and

human rights. Careful consideration needs to be given to the question - are medical ethics in armed conflicts identical to those in peacetime?

## **The Evil of Josef Mengele, Twin Experiments, Auschwitz and Informed Consent**

### **Ken J. Berger**

*University of Toronto Faculty of Medicine and Department of Health Policy Management and Evaluation, K.J Berger\*, O. Hannigan, M. Cabarubias, J. Kim, Ontario, Canada*

Josef Mengele's unlawful experiments on twin children at Auschwitz was barbaric and inhumane. They were justified by the Nazi propaganda deeming prisoners of war as being less than human. Mengele did not require a person's consent and forced others to ignore ethical safeguards to protect human dignity, to prevent human exploitation and right to life.

After the Nuremberg trials, the abuses suffered by those who unwillingly participated in Mengele's experiments led to the development of the Nuremberg Code, a watershed moment in bioethics and medical law. The Code emphasized informed consent, requiring legal capacity to give consent, with free power of choice. The Code barred informed consent given by someone other than the child and prohibited any nontherapeutic treatment on children.

The Code was so strict that no country adopted it. It was followed by the Declaration of Helsinki in 1964 and in 1997 the Council of Europe signed a treaty creating a balance between research and advancement, and the rights of children.

Should child experiments be justified if they bring therapeutic advancement to the individual? Should child experimentation be permitted solely for the greater public good? Should the knowledge gained from illegal experimentation, such as occurred at Auschwitz, ever be used if they provide medical advancements with future beneficial outcomes, regardless of how it was obtained?

This presentation will discuss historical perspectives on Informed Consent, where we have been, where we are and where we are going from the eyes, ears and voices of our vulnerable innocent children.

### **Bioethics and the Holocaust: Teaching the Past for Improving the Future**

**Tessa Chelouche**

*Rappaport Faculty of Medicine, Technion Institute, Israel; Unesco Department for Bioethics and the Holocaust; Maimonedes Institute for Medicine and the Holocaust, Israel*

On reflection of medicine during the Third Reich and the Holocaust, we encounter some of the most difficult and profound choices of our humanity. Medical practice during this era provided the basis for the present bioethical doctrine. Consequently, it is safe to state that this subject does not belong to history but rather, as I believe, to the future. Discourse on the lessons that can be learned from the practice of medicine during the Third Reich and the Holocaust should be an essential component of all healthcare professional education.

To this objective we have published a casebook on Bioethics and the Holocaust for UNESCO Chair of Bioethics using personal cases on various bioethical issues that are relevant and pertinent to today's bioethical discourse. These cases address the various aspects of medicine during the Third Reich with each case provided with historical background to provide the correct social context and a wider perspective on the issue. This is followed by an ethical discussion whose aim is to provide a tool for reflection and dialogue on bioethical issues both in the Holocaust, and in our own times.

In this presentation I shall demonstrate how these cases can serve as a platform for present and future bioethical education. Greater knowledge and ethical discussion on these profound issues can not only help combat ignorance and prejudice, but can also inspire healthcare professionals to practice with greater compassion, knowledge, tolerance, respect and justice on behalf of their patients.

## **Medical Ethics in Ukrainian Prison System: Current Situation and Challenges**

### **Igor Katsytadze**

*International Committee of the Red Cross, Kyiv Ukraine*

Ukrainian prison health system is on way of reforming. Soviet standards of medical care in detention and structural organization of health services are out of acceptable rules and moral. The questions of medical ethics for a long time were hidden. The aim of this work is to present the current problems with medical ethics in prisons and possible ways of capacity building of the prison medical staff. Materials and methods. In our project were involved 20 medical doctors from 10 biggest pretrial places of detention all over Ukraine. We provided seminars and training for the health management in prisons including the topic of medical ethics. After each training, a short evaluation form were requested to fill by participants and early feedback showed the importance and primary interest to study this field of medicine.

During follow up visits to priority places of detention, we collected information about practical implementation and effectiveness of suggested method using evaluative tools. The analyses and recommendations will be reported during presentation.

## **ORGAN TRANSPLANTATION AND FORENSIC MATTERS**

### **Who do we Prioritize in Organ Transplantation Policy? Lessons from Israel**

#### **Corinne Berzon**

*Bar Ilan University, Israel*

The individualist, non-interference model of autonomy adopted by voluntary organ procurement policy requires express consent to posthumous organ retrieval. This implies that individuals have a right to choose whether their organs will be used to save the lives of potential recipients. Voluntary procurement also prioritizes the interests of potential donors' next of kin by permitting family to veto organ retrieval even in cases where the decedent has consented. By characterizing organs as a 'gift of life' the donation of which is a supererogatory act, voluntary organ donation adopts a specific understanding of the status of organs. Namely, that organs belong to the dead or their families

to dispose of as they wish. This neglects potential recipients as the primary stakeholders in transplantation policy. Another possible understanding of transplant organs is that they are a life-saving medical resource that the sick have a right to. If this is the case, then policy makers may be obligated to facilitate the retrieval of organs as an easy rescue: the lives of potential recipients can be saved at zero cost to the donor since they are dead and cannot be harmed or benefitted. This perspective would seem to support organ conscription regardless of the consent of the decedent or their family. However, conscription seems unduly coercive. This paper examines balancing the interests of all involved parties in organ transplantation in pursuit of a coherent, fair, and efficient procurement policy. The Israeli experience with the innovative priority points policy is instructive in this discussion.

### **Organ Allocation and the Reciprocity Principle**

#### **Nils Broeckx**

*Visiting professor University of Antwerp (AHLEC & ALLIC); Lawyer Dewallens & Partners, Leuven, Belgium*

Organ transplantation is widely regarded as a successful treatment for various types of organ failure, but is unfortunately not always an option due to a lack of transplantable organs. Human donors have always been the main source of transplant organs, but there just aren't enough organ donors to meet the needs.

It has already been argued by different authors that this organ shortage could partly be mitigated by only - or preferably - allocating organs to patients who are willing to be organ donors themselves after death (the reciprocity principle). It is assumed that this would incite more people to register themselves as organ donors, which eventually should lead to more donor organs.

The key question is whether the introduction of this reciprocity principle can be justified from an ethico legal perspective. This must primarily be evaluated in light of the right to equality and non discrimination. This human right basically states that everyone should be treated equally, unless there are pertinent reasons that justify a different treatment. In the context of organ allocation this means that every patient on the transplant waiting list is equally entitled to receiving a donor organ, unless there is a pertinent reason to give priority to a certain patient. Whether willingness to be a donor yourself can be such a pertinent reason mainly depends on the interaction between three ethical values: equity, utility and autonomy.

The conclusion is that the reciprocity principle can be justified, but only within certain legally defined limits.

## **Policies Pertaining to Kidney Donation**

### **Yuval Cherlow**

*Zohar Rabbiess, Rannah, Israel*

The general guidelines of living kidney donation in Israel today are:

- A person is permitted to donate a kidney, but is not allowed to receive compensation for it.
- He or she is permitted to donate to a certain person - or anonymously - but the donation cannot be conditional on the premise that it is only for the purposes of a specific person or groups of persons.
- There are private organizations that deal with connecting donors to recipients and this can even be done via social media.

The lecture will re-examine these three ethical issues

## **Altruistic Kidney Donation – A Personal Story and Ethical Deliberation**

### **Nili Levy**

*Tel Aviv University, Ono Academic College, Israel*

Three years ago, my husband and I each donated a kidney to people who were in need. During this process, we encountered and dealt with many ethical dilemmas. Moral deliberation revealed that we had different and somewhat conflicting moral intuitions, which were derived from three moral perspectives: Rights Ethics, Interests Ethics and Care Ethics. Each moral perspective represents the morality of a different arena and reflects a different point of view, all of which should be taken into account. It became clear that although Israeli legislation and ethical discourse reflects Rights and Interests Ethics, in approaching altruistic ethical dilemmas, Care Ethics is the most prominent and important perspective, and it cannot be neglected.

## **Sexual Assaults and Errors in the Application of Justice**

### **Luis Ravanal**

*Forenses Chile, Chile*

The reports of medical experts at a trial constitute one of the most frequently used sources of objective evidence on technical matters beyond the knowledge of the tribunal, particularly in the assessment of sexual violence. From time to time, for a variety of reasons, the opinion submitted in the forensic medical report from the direct physical examination of the victim and from the subsequent laboratory investigations is not supported by the scientific

evidence and lacks objectivity. This study presents a series of cases in which sub-standard clinical examinations and misinterpretation of injuries led to unwarranted judicial decisions.

Conclusion: When clinical investigations on an alleged victim of sexual assault are not carried out to appropriate and accepted scientific standards, judicial errors can ensue which may lead to the conviction of the innocent or the freedom of the offender.

### **Ownership of the Dead Human Body During the Forensic Investigation in Greece**

#### **Grigorios Leon**

*Medicolegal Office, Athens Greece, Katerina Kanaki, University of Crete, Anna Razou, General Hospital Asklepieio Voulas, Fotios Chatzinikolaou, Aristotle University of Thessaloniki, Greece*

Issues of ownership of the dead human body frequently arise during the forensic investigation. The present study will analyze the contemporary provisions of the civil and penal code of Greece, as well as the relevant jurisprudence, in order to present the legal significance of the corpse in Greek law.

Greek law has been mainly influenced by Roman law. In Roman law, there were no special provisions on ownership of the human dead body. From the definitions, however, that the place, that ought to belong to the deceased, where the latter had been buried in an appropriate manner became “sacred” (*religionis*), it was concluded that the dead buried in this area acquired the status of “*res extra commercium*”.

In the present study, amongst others, we attempt to provide answers mainly on ownership of the corpse in relation to forensic investigation. In addition, issues such as the ownership of bodies that have undergone advanced sepsis or burning are also dealt with. Finally, we conclude with the notion of ownership, either in terms of human skeleton bones or in relation to genetic materials.

Hence, the study proves that according to Greek law, neither individual, nor the state has any right of ownership on the corpse. The State applies only public protection on the corpse, as to an object of religious interest, forbidding any desecration or indecency towards it.

## **CORONER – FORENSIC MEDICINE**

### **Official Medicolegal Investigation of Deaths Involving Celebrities and Prominent Political Individuals: Special Concerns and Considerations**

#### **Cyril Wecht**

*Forensic Pathologist, Pittsburgh, Pennsylvania, United States*

When a prominent political person or national celebrity dies suddenly and unexpectedly, it is understandable that there will be immediate overwhelming attention focused upon that individual by every segment of the news media world. This intense coverage, of course, is markedly increased if the death is violent and controversial.

No matter how well organized and experienced the official governmental medicolegal investigative office in charge of the case may be, the pressures brought to bear in such matters are vastly different from routine, usual cases, even those of an atypical nature that do not involve famous people.

The smallest, non-malevolent procedural error can be blown completely out of proportion and may survive even after the death has been officially adjudicated. It is therefore imperative that the individuals in charge, i.e., law enforcement, forensic scientists, and governmental leaders, initiate appropriate measures to ensure that the death investigation is conducted in a thorough, meticulous, objective, and unbiased fashion, utilizing the most experienced and competent members of their respective staffs.

As in every medicolegal death investigation, the basic objectives of the forensic scientific office will be the determination of the cause and manner of death. Of course, there will be numerous, additional, important related aspects of the case to be evaluated and addressed that will involve other people, e.g., relatives, attending ante-mortem clinical physicians, witnesses, etc.

In my presentation, various examples of both procedural and substantive errors, premature rulings, professional/personal bias, and intricate political influence and manipulation will be presented that were involved in major cases of international interest involving famous celebrities and prominent political leaders.

## **Incapacitating Terrorists: Causes of Death, Ethical and Interpretive Challenges**

### **Chen Kugel**

*Israel National Center of Forensic Medicine, Maya Furman Israel National Center of Forensic Medicine Chaviv Israel National Center of Forensic Medicine, Israel*

Terror acts have become frequent all over the world in recent years. Many of the terrorist attacks come to an end when the terrorists are neutralized and in many cases - killed. Detailed description and thorough examination of the bodies can assist in assessment and investigation of the security forces response, and can shed light on its effectiveness.

We have reviewed all the post mortem examination reports of terrorists' bodies that were brought to the Israel National Institute of Forensic Medicine in Tel Aviv during the years 2001-2016.

During this period 343 bodies of terrorists were examined in our institute. Of these 136 were suicide bombers who died of explosion injuries. The rest died of gunshot wounds apart of one case of stabbing injuries.

In this presentation we will describe the pattern of injuries, the location of bullet entrance wounds, and will remark on the range of fire, type of ammunition used, and number of shots used to incapacitate the terrorists. These can reflect on the time needed to incapacitate the terrorists, the effectiveness and appropriateness of the neutralizing response.

We will also refer to the identity of the person who effectively carried out the incapacitation, whether it was a military person, a policeman or a citizen that was bearing a weapon. This can reflect on the availability of firearms and presence of armed persons in the population.

Keywords: Incapacitation, terrorists, firearms, gunshot wounds

## **Why Do a Documentary Such as Coroner**

### **Ben Hethcoat**

*Producer, California, United States*

Dr. Thomas Noguchi served as Chief Medical Examiner/Coroner of Los Angeles County for 15 years, and in that time he not only managed to leave an indelible mark on the field of forensics, but on American culture as well. His high-profile cases put his name alongside some of the most famous and sometimes notorious figures of the 20th century including: Marilyn Monroe,

Robert Kennedy, Charles Manson, and Natalie Wood. Noguchi staunchly believed that each death can tell us something about how we live, and he abided by a personal creed to “tell it like it is.” But his candor was not embraced by all. His statements in press conferences and interviews often revealed personal details of drug abuse and depression that made Hollywood bristle. During his tenure as the “Coroner to the Stars”, he managed to push the role of coroner from relative obscurity into the national zeitgeist. But he also made enemies, some of whom were high-profile and bent on taking him down. Dr. Thomas Noguchi’s story is an immigrant’s struggle to make it in a new world, a scientist’s bumpy road through the world of politics and an examination of fame and celebrity culture.

### **Urgent Need to Establish Guidelines for Ethics in Practice of Forensic Sciences**

#### **Thomas Noguchi**

*Keck School of Medicine University of Southern California, United States*

There are similarities and dissimilarities between medical ethics and ethics in the practice of forensic science. Medical ethics has been accepted globally, but organized ethics does not exist within forensic ethics.

Forensic pathology is a branch of medicine, and so pathologists are bound by the AMA code of medical ethics in the United States. This means that physicians must maintain current skills and knowledge. The U.S. National Science Academy in 2009 issued that any scientists who handle evidence and express opinion in a criminal justice must be qualified and hold a specialty board certification; furthermore, the laboratory must also be accredited by the specialty board through periodic inspection.

For many decades, from time to time, we come across news items dealing with errors or mishandling indicating a lack of care. To address these complications we need solutions that encourage organization and an overall improvement of the office using a peer review process. If we do not improve, that error will show up someday or somewhere. Bringing the established medical credentialing process, accreditation and certification of competency will significantly lower the probabilities of errors. If an autopsy is involved, it should be accredited by the NAME Autopsy Standards or through international accreditation. We should develop a system such as in the medical peer review organization, where there is no blaming, but instead a drive to find the root cause. Our experience and errors are often due to inherited procedures. A nationwide effort of improvement planning is necessary.

## **BIOETHICS AND LAW INITIATIVE INAUGURATION – HUMANITARIAN MEDICINE, ETHICS AND CURRENT CHALLENGES IN ISRAEL**

### **Removing Borders: The Humanitarian Treatment of Syrian Nationals at the Galilee Medical Center**

#### **Samuel Tobias**

*Department of Neurosurgery, Galilee Medical Center, Jean Soustiel, Israel*

In 2013, the government made an historically unprecedented decision to open its borders to Syrian nationals injured in the ongoing civil war.

The Syrian Civil War has entered its seventh year and has resulted in a death toll that tops over 550,000 including children, women, elderly and men. It has resulted in the disruption of all the medical services and the displacement of over 6 million citizens and another 4.7 million are listed as refugees in the neighboring countries.

Over 2500 syrian nationals have been treated at the Galilee Medical Center.

Since March 2013, we have received over 400 Syrian casualties that have sustained very severe head injuries including blunt, blast and penetrating injuries, many of them requiring multiple surgeries. About 40% of the injuries are related to missile penetration of the cranial cavity including high velocity (gun shot wounds) and low velocity (Shrapnel) projectiles. The average stay in the hospital is about 40 days with 25 of them in intensive care. In the entire cohort the most common complication has been infection (40%), cerebrospinal fluid leak (20%), and hydrocephalus (10%) Mortality has been surprisingly low and reached 18%. In contrast, high velocity missile injuries conveyed meningitis in 47%, CSF leak (33%) and hydrocephalus (33%), with a mortality of 14% . Caring for the sick and wounded has enabled our medical center to raise its level of the treatment provided to victims of armed conflicts and hopefully will be the bridge for trust building between the two nations.

## **Legal Regulation for Reciprocal Benefit: Stopping Organ Trafficking and Improving Unpaid Donation**

### **Alexander Capron**

*Vice Dean for Faculty and Academic Affairs, Scott H. Bice Chair in Healthcare Law, Policy and Ethics, Professor of Law and Medicine, Keck School of Medicine, Co-Director, Pacific Center for Health Policy and Ethics, USA*

Up to 10% of transplanted kidneys involve trafficked organs. Adhering to the prohibitions on purchasing organs, as recommended in numerous intergovernmental and professional documents, would thus seem to reduce the number of transplants. Yet the result is the opposite: besides avoiding exploitation of vulnerable organ sellers, legal regulation actually increases the number of transplants.

## **GENETICS, ETHICS AND LAW**

### **Genetic v. Legal Identity**

#### **Judit Sandor**

*Central European University, Budapest, Hungary*

Genetic identity and the related phenotypic profiles often differ from established forms of cultural identity (ethnicity, gender, class, citizenship) or from the family law status. Over the past two decades, however, we can observe that genetic features have become more and more important elements of personal identity. Genetic testing and genetic screening, paternity testing and forensic identification have emerged as powerful determinants of who we are and whom we can identify with. Advances in genetics have undoubtedly provided useful methods for criminal justice, but they also created new challenges for interpreting forensic research findings in a non-discriminatory way. This paper explores and discusses the current legal dilemmas of using genetic identity in place of personhood in ancestry search, reproduction policy, in assisted reproduction and in other domains of legal policies, and argues that law should keep the distinction between genetic identity and personal identity.

## **Deep Genomics Analysis Becomes Mainstream**

### **Noam Shomron**

*Faculty of Medicine, Tel Aviv University, Israel*

Next-generation sequencing (NGS; also known as deep sequencing) has probably been the most significant tool for genomic research over the past decade. NGS has led to numerous discoveries and scientific breakthroughs in the genetic field. These sequencing technologies are now entering the clinical diagnostic laboratory aiming to revolutionize current medical treatments. Consequently, physicians and medical professionals, exposed to a vast amount of genomic data, face major challenges of processing, analyzing and interpreting the information in order to carry out decisions based on new world medicine.

## **Can Genetic Information Be Disclosed to Relatives?**

### **Cindy Cornelis**

*University of Antwerp, Antwerp, Belgium*

Genetic testing not only reveals information about the person tested. It can also reveal information about certain relatives. A patient's genetic diagnosis can thus be of great importance to genetically at-risk relatives. For example, when a patient has Huntington's or Cystic Fibrosis, his or her children have a 50 % chance to have inherited the disease. This can be important information to make further life choices. Or there can be a case of familial colon cancer or BRCA. When relatives are aware, they can take preventive actions like screening or preventive surgery.

So what if a patient doesn't share this information with his or her family? Can or should genetic information be communicated towards family members by a physician? The shared nature of genetic information creates a conflict between established principles of medical law and ethics namely the right to autonomy and privacy of the patient, the right to information of the relatives, the duty to warn and the duty of professional secrecy. So, can a physician do something or is he or she irrevocably bound by the duty of professional secrecy?

In order to find an answer to this question, I looked at how this is dealt with in Belgium, Australia, Canada, the United States and the United Kingdom. Overall, there seems to be a consensus that a breach of professional secrecy could be justified based on an act of necessity provided that certain conditions are met. The most important condition is that it concerns a treatable genetic condition.

## **Accompanying Family Members in Genetic Counseling: Clinicians' Perception**

### **Sivia Barnoy**

*Nursing Department, School of Health Professions, Tel-Aviv University, Roy Gilbar Senior Lecturer, School of Law, Netanya Academic College, Netanya, Israel; Honorary Senior Lecturer, School of Law, University of Leicester, Leicester, UK, Israel*

As other areas of medical practice, relatives accompany patients to genetic consultations. However, unlike other areas, the consultations may be relevant to the relatives' health because they may be at risk of developing the same genetic condition as the patient. The presence of relatives in genetic consultation may affect the decision-making process and it raises questions about the perception of patient autonomy and the way it is practiced in genetics. However, these issues have not been examined in previous empirical studies.

In this paper, we report findings from a qualitative study with clinicians working in the area of inherited breast cancer. The findings indicate that family presence has an impact on the patient's decisions to undergo genetic testing and preventative operations when she is diagnosed as a carrier. The findings further indicate that unlike other areas of medical practice, blood relatives who are present in consultations are perceived by clinicians as patients or potential patients, and this in turn increases their involvement in discussions in the consultation room. Finally, the findings indicate that decisions are made in a social context, where the relatives' views are heard and taken into account.

The findings suggest that the conventional bioethical approach to autonomy, which perceives the decision-making unit comprised of a clinician and an individual patient, is challenged in genetics. The findings thus require bioethicists, lawyers and policy-makers to consider whether this individualistic approach is still valid and applicable.

## **Human Germline Edition and Mitochondrial Transfer in Portugal**

### **Fernanda Almeida**

*Faculty of Law, Coimbra, Portugal*

We analyse the Portuguese law - Law n.º 12/2005 (personal genetic and health information law). Article 8 of this law states that only for preventive or therapeutic reasons, and subject to the regime established therein, medical intervention is permitted with the intention of modifying the human genome. Outside this standard it is not permitted any medical intervention which aims

any genetic manipulation of the characteristics considered normal, as well as the change of the germinal line of a person.

It is questionable what should be understood by normal characteristics and who establishes the normality pattern.

In addition, are improvements planned for non-medical purposes? Is it permissible to change characteristics which, if the term medical intervention does not fit, allows for the modification of non-normal characteristics?

Finally, does the rule prevent the creation of gametes from IPC cells and their modification? And does it prohibit the possibility, in Portugal, as in the United Kingdom, of mitochondrial transfer between oocytes in order to avoid the transmission of hereditary diseases through the maternal route, thus giving birth to the child with DNA of three persons?

## **RISK MANAGEMENT, MALPRACTICE AND MEDICAL EXPERTS**

### **Medical Negligence and Mental Harm Compensation Challenges**

#### **Tina Popa**

*RMIT University, Victoria, Australia*

Patients who become victims of medical negligence often sustain devastating injuries (including mental harm) and rely on the legal system to obtain financial compensation to assist in managing life after injury. More than a decade ago, Australian states reacted to a perceived medical indemnity crisis by enacting statutes reforming the entitlement to compensation in medical negligence. Restrictions were imposed, including injury thresholds and caps on damages. The reforms were extensive, with prominent Australian academics questioning whether the rights of plaintiffs with meritorious negligence claims were unfairly curtailed. In 2015 remedial amendments were introduced to ease some of the harshness of the restrictions.

In a 2016 doctoral study the author explored perceptions from lawyers regarding the impact of the reforms on medical negligence. The qualitative project explored the effect of the original legislative changes, the 2015 amendments and the perceived effect on party rights. 24 tort lawyers drawn from the senior profession and judiciary in Melbourne Australia were interviewed. Analysis of the data shows many of the participants viewed the legislative restrictions as unfairly impact on possible claimants. Some participants expressed the view that a no-fault compensation scheme was preferable over a tort-based system.

This paper explores whether international jurisdictions such as New Zealand's no-fault scheme or comparable fault-based systems offer more desirable approaches to compensating claimants affected by medical negligence or suffering mental harm. The paper argues that Australian legislators should look to these international systems for guidance on future medical negligence reforms.

## **A Proposal for International Legal Framework to Regulate Medical Negligence**

**Folashade Adegbite**

*University of Lagos, Lagos, Nigeria*

Infirmity is both ubiquitous and a life's certainty; an existential crises plaguing humanity. Consequently, good medical care is vital to the restoration of good health. When a patient subjects himself to medical treatment, there is the implicit assumption that the healthcare giver has the sufficient skills and that, there are basic standard regulating these skills. Humanity expects justice to prevail in cases of negligence. Redressing negligence is usually in the purview of each nation state, however, medical treatment has over time migrated from the confines of domestic arena to global stage. Consequently, there is a need to have a universal minimum standard of regulation serving as base line for global governance from which all domestic orders draw from. This becomes crucial because of emerging realities of medical tourism and international travels among others. This paper, using the doctrinal research method, interrogates the existence of any international framework or mechanism regulating medical negligence, it reviews the need, sufficiency or otherwise of these standards. It distinguishes the existence, relevance and limits of international self-regulatory institutions and extant laws to the public international law. It further examines the various international regulatory bodies and laws presently in place, with regards to self-regulatory and the public international structures. it ends by exposing issues and challenges posed by self-regulatory structures which underscores the expediency of a global unified process that will moderate, challenge as well as harmonize the minimum standard of redress structures of all nations to safeguard the trust of humanity in the medical practice.

## **The Active Role of Medical Experts**

### **Patrick Zonderman**

*Lawyer Dewallens & Partners, Vlaams-Brabant, Belgium*

Under certain conditions Courts can decide to appoint a medical expert in medical malpractice litigation for advise. The expert will investigate the case and write down his conclusions about the possible negligence of the health care professional. In the case of Kurt Erdiņ and Others against Turkey, the European Court of Human Rights holds that there has been a violation of Article 8 of the Convention (right to privacy) (ECHR 2017/14, 6 june 2017, no. 50772/11 – second section) because the expert report did not address the question whether the doctors had contributed to the damage. The High Contracting Parties have a positive obligation under Article 8, section 2, to provide victims of medical negligence access to proceedings in which they could obtain compensation for damage. This entails the requirement that the experts examine carefully all relevant points and set out in enough detail the reasons for their conclusions and that the courts or other authorities dealing with the case then scrutinise properly those conclusions. While the report in this case finally concludes that the doctors did not commit a fault, it did not specify, apart from evidence of the existence of risks in literature, the grounds on which this conclusion is based. The report is therefore insufficiently substantiated. The importance of this decision shows that medical experts do have an important “active” role. Its relevance for malpractice litigation will be discussed from a Belgian law perspective.

## **Forensic Expertise of Medical Staff Misconduct: Legal and Ethical Perspectives**

### **Vugar Mammadov**

*Azerbaijan Medical University; Law Faculty, Baku State University, Vafa Mammadova Institute of Law and Human Rights, National Academy of Sciences of Azerbaijan, Baku, Azerbaijan*

Despite of the existence of a set of relevant laws in the field of health and numerous legal regulations in all countries medical staff misconduct is always present. Nurses, doctors and health authorities should be always aware about responsibility for misconducts in own professional practice

This awareness should be first created at the medical universities and colleges of undergraduate level and then permanently kept on postgraduate courses.

Main types of medical staff misconduct include a/ medical crimes and faults due to professional malpractice and negligence, b/ medical accidents, c/ medical errors.

According to Azerbaijan national legislation there are 4 types of responsibilities for medical staff misconduct: criminal, civil, administrative and disciplinary responsibilities. Responsibility comes when facts and evidences prove the guiltiness and this is full competence of the court. However, forensic-medical expertise of medical staff misconduct plays a key role in preliminary and court investigations because lawyers themselves are not always able to find and focus on necessary details to make research full and investigation complete. Nowadays, increasing alerts in society are related that forensic medical experts coming more from corporate interests of medical profession and belonging from the same health system rather than to the interests of justice and objectivity. To respond these challenges, ethical and legal considerations of forensic medical expert activities during conduction expertise, forensic ethics matters become very important. Few recent cases of medical staff misconduct will be given in presentation.

### **Criminal Liability of Healthcare Professionals for Improper Care in Russia**

#### **Svetlana Pospelova**

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There has recently been a significant increase in the number of criminal cases against healthcare professionals. Russian Investigative Committee received 3 times more reports of such offenses in 2017 compared to 2012. For each third medical case it was decided to institute criminal proceedings. Only one out of every ten criminal proceedings was sent to the court with the indictment.

The medical specialties involved in most criminal cases are: 1. surgery, 2. obstetrics and gynecology, 3. anesthesiology and emergency medicine, 4. pediatry.

The vast majority of criminal proceedings are instituted under article of the Criminal code, providing responsibility for causing of death on imprudence (article 109, part 2) due to improper execution of professional responsibilities. However, in recent years there has been a tendency of unreasonable application of art. 238 of the Criminal code (violation of safety requirements for medical services) to healthcare professionals. This article shall be applied only in the case of willful violation of the licensing requirements in the provision of medical services. The object of this crime is indefinite circle of persons, but not a particular patient.

In law enforcement practice can be noted cases of wrong qualification of inadequate medical care under article 124 'Failure to help the patient' and article 293 'Negligence' of the Criminal code.

To solve this problem and harmonize law enforcement practice it is necessary to include a separate article in the Criminal code 'Inadequate medical care' with a special subject - healthcare professional.

## **RELIGIOUS LAW, SEXUALITY AND FERTILITY**

### **Islamic Jurisprudential Gerontology in Bioethics: Personhood and Parenthood**

#### **Osman Tastan**

*Professor of Islamic Law at Ankara, Turkey*

Parental responsibility concerning childcare is associated with the idea of fitra/naturality in Islam while descendants' responsibility to care for elderly parents is justified in a compensatory manner as a positive response to the childcare provided by them at the time. In either case, the recipient of care, a child or an elderly, is associated with incapacity in terms of full -human or legal -personhood. Incapacity of a human person in childhood or in dotage entails restrictions to the capacity of the care taker too by the best interest of the underage or the senile. Thus, the naturally incapacitated person's interest is safeguarded by legal measures avoiding the abuse of legal capacity either by the recipient or by the provider of custody. This paper will elaborate upon the personhood and parenthood in terms of Islamic Jurisprudential gerontology in bioethical context.

## **Attitudes to Sexual Disabilities in Islamic Law : The Shift from Classical Fiqh to Contemporary Solutions**

### **Vardit Rispler-Chaim**

*Department of Arabic Language & Literature, Haifa University, Haifa, Israel*

The fiqh literature lists by their names a number of sexual disabilities that may befall both males and females, or only one of the groups, and how the different schools of law have viewed the impact of each sexual disability on the fate of marriage. Thought is given in it to the sexual disabilities of a married spouse, and how this might influence the healthy spouse, and whether the latter has the right to get out of a marriage when the partner is sexually disabled. There is also consideration of “sexually disabled” people who are unmarried, and what is their chance of getting married. In medieval times the medical condition itself was almost untreatable, therefore the jurists concentrated rather on the social impacts of the physical disabilities.

With the development of medical innovations and through contemporary anthropological research literature on the ART- Assisted Reproductive Technologies, for Muslim communities, muftis’ perceptions have recently changed, and several new medical solutions have been legitimized. This change results in the birth of babies to parents who suffer from a variety of sexual disabilities, incurable until several decades ago. This outcome almost annihilates the social problems created by infertility in the past. This could have a major impact on Islamic marriages in particular, and perhaps on Islamic societies et large.

## **Legal and Ethical Status of Embryotomy in Yerushalmi vs Bavli**

### **Moshe Pinchuk**

*Netanya Academic College, Israel*

The Talmud is the definitive and authoritative textual corpus of Jewish law, legal thought, philosophy and practically all aspects of Jewish culture. The term Talmud normally refers to the collection of writings named specifically the Babylonian Talmud as it was created by the Jewish centers in Babylon (third to sixth or seventh centuries CE). There is another Talmud known as the Yerushalmi or Palestinian Talmud, which was created by the Jewish centers in Israel (redacted c. 360 – 370 CE).

Medical references abound in Talmudic literature. Indeed, Jewish medical ethics and Jewish medical law have carved out their portions as independent disciplines. However, not much research has focused on the medical sources, or to be more precise the different medical schools that influenced rabbinic

understanding and conception of medical phenomenon. Naeh has identified traces of Hippocratic influence in Yerushalmi sources. Kipperwasser has demonstrated the Hippocratic influence on development of the Talmud Yerushalmi embryo-conception theory, as opposed to the influence of Iranian embryo-conception theories, similar to those represented in the Bundahishn, on the development of the Babylonian Talmud embryo-conception theory. In this paper I will show an additional instance of Hippocratic influence on Yerushalmi childbirth theory as opposed to the influence of Eastern or later medical theories on the childbirth theory in the Babylonian Talmud. A further novelty of this example will be to show how both talmuds, despite their radically opposing medical understanding of parturition, reach identical legal and ethical conclusions concerning embryotomy in case of acute dystocia.

### **The Right to Procreate in Israel: The Case of Postmortem Sperm Retrieval**

#### **Avishalom Westreich**

*College of Law and Business, Israel*

The paper examines the debate over postmortem sperm retrieval of fallen soldiers in the Israeli legal and religious spheres. It analyzes the views of two groups: the Israeli Supreme Court, supported by the Attorney General and public commissions, on the one hand, and a proposed legislation, supported by bereaved parents and public opinion on the other, from both legal, bioethical, and Jewish law perspectives.

The paper argues that the modern debate is generated by a conceptual distinction between an individual right to procreate and a communal, or familial, right to continuation, alongside with the fascinating tension between the legal system and the social and political atmospheres. The paper then explores the representations of the two rationales within Jewish law sources and examines a possible influence, or inspiration, of these sources and their rationales on the modern debate in the Israeli context.

In its conclusion, the paper suggests viewing the case of postmortem sperm retrieval as a typological case of a constructive conjunction – a conjunction of law, bioethics, and religion, in the complex Israeli situation.

## **Fertility Treatment for Couples With Mental Disabilities in Jewish Law**

### **Gideon Weitzman**

*Puah Institute, Jerusalem, Israel*

Fertility clinics are sometimes faced with an ethical dilemma when a couple present who have mental disability and their capabilities of raising children are under question. Can the clinic decide who can have access to fertility treatment and refuse to treat them? Who has the authority to make such a decision and does the couple have autonomy over their own lives and decisions? Should the clinic make a decision based on the possible negative outcome for the children that may be born or do the couple's rights take precedence over the child's rights before the child is conceived? Does the existence of a formal or informal support system have any impact on this question?

Jewish law has discussed the status of a person with mental disabilities and their obligations and rights. In this lecture we will present the dilemmas facing the medical community in such a case and how Jewish law would act in such a case.

We will present several relevant case studies from our extensive experience in Puah dealing with such couples.

## **Halacha and Modern Medicine in the Lithuanian Environment: The Metzitza Debate**

### **Elimelech Westreich**

*Tel Aviv University, The Buchmann Faculty of Law, Roi Westreich, Soroka Medical Center, Israel*

The lecture focuses on the controversy that raged at the end of the 19th century among halakhic sages and within the Jewish communities in the Lithuanian environment of the Russian Empire. The question was whether to continue the age old custom of sucking the circumcision blood (metzitza) by the circumciser (mohel). We find various approaches, from unconditional acceptance of the tenets of modern medicine to their complete rejection, including a challenge to the value of modern medicine altogether. In our lecture, we analyze the various approaches, characterize them, offer a halakhic structure, and explore the connections of the halakhic approaches to the intellectual biographies of the various sages.

Circumcision, especially the sucking of the blood, is one of the first topics concerning which Halakha runs afoul of medicine in the modern era. Interactions between Halakha and medicine were frequent during the long

history of Halakha, because both fields focus on human beings, their behavior, and their environment, including the animals that surround humans and supply their needs. The frictions between medicine and Halakha intensified in the modern era, as medicine began to rely more and more on modern science. Rooted strongly in the Enlightenment, modern science considers human reason to be the supreme judge, and rejects any other authority. In contrast, Halakha, the religious law, considers G-d and the Torah revealed on Mount Sinai as the supreme authority and guide.

The duty to circumcise is one of the mitzvot (commandments) of the Torah. The rite of circumcision includes three parts: cutting the foreskin, removing the skin from the crown, and sucking out the blood. The custom that spread among Jewish communities was to perform the sucking by mouth. Note that sucking the blood of a wound by mouth was a customary medical approach in the pre-modern era. The first time that sucking the blood became an issue was in the fourth decade of the 19th century. In central and western Europe, both Jewish and gentile physicians began to criticize this procedure because of aesthetic and medical reasons. They argued that sucking the blood in itself does not contribute to the health of the infant, and it might even endanger it.

The sages in the German-speaking countries and in Hungary responded to the new challenge in an extreme way, mainly by rejecting demands to make changes in the common custom. The response of Lithuanian rabbis, who were faced with this challenge a generation later and knew the writings of these sages, differed in important ways, including the interpretation of the binding sources, formulating the halakhic foundation, the willingness to change deeply rooted customs, the attitude toward modern medicine, and the threats of secularization and religious reform.

## PUBLIC HEALTH

**Ethical Issues Faced by Public Health Nurses in the Treatment of Children of Asylum Seekers in Israel****Anat Amit Aharon**

*Sackler Faculty of Medicine, Nursing Department, Tel Aviv University, Israel*

Approximately 22,000 Eritrean asylum seekers live in Tel Aviv city and about 4000 children are under six years old. Preventive medical services are provided to this community by Mother and Child Health Clinics, MCHC, (called Tipat Halav), as they are provided to the entire population of Israel. These services are free of charge for every child in Israel. Only about a third of the asylum seekers children have health insurance, which involves a monthly premium. The children that are not insured are not entitled to medical care services such as: treatment by a pediatrician in acute or chronic medical needs or cognitive- developmental treatment.

Public health nurses who work in the Tel Aviv-Jaffa MCHC's provide most of the preventive medical services for the asylum seekers community.

In a study conducted in 2015, we found a significant variance in the growth and development indices between children of asylum seekers and Israeli children. These disparities pose many challenges and ethical issues for the public health nurses:

Where should a child be referred to for further diagnosis and treatment, in the absence of health insurance? What is the use of conducting early screening

processes by the nurses (in compliance with the instructions of the Ministry of Health) if the establishment response to the pursuant needs is low? How should nurses act when a parent does not take the child for further diagnosis and treatment? Is it considered parental neglect and should nurses report to the social services? If lack of health insurance for asylum seekers children stem from cultural differences what can we do about it?

These are the main ethical and professional problems that public health nurses face in the challenging encounter between politics, policy, nursing profession, cultural compatibility and professional integrity which we will refer to in the presentation.

### **Off-Label Use under EU Competition Law: Before and After Avastin/Lucentis**

**Alexandr Svetlicinii**

*University of Macau, Macao, China*

The off-label use of medicines has been discussed from various angles including sector-specific regulations, pharmacovigilance obligations, organization of the national health care systems, and professional ethics. The recourse to off-label use of medicinal products is gaining on importance as national health budgets are shrinking and the governments are looking for more affordable means to supply health care services to their citizens. Therefore, any relevant legislation or judicial interpretation should be analyzed in the view of the public health objectives. The proposed paper deals with the phenomenon of off-label use of medicines under EU competition law on the basis of the Avastin/Lucentis case, which has been recently addressed in explanatory ruling by the Court of Justice of the European Union. The case originates from the investigation of the Italian competition authority finding anti-competitive collusion related to suppression of the off-label use. The paper addresses the regulatory framework for off-label use in the EU as reflected in 2017 EU Commission's Study on off-label use of medicinal products and the likely effects of the CJEU's interpretation concerning pharma companies' involvement in monitoring and reporting possible health risks related to the off-label use. It demonstrates that the differences in regulatory approaches across EU Member States would lead to the diverging competitive conditions on the national markets for prescription drugs reimbursed under the national health insurance systems. As a result, the competition law cases concerning off-label use of medicinal products would have to take into account national specifics of the medicines' markets.

## **Fetal Monitoring in Africa: A Public Health Threat**

### **James C. Johnston**

*Addis Ababa University, Ethiopia, Thomas P. Saartwelle, Hicks Davis Wynn, PC Mehila Zebenigus Yehuleshet Specialized Clinic and Neurology of Addis Ababa University Texas (USA), Berna Arda, Ankara University, Turkey, Mehila Zebenigus, Addis Ababa University, Ethiopia*

Electronic fetal monitoring (EFM) has no proven efficacy in routine childbirth yet is increasingly employed throughout sub-Saharan Africa (SSA) in a misguided approach to reduce the high perinatal mortality and morbidity. EFM has a 99.8% false positive rate, and does not predict or prevent cerebral palsy (CP) or any other neonatal neurological injury. It causes significant harm to mothers and babies through unnecessary C-sections with all of the attendant complications, as well as significant risks in subsequent pregnancies such as repeat C-sections for life with high rates of operative complications, uterine rupture, and placental abnormalities like accreta and previa. These risks are higher in the African setting. Another concern with false positive EFM-motivated C-sections is evidence suggesting that babies born in this manner are exposed to the potential risk of developing chronic diseases (i.e., asthma, diabetes, inflammatory bowel disease, juvenile arthritis, neuropsychiatric disorders). Moreover, EFM as used today is blatantly unethical, eviscerating the meaning of informed consent. The authors recommend ending continuous EFM in normal pregnancies, which aligns with the new Australian, Canadian, New Zealand and UK guidelines, and comports with the WHO Quality of Care Network goals of reducing maternal and neonatal mortality by 50% in five years. EFM represents an utter waste of very scarce resources while simultaneously adding another layer of morbidity and mortality to the desperately critical situation in SSA. EFM related funding should be redirected to improve healthcare services for mothers, recruit and train birth attendants, and treat children with CP and related disorders.

## **Ethics and Politics in “One Health” – the case of Brucellosis in the Negev**

### **Barak Hermesh**

*Department of Health Systems Management, Faculty of Health Sciences, Ben-Gurion University of the Negev, Tel Aviv, Israel*

Brucellosis is a zoonotic disease, transferred by unpasteurized milk and contact with infected livestock. The rates of Brucellosis in the Bedouin society of the Negev, a socioeconomically disadvantaged seminomadic population, are among the highest worldwide, which creates heavy economic, juridical and ethical consequences. While Brucellosis interventions tend to incorporate multidisciplinary principles of One Health, this approach’s “reductionist”

character often prevents it from dealing with socio-political preconditioning factors that shape the impact of diseases.

Using qualitative methods – in-depth interviews, participant observation and document review – we conduct stakeholders mapping and explore their perception of the disease’s social, political and historical causes and the means to achieve successful interventions. We use qualitative analysis software to construct an empirical-theoretical map that corresponds with holistic One Health considerations and offers policy guidelines.

Our preliminary results reflect three conceptual “boundaries” that effect policy in Brucellosis control. The political-professional boundary suggests that segregation of practitioners’ formal roles overlooks “the broader picture”, and disregards influences of social inequities in shaping public distrust in the intervention. The “participatory boundary” indicates that exclusion of public representatives from decision-making prevents the acceptance of fundamental principles such as the compensation for infected herds culling. The “geographical boundary” shows that monitoring Brucellosis in the Negev-West Bank border could benefit from a “single epidemiological unit” approach.

To conclude, our study offers a public health ethical framework that considers local political aspects that influences the policy of Brucellosis, and calls for a holistic One Health approach in order to sustainably control the disease.

## **Improving Healthcare Access in Sub-Saharan Africa**

### **James Johnston**

*Addis Ababa University, Ethiopia, Mehila Zebeignus*

Ill-health and poverty are inextricably entwined in a mutually reinforcing cycle, with multiple interconnected, contributory and reciprocal factors, leading to profound effects on the economic, social, and political stability of developing nations. The success of any poverty reduction strategy mandates improving healthcare disparities, which are attributable to myriad diverse factors, some specific for particular regions and circumstances, and affected by local values and ideologies. But the underlying commonality in every affected nation is a lack of access to healthcare resulting in untreated non-communicable diseases (NCD) that are driving millions of people into poverty annually. The most disconcerting NCDs are the neurological disorders, which have an extraordinarily high rate of morbidity, afflicting millions of people, resulting in poor cognition and physical impairment, rendering them unable to reach their full potential, with lost income and fewer opportunities, leading to increased vulnerability, marginalization and exclusion. These particular

disorders are disproportionately increasing in developing countries, with a profound impact on the poor, and represent the greatest threat to global public health. There must be significant improvement in neurological services in order to achieve any meaningful poverty reduction, and this necessitates a cross-cutting approach to “reach the furthest behind first,” which means focusing on the least developed nations in sub-Saharan Africa. The authors provide recommendations for advancing healthcare through sustainable ethically congruent collaborative partnerships based on their experience developing the highly successful Ethiopian training program, with the underlying goals of increasing access to services, improving quality in tandem with quantity, and expanding triangular cooperation.

## **JEWISH LAW AND MEDICINE**

### **Big Data and Medical Decision Making from the Perspective of Halacha**

#### **Shabtai Rapoport**

*Israel*

In recent years there has been a significant increase in the use of large data-analysis and data-gathering tools that can be extremely useful in medical cases which are too complex to be fully analyzed. A doctor might receive an instruction to administer a drug to a neonatal before any signs of crisis appear to the human eye but which are apparent to the data analysis algorithm. The doctor does not know why and the substance might be a dangerous one – but would it be irresponsible to ignore the “mindless” instructions of an algorithm or an artificial intelligence? This is the next step going beyond the realm of statistical medicine (since all the information is available and not only samples of it and it requires examinations on the various levels of Ethics, General Law and Jewish Law (Halacha).

For Example – is Halacha concerned with the knowability of the process that leads to danger or only on the use of the system providing the warning and procedures? Does this new paradigm change the definitions of dangers, different levels of health etc.? are there privacy issues to be dealt with in sharing information for the algorithms to learn?

Some more detail:

In recent years, a foundational shift has occurred in basic science and technology, effecting all walks of life and research. This trend is sometimes called “Big Data” – denoting the use of an overwhelming amount of data to achieve results that bypass the traditional notions of causality and explanation. Law-like behavior is now more often considered heuristic,

rather than analytical or objective in nature. Utilizing Big Data tools such as Deep Learning and the current applications of neural networks is becoming progressively more attractive for industry and government as it subsumes the search for mechanisms and causal frameworks.

In the realm of medicine, public health and the broader allocation of scarce resources, these developments challenge the existing apparatus of professional, legal and moral approaches to situations in which lives are at stake.

The practical benefits of this mode of science and technology are appreciable and undeniable – lives are saved - and automated systems are being developed to minimize casualties in life-threatening situations or to improve quality of life. On the other hand, these developments raise major dilemmas. For example, should we accept actions dictated by algorithmic results beyond the scope of our intellect, eliminating moral agency? If a health-plan is tailored by data gathering to specific patients, this spells a new era of information-use issues, which we are now beginning to see in the public sphere.

## **Philosophical Perspective on Jewish Law and Medicine**

### **Azgad Gold**

*Be'er Yaa'kov Mental Health Center, Israel*

The intersection of Jewish law and medicine is traditionally limited to legally-oriented discussions regarding to practical dilemmas raised by Jewish religious people who are committed to the Halacha (Jewish law). The basic halachic approach, in terms of methods and principles, is the same for questions relating to medical issues, such as abortion and brain death, as for questions relating to non-medical issues, such as the laws of Shabbat. Given these characteristics, two cardinal questions may arise, as follows: Is Jewish law pertaining to medical issues akin to Jewish medical ethics? Can Jewish law be relevant and useful to non-orthodox Jews or even to non-Jews who are interested in medical ethics and philosophy of medicine?

Several limitations pertaining to the traditional halachic discussion of medical issues will be presented. Then, it will be suggested that a philosophically-oriented analysis of Jewish law may expand the scope of Jewish law in a way that will open the text to psychological, ethical, existential and philosophical dimensions embedded in the text. The fruits of the secondary philosophical analysis of Jewish law may provide valuable contribution to the fields of medical ethics and philosophy of medicine.

## **The Enduring Power of Attorney in Jewish Law**

### **Yardena Cope-Joseph**

*The Department of Jewish Law, Israeli Ministry of Justice, Israel*

Up until 2017 Israeli law provided that proxy decision making and acting as agent for an incapacitated senior (due to old age or infirmity) or for an incompetent adult could be done only through a court appointed legal guardian. Even the guardian's identity could not be guaranteed by the ward. The revolutionary 2017 amendments to the Guardianship Law now allow for a competent individual to grant an enduring power of attorney for health care and/or for finances to a person of his or her choice, or pre-select a legal guardian and create legally binding advance directives.

We will analyze whether there is basis in Jewish law for an enduring power of attorney or whether agency ends when a person becomes incompetent, or, at the very least, cannot be acted upon during the period that an individual is incompetent based on the rule, that if the consignor can't legally do something than neither can the agent do so on his behalf. Our primary sources will be Mishna GIttin 7:1 and the Talmudic discussion in Tractate Gittin on what to do if after an agent's appointment to give a Get (Jewish divorce the husband becomes incompetent and the commentaries and codes that address that Talmudic discussion and the scope of its application.

## **Mental Illness and Halacha: Sensitivity and Ethical Commitment in Jewish Law to the Psychiatrically Ill Individual**

### **Rael Strous**

*Mayanei Hayeshua's Mental Health Wing, Israel*

In the age of multiculturalism and globalization, attention to issues of culture and diversity has become important in the professional care of patients in medicine. Considering the crucial role that sensitivity has to play in the management of the individual with mental health in particular, this cultural sensitivity becomes paramount in the ethical management of the psychiatrically-ill patient. Psychotic illness, arguably the most challenging and pervasive of all psychiatric disorders, is most frequently associated with the concept of the "shoteh". While the concept of shoteh remains one associated with psychosis, a more precise description of its phenomenology and its application to contemporary clinical psychiatry remains unclear. This becomes especially important considering the different subtypes of shoteh and their association with contemporary diagnostic classification including schizophrenia, manic depression, delusional disorder etc. Jewish law (Halacha is both complex and sophisticated regarding the management of the psychotic individual in

various aspects of liability, responsibility and religious practice. However, what remains fundamental is an exquisite sensitivity to both the needs of the mentally-ill individual as well as the needs of those surrounding him or her. These issues will be explored in this presentation as well as an in-depth discussion of the shoteh's status in halacha and various modern-day halachic issues applying to the shoteh.

## **RIGHT TO HEALTH – THE FETUS AND PROSPECTIVE RIGHTS**

### **Right to Health vs. Medical Tourism - Opportunity or Circumvention of the Law**

**Mariya Petrova**

*European Institute of Healthcare Law, Healthcare Management and Public Health, Bulgaria*

The goal of this paper is to show the legal and ethical challenges in front of worldwide providers of medical services who organize medical tourism activities. Differences between legislation in each country bring a lot of legal risks for all sides – doctors, patients and governments.

Until 2016, most of the challenges of medical tourism were about malpractice litigation, insurance litigation, safeguarding patients, etc. Nowadays, legal and ethical risks relate to transplantations, cyberattacks on telemedicine or e-health, euthanasia, surrogacy, health data protection, genetic selection and considerations of “Do Not Resuscitate”.

This work takes into consideration the existing norms – national laws, EU law and specific regulations, as well as the existing body of case law (court practice). Comparative legal analysis is made of all the main alternatives provided by current legislation, identifies legal gaps and defines opportunities to regulate better the organization and practice of medical tourism.

During the working process on this paper, we found that neither patients, nor doctors are aware of the legal risks of medical tourism. There is no Global strategy or Ethic code for providing medical services within the frame of Medical tourism and this creates potential for opportunism and legal abuse.

Keywords: medical tourism, medical law and ethics, right to health

## **Can we Recognize Parenthoods Right as a Positive Right?**

### **Orit Cherny-Golan**

*Max Stern Academic College of Yezreel Valley; Yezreel Valley, Yokneam Illit, Israel*

Over a relatively short time fertilization has changed from an intimate, couple process into a

process involving the medical and legal system. The cost of using artificial fertility technologies is very high, and therefore a state's public policy regarding funding or subsidization of their use directly and dramatically influences the possibility of their use. However, despite the lively debate on this issue, there is currently no literature available that supports public financing of fertility treatments in ethical terms. The prevailing approach in bio-ethical literature is one which recognizes and supports the negative right to parenthood, meaning recognition of an existing interest in fulfilment of parenthood, which imposes an obligation on the state not to intervene in its realization. The purpose of this lecture is to offer an expanded approach, namely, an ethical approach that supports citizens' right to aid and/or government assistance in realizing their right to parenthood, under certain conditions. Based on recognition of this right as a positive right, and in light of the extent of this right, which naturally has to be limited, finally I would like to offer offers criteria for realization of the right to parenthood

The main contributions of this work are: first, the right to parenthood assisted by technology belongs to the class of social rights, and therefore this right can be recognized only within the context of a given society. The second conclusion right to health is the ethical base of recognition the right to parenthood as a positive.

## **Controversy Over “Urgent Medical Aid” for Illegal Immigrants in Belgium**

### **Julie Vermeulen**

*Dewallens & Partners, Flanders, Vlaams-Brabant, Belgium*

In Belgium, illegal immigrants do not have access to healthcare except via a procedure called “urgent medical aid”. Contrary to its significance, urgent medical aid is not limited to health emergencies but encompasses preventive and curative treatment as well. Urgent medical aid is a strong signal of Belgium's commitment to respect the fundamental right of accessible healthcare. Despite this, the complexity of the current procedure is harmful to all parties involved and often impedes access to equitable health care for this vulnerable population.

A new bill, accepted by the Belgian Parliament in March 2018, has defined a tool to limit this right to urgent medical aid. Physicians of newly founded control departments will review the compliance of provided healthcare through the criteria of urgent medical aid. This review policy is not without controversy. A breast implant for cosmetic purposes is a clear case of noncompliance. But what about circumcision for religious reasons? What about medical tourism?

The responsibility for determining whether an intervention is urgent lies, after all, on the physician, however healthcare providers are seldom able to gain an accurate view on immigration or medical status at the moment of medical need. In the case of noncompliance with the criteria of urgent medical aid, this new post-hoc control will penalize the health care provider by not reimbursing medical costs.

In this article, the right to health care for illegal immigrants will be critically analyzed. The possible problems in the application of this new legislative scheme will be identified.

### **The Non Identity Problem and The Fetus**

#### **Ahuva Ticho**

*Ahuva Ticho Law Office, Israel*

The non-identity problem reveals the conflict between basic moral intuitions and the logic metaphysic implications of the problem. The claim that a person might be harmed by the very fact of being brought into the world in its own existence is, *prima facie*, non-coherent, because that person benefited his life due to his existence. Even though, every society that regulates fertility means, considers it obvious to guarantee the good and health of the potential children.

The main characteristic of wrongful birth cases is the harm caused to a newborn from its own existence with congenital abnormalities, while he could not have been born otherwise. Therefore, preventing the damage to the newborn is possible only by preventing it from being brought to life. According to the non-identity problem there is no meaning to a claim of a person x that his condition is worse or more being born enabled, since if his claim is right he wouldn't have been born at all and a different person, person y, would have been born instead.

Thus, a personalist moral view cannot judge or condemn the act as immoral.

The study doubts the validity of the non-identity problem and its consequences and appeals against the logic-metaphysic basis of the non-identity problem. The proposed solution is in the metaphysical level, in the category of the fetus

in the prenatal phase. According to Kripke's origin view the fetus is in fact actual due his original and essential identity by virtue of its genetic makeup. In the prenatal category, wrongful-birth choices are dealt according to the Parfitian classification, as opposed to wrongful-life choices which deals with purely potential persons.

In cases of wrongful birth choices the fetus is actual and has an essential genetic identity according to Kripke's origin view. Therefore, the fetus is not to be seen as a potential person, because the act did cause him harm. The fact that the fetus is actual, having its own original genetic makeup which is essentially transitive, correlates the fetus identically to the newborn that will be born as a person and that will grow after birth. All these give the fetus its moral status, even though it has no legal rights or duties. The application of Kripke's origin view on the fetus through the prenatal phase signifies the genetic makeup, which comes from the gamete that the fetus is developed from, as its modal identity-criterion in every other possible world. This essential genetic makeup will identify this child, who will be born and be a person, as having the same genetic makeup. The biological numerical identity will develop into a narrative identity throughout time. The fetus already contains a potential basic genetic identity, and from it will grow a 'personal identity' in mental, psychological and subjective senses.

Rawls's theory of justice supports our conclusion regarding the moral status of the fetus, despite the conceptual difficulties with its applications in decisions of fertility and birth. Rawls is a pioneer in expanding his theory of justice to the intergenerational scope. According to his theory, the current generation is committed to protect the basic interests of the future generation and to preserve its natural assets and human heritage. His theory does not depend on the question who will be the persons that will live in the future. The intergenerational fairness doctrine is not affected by the non-identity problem, a problem that affects the alternative doctrines (the utilitarian, the contractual or the communitarian) and therefore are not applicable to choices of fertility and birth relating to future generations.

## **Right of a Viable Fetus to be Born Healthy-Does the State and the Lawmaker Have an Obligation to Protect Future Children from In-Utero Harm**

**Pnina Lifshitz-Aviram**

*Zefat Academic College, Israel*

In most jurisdictions, the viable fetus has no legal or moral rights to protection, while a pregnant woman is an autonomous person and therefore has a right to protection and is entitled to make her own decisions. In this article we suggest adopting a concept of “fetal personhood. We examine the arguments for the state and lawmaker’s intervention on behalf of the future child, to protect it from in-utero harm, being made by the woman (her conduct, passive or active; We examine the ethical challenges of the unique legal rights of a viable fetus and the woman during pregnancy. We suggest that even if the fetus is not regarded as a separate person and does not have the legal or moral status of a person, there is an arguably ethical and legal case for the state and lawmaker in intervening to prevent harm and to enable it to be born healthy. In the case “state authority” –woman regarding the fetus... There may be room to presume that the state’s instructions and law are based on their best judgment as to what is appropriate for the woman to do from the point of view of the fetus’s health.

## **The Davies Award: Promoting Non Biased Academic Research in Public Health Law**

**Jonathan Davies**

*Jonathan Davies & Co. Law Offices, Israel*

The Davies Award is a good opportunity to review the influence Epidemiology research Methodology on medical law and specifically medical malpractice in which Medical evidence play a major role.

Over 50 years ago my father Prof. Davies started the Jerusalem Perinatal study (JPS

A research project that tried to find the causes of hypertensive disorders of pregnancy and the frequency of cardio vascular diseases in the Jerusalem population.

The JPS was set up to study clinical epidemiology to capture all cases in a defined population with standardized/ diagnosis and complete follow up of all deliveries in Jerusalem between 1963 – 2007 that took place in 4 hospitals.

The study recorded all live and still births of residents of west Jerusalem and follow up developmental origins of chronic diseases and the correlation between birth weight and coronary heart disease, maternal obesity and offspring cardio metabolic risk factors and questions like Do genes account for the associations of maternal traits with offspring phenotype?

The finding of the JPS had an important contribution towards preventive medicine which is a major factor of public health and research methodology. Despite the improvement in technology it's doubtful if the JPS could be repeated today, last so long and still have such an impact.

Medical evidence has to be methodically based and reliable. In recent years the medical community has developed a field called "Evidence Based Medicine", meaning, use of medical information based on the best information in the medical literature relevant to the condition being treated. Evidence Based Medicine distinguishes between recognized scientific theories and what is called "Junk Science".

We should attempt to study the influence of scientific research over Experts who appear in court and testify on scientific issues while representing one of the parties. The writing of an expert opinion for legal purposes is a judicial process in which a non-legal expert attempts to influence the outcome of legal proceedings. Expert opinions are presumably objective and based entirely on the expert's credibility, experience, and knowledge. The opinion of a medical expert should be supported by medical evidence and data collected according to EBM (Evidence Based Medicine) rules, and rely on published medical literature, scientific research, textbooks, and journals.

The multiplicity of opinions and scientific data requires special expertise in statistics and epidemiology as it might influence the expert submitting an expert opinion to base his opinion on scientific theses which have not been recognized scientifically, are not based on facts and are not supported by professional literature.

The increasingly influential trend of applying guidelines as principles of decision making theory in clinical medicine and the impact of evidence based medicine on the clinical practice is yet uncertain. Biased research might also influence and negatively impact on experts who rely on misleading publication.

Therefore it could be challenging to research the impact of scientific research and so called analyzed evidence based medicine on decision makes, experts, courts and patients who seek to make self-decisions.

## POSTER SESSION

### **A Limited Study: Ethics in Psychiatry from Medical and Nursing Points of View**

#### **Berna Arda**

*Ankara University School of Medicine, History of Medicine and Ethics Department, Ankara, Turkey, Senay Gul Hacettepe University Faculty of Nursing, PhD candidate of History of Medicine and Ethics Department of Ankara University School of Medicine, Ankara, Turkey*

**Aim:** This limited study aims to reveal whether there is a difference in the ethical problems faced by physicians and nurses in the field of psychiatry in different institutions and in the solution proposals.

**Methods:** The study was carried out in Ankara in the fall semester of 2017 within the scope of Medical Ethics Special Topics course, which is included in the doctoral program of Ankara University School of Medicine, Department of Medical History and Ethics. Face-to-face structured interviews with three psychiatrists and three nurses specializing in the field of psychiatry were carried out and analyzed by voice recording. The interviews were independently analyzed in the light of relevant literature.

**Finding:** Approaches in ethical education in terms of psychiatry physicians and nurses, psychiatric labeling, psychotherapy / psychopharmacological treatment and patient confidentiality, psychiatric diagnosis and treatment methods (forced hospitalization/ treatment, ECT, isolation), assisted suicide and euthanasia have been examined in detail in the context of medical ethics. The common complaint of all participants was the lack of a law / regulation on mental illnesses.

**Conclusion:** It is very valuable for psychiatrists and nurses who serve in the same field to recognize the ethical problems during their daily practice. It is concluded the problems faced by the interviewed experts in the field of psychiatry and the solutions they proposed contain many things in common.

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## **Mental Health, Law and Ethics**

### **Nigar Mammadli**

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Mental health law introduced a broad spectrum of legal topics and relates to people with a diagnosis or possible diagnosis of a mental health condition, as well as to the people, which are also introduced to the process of managing or treating patients. Patients suspected to the mental disorder, occasionally from diverse elements in society including institutions, relatives, caregivers, professionals, friends, and law enforcing agencies, which is going to lead an imperative for a protective mechanism to ensure appropriate, adequate, and humane health care services.

Legal and ethical concepts of mental health law include ethics, bioethics as well as principles of bioethics. On that account, ethics are going to represent with itself study of philosophical beliefs about what it considered right or wrong in society, whenever bioethics introduce ethical questions arising in the health care. In the same time justice, autonomy, fidelity, veracity, beneficence are going to make up the principles of bioethics. Respectively ,civil rights and due processes also have to be counted. People with mental illness are guaranteed same rights under federal or state laws as any other citizen, at the same time courts have recognized involuntary commitment to mental hospital is “massive curtailment of liberty” requiring due process protection.

Moreover, patients’ right to treatment requires that medical and psychiatric care and treatment have to be provided to everyone admitted to public hospital, when right to refuse treatment introduce with itself right to withhold or withdraw consent for treatment at any time.

## **Penitentiary Psychiatry Between Human Rights and Therapeutical Needs**

### **Bogdan Malinescu**

*Ilfov Medico-Legal Service Gabriela Costea “Mina Minovici” National Institute of Legal Medicine Bucharest, Romania Dan Rosca “Alexandru Obregia” Clinical Hospital of Psychiatry, Bucharest, Romania Magdalena Dragu Buzau Medico-Legal Service Bucuresti, Romania*

### Introduction

According to the ethics of physicians' practice and with the international regulations, public mental health policies in Romania also target psychiatric care in the penitentiary. There is a category of patients that require psychiatric treatment, but this can be applied with difficulty or not at all.

### Material and Method

Two studies conducted on a total population of 245 patients admitted in a penitentiary hospital analyzed the causes of patient refusal to receive psychiatric treatment. We applied: semistructured interview, clinical scales, psychological tests. Medical and social documents were analyzed. We used SPSS 18 for Windows.

### Results and Discussions

In all cases, patients convicted at the time of examination or those having a criminal record for crimes of violence against a person and hospitalized for somatic pathology, refuse psychiatric treatment without a logical argumentation. Their psychic symptoms disturbed the medical care on the wards where they were hospitalized. This behavior was considered to be part of the psychopathological background of “true psychopathy”.

### Conclusions

In the case in which patients of a penitentiary hospital, who are not covered by the provisions of the Romanian Penal Code which requires mandatory psychiatric treatment, ask for this type of care, it cannot be administered. Punitive measures are counterproductive and useless. Respect for a person's right to refuse the treatment prevails over the right to a specific treatment with all immediate and long-term consequences. This difficulty in penitentiary healthcare makes the avoidance of the recidivism more difficult.

**Key Words:** penitentiary, aggressivity, refusal of treatment

## **Forced Hospitalization of People with Autism**

**Yulia Shtenberg**

*Israel*

Psychiatric hospitalization is intended for persons on the autistic spectrum who cannot be at their residential homes (in their homes or in other frameworks) for one or more of the following reasons:

- They endanger themselves and their surroundings
- Their behavior lacks judgment (e.g. a person who displays indecent or threatening body language)
- The intensity of symptoms is high and necessitates intensive supervision

The Tel Aviv District Court ruled on 15/1/2018 that autism is not considered a mental disorder and therefore autistic people are being treated in the framework of the Ministry of Social Affairs and not in psychiatric departments. The Court thus sharpened the separation between mental disorder and neurodevelopmental disorders such as autism and the appropriate difference in treatment of both cases.

Forced hospitalization in psychiatric wards is subject to the Israeli Law on treatment of people with Mental Illness, which gives district psychiatrists the authority to order hospitalization in cases of self-endangerment and danger to the environment due to the psychiatric disorder

According to the court's decision, autism is a developmental disability and that "this is a disorder that is primarily a mental impairment" and therefore falls within the scope of the Welfare Law. Because of this determination, the district psychiatrist cannot order forced hospitalization of a person suffering from autism.

In Israel there is only one department for the hospitalization of adults with autism. Many autistic people currently reside in psychiatric hospitals. In most cases, these patients are diagnosed as having "double morbidity," that is, those who have been diagnosed both on the autistic continuum and in mental disorders. There is an upward trend in involuntary admissions of autistic people who are not psychologically disturbed.

## **Who is at Risk for Involuntary Psychiatric Hospitalization in Israel: 2001-2017**

### **Rafael Youngmann**

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Director of the Health Information Division of the Ministry of Health, Israel.  
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**Background.** The mental health system in Israel has undergone major changes in the past 15 years: reduction in hospital beds and length of hospitalizations, implementation of community-based rehabilitation, and change in health service provided.

**Study Questions.** What is the profile of service consumer who require involuntary hospitalization (IH)? Have rates of IH changed over the last 15 years?

**Data.** All hospitalization in National Psychiatric Case Register between July 2001 – June 2017 for persons 18+ years (N=322,670) and all persons first hospitalized in this period (N=65,008).

**Results.** Age-adjusted and age-specific rates of IH per 100,000 persons increased by a third since 1990's (109 to 144 per 100,000), but decreased slightly in the last study year. Median length of IH decrease from 23 days in 2010-2011 to 18 days in 2016-2017. Age-adjusted rates of IH per 100,000 persons increase for all study groups, where higher among males compared to females, Jews and others compared to Arabs, and Ethiopian and new FSU immigrants compared to Israeli-born/old time immigrants. Multivariable analysis indicated that immigrants from Ethiopia had a much higher risk, FSU immigrants had a lower risk and Arabs a higher risk.

**Conclusion.** Increased IH was documented in recent years, concomitant with decrease in length of hospitalization. Initial indication that the mental health reform has reversed the trend of increasing IH was found.

## **Ethical and Legal Aspects of Treatment of Specific Conditions Such as Anorexia and Depressions**

### **Medina Kazimova**

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Baku, Azerbaijan*

Eating Disorders characterize illnesses that are caused by irregular eating habits and severe distress about body weight or shape.

Eating disturbances may include inadequate or excessive food intake which as a result can damage an individual's well-being. The most common forms of eating disorders include Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder and affect both females and males.

Eating disorders are most likely the result of a combination of genetic and environment factors. While environmental factors alone cannot cause an eating disorder, many people have pointed to the role of social pressures as a factor that can have an impact on individuals, genetically predisposed to eating disorders.

However, guidelines for ethical and legal decision making related to the treatment of eating disorders have not been well described in the literature. In spite of the serious health risks related to such disorders, and the ethical challenges when working with this population of clients, the literature has presented a minimal amount of research regarding ethical clinical interventions. Research has not adequately addressed legal and ethical issues when counseling a client who refuses treatment while his health is endangered. The passage of mental health parity means that, legally, mental health must be covered on par with physical health. Speaking of legal aspects of treating such disorders, issues such as competence and coercive treatment should be further considered. Eating disorders are serious, potentially life-threatening conditions, which need to be dealt with.

## **Disorder of Communication in the Health Care or With a Patient**

**Snjezana Cerjan**

*Association of Lawyers in Health Care, Croatia*

Research confirms that quality communication between healthcare workers and between with patients is important and necessary because it can affect the quality of patient care. Good communication is achieved through a close relationship between the participants because it improves the patient's healing and satisfaction, and with such a relationship, he has a clearer understanding of his illness. The number of complaints about the work of health workers is also reduced.

In the medical profession, poor communication can lead to a series of misunderstandings, which can have many unpleasant consequences both for the patient and for the healthcare worker, so it is very important to communicate between healthcare worker in the health care team.

Information exchanged with the patient or his family must be precise, simple, understandable to the average person. Most patient complaints relate to unsatisfactory communication with healthcare workers, although the relationship of the health worker to the patient is very important in all phases of treatment.

The aim of the paper is to point out good and poor communication in the health system for the benefit of the patient, and to prevent clinical errors, dissatisfaction of the users and members of the health team, and thus the reduction of court procedures.

The quality of communication depends on the team's functioning as a whole, and the reduction of the creation of hostile situations, the nervousness in work and distrust among the associates, but the patient is at the center of the event.

## **The Content and Readability Analysis of Informed Consent Forms in General Surgery**

**Perihan Elif Ekmekci**

*TOBB ETU Medical School, Müberra Devrim GÜNER Rabia ÇATAL  
Merve Erdem, Ankara, Turkey*

The main idea behind getting informed consent (IC) is that, no person should be subject to any medical intervention without understanding and agreeing to potential consequences of the medical diagnosis or treatment, and that it is the individual's fundamental right to decide and act according to her own free will. The lack of a proper IC procedure prevents patients from realizing their autonomy, which may drive them to seek their rights in court. Despite the legal and ethical norms, there are various flaws in IC procedures, one of which is the poor content and readability of the forms. This study examines 109 IC forms designed for several surgical procedures which are currently in use either in state or university hospitals in Turkey. The forms are selected randomly among the available IC forms in official web-sites of the health institutions. The evaluation criteria are categorized in two major sections: content and readability. The results of the content analysis show that most of the forms lack sufficient information about the diagnosis, the severity/ grade of the patient's disease, the duration of the proposed treatment and alternative treatments and their prospects, the time needed to return to normal life course, the duration of hospitalization and treatment, the expected benefits of the treatment and, third party involvement if the patient is incompetent. Moreover, the forms generally showed poor readability. The study concludes that the IC forms currently in use in Turkey need comprehensive revision to comply with ethical and legal requirements.

## **Aligning the Prowess of Aesculapius and Themis**

### **Tiina Titma**

*Department of Health Technologies of School of Information Technologies, Tallinn University of Technology; School of Governance, Law and Society of Tallinn University, Tallinn, Estonia*

International relations scholarship focusing on health issues have provided primarily three dominant frameworks for international health cooperation: (i) national and security interests; (ii) domestic and global economic development; and (iii) international human rights. Legislative regulations are more than ever targeted to underlying determinants of health that are not linearly related to state prevailing interests. Through the creation of new regional institutions for global health governance, norms have come to frame a more expansive vision of justice in global health. Today, the norms are behold as not power-driven but discourse guided actions.

New techniques using tissue engineering, CRISPR therapeutics, allogeneic or autologous stem cell transplantation and numerous other fundamentally new techniques address questions on borderline regulation of particular products or procedures. To the date, there is no general agreement whether the tissue engineering is a medical procedure or therapeutic. Should the tissue grafting which is an encouraging lifeline in military medicine classified as surgery or medicine or even medicinal product and what kind of marketing authorization is needed? Variety procedures are already going on without proof of safety and efficacy. Marketing of untested stem-cell treatments and direct-to-consumer (DTC) stem cell products has exposed patients to unjustifiable risks. May we need better standards for informed consent? However, the best practice is to treat not the norms or therapy but the patient.

The global harmonization affects us in various ways sometimes narrowing even cultural diversities. One might see that harmonization in the area of health law would benefit us all.

## **Legal, Ethical and Professional Obligations of Confidentiality**

### **Mariela Deliverska**

*Medical University - Sofia, Faculty of Public Health, Bulgaria*

Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care.

Appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients. Confidentiality is one of the core duties of medical practice. It requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient. Creating a trusting environment by respecting patient privacy encourages the patient to seek care and to be as honest as possible during the course of a health care visit. It may also increase the patient's willingness to seek care.

Under the Treaty on the Functioning of the European Union, confidential information is warranted special protection. At the same time, access to this information can be necessary for an addressee of a statement of objections to properly exercise its rights of defense.

The importance of the ethical mandate of confidentiality, and the need for health professionals to maintain the confidence of sensitive patient information, is illustrated by the fact that breach of such ethical requirements has been subject to professional disciplinary sanctions in Member States across the European Union and worldwide.

The need to safeguard health information is universal and it is subject to considerable limitations in practice

## **Personal, Social and Civil Considerations Regarding the Right to Confidentiality**

### **Aviad Hollander**

*Jewish Law Association, Israel*

The patients' right to the confidentiality of their medical information is a complex ethical issue, with often conflicting social, and moral aspects. The study and debate over medical confidentiality has been continuing for the last decades.

Among the cases I will discuss are: divulging the fact that a woman will not be able to have children to her fiancée; publishing the name of a woman carrying HIV and intending on infecting men; supplying information to the Ministry of Transportation regarding a person suffering from epilepsy, etc.

Three trends are noticeable: One claims that the prohibition of Slander does not prohibit dissemination of true knowledge to prevent possible damage. Thus a doctor may – and even MUST – divulge the confidential medical information to prevent damage to third parties.

On the other hand, there are those who think that one must take into consideration a likely social result of divulging personal medical information: if people do not feel their personal information is kept in confidence, they may avoid going to doctors, a result of which will surely be that more innocent people lose their lives.

Concurrent with the consideration of the likely societal effect of disclosure, there is another consideration, which reflects a civil ideology (Mamlakhtiyut. According to this, one should trust in the decisions of the various committees convened by the government on such issues.

## Outpatients' Cognition on the Mode of Medical Alliance

### **Yunbin Yang**

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**Objective:** To investigate the outpatients' cognition to the medical alliance mode between hospitals and community health service (CHS) centers in Shenzhen, to analyze the factors that put impact on the cognitive situation, and to provide the reference and advice for promoting medical alliance mode work methods: Questionnaire was designed by the research team. Through stratified random sampling method, a questionnaire survey was conducted among 5 hospitals and 21 CHS centers in Shenzhen for outpatients aged 18 and above. We descriptively analyzed its basic situation. The  $\chi^2$  test and binary Logistic regression were used to analyze the influencing factors of patients' cognition. **Results:** The cognition rate of the medical alliance mode in hospitals and CHS centers outpatients were 46.3% and 39.0%, respectively, showing statistical significance ( $P < 0.05$ ). Multifactor Logistic regression analysis showed that age, career, the type of medical insurance, access to health knowledge, referral experience, the awareness of two-way referral were the influential factors of the patients' cognition of medical alliance mode ( $P < 0.05$ ). **Conclusion:** The medical alliance popularity was not high in Shenzhen, the awareness rate of outpatients in hospitals and CHS centers were both less than 50%. The medical alliance popularity was not balanced and the outpatients' cognition in CHS centers is lower than that in the hospitals. According to the influential factors, it's necessary to construct medical Internet + platform perfect the family doctor signing system and use various sources to strengthen the publicity, which could be improving the awareness rate of outpatients.

**Key words:** Medical alliance; cognition; outpatient; influential factor

## **Practical Governance of Radiation Protection at Model Hospital of Guangxi Region**

### **Jiying Yan**

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During 2014-2017, a series of special radiation protection guidances were implemented in Guangxi Zhuang Autonomous Region and it achieved a great effect in model hospitals. This essay will summarize the achievements from 3 aspects. The early stage of validity judgment and reasonable application of radiation diagnosis and treatment, the radiation protection process, and the reduction of radiation dose and the supervision of radiation protection.

Guangxi actively constructs model hospitals which are good at radiation protection that can be replicated and promoted. It also strengthens the management of radiation protection organizations and standardizes the management of occupational health records. Guangxi uses “Five Unity” (ie: “unification of file management, unification of management systems, unification of promotional content, unification of warnings and unification of information disclosure”). Radiological protection warning propaganda adopts “Internet +” radiological protection monitoring system and standardizes X-ray examination applications. Guangxi is providing experience and methods in order to further strengthen and improve the radiological diagnosis, treatment, supervision and management throughout the nation.

## **Inter-Professional Rivalry in Nigerian Public Health Sector**

### **Enejo D. Abdu**

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The public health sector in Nigeria is plagued by workplace disharmony arising from an internecine inter-professional rivalry between doctors and dentists on the one hand, and other healthcare professionals on the other. It is our opinion that other healthcare professionals have abused legislative and judicial interventions to harass and prevent medical doctors from practising aspects of medicine related to their professions like medical laboratory technology and radiography. In pursuit of the rivalry, they have agitated for pay parity with doctors and have frequently engaged in strikes to press their demands. Doctors have engaged in counter strikes whenever the government yields to the demand of the other healthcare professionals.

In 2003 the National Assembly of the Federal Republic of Nigeria enacted the Medical Laboratory Science Council of Nigeria Act. The Act created the profession of medical laboratory science profession. Its scope of practice included analysis of human tissue and fluids for medical laboratory diagnosis, treatment and research. We are of the opinion that it has been used as a tool to prevent doctors from practising clinical laboratory medicine. Pronouncements by the National Industrial Court of Nigeria in 2013 and 2016 have been used by the other healthcare professional to buttress their demands for pay parity and further harass doctors in their practice. The professional regulatory agencies ought to have a positive influence on the problem.

We seek to review the negative effects of the inter-professional rivalry on the public health sector and the role of poor regulation in perpetuating it.

## **Experiences of SP Methodology within Athletic Therapy Program**

**Eva Hava Peisachovich**

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Many sources suggest that professional-competence development is influenced by human interactions. Linkages between organizations, tasks, and individual providers influence human behaviour, affect organizations' or systems' performance, and are a key component of professional-competence development. Additionally, insufficient or ineffective interprofessional communication between professionals is contributory to adverse events globally. These occurrences provide the impetus for learners to provided with realistic simulated learning opportunities. experiences that alue of realistic simulated-experiential approaches, such as the one proposed in this project. This paper reflects on the experiences of learners of simulated person SP methodology in the athletic therapy program learning setting. The participants provided qualitative and quantitative feedback to enhance understanding of the learning experience.

## **The Medical Accident Investigation System in Japan and Future Challenge**

**Ryoko Hatanaka**

*The University of Tokyo, Bunkyo, Japan*

Japan launched a medical accident investigation system in October 2015. Almost three years will be passed in the middle of 2018. I described its activities and performance for the initial 2-3 years period.

When the system was initially established, it was expected that the center of system would receive between 1,300 and 2,000 reports. As it turned out, however, the actual number was only about a third of what had been expected. Thus, there are challenges ahead when it comes to the system's social recognition and operation. The purpose of this presentation is to consider how the medical and legal communities should collaborate with each other to promote the development of the medical accident investigation system. In so doing, discussions that took place during the process of establishing the system, as well as the performance of the system during its initial few years, will be reviewed

The biggest reason why Japan launched this investigation system is that some criminal cases for medical malpractice threatened for doctors in the past 20 years and some doctors complained the courts decided doctor's action was legal or illegal. This system is managed by medical community and adopt no blame system.

Attempts to identify the cause of medical accident through criminal investigations or civil lawsuits may become more subdued once there is greater recognition regarding the social significance of accident investigations, although certain challenges may remain when it comes to the relationship between investigation reports by doctors and the criminal liability system.

## **Legal Rights and Responsibilities of Contracted Family Doctors Services in China**

### **Lihua Fan**

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In recent years, contracted family doctors services (CFDS) have been successively implemented across China and obtained some achievements. However, there is still no clear definition of the content of civil rights and obligations. Combing the legal relationship of the CFDS and defining the rights and obligations of the contract subject, and these actions contribute to the development of the family doctor system and respond to legal challenges in the service of family doctors. According to the development situation of contracted services among Chinese family doctors, this study has been carried out through a questionnaire survey on the contracted parties (family doctors' team and residents) and combined with the 2 rounds of expert consultation results, to explore the legal rights, obligations and responsibilities among residents and family doctors in the implementation process of the CFDS system.

## **Legal Implications for Healthcare Institutions in the Age of EHR and eDiscovery**

### **Ashley Remeza**

*Aviva Healthcare Solutions, Thomas Bojko Aviva Healthcare Solutions, New York, United States*

Cyber security is a top concern for hospitals and other healthcare institutions. In 2016 alone, the health records of 16.6 million Americans were exposed due largely to hacking. Most of these attacks used ransomware, a type of malware that blocks access to a users computer or data until a ransom is paid.

Patient records are particularly vulnerable to attacks due to the information they contain: name, social security number, and date of birth, making them prime targets for identity theft and blackmail.

Failing to prevent cyber attacks can place entities in legal jeopardy. In the USA, while HIPAA does not always provide an individual the right to sue in federal court, healthcare institutions face liability and damages should individuals sue for invasion of privacy and/or breach of doctor-patient confidentiality in state courts. In such cases, HIPAA privacy and protection standards may be used to establish negligence. The European Union and other countries have similar laws to protect patient confidentiality.

Electronic Protected Health Information (e-PHI) may be particularly vulnerable during eDiscovery in healthcare-related litigation cases. eDiscovery experts should ensure data remain protected at all times by adhering to the Minimum Necessary Rule, encrypting data during transfer and ensuring the location where data is reviewed is secure.

## **John Cunningham Virus Status and Progressive Multifocal Leukoencephalopathy as Material Risks when Treating Relapsing Remitting Multiple Sclerosis**

### **Roy Beran**

*University of New South Wales; Griffith University; Strategic Health Evaluators, University of Queensland, Sandiya Sathiyseelan Strategic Health Evaluators John Devereux University of Queensland, Australia*

### Introduction

Progressive Multifocal Leukoencephaly (PML) is an opportunistic central nervous system infection with John Cunningham Virus (JCV) that is potentially fatal or severely debilitating. Following informal discussion with colleagues, it is our contention that most neurologists think the risk of PML with JCV positive patients, treated with either fingolimod or dimethyl fumarate, is so low that they avoid testing or discussing it with patients.

### Patients and Methods

Patients with MS who attended the outpatient clinic, in order of attendance, were offered testing for JCV, as part of due diligence and routine care, rather than as part of a research project, and they readily accepted the option, despite being advised that most neurologists would not order the test and would take little note of the result.

### Results

The 4 patients who were positive for testing for JCV all opted to change treatment to a perceived less efficacious medication, which has no reported cases of PML associated with it.

### Discussion

The Australian case of *Rogers v Whitaker* set the benchmark for material risk consideration in which such risk should be respected when doctors discuss treatment with patients. In *Rogers* the risk was 1/14,000 while for fingolimod the risk is 1/10,000, if JCV positive, and less so for dimethyl fumarate. This

report confirms that even these low risks directly influenced patient choices and thus may leave clinicians liable in negligence if not informing patients who subsequently develop PML.

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**Ethical and Legal Issues of Clinical Trial****Song Bai**

*Beijing No.2 Intermediate People's Court, Fengtai District China*

There is a case about clinical trial in which the patient wanted to participate in the drug test while the researchers refused, then the patient sued at law but lost. Clinical trials are important for the development of medical science and should obey laws and ethics principles. Patients cannot decide whether to participate in the clinical trial or not and they shouldn't be given test drugs without permission. There are some flaws in the informed consent which caused misunderstandings of patients. Relevant laws and regulations should be issued to regularize clinical trials and solve the problems in practice.

## **Clinical Research in European Union**

### **Olena Pasechnyk**

*National University "Odessa Law Academy", Odessa, Ukraine*

Preclinical researches are conducted within so-called. "Appropriate clinical practice" (good clinical practice - GCP) that it is fixed at the level of the Union. In legal regulation of carrying out clinical tests of medicines it is possible to mark out two main objectives: 1) protection of human rights during clinical tests, 2) safety of the circulation of medicine. The directive 2001/20 defines GCP as a complex of internationally recognized ethical and scientific qualitative requirements which have to be observed creations, introductions, fixing and the reporting on clinical tests in public. Performance of this appropriate practice provides the rights, safety and wellbeing the subjects of tests at reliability results of tests. Appropriate observance of rules of such practice (ensuring her performance) has to guarantee protection of the rights of examinees, their safety and that is especially important, to guarantee reliability of results of clinical trials.

## **Health Treatment of Prisoners of War Under the View of IHL**

### **Jihong Wang**

*Air Force Medical University, Wei RAO Air Force Medical University, Shaangxi, China*

Prisoners of war (POW), as the belligerent of the power of the enemy, are possibly offended by the detaining power. Therefore, the humane treatment of POW is required by the international humanitarian law (IHL). A legal framework is necessary to safeguard the right of POW, by which the protection of POW can be implemented smoothly, completely and regularly.

Present subject demonstrates the importance and the security of health treatment of POW regarding with three main views, the legal attribute of POW, the principle of humanitarian treatment of POW by IHL, and the essential requirement for combatant nations to catch the same treatment for their POW. Geneva Convention relative to the Treatment of Prisoners of War of August 12, 1949 (Third Geneva Convention) regulates the humanitarian protection of POW and stats health benefits of POW especially. Meanwhile, Third Geneva Convention is also the fundamentals of other protections for POW. The health treatment of POW is mainly consisted of basic living condition, regular health care, medical treatment, medical clinic, etc. The implementation of above treatments is counted on that the detaining powers carry out their international humanitarian law obligations. The liabilities of the High Contracting Parties on the health treatment contain the establishment of health protection mechanism for POW, the formation of operating manual that facilitates the management of POW in rules, the propagate education of the concept and specific provisions that safeguards the health of POW, and the strictly implement of the duty that protects the health of POW.

## **Legal IT Solutions for Patient Verification and Medical Records Unifications**

### **Maksym Baryshnikov**

*Maksym Baryshnikov, Svitlana Postol Svitlana Postol, Kyiv Region, Ukraine*

In today's World most of medical treatments use different kinds of special computer programs as a tool based on national healthcare law regulations. Despite of this we should agree that the same illnesses throughout the World have completely different list of cover medical documents.

One more serious and real problem is providing and defending Patient's right to protection of personal data, followed by mirror effect at time when patients try to seek treatment in different countries, other than their country of birth or permanent residency.

Is there any sufficient way to personalize certain Patient, his relatives or representatives from different countries and to provide quick and efficient translation and further provision of medical records between two or multiple countries?

Modern conveniences and already existing technologies can provide it but we need new internationally recognizable legislation for this. We suggest the next opportunities:

1. Patient on-line verification using opportunities of KYC verification.
2. PGP based digital signature on line appropriation.
3. Medical programs interface unification with automatic translation and encryption.
4. Trained medical professionals and Patients identification with self-generated Digital signature.

Basic principles of our idea are:

1. Independence from national legislation rules.
2. Using free shareware and noncompromising solutions.
3. Preparation of WHO based recommendations on medical documents and patients identification and an easy way to exchange solutions.

## **Problems of Evaluation of Expert's Report at International Cooperation**

### **Sevinj Ismailova**

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International cooperation in a field of law is possible only if legislation of an initiator and executor of request on assistance (cooperation) is corresponded each other on basic positions. This is particularly important in part of evidence and proving as interaction in form of rendering assistance mainly based on these institutions of law.

According to legislation of practically all states of the world community, proofs are recognized as admissible in court proceedings if they correspond to procedures of their receiving, investigating and evaluating established by national legislations.

This fully applies to the forensic expert's report however there are no standard provisions in this matter that makes difficult, and in some cases, excludes using this kind of proof at international cooperation.

So, Legislation of different countries, including Azerbaijan, contains the norms, according to which an expert examination on request concerning legal aid will be produced in compliance with legislation of the country.

In addition, a forensic expert's report might be accepted as proofs in court proceedings of Azerbaijan if it also received in compliance with orders of Azerbaijani legislation.

However, procedures of assignment and production of forensic expert examinations in many countries differ from the procedures provided by legislation of Azerbaijan Republic.

There is no unity in status of forensic experts and specialists; evaluation of experts' reports is produced on various standards, methods and techniques of production of expert examinations, participation interested persons in it and many other ones contain essential differences.

## **On the Issues of Repeated Forensic Medical Examination in Ukrainian Procedural Law**

### **Olena Kostiuchenko**

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One procedural matter that arises at times in the Ukraine is, whether it is possible to expand the list of initial questions put before an expert during the initial examination with additional questions when appointing a repeated forensic (commission) examination given to another expert institution.

Repeated examination is always entrusted to another expert or another expert institution. The legislator does not specify any other procedural features of the court's additional expertise appointment. It should be emphasized that participants of a trial are entitled to propose the court questions which they regard as such that should be clarified in an expert's conclusion. The questions which should be under examination, appointed by the court, must be finally defined by the court, which means that the court can, at its own discretion, determine without any restrictions and reservations the final list of questions that require conducting either primary, or secondary, or additional examination. However, if the questions proposed by the participants of the trial are rejected or changed, the court is obliged to explain the reason of their rejection or change.

For the purpose of procedural economy, ensuring the procedural expediency and the interest of justice, the range of questions put up before an expert (experts) during repeated examination, including forensic medical examination, can be expanded.

## **Chinese Health Law System**

### **Xiuqin Shen**

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“Healthy China 2030” stratage has been issued and became a national stratage. on the background of this situation, the author discussed the idea of” great health”, the value of promoting fairness, and the principles of prevention first, participation by all people, health policy, suggested to enacting the law of “basic medical health care and health promoting”as soon as possible, to perfecting different kinds of medical system, such as medical insurance system, pharmerceutical service, health industry, hospital management,etc. The final aim is to design the frame of health law legislation, construct relatively perfect legal system of China

## **Bioethics and Organ Transplantation in China**

### **David Matas**

*Canadian Council on International Law, Manitoba, Canada*

The author is of the opinion that there is substantial evidence of past and ongoing transplant abuse in China and, in particular, sourcing of organs for transplantation from prisoners killed through organ extraction and their bodies cremated.

The Government of China acknowledges past sourcing from prisoners sentenced to death but claims that it has stopped. It is the contention of the author that the evidence points to the sourcing of organs from prisoners of conscience, which the Government of China denies.

This paper would explore the implementation and effectiveness of what the author considers Chinese bioethical standards in the context of organ transplantation. The paper would examine the issue generally and consider specifically pharmaceutical trials of anti-rejection drugs, the experimentation of Wang Lijun on transplantation with organs sourced from prisoners, and the plastination of bodies for commercial display.

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## **Attitude, Knowledge and Willingness Towards Organ Donation in Poland**

**Paulina Mularczyk**

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**Background:** Organ transplantation is currently the most effective treatment for patients with end-stage organ failure. The number of organs transplanted is affected by a wide range of factors, including ethical, legal and organisational aspects. However, the most important factor is definitely the perception of the idea of organ transplantation by society.

**Aim:** The aim of the study was to learn the attitudes and knowledge of students of medical universities in Poland towards organ transplantation and to assess the knowledge of legal regulations in the discussed field.

**Material and methods:** The survey was attended by 2,763 (W=2278; M=485) of various fields of study at medical universities in Poland. The research was conducted in 2016-2017, as part of the grant project Young Scientist. The study was carried out by a diagnostic survey. The research tool was an original questionnaire consisting of 24 single- and multiple-choice questions.

**Results:** The procurement and transplantation of organs from deceased donors is strongly accepted by 81.14% of respondents. 67.61% of students would agree to donate their own organs after death. 47.98% of respondents would agree to donate organs for transplantation from family members. Half of the respondents (50.74%) correctly indicated the current model of regulation of organ transplantation from deceased donors in Poland.

**Conclusions:** Students of medical universities support the idea of organ transplantation. However, the enthusiasm and goodwill associated with the transplantation of organs after death diminished when the problem affects members of the family and their own.

## **Propofol Intoxication According to Medicolegal Researches of Corpses**

**Ng Ming Jui**

*Svetlana Lisovskaya Svetlana Lisovskaya Elena Vasiljeva Elena Vasiljeva  
Yuri Morozov Yuri Morozov, Moscow, Russian Federation*

**Introduction** Propofol is an intravenous anesthetic agent. According to the forensic medicine clinical reports, the findings have shown, there are complicated cases with the propofol usage. Therefore, it is urgent to determine the pathogenesis and tanatogenesis of acute propofol intoxication, which is obvious, based on the clinical and morphological findings.

**Objective** According to the forensic medical examination results, the investigation has shown adverse effect with the propofol usage in anaesthesiological practice. In contrast, the clinical results, sectional, and laboratory studies with literature, they try to find the propofol's general mechanism and its role in tanatogenesis.

**Methods** Review of reported cases, with adverse effects after the propofol usage, as an anesthetic. These analysis have been provided in the medical history, sectional puncture, and the laboratory studies.

**Results** Since the year 2013, the Moscow Forensic Medical Examination Bureau. There were 4 death cases reported, 3 women and 1 man, between the age 24 and 49, after anesthetist administered the propofol. Death from acute heart failure, that occurred within the first hour after the administration of propofol. Pathomorphological examination had detected the toxic dystrophic changes of cardiomyocytes, brain edema, and pulmonary edema. The cause of death in these two cases were cardiomyopathy, the other two cases, are malignant tumor and the combination of injury.

**Conclusion** Propofol usage as anesthetic, which has an increased risk of sudden death within next hour after the administration.

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**Legal Analysis of Conditions and Order of Organ Donation in Ukraine****Viktoriiia Formaniuk***Formaniuk Viktoriiia, Odesskaya, Ukraine*

This poster considers of the challenges related to organs donation from living people and post-mortem organ in Ukraine. Organ transplantation received from minors are problem in Ukraine's legislation because only a full age competent person is allowed to be a donor. Also a new technology give us a new perspectives in this sphere. For example, we talk about 3d technology and its legal implications in Unkrainian law.

## **Euthanasia as a Vision of Future for the Third Age**

### **Sanjin Dekovic**

*Clinical Center of University in Sarajevo, Gynecology and Obstetric Clinic Sarajevo, Bosnia and Herzegovina, Selma Kadic - Dekovic Public Institution of Community Health Care " Vrazova", Sarajevo, Bosnia and Herzegovina, Canton Sarjevo, Bosnia and Herzegovina*

The third age often represents great challenge for health of every human being. Even though medicine has undoubtedly advanced, a large number of diseases still lead to numerous people dying without dignity and in agony, without even their closest relatives being able to help them in their suffering and very limited possibilities of palliative care, while many countries do not have the capacity to finance the expensive healthcare services.

Authors analyse whether euthanasia, as a choice, represents vision of more comfortable future for the third age. when the chance of developing serious, as well as incurable diseases is at its highest.

Euthanasia represents one of the most controversial issues in the field of Medical Law, and it has only been permitted in very small number of countries. Although it could be applied to all generations and different social categories, it seems that the people in the third age could be most interested in its legalization in countries where it has not been legally allowed yet. Often dying without dignity, in case of the most severe diseases, for a large number of them the authors believe that it would be a great relief to have the option of euthanasia, regardless of their views and beliefs.

We believe that possibility of choice of euthanasia in the third age should exist as option. This would bring great relief in case serious diseases to people who would rather opt for euthanasia than to be burden to their offspring, relatives, community, and give them opportunity to die with dignity.

## **Ethical Challenges in Treatment of Syrian War Injured in Israel**

### **Sarit Eizenberg**

*Galilee Medical Center, Simion Faitsvaig Galilee Medical Center Ronit Kalman Galilee Medical Center, Galilee, Israel*

The Syrian bloody civil war has been on the Israeli border for six years. Many Syrian wounded have arrived at the border, in order to be evacuated for treatment in Israel - many of them young, in critical condition; women and children.

At the Galilee Medical Center, the treatment of Syrian wounded is carried out in a special department called "The Guest Department". The treatment is a professional challenge reflected in the following aspects:

1. The trauma is characterized by multiple injuries including fields of neurosurgery, orthopedics, head and neck, ear nose throat, and general surgery. Knowledge and professional skills related to the nature of the injury are requested from the nursing staff.
2. The team's handling of infections and prevention. Resistant bacteria, not found in the typical Israeli patient, are detected in the wounded. Accordingly, special assessments are required, including unique work patterns, division of the hospitalization areas into isolation spaces, sterile treatment rooms, and more.
3. The therapeutic experience involves emotional, ethical and moral aspects. This experience expresses a reality in which Arab and non Arab nurses treat wounded from an Arab enemy state. Accordingly, the patient-caregiver attitude must not be biased by political considerations.

The therapeutic encounter with the Syrian patients carries an unparalleled significance.

The therapist complex task implicates maintaining the delicate balance between necessary involvement and therapeutic distance.

The deepening of the discussion on the issue of treatment of Syrian wounded sheds light on the nursing work in Israel.

## **The Israeli Case: A Policy Change in Acute Stroke Decision-Making**

### **Savannah Karmen-Tuohy**

*New York University, Oren Asman, Tel Aviv University, Silvia Koton Tel Aviv University, Israel*

Stroke is a main cause of death in the US, Europe, and Israel, and yet literature on best practices for end-of-life care in stroke settings is relatively sparse. Approaching the nuanced topic of medical decision-making from a stroke context, we seek to highlight the need for more consistent use of specific, adequately informative advanced care directives as a means to aid surrogate decision-makers, who are often under-informed, emotionally distressed family members. With the recent legislative change in Israel – the amendment to the Legal Competence and Guardianship Law that re-established a durable power of attorney “proxy” role as of June 2017 – training sessions on drafting healthcare durable power of attorney documents are now held for lawyers and patient rights organizations are publishing information to educate the public about the value of advanced care directives. In order to establish current knowledge about end-of-life decision-making in stroke, a systematic literature review was performed, revealing a dearth of information on the topic. Publications analyzed centered on the factors important to family members in decision-making, the desired role of the physician in communicating with decision-makers, and the potential fallacies, biases, and burdens placed on under-informed surrogates. Using the medico-legal framework in Israel as a case study, increased use of informative advanced care directives can be a solution both to protecting the autonomy of stroke patients, many of whom are debilitated and cannot themselves participate in decision-making, and to alleviating the responsibility unexpectedly placed on surrogates to make decisions in accordance with their loved one’s wishes.

## **Movement and Meaning - Do You See What I See?**

**Sandra Adiarte**

*University of Bamberg, Germany*

Laban Movement Analysis (LMA) and Laban/Bartenieff Movement Studies (LBMS) have a structured approach towards training and applying movement observation in theory and practice. These methodologies have been used and documented in various fields of research such as: dance and movement therapy (Van Dyck, Maes, Hargreaves, Lesaffre, & Leman, 2013; Koch, 2011), development of movie animation and computer games, robotics (Burton, Samadani, Gorbet, & Kulić, 2015; Lockyer, Bartram, Schiphorst & Studd, 2015) and motion-capture systems (Bernstein, Shafir, Tsachor, Studd, & Schuster, 2015; Calvert, 2015), as well as deception detection (Adiarte, 2016; Davis, 2006). Non-biased assessment of individuals and their movement (in real time and data based) before, during or after criminal incidents is critical and investigators, judges and law enforcement personnel share the goal of time efficient and reliable evaluation. LMA and LBMS provide macro and micro analysis of movement and capture conscious and unconscious movements and although the significance and benefit of detailed movement evaluation is documented in research, LMA/LBMS framework has not been used in forensics yet. As researchers in and around forensic science and law are currently facing a paradigm shift, new approaches are needed in order to meet contemporary challenges and needs of the field. This implies ethical and legal questions concerning how research in this field needs to be conducted. Challenges and possibilities of an interdisciplinary approach using LMA/LBMS in forensics are discussed.

**Keywords:** Movement Analysis, Laban-Bartenieff Movement Studies, observation methodology, ethics

## **Adverse Events in Cases of Medical Malpractice**

### **Søren Birkeland**

*University of Southern Denmark, Ida Rasmussen, Søren Bie Bøgh, Southern Denmark*

While adverse event (AE) reporting schemes have been widely introduced to address quality issues in healthcare delivery, the question arises as to their interplay with systems focusing on individual health professional responsibility. However, there is little empirical knowledge available about what characterizes the events typically underlying the different systems and to what extent they actually may overlap. In order to investigate the crossing edge between AEs and malpractice cases (MCs), the present study provides an audit of general practice MCs completed by the Danish Health Professionals' Disciplinary Board from the perspective of AE analysis. There were 118 MCs with stated negligence among 574 cases filed against general practitioners. Seventy-six percent of MCs (n=90) could be classified as AEs. Remaining cases mostly concerned legal issues (medical records keeping, right of access to medical records etc.). AEs related to 79 courses of patient treatment. Regarding severity, 47 AEs belonged to the 'life-threatening or disabling' category and eight AEs resulted in death. The content analysis revealed four major AE categories with 'Interpretation of symptoms and findings' (51 AEs) and 'Intervention' (25 AEs) being most common. Clinical problems most frequently concerned cardiovascular or neurological disorders and AEs were medication-related in one-fifth of cases. MC analyses pointed to the problem that patient safety purposes can be counteracted by the sanctioning system calling for a reevaluation of the regulation. Further studies are merited to add to our knowledge about the interplay between AEs and the disciplinary responsibility system while upholding the goal of improving patient safety.

## **Contribution of the Aggrieved Party and Improperly Performed Medical Practice**

**Weronika Wojturska**

*University of Warsaw, Warsaw, Poland*

The presentation reveals results of the author's legal analysis of a comparative and interdisciplinary nature. Legal constructions, such as the contribution of the injured patient and professional negligence of doctors were considered. It is important to consider not only the evaluation of determinants assessing the behavior of the victim in the context of contributing to the injury, but also the enforceability of medical liability for a medical doctor who, while practicing medicine, is obliged to maintain a higher degree of diligence based on an objective criterion.

Both issues in the context of the exercise of the right to health constitute a link to causing damage, entailing both administrative and civil liability. However, only the comparison of the solutions adopted by the Polish legislator in comparison with the US system allows for a better understanding of the matter.

A comparative analysis, drawing on the achievements of domestic and foreign doctrine and jurisprudence, has allowed us to prove a research thesis, which sees the correlation of the indicated systems.

## A “Behind the Scenes” Weapon in Medical Malpractice Lawsuits

### **Ofra Mehoudar**

*Medi-Kal.com Medical Information, Israel*

#### Background

One of the most complex issues in medical malpractice (MM) lawsuits is Causation. Factual causation is generally tested based on the opinions of expert medical witnesses. In our days of Information highway, research about different causes of illness is done all over the world simultaneously and yields rich information about options and probabilities. In court, interrogations and counter-interrogations may refer to minute details. Even the most specialized doctors struggle to keep ahead of the literature. Moreover, not all doctors are skilled in interpreting quantitative data.

When can a scientific literature review (SLR) prove useful for MM lawsuits?

1. Case “review” stage: Go/No-Go decision, when the case is legally unprecedented.
2. Supporting an alleged causal relation and refuting alternative causes.
3. The “but for” test: Research papers present control groups.
4. Cross examination of the expert witness: Challenging the expert’s knowledge.

#### Case example

1. Woman had LASER removal of facial hair and afterwards suffered overgrowth of hair. Claimed malpractice. A brief SLR revealed overgrowth of hair to be a normal, but unexpectable side effect of the procedure.
2. MM lawsuit for a delay of 6 months in diagnosis of cancer, which by then proved incurable. SLR demonstrated that within such time, survival rates in this illness drop by 70-80%, rather than by 40-50% as estimated by the expert.

#### Conclusion

SLR offers information crucial for some MM claims. On the Information Highway, there might be a need for a new specialization: SLR writer.

Acknowledgments: Hadas Prion Adv.

## **The Challenges of Medical Regulation in Nigeria and Way Forward**

### **Tajudeen A B Sanusi**

*Registrar Medical and Dental Council of Nigeria, Philip Sokfa Chechet Assistant Legal Adviser to Medical and Dental Council of Nigeria Enejo D Abdu Assistant Registrar/ Head of Professional Discipline at Medical and Dental Council of Nigeria. Yusuf B Shaba Legal Adviser to Medical and Dental Council of Nigeria Federal Capital Territory Nigeria*

The medical profession in Nigeria is statutorily regulated by the Medical and Dental Council of Nigeria (MDCN) in collaboration with stakeholders at different levels of government ranging from Federal Ministry of Health and its agencies, to states ministries of health and their agencies. This study will focus on challenges faced by the Council in medical regulation in Nigeria with the view of proffering solution therein.

The Council is established by the Medical and Dental Practitioners' Act Cap M8 Laws of Federation of Nigeria 2004. It regulates medical and dental education in Nigeria, registers medical practitioners and dental surgeons, prescribes a code of conduct for practitioners and disciplines violators. It also controls the practice of alternative medicine and regulates the practice of laboratory medicine by medical practitioners. All this is with a view to protect the public by ensuring that registered medical practitioners and dental surgeons are competent persons who practice safe, ethical and responsible medicine.

Frequent dissolution of the Council and judicial intervention has hindered its ability to carry out the mandates.

We shall attempt to discuss and make recommendations for the resolutions of the problems identified.

## **The Brazilian Medical Ethics Code: Conflicts with the Law**

**Eduardo Dantas**

*University of Coimbra, Pernambuco, Brazil*

Medical sciences and their developments are causing a social phenomenon in Brazil. The legal system is not prepared to regulate the new technologies, possibilities or interactions created by the evolution of medicine, leaving a void that has been fulfilled by the Federal Council of Medicine, and their administrative Resolutions.

Taking advantage of the legislator's negligence, the Federal Council of Medicine has been issuing Resolutions on important matters, such Euthanasia, Palliative Care, Human Assisted Reproduction and Advance Directives in the past few years.

These Resolutions should be a guideline for physicians and their ethical behavior, but due to the lack of proper laws, have been used as a surrogate semi-legal text to solve conflicts and judicial disputes all over the country. But what happens when these Resolutions exceed their field of competence? How far can the Federal Council go when establishing rules beyond medical ethics, affecting society as a whole, by regulating issues that are originally and exclusively National Congress' competence?

The aim of this paper is to analyze the development of these Resolutions, including the new Medical Ethics Code, highlighting the conflicts with civil law, the Federal Constitution and ordinary legislation, discussing the role of ethical guidelines as a replacement for nonexistent laws.

## **Legal Value of Ethics in the Medical Law System of the Russian Federation**

**Vladimir Kuranov**

*Vagner Perm State Medical University, Perm Krai, Russian Federation*

In accordance with the law on health protection, the priority of patient interests is realized by observing ethical norms. There is also a requirement for medical professionals to carry out their activities, guided by the principles of medical ethics and deontology.

The Russian legislator considers morality as a source of law. But Russian legislation does not contain a list of moral standards that must be followed by medical workers.

The fundamental deontological norms are contained in the Principles of medical ethics adopted at the 37th session of the UN General Assembly and approved by Resolution n 37/194. Foreign law enforcement agencies know the codes of ethics for health professionals (deontological codes).

The Russian sources of ethical regulation of the behavior of the medical corps include the code of Ethics of the Russian doctor and the Code of professional ethics of the Russian Federation doctor.

The norms of medical ethics are also applied in the law enforcement practice of Russian courts. So, the Belgorod and Tomsk regional courts upheld the decision of district court to which satisfaction of the statement of claim for cancellation of the order for imposing on the medical worker of disciplinary punishment is refused. Thus vessels it was established that in actions of the medical worker there are violations of the Code of medical ethics.

It should be noted that in the case of the actual consolidation of morality as a source of health law is not their incorporation into the system of normative regulation.

**Pharmacists – Patients Relation from the Perspective of Indonesian Law****Gunawan Widjaja***Universitas Tarumanagara, Jakarta, Indonesia*

Role of pharmacists in medical treatments have become more important today. From drug oriented to patient oriented. Nowadays, pharmacists is not only responsible to provide good medicine, pharmacists must provide rational medication and avoid medication error. Understanding of pharmacists and patients relation become more important from time to time. This research aimed to explain legal relations between pharmacist and patient, and the liabilities that come together with these legal relations from the perspective of Indonesian laws and regulations. This research is a normative legal research. It conducts literatures review on the prevailing laws and regulations on pharmacy practice and pharmaceutical care in Indonesia. This research used secondary data which consist of applicable rules and regulations to identify and understand the role of pharmacists in providing pharmaceutical care to patients and the liability that might arise from pharmacists – patients relations. Analysis to the rules and regulations proved that there are at least two kinds of relations existed between pharmacists and patients. First is the non-contractual relations established by laws, and the second is the contractual relations between pharmacists and patients. These two relations may co-exist in pharmaceutical care. Finally, it is suggested that to understand the relation and therefore legal liability of pharmacists to patients, either pharmacists and/or patients must understand each roles in pharmaceutical care.

## **Mapping Ethical Challenges in Internal Medicine**

### **Gila Yakov**

*The Max Stern Izreel Valley College, and The Faculty of Medicine of the Technion Israel Institute of Technology, Megido, Israel*

Ethical challenges and controversies are common in the daily activities in medical departments and clinics. Students that will graduate from medical school will face such ethical dilemmas, thus providing them with the best tools to handle such challenges is essential. The Main Research Questions were what are the most common ethical issues physicians are facing in an internal medicine department? What are the most common approaches in handling such challenges, and could those strategies be utilized as educational tools for medical students?

The aims were to Map common ethical challenges and dilemmas, explore ways of dealing with these in the internal medicine department in order to build appropriate and relevant teaching program for medical students. Twenty-three physicians were interviewed and the conversations were analyzed for repeated theme.

The most common ethical challenge identified through the research relates to the inherent ethical complexities imbedded into the relationship between medical staff and the patient's family, such as family members exert pressure to obtain information about the patient's condition, or to prevent information from the patient, and family members seek to provide or withdraw treatment from the patient.

The findings indicate that the rights for confidentiality and autonomy of the patient are threatened by family need for information and requests to conceal troubling information.

Our findings allude to the importance of physicians' ethical reasoning in the process of solving ethical dilemmas and conflicts in their interactions with family members of their patients.

## **The Right to Health- Stillbirth**

### **Natali Goldring Kabra**

*Lawyer, Israel*

Stillbirth medically defined as a birth of infant that died in the womb in late weeks of pregnancy. The Israel social security law defined Stillbirth as a birth of dead embryo later than 22 weeks of pregnancy. In Israel 5-6 of 1000 births are a stillbirth , yet no current known methods to further diminish this phenomena are known to medicine.

Other than the obvious emotional burden that it may entail, stillbirth raises various legal and ethical issues, which will be discussed in our presentation:

1. **Medical Negligence:** In a related to stillbirth an Israeli verdict tried to determine some of the proper medical conduct to prevent stillbirth such as Medicals records, Monitoring pregnant surplus regularly, Explain all the optional medical procedures . The lack of knowledge about the reasons of stillbirth impact the medical care maternity gets and requires a new researches and medical working procedure.
2. **PTSD –** Late research find out that women after stillbirth suffer from post trauma as military soldiers . The hard psychology influences of stillbirth obligate evaluation of the system to psychology support even in a level of compressive policy.

## **Forced Sterilization Surgery and New Noninvasive Prenatal Genetic Test in Japan**

**Mitsuyasu Kurosu**

*Tokyo Medical University, Tokyo, Japan*

In January 2018, a woman in sixties raised a lawsuit seeking the Japanese government to apologize and compensate for forced sterilization surgery. She was forced to former Eugenic Protection Act (1948-1996) when she was 15 years old. More than 15,000 men and women were operated without their consent. In 1971 an unmarried woman in twenties was performed sterilization surgery as a congenital mental weakness. The Eugenic Protection Act was amended in 1996, the provision of eugenic sterilization surgery was deleted and became the Maternal Protection Act. After that the new noninvasive prenatal genetic test, NIPT, became available, over 90% of those who became positive selected abortion. Also, in 2017, a former employee at a disabled facility caused a case of stabbing 19 residents from the view that “There is no need for people with disabilities.” The necessity of ethics education is increasing not only in schools but also in the workplace such as health care and welfare facilities.

## **Law on Euthanasia- Pros and Cons**

### **Y.S Kiran Kumar**

*Research Scholar, Department of Law, Telangana University, Nizamabad T.S., Asia, India*

Law on Euthanasia can be a death blow to the poor and economically weak, infirm and disabled, as they cannot afford the exorbitant costs of healthcare for terminal illnesses. This makes them potential live donors of organs in hospitals. This highlights the state's apathy and indifference in providing proper palliative care to the needy. Every individual with rational thinking and visionary mindset should initiate steps on his Living Will and should initiate steps on his independent idea about death related conversations to be known to his kith and kin :

1. As a power of Attorney for my health care in future.
2. Living Wills.
3. A good bye letter to all.
4. Where do I die – At home or at hospice –by choice of patient.  
(Consent of Kith and Kin if patient is unconscious)

In this modern world living in a death denying culture that makes it difficult both to the doctors and patient and his kith and kin to come to terms, a very hard time accepting death.

As already explained above the working of ICU – a modern torture chambers or Yama Loka for the terminally ill is also supported by Dr. George Lundberg who said “A sophisticated hospital in the last place you want to be when terminally ill. Once you are in the hospital setting you're trapped. The staff owns you; they will do those terrible things they have been trained to do to prolong life, no matter how artificially or hopelessly .

Therefore strict protocols are required.

## **Assisted Reproduction after Death - Medical and Ethical Aspects**

### **Mariya Petrova**

European Institute of Healthcare Law, Healthcare Management and Public Health, Bulgaria

The purpose of this poster is to present a comparative legal analysis of the opportunities and solutions in Europe for assisted reproduction after death.

With the development of biotechnology, genetics and medicine, the potential of assisted reproduction has dramatically increased. Medically assisted reproduction is expanding the forefront of what was considered possible and, as often happens, technological breakthroughs challenge not only our physical abilities, but also our understandings, moral and our legislation.

Assisted reproduction after death sets attention to both ethical and medical questions. Can a genetic matrix be inherited? Is there a valid will after death? How is the best interest of future generations preserved and by whom? Is reproduction after death a benefit of the life created or is it a benefit solely to the creators?

These emerging questions and subsequent decisions affect not only the patients and parents, but health professionals, organizations and the medical industry. That is why it is crucial to have an overview of current legal body on the matter and thus to formulate a vision of the future.

## **The National Public Health Institute of Ukraine**

### **Sviatoslav Malyshevskiy**

*The Education and Research Centre for Medical Law of the Law Faculty of the Taras Shevchenko National University of Kyiv, Kyiv, Ukraine*

The need for a coherent and radical healthcare reform in Ukraine is necessitated by its failure to adequately carry out the tasks assigned to it by the Constitution of Ukraine. We are of the opinion that a current effort in restoration of public confidence in the existing national institutions that regulate and manage healthcare services is failing. We argue that, a fundamentally new system of national institutions is needed in order that have a historic chance to become a unique and secure platform for establishing a conceptually new healthcare system in Ukraine.

On its way towards a truly effective national healthcare system, Ukraine has the ability to implement the most effective practices used by the leading healthcare systems in the world, making this process less demanding in terms of resources required for innovation. This “borrowing” strategy requires an effective network of partnerships both internationally and domestically in order for such adjusted implementation to succeed. Therefore, establishment and maintenance of such network should be a priority in the strategy to reform the healthcare system of Ukraine.

There is an urgent need for the government of Ukraine to establish a national research institute of public health with the assistance and direction from similar foreign institutions that have demonstrated their effectiveness in solving relevant problems. National public health institutes also play an important consultative role within national governments and confidently use their authority to publish and disseminate information and advice to the public.

Ukraine requires international support and domestic unity in order to establish a truly effective healthcare system. Together we can do it!

## **Vaccine and Neurological Injury: The Dilemma is Still Here**

### **Avinoam Shuper**

*Former Director of Pediatric Neurology Unit, Schneider's Children Medical Center of Israel, Israel*

Compulsory childhood vaccinations are considered one of the major public health achievements of modern time. Due to their use, severe, life threatening infectious diseases were totally or at least significantly eradicated, the most prominent of them are variola and poliomyelitis. Nevertheless, in parallel with the time of initiation of public vaccination policy, it became clear that they can be associated as well with major side effects, especially neurological ones. Two examples of the clinical presentations are epilepsy, especially a very severe clinical type, called infantile spasms, a devastating neuro-developmental disorder; and the other is psycho-motor retardation. These side effects were termed "vaccination-related" encephalopathy.

On the other hand, there is no any proof, neither by imaging study nor by any laboratory or other test, for the cause and effect connection of this morbidity with the vaccination. Infantile spasms, for example, occur generally in the same time frame of vaccination. So, does this epilepsy reflect a vaccination side effect or is it just coincidental? Is there a specific time frame for the side effect to occur that will relate it to the vaccine? one day? 3 days? a week? For instance, if a child had a seizure within 24 hours of the vaccination it is very reasonable that it is due to the vaccine. What happen if it happens after 4 or 7 days?

Of interest is to mention are claims for an association between autism and vaccine, that although rejected by many medical authorities, time frame considerations point towards potentially true connection.

It should be noted in this regard that the mechanism by which the neurologic damage is caused is not known, but it is presumed to be related to an immunological process. By the process of vaccination, foreign material is being injected into the child's body, a procedure which is expected to influence his immune system to protect him from specific infectious diseases. This action can be non-the less harmful, although in a small percentage of the vaccines. This idea is supported by an "accepted" association between vaccination and inflammatory, auto-immune processes, namely Guillain Barre syndrome and brachial neuritis.

Health authorities do accept that a minimal number of the immunized children can be injured by a vaccination-related encephalopathic process. Once a child is injured by this way, what is required in order to get court agreement to

this connection? Who is the one responsible for the injury if at all? Do the governmental health authorities, those who instituted the vaccination policy, take full responsibility for covering vaccination related injury?

In conclusion, we should not stop vaccinating children. However we, as a community, should be sensitive enough to the claims of those injured, and provide sufficient compensation where appropriate.

## **Public Health Challenges at Armed Conflicts**

**Ivan Demchenko**

*Legislation Institute of the Verkhovna Rada of Ukraine, Kyiv, Ukraine*

Nowadays, there are more than 30 (both international and non-international) armed conflicts all over the world. Despite clear protection under International Humanitarian Law – healthcare professionals, facilities, patients become a target from forcible actions made by different actors. Use of force against healthcare professionals, facilities, patients are classified as a war crimes. It's presumed, that such actions had significant immediate negative effect. But, looking from different point of view – such actions impact on the whole affected population, constituting threat to public health at long perspective.

The impact of the armed conflict on public health in terms of human “right to health” violations, the risk of the spread of infectious diseases, and an increase the burden of non-infectious diseases - are discussed in this paper. In addition, what is more important, recommendations about possible actions (at international and national level) in order to response public health challenges are proposed. Especially focus made on accountability and responsibility question.

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