VI. DINAMARCA

VI.1. LEGISLACIÓN

Law No. 482 of 1 July 1998 on patients' rights.
(LOV nr 482 af 01/07/1998 Patientretsstillingsloven)
(Lottidende, 1998, Part A, 2 July 1998)

Law No. 312 of 5 May 2004 amending the Law on patients' rights. (Lovtidende, 2004, Part A, 6 May 2004)

Law No. 546 of 24 June 2005 «Health Act»

Order No. 663 of 14 September 1998 on living wills. (Lovtidende, 1998, Part A, 22 September 1998)

Circular No. 157 of 15 September 1998 on the duties of physicians in connection with living wills, etc. (Ministerialtidende, 1998, 24 September 1998)

Guidelines No. 158 of 15 September 1998 on the duties of physicians in relation to the content of living wills. (Ministerialtidende, 1998, 24 September 1998)

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Law No. 482 of 1 July 1998 on patients' rights*.

(LOV nr 482 af 01/07/1998 Patientretsstillingsloven)**

Chapter 1

Purpose, scope definitions; etc.

1. The Law shall contribute to ensuring that the patient's dignity, integrity, and autonomy are respected. The Law shall also contribute to ensuring that the relationship between the patient and the health care provider is one of confidence and confidentiality.

2. The Law shall be applicable to patients who, within the health system or in other places in which health services are provided, receive or have received a treatment from a health care provider, subject to other specific provisions laid down by legislation.

3. Within the meaning of this Law, treatment' means examinations, diagnosis, the treatment of disease, rehabilitation, therapeutic and preventive care, etc., in connection with a particular patient.

4. Within the meaning of this Law, 'health care provider' means a person authorized by virtue of specific legislative provisions to dispense health care on a professional basis and also persons acting under his responsibility.

5. If a patient is unable personally to ensure that his interests are protected, the person or persons thus authorized by legislation shall intervene to uphold the patient's rights under the law, to the extent necessary in order to ensure that his interests are protected in the situation concerned.

Chapter 2

Self-derennination
Informed consent

6. (1) No treatment may be begun or continued without the patient's informed consent, unless otherwise provided for by this Law or in regulations made for its implementation or in pursuance of Sections 8 to 10.

(2) The patient may at any time withdraw the consent referred to in subsection 1.

(3) Within the meaning of this Law, 'informed consent' means consent given on the basis of adequate information provided by the health care provider, in accordance with Section 7.

(4) Under the terms of this Chapter, informed consent may be written, verbal, or tacit.

(5) The Minister of Health shall be empowered to lay down specific rules on the form and content of consent.

7. (1) The patient shall have the right to obtain information on his state of health and on the Possibilities of treatment offered to him, including that relating to the risk of complications and side-effects

(2) The patient shall have the right to refuse the information referred to in the preceding subsection

(3) Information shall be communicated as and when available and present the disease, examinations, and the envisaged treatment in comprehensible terms, Information shall be communicated in a considerate manner and shall be appropriate to the particular situation of the patient: his age, maturity, experience, etc.

(4) The information communicated shall include details concerning the relevant possibilities with regard to prevention, treatment, and care, including other medically justifiable possibilities of treatment and information on the consequences of nor carrying out any treatment. Information shall be more comprehensive if treatment entails the immediate risk of serious complications and side-effects.

(5) If it is considered that the patient is unaware of elements that are important to him in taking the decision referred to in Section 6, the health care provider shall undertake to inform hini accordingly, unless the patient has expressed the wish not to be informed, in accordance with subsection 2.

(6) [Competence of the Minister of Health]

Minors

8. (1) A patient who has attained the age of 15 years may personally give informed consent to treatment, The person holding parental authority shall also receive information in accordance with Section 7, and shall participate in the decision taken by the minor.

* Fuente: http://waml.haifa.ac.il/index/reference/legislation/denmark/denmark1.htm

** El texto completo en versión danesa se puede consultar en: https://www.retsinformation.dk/Forms/R0710.aspx?id= 87608

(2) If the health care provider considers, after carrying out an assessment of the individual concerned, that the 15-year-old patient is nor capable on his own of understanding the consequences of his decision the person holding parental authority shall be empowered ro give informed consent.

(3) A patient who has attained the age of 15 years shall have the right of access to the files concerning him, in accordance with the provisions of Chapter 4, and may give his consent to the disclosure of information relating to his health etc. in accordance with the provisions of Chapter 5.

Patients who are permanently incapable of giving informed consent

9. (1) If a patient is permanently incapable of giving informed consent, the person most closely relared to him may give informed consent to treatment. In cases where the patient is placed under guardianship that encompasses his personal circumstances including his health as referred to in Section 5 of the Guardianship Law, the guardian shall be empowered to give informed consent.

(2) If a patient who is permanently incapable of giving informed consent has no next-of- kin or guardian, a health care provider may carry out the envisaged treatment if another health care provider competent in this field gives his agreement, provided that this person has not previously participated in the treatment of the patient concerned and will nor be called upon to participate in such treatment in the future.

(3) In the cases referred to in subsection 2, the health care provider may however, without involving another health care provider carry out the envisaged treatment if such treatment is nor of a very radical nature with regard to its extent or duration.

(4) If he considers that the patient's next-of-kin or guardian, in accordance with subsection 1, carries out his duties with regard to consent in a manner that is obviously detrimental to the patient or the outcome of the treatment, the health care provider may carry our the treatment, provided that the competent State medical institution has given its agreement.

Need for immediate treatment

10. If a patient, who is temporarily or permanently incapable of giving informed consent or who is under 15 years of age, finds himself in a situation in which he requires immediate treatment in order to survive or in order to improve his chances of survival or considerably improve the outcome of the treatment, a health care provider may begin or continue such treatment without rhe consent of the patient, the person holding parental authority, the next-of-kin, or the guardian.

Participation of the patient

11. A patient who is incapable of giving informed consent himself shall be kept informed and involved in the discussions relating to his treatment, to the extent that he is able to understand the situation with regard to treatment, provided that such involvement is not detrimental to him. Importance should be attached to the information provided by the patient, insofar as it is current and relevant.

Responsibility of the health care provider

12. The health care provider responsible for the treatment shall be required to ensure that:

1. informed consent is obtained in accordance with Sections 6-8 and subsection 1 of Section 9;

2. the agreement of another health care provider has been obtained in accordance with subsection 2 of Section 9;

3. the agreement of the appropriate State medical institution has been obtained in accordance with subsection 4 of Section 9; and

4. the patient has been informed and involved in the discussions relating to his treatment in accordance with the provisions of Section 11.

Chapter 3

Self-determination in special cases

13. Sections 6 and 7 on informed consent, Section 8 on minors, Section 11 on the particípof the patient, and Section 12 on the responsibility of the health care provider shall also be applicable to the provisions of this Chapter. However, Section 8 on minors shall nor be applicable to Section 17 on living wills.

Hunger strike

14. If it is clear that a patient has begun a hunger strike and has been informed of its consequences for his health, the health care provider shall not have the right to terminate it.

Refusal to receive blood

15. (1) A treatment involving the transfusion of blood or blood products may not be begun or continued without the patient's informed consent.

(2) The patient's refusal to receive blood or blood products shall be expressed in connection with the current state of the disease and based on information supplied by the health care provider concerning the health-related consequences of omitting to provide blood or blood products as part of the treatment.

(3) If the administration of a treatment without the use of blood or blood products is contrary to his ethical convictions, the health care provider shall not be under an obligation to provide such treatment and the patient may be referred to another health care provider, unless his case is such that it urgently requires the intervention of a physician, in accordance with subsection 1 of Section 7 of the Law on the practice of medicine.

Treatment of patients whose death is inevitable

16. (1) A patient whose death is inevitable may refuse a treatment the sole purpose of which is to postpone the moment of death.

(2) If a patient whose death is inevitable is no longer in a position to exercise his right to self-determination, a health care provider may refrain from beginning or continuing a life-prolonging treatment, in accordance with subsection 3 of Section 17.

(3) A patient whose death is inevitable may receive the analgesics, tranquillizers, or similar medicaments necessary in order to alleviate the patient's condition, even if this may precipitate the moment of death.

Living wills

17. (1) Any person who has attained the age of 18 years and is not under guardianship that encompasses his personal circumstances, including health, as referred to in Section 5 of the Law on guardianship, may draw up a living will. The person concerned may express in the will his wishes concerning treatment in the event of his being in a situation where he is no longer able to exercise the right of self-determination by himself.

(2) In a living will, the patient may stipulate:
1. that he does not wish to have recourse to life-prolonging treatment in a situation in which his death is inevitable; and
2. that he does not wish to have recourse to life-prolonging treatment in a case where disease, advanced infirmity trough old age, an accident, cardiac arrest, or the like result in such severe incapacity that he is permanently unable to take care of himself both physically and mentally.

(3) Life-prolonging treatment means treatment that offers no prospect of cure, improvement, or alleviation, but merely the prolongation of life,

(4) If, in a case where a patient is unable to exercise his right of self-determination by himself, a health care provider envisages commencing life-prolonging treatment for a person whose death is inevitable or continuing such treatment in a situation such as that referred to in point 2 of subsection 2, the health care provider shall contact the Living Will Register, referred to in Section 18, in order to ascertain whether a living will exists.

(5) The testator's wishes under point 1 of subsection 2 shall be binding for the health care provider, whereas any wishes expressed in accordance with point 2 of subsection 2 shall merely serve as a guide for the health care provider and shall form part of the latter's considerations with regard to treatment.

18. (1) The Minister of Health shall establish a living Will Register and lay down specific rules on the drawing up, formulation, registration, and revocation, etc., of living wills.

(2) [Registration fees]

Chapter 4

Right of access to files

19. (1) The rules laid down in this Chapter shall be applicable to patients' files, etc., prepared by health care providers and kept in public or private hospitals, clinics, Outpatient centres, in a private practice or in connection with treatment in private homes, or in other public or private establishments, etc., whose activities in the field of health include the treatment of patients,

(2) The rules laid down in this Chapter shall not be applicable to the registers covered by the law on the registers of public authorities or to registration carried out purely for scientific or Statistical purposes.

(3) [Competence of the Minister of Health]

20. (1) If a patient so requests, he shall be informed of the extent to which use is made of the health data concerning him and contained in his file, etc. If use is made of such data, the patient shall be informed, at his request and in easily comprehensible terms, of:

1. the nature of the data used;
2. the purpose of such use;
3. the categories of recipients of the data; and
4. any information available on the origin of such data.

(2) The right referred to in subsection 1 may, however, be restricted to the extent that the patient's interest in being informed of the data must be sacrificed in favo,: r of considerations that are of crucial importance to the person concerned or to other private interests.

21. (1) Decisions concerning the right of access to files shall be taken by the authority, establishment, or health care provider holding the patient's files, etc.

(2) The competent authority, establishment, or health care provider shall decide as rapidly as possible whether a request to consult a file can be complied with, and whether such consultation should take the form of on-the-spot examination of the patients file, etc., or whether a transcript or copy of the file should be communicated to the person concerned.

(3) If a request to consult a file has not been complied with or refused within 10 days of its reception by the competent authority, establishment, or health care provider, the authority, establishment, or health care provider shall inform the patient of the reasons for this delay and shall indicate when a decision can be expected to be taken-

(4) In cases in which a health care provider, in accordance with subsections 1 to 3, is authorized to this end, overall responsibility for authorizing consultation of the file, in accordance with this Law, shall lie with the authority responsible for the management of the establishment concerned.

22. (1) [Competence of the Minister of Health]

Chapter 5

Professional confidentiality and the disclosure of health data, etc

Right of the patient to have the confidentiality of the data concerning him respected byhealth care providers

23. (1) A patient shall have the right to demand that health care providers respect the confidentiality of the data that have come to their knowledge during the practice of their profession or the assumptions that they may make concerning his state of health, as well as the confidentiality of other strictly private or confidential information, subject to the rules laid down In this respect by this Chapter.

(2) In cases where a health care provider referred to in this Chapter is authorized to this end in pursuance of specific provisions, the overall responsibility of communicating the data, in accordance with this Law, shall lie with the authority responsible fur the management of the establishment concerned.

Disclosure of health-related data, etc, in connection with the treatment of patients

24. (1) Subject to the patient's consent, the health care provider may disclose to other health care providers data concerning the health of the patient, as well as information of a strictly private or confidential nature in connection with the patient's treatment.

(2) The data referred to in subsection I may be disclosed without the patient's consent if:

1. such disclosure is necessary with regard to the current development of the treatment dispensed to the patient and due consideration is taken of the patient's interests and needs;

2. such is necessary for the protection of an obvious common interest or of important interests of the patient, health care provider, or other persons; or

3. such disclosure is made to a general practitioner treating the patient by a beam tenens operating on the former's behalf.

(3) In the case of the disclosure referred to in point 1 of subsection 2, the patient may at any time during the course of the treatment dispensed to him request that the data are not disclosed.

(4) The health care provider in possession of confidential data shall determine to what extent the disclosure of such data is justified under subsection 2.

(5) If data are disclosed in accordance with item 2 of subsection 2, the person to whom the data relate shall be informed of such disclosure and of the reasons for this.

(6) [competence of the Minister of Health]

25. (1) The consent referred to in subsection I of Section 24 shall be given verbally or in writing. Consent may be given to the health care provider who divulges or to the health care provider who is the recipient of such data. Consent shall be recorded in the patient's file.

(2) [competence of the Minister of Health]

Disclosure of health-related data, etc, for other purposes

26. (1.) Subject to the patient's consent, the health care provider may disclose to authorities, organizations, private persons, etc., data relating to the health of the patient, as well as strictly private or confidential information concerning him, for purposes other than therapeutic ones.

(2) The data referred to in subsection I may be disclosed without the patient's consent if:

1. under the Law or provisions made for its implementation, the said data must be disclosed and must be considered as having considerable importance for the authority responsible for examining the file;

2. their disclosure is justified for the protection of an obvious common interest or for the protection of important interests of the patient, health care provider, or other persons; or

3. disclosure is necessary in order to permit the authority to carry out its inspection and control functions.

(3) The health care provider in possession of confidential data shall determine to what extent their disclosure is justified under subsection 2.

(4) If data are disclosed, in accordance with point 2 of subsection 2, the person to whom the data relate shall be informed of their disclosure as soon as possible and of the reasons for such action.

27. (1) The consent referred to in subsection 1 of Section 26 shall be given in writing. Exceptions may be made to the requirement for written consent if indicated by the nature of the file or the circumstances involved. Consent shall be recorded in the patient's file.

(2) The consent referred to in subsection 1 shall cease to be valid at the latest one year after the date on which it was given.

(3) [Competence of the Minister of Health]

Disclosure to next-of-kin of data relating to the health of deceased patients

28. (1) A health care provider may disclose data to the next-of-kin of a deceased patient concerning the development of the latter's disease and the causes and manner of his death, provided that this is not perceived as running counter to the deceased's wishes and that the respect due to him or other private interests do not strongly suggest that this is inappropriate. Data may also be disclosed to the deceased's next-of-kin in accordance with item 2 of subsection 2 of Section 26.

(2) The general practitioner treating the deceased or the physician responsible for the deceased's treatment may obtain from a hospital or a health care provider the same data as those referred to in point 1 of subsection 1, provided that the deceased's next-of-kin have expressed the wish to receive such data from the physician concerned.

Disclosure of/wa/tb-related data for special purposes (research, statistics; etc.)

29. (1) Data concerning the state of health of private persons, as well as strictly private or confidential information recorded in patients' files, etc., may be disclosed to a researcher for use as part of a concrete biomedical research project, provided that the project has been authorized in pursuance of the Law [No. 503 of 24 June 1992 on the scientific ethics committee system and the examination of biomedical research projects [as promulgated by Order No. 221 of 4 March 1997 (see ibid., 1997, 48, 354, Den- 97.19].

(2) If the Law on the scientific ethics committee system, etc. is not applicable to a research project, the data referred to in subsection 1 may be disclosed to a researcher for use as part of a concrete research project of substantial interest for the community, after approval has been given by the National Board of Health, which shall be responsible for determining the conditions governing such disclosure.

(3) ....

30. (1) The data referred to in Section 29 may be disclosed for statistical use or planning after approval has been given by the National Board of Health, which shall be responsible for determining the conditions governing the use of such data, etc,, in accordance with subsection 2.

(2) The data referred to in subsection 1 may be disclosed without the approval of the National Board of Health if the disclosure of such data is mandatory under the law.

31. (1) Data collected under Sections 29 and 30 for use in research, statistics, or planning shall not be subsequently used for purposes other than scientific or statistical ones.

(2) The data referred to in subsection 1 may only be published in a form that guarantees the anonymity of the persons concerned.

(3) [Competence of the Minister of Health]

Disclosure to third countries

32. [Competence of the Minister of Health]

VI.2. DOCUMENTOS

Euthanasia - legalizing killing on request? The Danish Council of Ethics' 2003 report. Chapter 2 outlines the Council's arguments leading to this advise.

«Patient Rights in the EU - Denmark»
(H. NYS, et al.,).- European Ethical-Legal Papers N°2, Leuven, 2007.

• Euthanasia – Legalizing Killing on Request»

El Danish Council of Ethics ha elaborado un dossier sobre el aspecto ético, dudas y problemas que supone abordar el tema del «fin de la vida». El dossier comprende tres informes titulados: «Spiritual Care for the Dying», «Treating the Dying – The Difficult Decisions», and «Euthanasia – Legalizing Killing on Request», estos informes han sido publicados sucesivamente en los años 2002 y 2003. A continuación, debido a la extensión del documento, solo recogemos el sumario del último informe «Euthanasia – Legalizing Killing on Request», publicado en septiembre de 2003, cuya última versión de diciembre de 2005 se puede consultar en:

(http://www.etiskraad.dk/graphics/03_udgivelser/engelske_publikationer/euthanasia/Eutanasi03_engelsk_/euthanasia/ren.htm

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• «Patient Rights in the EU - Denmark»

(H. NYS, et al.,).- European Ethical-Legal Papers N°2, Leuven, 2007.

Documento elaborado por «Centre for Biomedical Ethics and Law of the Catholic University of Leuven» Organismo europeo, pionero en la investigación sobre bioética, que promociona, participa y coordina diferentes proyectos europeos de investigación.

Este documento describe la legislación sobre los derechos de los pacientes en Dinamarca desde la perspectiva la «European Convention on Human Rights and Biomedicina» (Oviedo, España, 4 de abril de 1997).

Dada la extensión del documento solo vamos a incluir el índice, la introducción y las conclusiones. El texto completo del documento puede consultarse en:

http://en.eurogentest.org/files/public/unit4/full_text_Denmark.pdf

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I. INTRODUCTION

EuroGentest is a five-year EU funded program that aims to develop the necessary infrastructure, tools, resources, guidelines and procedures that will lead to the establishment of harmonized, qualitative genetic testing services in Europe. Within EuroGentest we are dealing with the ethical and legal issues of genetic testing.

Harmonization of the technical aspects of genetic services in Europe requires a legal and ethical framework that respects cultural, religious, philosophical and other domestic characteristics of a given country and its population(s), but at the same time conforms to basic and universally accepted human rights. To continuously supervise the legal and ethical developments regarding the promotion and protection of the rights of patients and users of health services and to make the results of our research publicly available is a permanent challenge. This publication in the European Ethical-Legal Papers aims to contribute to it.

Opened for signature almost 10 years ago (in Oviedo, Spain, on 4 April 1997) the European Convention on Human Rights and Biomedicine is now of growing importance as a standard to evaluate the efforts and the progress made by the Member States of the European Union to promote and protect the rights of pa-

tients and users of health services. In this second issue we present the results of this evaluation for Denmark, one of the EU Member States that have ratified the Convention.

The content of this publication is as follows.

In an introductory chapter we describe briefly the Kingdom of Denmark according to some of its main features related to its political and economic background and its health care system. This is followed by an encompassing overview of the rights of patients in Denmark. In a first paragraph the legal status of the Biomedicine Convention is situated against the background of Danish constitutional law. Then we turn to a description of the national legislation on patient rights. There exists many different enumeration of patient rights. Because we are particularly interested in the way the Biomedicine Convention has been received in the Members States of the European Union we follow the structure of the Convention. The right to informed consent (articles 5, 6, 8 and 9 of the Convention) comes first, followed by different aspects of the right to private life and the right to information (article 10 of the Convention) such as: patient rights regarding the medical file; the right to medical secrecy/confidentiality and the right to privacy and protection of private life. This part of the analysis ends with the right to complain in case of unlawful infringement of a patient right (article 23 of the Convention) and the right to compensation for undue damage (article 24 of the Convention). In the next chapter we look at the rights of patients as users of genetic services: are the rights of patients complemented by more specific rights for users of genetic services? (articles 11 and 12 of the Convention). With some concluding remarks we finish this paper N° 2 of the Ethical-Legal Papers. Without the help of Mette Hartlev (Associate Professor of Health Law and Biolaw in the Faculty of Law, University of Copenhagen), we could not have accomplished this work. She furnished us valuable information on the status of patient rights in Denmark and answered our repeated questions accurately and patiently. In the footnotes we refer to the information provided by her as «personal communication of M. Hartlev». The possible mistakes and wrong interpretations are our responsibility. We are also aware of the limitations of this endeavor not the least because of differences in languages. Nevertheless we hope that this publication will stimulate the discussion on the promotion and protection of patient rights in Denmark. Therefore we welcome all reactions on www.cbmer.be .

Leuven, 20 January 2007

The research for this publication was supported by the Eurogentest

Network of Excellence of the EU, FP6 – 512148 and its coordinator

Prof.Dr. J.J. CASSIMAN

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V. CONCLUDING REMARKS

1. Denmark has signed and ratified the Biomedicine Convention which entered into force on 1 December 1999. Denmark has expressed a reservation in respect of article 10 §2 of the Convention concerning the right to know any information collected about his or her health.

2. The manner in which Denmark has formalized patient rights is in common with other Scandinavian countries. A number of initiatives have been introduced to strengthen the rights of patients in the Danish health care system and this process started already years before the ratification of the Biomedicine Convention. In 2005 the Danish Parliament adopted the Health Act - Law No. 546 of 24 June 2005 – putting together different acts related to patient rights, especially Law No. 482 of 1 July 1998 on patient rights and a number of other acts which contain patient rights provisions (e.g. the Act on Abortion, the Act on Assisted Reproduction, the Act on Transplantation).

This new act on patient rights has come into force on 1 January 2007.

3. Danish law contains elaborated rules with regard to the protection of the right of patients to give or refuse informed consent either actually or through previously expressed wishes. Regarding the latter however, Danish law is not completely in accordance with article 9 of the Convention as there are only rules regarding previously expressed wishes in specific circumstances.

4. In Denmark minor patients who have attained the age of 15 are – as a general rule – considered to be capable to provide informed consent. Parents must however be informed and be included in the decision-making process. If a minor of 15 years or older is unable to provide informed consent his parents are competent to do so. Under the age of 15 years parents must always consent to a medical intervention.

5. With regard to incompetent adult patients Danish law distinguishes between permanently incompetent patients and temporarily incompetent patients. When a patient is permanently unable to provide informed consent the closest relative or when the patient is under guardianship, the guardian can provide informed consent. For persons who are temporarily incompetent Danish Law does not permit informed consent by the closest relative. Apart from the situation where a guardian is appointed who is allowed to take decisions in health matters as well, the law does not regulate who may give informed consent during the period that someone is temporarily incompetent.

6. Danish law does not regulate the right to information about his or health as a separate right. The right to receive information regarding one's state of health is mentioned in the Health Act 2005 as part of the right to informed consent. The right not to know has to be respected. A peculiarity of Danish law is that the therapeutic exception is illegal since 1998 although it is possible to refuse a patient access to his health record if this is considered to be harmful to the patient.

7. Another interesting feature of Danish law relates to access to the medical file of an (permanently) incompetent patient. If a guardian has been appointed, he has the right to access the medical file of the patient. The closest relatives of an incompetent patient are only competent to provide consent to treatment. In other matters – like access to the medical file – the closest relatives cannot make a decision on behalf of the patient. Minor patients who are 15 years or older are entitled to have access to their medical file autonomously.

8. With regard to the right to medical secrecy and confidentiality, Danish law is particularly elaborated regarding the transmission of medical information to colleagues, other health care workers and social services. As a general rule, consent of the patient is required. However, under certain conditions forwarding confidential medical information is allowed without the consent of the patient.

9. Although not comprehensively regulated in the Danish Constitution the right to privacy is protected in the Criminal Code which demonstrates the importance attached to privacy protection in Danish law. The Act on Processing of Personal Data prohibits the processing of personal data concerning health except for the circumstances and purposes mentioned.

10. The right to complain (to the Patient Offices, the Patient Complaints Board and the Parliamentary Ombudsman) and the right to compensation (by the Patient Insurance Scheme) are among the strongest protected patient rights in Danish law.

11. In Denmark genetic testing is mainly regulated through the legal framework that applies to the Danish national health

care system as a whole. The Health Act 2005 and its provisions on the rights of patients are mutatis mutandis applicable to users of genetic services.

12. In connection with insurance and employment there are special rules regarding the use of genetic information. Section 3a of the Act on Insurance Agreements and Pension Funds as amended by the Act of 10 June 1997 prohibits for insurance companies to demand or make use of information regarding a person's genetic predisposition. Accordingly, it is against the law to demand a genetic test or to ask whether a person has had a genetic test. It is furthermore prohibited to make use of the result from a pre-symptomatic genetic test – even in situation where the person voluntarily would like to reveal information (e.g. because the test shows that there is no predisposition). The use of health information in employment relations is regulated by Act No. 286 of 24 April 1996 on the Use of Health Information in Employment Relations.

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VI.3. DIRECCIONES WEB

Ministerio de Asuntos Exteriores de Dinamarca
http://www.denmark.dk

«Retsinformation» Información legislativa on-line
http://www.retsinfo.dk

Ministerio danés de Sanidad y Prevención
www.sum.dk

The Danish Council of Ethics
http://www.etiskraad.dk/sw293.asp

Legislation Denmark
http://www.lexadin.nl/wlg/legis/nofr/eur/lxweden.htm

EuroGentest
http://www.eurogentest.org/web/index.xhtml

Danish Medicines Agency
http://www.dkma.dk/1024/visUKLSForside.asp?artikelID=728