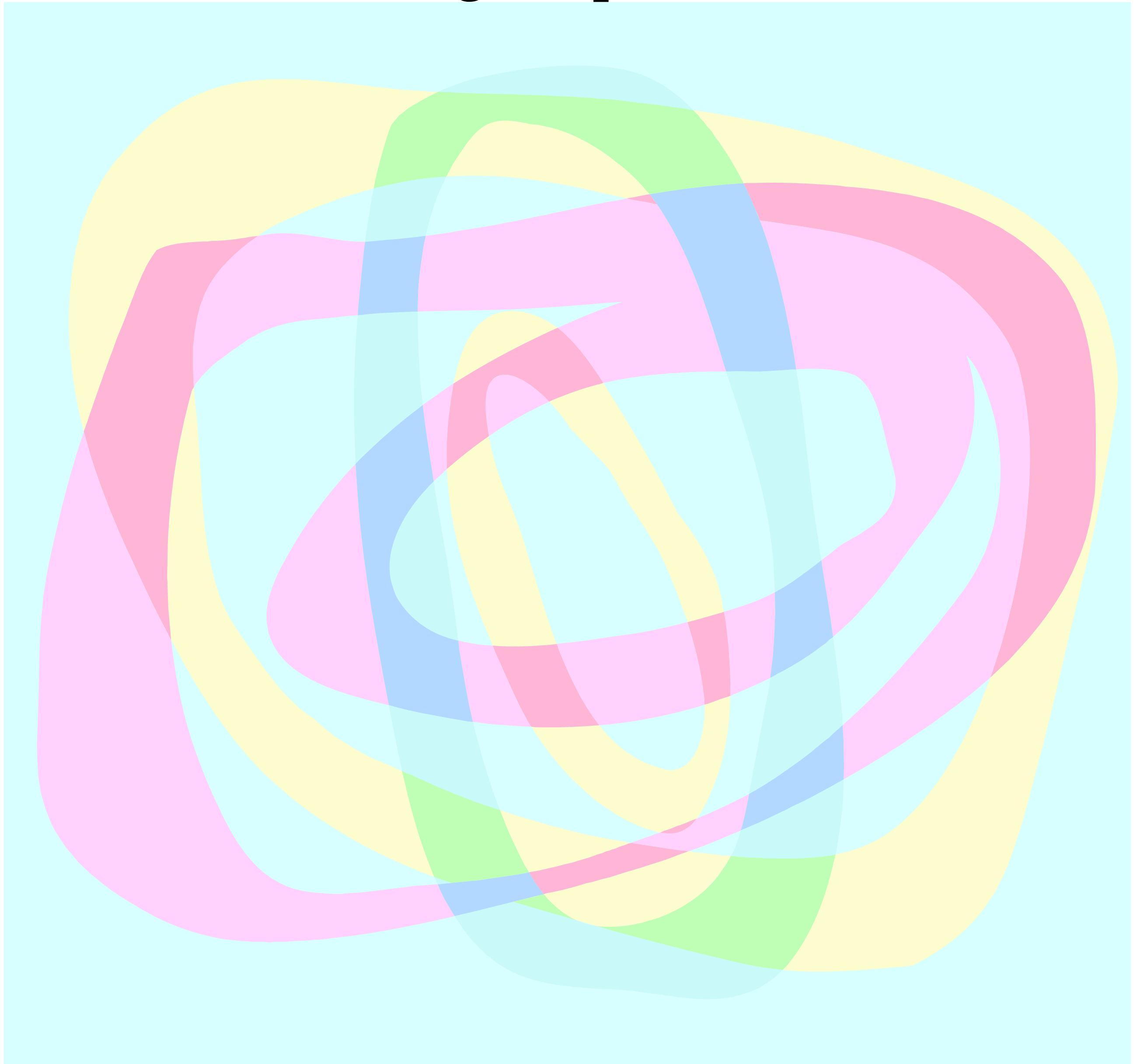
Staff Guidelines in Relation to Obtaining Consent for Children and Young People



The Children's University Hospital
Our Lady's Children's Hospital
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Consent Guidelines

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Table of Contents

PAGE

Purpose…………………………………………… 4
Policy……………………………………………. 4
Definitions……………………………………….. 4

Section 1

1.1 Introduction ………………………………………. 6
1.2 Common Law …………………………………… 6
1.3 Informed Consent………………………………… 7
1.4 Who can Give Consent…………………………… 7
1.5 Capacity of Person Consenting…………………… 7
1.6 What Parents Should be Told……………………….. 8
1.7 Elective and Non-Elective Procedure………………. 8
1.8 Timing of Consent………………………………… 8

Section 2

2.1 Parental Refusal to Consent………………………… 9
2.2 Development of the Child and Concept of Assent…. 10

Section 3

3.1 The legal Consent Process………………………… 11
3.2 Foster Children………………………………….. 12
3.3 Children of Legally Separated Parents…………….. 12
3.4 Unmarried Parents……………………………….. 12
3.5 The Minor Parent………………………………… 13
3.6 Unaccompanied Children………………………… 14
3.7 Children in Voluntary Care………………………. 14
3.8 Emergency Care Order or Interim Care Order………… 15
3.9 Care Order………………………………………… 15

Section 4

4.1 Enhancing Communication ……………………………… 16
4.2 Hearing and Visually Impaired Patients…………………. 17

References ………………………………………………… 18
Committee Membership……………………………………….. 19

Purpose

The purpose of these guidelines is to provide information and guidance to all relevant health care professionals on the legal requirements for obtaining valid patient consent. Further legal developments may occur after these guidelines have been issued, and health care professionals must remember to keep themselves informed on any of these that may have a bearing on their practice. These guidelines will be reviewed on a three yearly basis or as new legislation/government guidelines are implemented.

Philosophy

It is the philosophy of the Hospital to empower parents/ guardians/patients to make decisions about their care on the basis of sufficient information. The Legal principle is based on the high court judgement Geoghegan v Harris 2002 and the standard is 'information that a reasonable patient might expect' which is provided in a way that they can understand.

Definitions

Valid Consent: For consent to be valid the parent/guardian/patient must have capacity. Consent must be voluntarily given without duress and must be given with information regarding potential risks and benefits.

The parent/guardian/patient must also:

- Understand the procedure*
- Understand the nature and purpose of the procedure
- Understand the risks, benefits and alternatives of the procedure
- Have the ability to retain the information to make an informed choice

***Procedure: The word "procedure" is used here to include investigation, treatment or operation.**

Legal Guardian: "A person having the right and duty of protecting the person, property or rights of another who has not full legal capacity or otherwise incapable of managing his own affairs eg the parent of a minor" (Murdoch's Dictionary of Irish Law). A legal guardian is a guardian recognised in law.

Doctrine of necessity: This is a common law doctrine developed through case law. It applies to an emergency situation where a doctor treats a patient, in the absence of

consent, in the best interests of the patient, where the treatment is necessary to save the life or preserve the health of the patient.

General Guidelines

Section 1

1.1 Introduction

Consent is a parent's/ guardian's/patient's agreement for a health care professional to provide care. Parents/guardians have a right to decide what is in the best interest of their child and healthcare professionals therefore have a corresponding legal obligation to provide sufficient information to ensure that such decisions are taken on an informed basis. Parents/guardians/patients should be given sufficient information in a way they can understand, about the proposed treatment and the possible alternatives. Equally it is important to remember that as a healthcare professional taking consent has an obligation not to delegate responsibility for securing consent to someone you know or suspect to be under qualified for the task.

Information should be given, and consent obtained, by a health care professional that is competent and able to respond to and answer any questions the parent/guardian/patient may have, and give appropriate explanations regarding the procedure. Consent should be secured by someone who is suitably qualified and experienced that understands the proposed treatment and risks involved. Consent may be observed verbally, in writing or implied.

It is important to appreciate that securing informed consent is a process - not an administrative task. The signature on the consent form is evidence that the parent/guardian /patient has given consent, but is not a binding contract and is not proof of valid consent. The consent form exists to demonstrate that a process of communication has taken place during which the parents/guardian/patient has learned about their/their child's illness and treatment options and reached a point where they can decide, on an informed basis to proceed with, restrict, or decline the proposed intervention.

1.2 Common Law

It is a basic rule of common law that consent must be obtained for medical examination, treatment or investigation. The Irish Constitution reaffirms this rule, as does international law. Therefore, any exceptions to the rule would be subjected to intense

judicial scrutiny since the purpose of the rule is to uphold one of the most basic of all rights i.e. the right to bodily integrity.

1.3 Informed Consent

Consent is "informed" when the parent/guardian/patient understands, as far as possible, the nature and purpose of the procedure, including:

- uncertainties about diagnoses;
- options for investigations prior to the procedure;
- material or significant risks involved;
- common or serious side-effects;
- expected outcome, including benefits and limitations of activities;
- alternatives to the procedure;
- consequences of not having the procedure;
- who the procedure will be carried out by; the patient's consultant or a member of his/her team;

1.4 Who can Give Consent

Only parents who are guardians and guardians can give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children. Where parents are unmarried only the mother is automatically the legal guardian of their child. The Health Service Executive can give consent in relation to a child who is the subject of a care order.

1.5 Capacity of Person Consenting

To demonstrate capacity individuals should be able to:

- understand in simple language what the medical procedure is;
- the purpose and nature of the procedure and why it is being proposed;
- understand the principal benefits, risks and alternatives of the procedure;
- understand in broad terms what will be the consequences of not receiving the proposed treatment
- retain the information for long enough to make an effective decision.

(British Medical Association) (Currently being reviewed by the Irish Law Reform Commission)

1.6 What Parents/Guardians/Patients Should Be Told

Before being asked for their consent to any procedure the parent/guardian/patient should be given information to enable them to make an informed choice including:

- be given the name of the doctor who will have overall responsibility for the patient and have explained, where appropriate, that no guarantee about who will carry out the procedure can be given;
- be reminded that they can withdraw consent at any time and that they always have the right to a second opinion.
- risks associated with the procedure

1.7 Elective And Non-Elective Procedure

In any proposed procedure, appropriate information must be given to the parent/guardian/patient to enable him/her to consent to or refuse consent to that treatment. However, you should be aware of the distinction, which the Courts have made in recent years between elective and non-elective surgery. This is because, in general, the necessity for elective surgical treatment, and the risks of not having surgery, is less obvious than in an emergency case, and the decision for the parents will be more difficult. So in the case of elective surgery the duty to disclose information to the parent/guardian/patient is therefore much more onerous, particularly where there may be serious or material risks associated with the proposed procedure.

1.8 Timing of Consent

There is no legal guidance on the length of time that consent is valid for. However, it is considered best practice if there is a change in the patient's condition between the consultation and admission resulting in a significant change in the nature, purpose or risks associated with the procedure consent must be obtained again.

On admission to hospital for an elective procedure, the attending doctor or designate must once again interview and inform the parent/patient of possible risks associated with the procedure.

Section 2

2.1 Parental Refusal To Consent To Treatment Of A Child

Where parental consent is being withheld in circumstances where the doctors are of the opinion that the procedure is necessary to preserve the health and safety of the child, then immediate steps should be taken by the hospital to notify the Health Service Executive area in which the child lives. In such cases it is particularly important to accurately record the discussions with the parents/guardian/patient, including the treatment that has been offered, the parents' decision to decline and the fact that the implications of this decision have been fully outlined.

An application for a Child Care Order may then be made by the Health Service Executive before a Judge. The Order may be temporary and limited specifically to the period required to undertake the procedure. A District Court Judge may make the Order at any time, day or night. It should be remembered that parents do have the legal right to consent/refuse consent on behalf of their child and the courts will only override such a decision if the parent's/guardian's decision is regarded as unreasonable. In highly stressful times, parents will understandably be emotional and if parents are not calmly and properly informed of the treatment, they may decide not to give their consent. Thus, the first step is, if possible and if time allows, attempting to secure the consent from the parents.

Where a parent/guardian/patient refuses the procedure but requests an alternative, the treating healthcare professional must determine whether this alternative is in the patient's best interests. Where it is considered not to be so, the alternative procedure should not be offered. In such circumstances it is strongly advised to obtain the opinion of a suitably qualified colleague and to carefully document their views/input and the decision taken. It may also be appropriate to facilitate referral of the patient to another healthcare professional for a second opinion. Children may protest and clearly indicate that they do not want the procedure. This is often motivated by fear and anxiety. It is important to listen to and acknowledge the child's concerns. It may be possible to change the treatment or delay the procedure, which may be more acceptable to the child. Sometimes giving some choice allows the child to feel more in control. The child's welfare is paramount.

2.2 Development of the Child and the Concept of Assent

The term 'assent' implies agreement, especially as a result of deliberation

Decision-making involving the health care of children and adolescents should include, to the greatest extent feasible, the **assent of the patient** as well as the participation of the parents and the healthcare professional. Serious consideration must be given to each patient's developing capacity for participating in decision-making. **Assent** should include the following elements:

1. Helping the patient achieve developmentally appropriate awareness of the nature of his/her condition
2. Informing the patient what he/she can expect with tests and treatments.
3. Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he/she is responding.
4. Soliciting an expression of the patient's willingness to accept the proposed care.

American Academy of Paediatrics 1995

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Section 3

3.1 The Legal Consent Process

The doctrine of consent operates to best reflect the self-autonomy of the patient. It is increasingly, in many jurisdictions, regarded now as a fundamental human right. In Ireland, this fact is well established. In most judicial considerations the *welfare* of the child is paramount. (Child Care Act 1991) The Supreme Court has stated that:

The requirement of consent to medical treatment is an aspect of a person's right to bodily integrity under Article 40, s. 3 of the Constitution (In re a Ward of Court [1996] 2 IR 79 at 156, Denham J).

The Supreme Court in the same case has made it clear that:

If medical treatment is given without consent it may trespass against the person in civil law, a battery in criminal law and a breach of the individual's constitutional rights (ibid).

Anyone over 18 years of age is legally an adult. Anyone less than 18 years old is a minor / child. Minors between their 16th and 18th birthdays may give their own consent to medical, dental and surgical procedures (see Non-Fatal Offences Against the Persons Act 1997[1]). This includes consent to an anaesthetic, which is ancillary to the procedure and also includes any procedure undertaken for the purpose of diagnosis. The minor must have the mental and intellectual capacity to understand the proposed procedure. However, there may be circumstances where it is in the best interest of the minor, or where there is a doubt on the part of the doctor as to the mental competency of the patient to give consent, to also obtain the consent of the minor's parent or guardian. Ultimately, this is a decision for the doctor to make.

It is important that both the child and the family are involved in every step of the consent process in order to make a rational and co-operative decision. Ideally, the person with parental responsibility should also give consent, and must always do so if the child does not have sufficient understanding or intelligence to comprehend the complexity of the proposed procedure.

[1] *"The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parents or guardian".*

3.2 Foster Children

In an emergency situation, the doctor is entitled to intervene on his own authority, without the consent of a person *in loco parentis*. In considering whether the child's welfare demands that the procedure be undertaken urgently, the child's rights to prompt medical intervention and, more generally, to have his or her welfare considered is paramount. If a child is in the voluntary care of the HSE, in foster or residential care, consent has to be sought for treatment from the birth parent. If a child is the subject of a care order and is in foster or residential care, the HSE can give consent although it is good practice for the HSE to also get the parent's informed consent. (Ref: Guidelines for Foster Parents & Consent Circular 1999)

In accordance with *Section 4 43A of the Child Care (Amendment) Act 2007* a foster carer or relative can make an application to the court and be granted an Order giving them control over the child as if they were the child's parent provided that they have been in their care for five years or more. The Act states that 'any consent given by a foster parent or relative of the child in accordance with an order shall be sufficient authority for carrying out of a medical or psychiatric examination or assessment'.

3.3 Children Of Legally Separated Parents

If the parents of a child are legally separated, either parent can consent to medical treatment. However, if the Court, in dealing with the legal separation conferred sole custody on one parent, a condition or direction would normally attach with regard to medical treatment for the child. For instance, if the child required medical treatment while on an access visit to the other parent, the parent who had sole custody should be contacted. If the parents disagree on treatment, more time will be needed for explanations and discussion.

3.4 Unmarried Parents

In the case of unmarried parents, it is the mother who is entitled to give consent to treatment, as the mother is usually the sole legal guardian. The law, however, provides that where an unmarried father and an unmarried mother have jointly completed a Statutory Declaration pursuant to the Guardianship of Infants Act, 1964 as amended by the Children Act, 1997, there may be joint guardianship and both, in such circumstances, are eligible to give consent. Furthermore, where an unmarried father has, pursuant to an order of the Court, been granted guardianship rights in relation to his child under the Guardianship of Infants Act, 1964 as amended by the Status of Children

Act 1987 and the Children Act, 1997 then he would be entitled to give consent to medical treatment of his child.

3.5 The Minor Parent

Situations may occur where a child may require medical treatment where the parent him/herself is a minor (thus, e.g. a mother who is 15 years of age with her child who requires a medical procedure). When such situation arises then:

- If the child of the parent requires emergency treatment—the formality of the consent process is dispensed with and the doctor must treat the child, as per the Doctrine of Necessity.
- If the child of the parent requires a therapeutic procedure (but not emergency), then where the parent is a minor him/herself, obtaining such consent presents a difficulty since it is uncertain whether or not a minor parent can consent to treatment for their child since minors are deemed to be legally incompetent to give consent.

In general, a minor under the age of 16 does not have the legal capacity to consent to medical treatment on their own behalf and therefore cannot give consent on behalf of anyone else including their own child. Some leeway is given in relation to the minor unmarried mother of a child, because in law, the unmarried mother of a child is the sole legal guardian. The unmarried minor mother's wishes, providing she is competent to understand the proposed treatment, are taken into account.

This situation has not been examined by the courts. In light of the legal uncertainty, it would be prudent practice to attempt to:

a) Obtain the consent of an appropriate next of kin who is competent to consent and which consent is in the best interests of the child

b) Include all parties in the consent process (including the minor parent)

c) Ensure that if the next of kin does give consent that their signature and name is recorded on the consent form and

d) Ensure that such situations are recorded in detail in the patient's medical record/notes

e) In case of doubt/ uncertainty, it is recommended that healthcare providers seek further legal advice.

This advice is similar to that in the UK where other recent guidelines entitled **Seeking Consent: Working with Children** (Department of Health UK, 2001) state:

> “Sometimes, the person with parental responsibility may be available, but is not competent to give or withhold consent: for example if the person with parental responsibility is under the influence of drugs, or the mother of a child is herself under 16 and is not competent to make that particular decision…In such cases, if there is no-one else with parental responsibility available and the treatment cannot wait, it will be lawful to provide it on the basis that it is in the child’s best interests.”

In relation to the minor father (under 16 years), he would be assumed not to have any legal capacity to consent on his own behalf or on behalf of his child on the grounds of age alone. Further, where he is not married to the mother, he would not have any rights to consent to treatment on the child’s behalf, as the minor mother would be the sole legal guardian of the child. If he is married to the mother, then he would have the same rights as the mother, insofar as she has any rights.

3.6 Unaccompanied Children

Children who arrive at the hospital without parents should not be examined except in an emergency. The parents should be contacted and asked to come to the hospital. In an emergency, the child should be examined and treated if delay would put the child in further danger. This should be recorded in writing, and there should always be a nurse present during the examination.

A child may arrive with a teacher or group leader who is *“in loco parentis” (in the place of a parent).* This means that the adult has been given the legal right to give consent for emergency medical treatment. The adult should have a document, signed by a parent, to this effect. Even so, an attempt should be made to get in touch with the parents directly. An interpreter may be necessary.

3.7 Children In Voluntary Care

When a child is in voluntary care the parent remains the legal guardian and responsible for giving medical consent. The Health Service Executive should seek the consent of the child’s natural parents. If the parents are unavailable then the health board would seek consent of the legal guardian of the child, if any. Failing that, the HSE would usually apply to court to have a Care Order made which can include rights to consent to treatment on behalf of the child. In emergency situations, the hospital should act in the best interests of the child.

In relation to children who are 16 years old and over, the provisions of Section 23 of the Non Fatal Offences Against the Person Act, 1997 should be borne in mind.

3.8 Emergency Care Order Or Interim Care Order

In relation to children who are under 16 years of age, the HSE can seek directions under Section 13 (7) or Section 17(4) of the Child Care Act 1991, as appropriate. If a child is 16 years or over, Section 23 of the Non Fatal Offences Against the Person Act, 1997 will apply. If there is any doubt about the competency of the child to consent, directions should be sought from the court.

3.9 Care Order

In relation to children under the age of 16 in respect of whom a care order has been made, the HSE can consent to elective treatment if it is in the best interests of the child. It may be prudent however, to consult the child's natural parents and in appropriate circumstances seek directions from the court in the matter.

Section 4

4.1 Enhancing Communication

It should never be assumed that a person does not have the capacity to give or withhold consent. Difficulty communicating should not be confused with inability to make informed decisions. Every effort should be made to facilitate communication with parents/guardians/patients. Unless the need for treatment is so urgent as to render it impossible it may be appropriate to use others in the communication process, such as colleagues with expertise in learning disabilities or speech and language.

Where necessary or appropriate, consideration should also be given to the use of communication aides and other forms of non-verbal communication. Whenever a third party is assisting with parent/guardian/patient communication it is important that they understand their role as that of translating the parent's/guardian's/patient's wishes only and not attempting to themselves decide what might be best for the patient.

This applies equally to circumstances where - due to a language barrier – a professional interpreter (a child should not translate for a parent) is assisting in the communication process. Whenever possible, information (both verbal and written), should be available to parents/guardians/patients in their first language. Refer to the hospital list of interpreter services. Such interpreters must adhere to a strict code of ethics and confidentiality.
Where the proposed procedure could safely be deferred and where communication might be easier in the future (e.g. when a particular communication aide becomes available or an interpreter can be accessed) the procedure should be postponed.

In all circumstances where communication is not possible, healthcare professionals must act in the best interests of the patient. In such situations it should be remembered that "best interests" might not be limited to medical considerations only. Other issues such as the patient's general well-being, wishes/views previously expressed (if known) and religious convictions might also be taken into account.

Where a decision is being taken about treatment in the absence of consent due to an inability to communicate with the parent, it is important to remember that nobody else can give or withhold consent. The decision about treatment in these circumstances

ultimately rests with the treating clinician. However, relatives should be included to the greatest extent possible in the decision making process and ideally decisions will reflect a consensus between the doctor and those closest to the patient. A relative can only consent if they are the legal guardian.

Where treatment is being given in the absence of consent due to inability to communicate, it is most important to carefully record the attempts that have been made to communicate, the decision making process undertaken (including discussion with relatives and consultation with other healthcare professionals) and the reasons for proceeding. Consultation with colleagues in these circumstances is highly advisable and their views/input should also be recorded. Any disagreement among healthcare professionals should also be documented.

4.2 Hearing and Visually Impaired Patients

Parents/guardians/patients who suffer from either poor vision or poor hearing should be provided with appropriate communication support in every consultation and at every stage of the treatment process. In the case of parents/guardians/children who are visually impaired, additional information may be provided on audiotape.

This may take the form of a tape recorder to secure consent. This recording must accompany an additional consent form, which must be signed by the attending physician and a witness who may be a member of healthcare team involved in the delivery of the patients care. Information regarding the proposed procedure must be given in audio form in order for the parent/guardian/patient to make a rational decision. The recording of the consent must be stored in a secure setting to protect patient confidentiality. Documentation of all communications between physician and parent/guardian/patient must be entered into the medical record.

If at all in doubt you should seek advice from the Clinical Indemnity Scheme Medical Legal help line at 01 664 0909 (Monday-Friday 9am- 5pm).

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