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DUBLIN HOSPITALS GROUP RISK MANAGEMENT FORUM



THE ADELAIDE & MEATH HOSPITAL, DUBLIN INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL TALLAGHT, DUBLIN 24

# Guidelines in Relation to Obtaining Patient Consent



BEAUMONT HOSPITAL Beaumont Road Dublin 9



St. Francis Hospice



Revised Edition May 2007



SAINT LUKE'S HOSPITAL



Our Lady's Hospice



The National Maternity Hospital



Founded 1908



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## INTRODUCTION

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The issue of consent in the context of medical care is highly complex and has been described as a "legal and practical minefield". Patients have an absolute right to decide what happens to them and healthcare professionals therefore have a corresponding legal obligation to provide sufficient information to ensure that such decisions are taken on an informed basis. Failure to discharge this obligation can result in civil actions and, in extreme cases, criminal proceedings for assault.

It is important to appreciate that securing informed consent is a process - not an administrative task. Merely "getting a consent form signed" is not what it is all about. The consent form is simply documentary evidence that consent was obtained. It is the reality of consent that is crucial. A consent form signed without a process of communication during which the patient has learned about his/her 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 has little, or no, value.

Recent years have seen dramatic changes not only in the law on consent, which continues to evolve, but also in peoples' ability to gather and process information. Higher standards of education, improved economic conditions, e-mail and particularly the Internet mean that many patients are now very capable of making choices about their treatment. It is no longer appropriate for healthcare professionals to take a wholly paternalistic approach to the issue of patient consent.

The Law Reform Commission, in their consultation paper on Vulnerable Adults and The Law: Capacity, recommends the introduction of capacity legislation. The Commission further suggests the capacity legislation should give the Minister for Health the power to appoint a Working Group on Capacity to Make Healthcare Decisions which would formulate a code of practice for healthcare professionals. The Madden Report<sup>1</sup>, following the Organ Retention Inquiry, has also been published which recommends the introduction of legislation with regard to obtaining consent for post-mortem examinations.

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<sup>1</sup> Report of Dr. Deirdre Madden on Post Mortem Practice and Procedures; December 2006

Until these recommendations are implemented and there are nationally agreed practice guidelines, and against a backdrop of increased public awareness, it is essential that all healthcare professionals involved in securing patient consent examine their own practices. It is hoped that the information provided here will assist healthcare professionals to understand more fully the issues relating to consent and thereby improve practices generally.

## SECTION ONE: *THE LEGAL CONSENT PROCESS*

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The doctrine of consent operates to best reflect the self-autonomy of the patient. It is increasingly, in many jurisdictions, now regarded as a fundamental human right. In Ireland, this fact is well established. 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 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*).

Thus, before undertaking medical treatment of any sort whatsoever, a healthcare professional must obtain the consent of the patient.

**PATIENTS HAVE A FUNDAMENTAL LEGAL AND ETHICAL RIGHT TO DETERMINE WHAT HAPPENS TO THEIR OWN BODIES. VALID CONSENT TO TREATMENT IS THEREFORE ABSOLUTELY CENTRAL IN ALL FORMS OF HEALTHCARE, FROM PROVIDING PERSONAL CARE TO UNDERTAKING MAJOR SURGERY. SEEKING CONSENT IS ALSO A MATTER OF COMMON COURTESY BETWEEN HEALTH PROFESSIONALS AND PATIENTS.**

Good Practice in Consent Implementation Guide:  
Consent to Examination or Treatment (*Department of Health, UK, 2001*)

### **1.1 COMMON LAW**

It is a basic rule at common law that consent must be obtained for medical examination, treatment or investigation. This is well established by virtue of the Irish Constitution, Irish law and in 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.

## **1.2 VALID CONSENT**

A valid consent is one that is made by a person (a) with capacity (b) is voluntarily given, without any element of duress and (c) with the requisite information, in a form and language they can understand, of why they need the treatment, the risks, side-effects and alternatives, so that the patient is in a position to make an informed decision as to whether or not to proceed with treatment.

## **1.3 CAPACITY**

In the context of medical care, an adult is presumed to have the capacity to give or withhold consent unless the contrary is established. However, a person may temporarily lack capacity, or have fluctuating capacity, because of unconsciousness, the effect of drugs, shock, severe fatigue or some impairment or disturbance of mental functioning.

It is therefore necessary to be satisfied the patient has the capacity to make healthcare decisions each time consent is obtained.

Whilst there is no universally agreed method for assessing capacity to consent, assistance in deciding what criteria to use can be obtained from The Law Reform Commission's Consultation Paper on Vulnerable Adults And The Law: Capacity. The Commission recommends the introduction of a code of practice for healthcare professionals, which would contain guidelines on the assessment of capacity to make healthcare decisions. The Commission further advises that:

‘ Such guidelines should take account of factors such as whether the adult, after a discussion in relation to the healthcare decision which is pitched at a level appropriate to the adult's individual level of cognitive functioning,

- Understands in broad terms the reasons for and nature of the healthcare decision to be made;
- Has sufficient understanding of the principle benefits and risks involved in the treatment option being presented and relevant alternative options after these have been explained to them in a manner and in a language appropriate to their individual level of cognitive functioning;
- Understands the personal relevance of the decision;

- Appreciates the advantages and disadvantages in relation to the choices open to them;
- Makes a voluntary choice.’

The above guidelines for assessing capacity are generally in keeping with the guidelines published in other jurisdictions,

When assessing capacity to consent the healthcare professional also needs to be aware that:

- To be regarded as having demonstrated capacity, the patient must be able to communicate their choice by any means where communication to a third party is necessary to implement the decision.
- A patient may have enough understanding to appreciate the implications of a simple procedure and be able to give consent, but the same patient may not be able to understand more complex interventions, and is technically incompetent to consent to those.
- A patient should not be regarded as lacking capacity merely because they do not take their doctor’s advice or make a decision that would ordinarily be regarded as imprudent.

## **1.4 EXPRESS OR IMPLIED**

Consent may be expressed or implied.

Express consent can be given orally or in writing but it is worth repeating that obtaining consent is a process of communication, often spread over a period of time. Giving the patient a consent form and simply asking him/her to sign it, without further consideration or interaction with the patient is neither acceptable practice nor fulfils the steps necessary to obtain a valid consent. A patient is entitled to receive sufficient information in a way that he/she can understand so that he/she can make a balanced judgement.

A question often asked is whether and when consent is required in writing. The UK Department of Health<sup>2</sup> has recently commented on the issue and it is worth taking some of their advice into consideration:

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<sup>2</sup> *Department of Health; Good Practice in Consent Implementation Guide: Consent to Examination or Treatment (November 2001)*

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions that led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

### **Written consent**

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent giving, not a binding contract.

It is rarely a legal requirement to seek written consent, <sup>1</sup> but it is good practice to do so if any of the following circumstances apply:

- The treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- The procedure involves general/regional anaesthesia or sedation
- Providing clinical care is not the primary purpose of the procedure
- There may be significant consequences for the patient's employment, social or personal life

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure were of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

It is important to remember that just because a patient has consulted a healthcare professional does not imply that the healthcare professional has carte blanche to treat the patient and carry out any examination or procedure whatsoever.

Consent should only be implied from the specific behaviour of the patient. For example, the most common quoted situation is that of a patient extending his/her arm to have a blood sample taken. However, this gesture in itself does not eliminate the right of the patient to an explanation prior to taking blood. Neither does it indicate that the patient understands what the healthcare professional proposes to do and why.

Practitioners should be cautious about implied consent. It is acceptable in some situations. In most situations the requisite information should be given to a patient and their express consent ought to be obtained.

Particular care is required if an intimate examination is to be undertaken. Poor communication is often the cause of complaints about intimate examinations and it is neither sufficient, nor good practice, to rely on implied consent in these circumstances. It should be explained to the patient why the examination is necessary and what it will involve. The patient should be allowed to ask questions and their consent to the examination obtained and recorded.

The Medical Council also advises:<sup>3</sup>

‘The patient, irrespective of age or gender, should be offered a chaperone’

If the patient does not wish to have a chaperon present then you should record that the offer was made and declined. If a chaperon is present then this fact, and the chaperon’s identity, should be recorded.

## **1.5 WHAT PATIENTS SHOULD BE TOLD?**

Before being asked for their consent to any treatment, investigation or examination patients should be:

- ◆ Given full details about their condition, diagnosis and prognosis including any doubts that may exist;
- ◆ Told what the treatment is and its potential benefits;
- ◆ Advised of the likely implications of not having the proposed treatment;
- ◆ Informed of any treatment options;
- ◆ Informed of any drug treatments;
- ◆ Fully advised about what to expect and about common and serious side effects;
- ◆ Told about any ancillary treatment/s and risks involved;
- ◆ Told about follow up treatment, if any.

Patients must also be:

- ◆ Told if the treatment is part of a clinical trial or is in any other way experimental;

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<sup>3</sup> *The Medical Council ‘A Guide to Ethical Conduct and Behaviour’, Sixth Edition 2004, paragraph 3.9*

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

Information should be provided in simple language the patient understands. In some cases it may be necessary to provide an interpreter, signers or other means of communication.

The patient's privacy should be considered and protected during the consent process. Discussions about relevant issues with patients in order to obtain consent, should take place where a patient's personal details are not, for example, overheard by others. It is important the patient feels comfortable in the location where such matters are discussed. Considerations such as these are likely to assist in ensuring an open and transparent consent process.

Except in an emergency you should not exceed the scope of the authority given by the patient. You should discuss with the patient the possibility of additional problems becoming apparent during a procedure when they are unable to make a decision, for example when they are under a general anaesthetic. You should seek their consent to treat problems which you think may arise and determine if there are any procedures to which the patient would object, or about which they would prefer to have the opportunity to consider further before you proceed. You should respect and abide by the patients' decisions. If there are exceptional circumstances and you decide to treat a condition that is outside the scope of the patients consent then you must be prepared to explain and justify your decision which may be challenged at a later date. You should also explain to the patient what you have done as soon as the patient has recovered sufficiently to understand.

## **1.6 EXCEPTIONS TO THE RULE**

It is generally acknowledged that there are two exceptions to the common law rule:

- a.  **THERAPEUTIC PRIVILEGE**  – a deliberate and well thought out decision not to disclose information to a patient, such decision being made in the interest of the psychological well being of the patient. The decision and the reason for it should be recorded in the notes.
  
- b.  **EMERGENCY**  - in an emergency life-threatening situation where the patient is unable to consent or to appreciate what is required a healthcare professional, acting in the best interests of the patient, may administer the necessary medical treatment to save the life or preserve the health of the patient without formal consent. However, the treatment given should be only that which is immediately necessary for the patient's well being. If time permits it would be prudent on the part of the healthcare professional to attempt to ascertain any prior wishes in relation to treatment expressed by the patient. If some coincidental and non-urgent problem is encountered during an emergency procedure it should not be dealt with until consent can be obtained at a later time.

There are two other reasons where the practitioner may retain information regarding a procedure from a patient:

- ◆ When the patient chooses not to hear all the information. A patient may wish not to participate in the decision making process concerning their treatment or care. The attending physician and other members of the clinical team will respect the wishes of the patient who is refusing detailed explanations, by (i) withholding the information and (ii) not discussing the procedure with the family. If such a situation occurs the patient, if willing, should be asked to sign a statement, stating that he/she does not wish to discuss the matter following the advice being offered. This should be documented in detail in the medical notes/record. If the patient is unwilling to sign such statement, this should also be documented in the medical notes/record.
  
- ◆ When the patient has prior knowledge. If the patient has undergone the procedure previously and has been informed of the material risks associated with the procedure, a review of the procedure, with the opportunity for the patient to

ask questions or seek clarification of any issues, prior to signing of the consent form may be all that is required.

## **1.7 WHO CAN OBTAIN CONSENT FROM PATIENTS OR GUARDIANS?**

It follows from the foregoing that consent can only be secured by someone suitably qualified or experienced to understand the proposed treatment and risks involved. The Medical Council states;

'Informed consent can only be obtained by a doctor who has sufficient training and experience to be able to explain the intervention, the risks and benefits and the alternatives'<sup>4</sup>

This individual must be in a position to respond to and answer any questions the patient may have.

It is worthwhile to look again at the UK's recent guidelines<sup>5</sup> on consent, which on the issue of who is responsible for obtaining consent state:

1. THE HEALTH PROFESSIONAL CARRYING OUT THE PROCEDURE IS ULTIMATELY RESPONSIBLE FOR ENSURING THAT THE PATIENT IS GENUINELY CONSENTING TO WHAT IS BEING DONE: IT IS THEY WHO WILL BE HELD RESPONSIBLE IN LAW IF THIS IS CHALLENGED LATER.
  
2. WHERE ORAL OR NON-VERBAL CONSENT IS BEING SOUGHT AT THE POINT THE PROCEDURE WILL BE CARRIED OUT, THIS WILL NATURALLY BE DONE BY THE HEALTH PROFESSIONAL RESPONSIBLE. HOWEVER, TEAM WORK IS A CRUCIAL PART OF THE WAY THE NHS OPERATES, AND WHERE WRITTEN CONSENT IS BEING SOUGHT IT MAY BE APPROPRIATE FOR OTHER MEMBERS OF THE TEAM TO PARTICIPATE IN THE PROCESS OF SEEKING CONSENT.

<sup>4</sup> *The Medical Council: 'A Guide to Ethical Conduct and Behaviour' Sixth edition 2004, paragraph 17.1*

<sup>5</sup> *'Department of Health; Good practice in consent implementation guide: consent to examination or treatment, November 2001'*

In view of the above a healthcare professional should not seek to obtain consent in circumstances where he/she feels that he/she is not suitably qualified or experienced to do so. If a healthcare professional has concerns in this regard, then he/she should ask a colleague for help, as failure to do so could result in the consent not being fully informed.

Likewise, healthcare professionals have an obligation not to delegate responsibility for securing consent to someone they know or suspect to be under-qualified for the task.

## **1.8 ELECTIVE AND NON-ELECTIVE TREATMENT**

In any proposed treatment, requisite information must be given to a 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. In the case of elective surgery, the duty to disclose information to the patient is more onerous, particularly where there may be serious or material risks associated with the proposed procedure.

## **1.9 TIMING OF CONSENT**

Consent should always be obtained prior to the proposed treatment or procedure. Under no circumstances should consent be obtained from a patient who has been pre-medicated or sedated in preparation for a procedure. In the case of planned elective surgery where there is unlikely to be a change in the patient's condition, consent could be obtained from the patient during an outpatient consultation. The surroundings of an outpatient consulting room may reduce anxiousness and the patient is more likely to retain vital information.

If a lengthy delay occurs between the outpatient consultation and admission to hospital to undergo the procedure, then consent should be obtained again on admission. It is recommended that consent must not be obtained more than three months before the expected procedure date. In the event of this time frame having lapsed, the patient must be re-consented. Likewise, 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 physician must once again interview and inform the patient of possible risks associated with the procedure. Written information concerning the procedure must also be available to the patient on admission to refresh their memories. The above considerations must also be given to non-elective procedures as delays can often occur between outpatient consultation and the procedure itself.

### **1.10 REFUSAL OF CONSENT**

Patients must be allowed to decide whether they agree to a proposed treatment even if a refusal is likely to result in harm and is not considered by the healthcare professional to be in the patient's best interests.

If a patient refuses to give consent the implications of their decision should be carefully explained to them. An accurate account of the discussion with the patient, the treatment offered, the patient's decision to refuse consent and the fact that the implications of this decision has been explained to them should be recorded in the clinical records.

The professional code of conduct for doctors' states;<sup>6</sup>

'A competent adult patient has the right to refuse treatment. While the decision must be respected, the assessment of competence and the discussion on consent should be carried out in conjunction with a senior colleague'

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<sup>6</sup> *The Medical Council: 'A Guide to Ethical Conduct and Behaviour' Sixth Edition 2004, paragraph 17.1*

## SECTION TWO: *SPECIFIC INFORMATION*

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### 2.1 ADULTS WITH LEARNING DISABILITIES/ INTELLECTUAL HANDICAP

#### **(Not necessarily of unsound mind or not detained under Mental Health Legislation)**

The Law Reform Commission has recommended the enactment of capacity legislation, which would make provision for substitute and assisted decision-making structures in the event an adult is deemed to lack capacity<sup>7</sup>.

Unfortunately until legislation to direct healthcare professionals is enacted, the position in Ireland with regard to consent to treatment of adults who lack capacity is grey and undecided, and is a matter of great concern to all involved in their care. However, the following practices have evolved over the years:

- ◆ If the person's mental condition or disability is such that it does not impair his/her ability to understand the nature, purpose and effect of the proposed treatment/procedure, then he/she can consent (or decline) to it.
- ◆ If the person's mental condition is such that he/she is unable to comprehend the proposed treatment/procedure, then the practice in this country has been to obtain the consent of the next of kin. While it may be the practice, there is, in fact, no legal or common law basis for it whatsoever. Common law has made it clear that no one can express consent on behalf of the adult patient. The practice, therefore, cannot be relied on to provide protection to the healthcare professional and is open to challenge in the courts.
- ◆ If a patient lacks capacity consideration needs to be given as to whether they are likely to regain capacity in the near future (e.g. regain consciousness). If this is likely then treatment can be delayed until that time, provided it is safe to do so.

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<sup>7</sup> *Law Reform Commission: Consultation Paper on Vulnerable Adults and The Law: Capacity (LRC CP 37-2005): paragraph 8.03*

Although the next of kin have no legal standing to give consent, and the decision to treat rests with the healthcare professional, the relatives should be included in the decision making process. Discussion with the patients' relatives, or partner, may be extremely helpful in ascertaining the patients' prior views or wishes. The ideal situation is for the decision to reflect a consensus view between the healthcare professional and those closest to the patient. However, it must be remembered that it is only the best interests of the patient that are relevant and not the interests of other parties.

The Medical Council advises<sup>8</sup>

'If a person with a disability lacks the capacity to give consent, a wide-ranging consultation involving parents/guardians and appropriate carers should occur. Where necessary, a second opinion should be considered before decisions on complex issues are made'

Also;

'For the seriously ill patient who is unable to communicate or understand, it is desirable that the doctor discusses management with the next of kin or the legal guardians prior to the doctor reaching a decision particularly about the use or non-use of treatments which will not contribute to recovery from the primary illness. In the event of a dispute between the doctor and relatives, a second opinion should be sought from a suitably qualified and independent medical practitioner.'<sup>9</sup>

It should be kept in mind that the 'best interests' may not be limited to medical considerations but may include the patients general circumstances, religious beliefs and any views expressed prior to loss of capacity.

In circumstances where there is no known next of kin (and the person lacks comprehension), but the doctor believes that the proposed treatment/procedure is necessary to save the person's life or to ensure improvement or prevent deterioration in the person's condition, then English case law suggests that the action of the doctor

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<sup>8</sup> *The Medical Council 'A Guide to Ethical Conduct and Behaviour' Sixth Edition 2004, paragraph 2.2*

<sup>9</sup> *The Medical Council. 'A Guide to Ethical Conduct and Behaviour' Sixth Edition 2004, paragraph 22.1*

in proceeding (with the treatment) is defensible since it is carried out by virtue of the doctrine of necessity and is in the best interests of the patient. It is difficult to predict what attitude the Irish courts would adopt in such circumstances. In view of the uncertainty of the situation, it would be prudent for the treating doctor to seek a second medical opinion prior to proceeding with the treatment. That said, it could still be challenged in a court of law, and the clinical rationale for proceeding with treatment should be well documented in the person's medical records. The consent form for such a category of patient cannot be a general one. It is recommended that a separate consent form be drafted to deal with this situation.

## **2.2 TREATMENT FOR MENTAL CONDITIONS/ DISORDERS**

There is no legislation in Ireland governing consent to treatment of adults for their mental condition. Accordingly, Common Law principles apply i.e. to treat adults for their mental disorder without obtaining their consent is unlawful unless it is an emergency and/or life-threatening situation.

However, doctors should be aware that when asked to make decisions about the care and treatment of the above persons, they are bound not only by the law, but also by their professional code of ethics. The profession's Code of Ethics demands that "doctors must do their best to preserve life and promote health". (The Medical Council: A Guide to Ethical Conduct and Behaviour; 6<sup>th</sup> Edition 2004).

When dealing with such a category of vulnerable persons, doctors must always act reasonably in the best interests of the patient. This should include a consideration of alternatives (if any) and/or less invasive procedures to the one proposed.

## **2.3 CONSENT FOR CLINICAL TRIALS**

Where the Hospital is involved in clinical medical research/trials:

- (i) The provision of the Control of Clinical Trials Act 1987, the Control of Clinical Trials and Drugs Act 1991 and European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 (S.I. 190 of 2004) will apply.

- (ii) A clinical trials protocol must be prepared in accordance with the requirements of the Acts, which include reference to principles, and conditions that apply in relation to minors<sup>10</sup> and incapacitated adults<sup>11</sup>.
- (iii) SI 190 of 2004 applies to all clinical trials in Ireland from **1<sup>st</sup> May 2004**. This supersedes the 1987 Act for all Clinical Trials authorised from this date.

## **2.4 FOSTER CHILDREN**

The Childcare Policy Unit of the Department of Health and Children issued a circular dated 30<sup>th</sup> November 1999 to all Health Boards and Voluntary Hospitals on consent to medical treatment for foster children. The circular is attached herewith (see Appendix One).

## **2.5 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.

## **2.6 UNMARRIED PARENTS**

In the case of unmarried parents, it is the mother who is entitled to give consent to treatment, as the mother is 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

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<sup>10</sup> *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 (S.I. 190 of 2004) Schedule 1 Part 4.*

<sup>11</sup> *European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 (S.I. 190 of 2004) Schedule 1 Part 5.*

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.

## **2.7 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 treatment is necessary to preserve the life, health and/or safety of the child, then immediate steps should be taken by the hospital to notify the Child Care Social Workers of the Health Board area in which the hospital is located with a view to taking the child into care. When such a situation arises the first step to be taken is the attempt to inform the parents of the necessity for the treatment and obtain their consent. If these attempts fail, then the second step is to utilise the provisions of the Child Care Act, 1991.

An application for a Child Care Order will then be made by the Health Board before a Judge. The Order may be temporary and limited specifically to the period required to administer the treatment to the child. The Order may be made at any time, day or night, by a District Court Judge and at short notice. Hospitals and Health Boards should ensure that some system to facilitate this is in place. 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 it is regarded as unreasonable. In times of necessity, 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, to attempt to secure the consent from the parents.

## **2.8 MINORS (16-18 YEARS OF AGE) AND MEDICAL TREATMENT**

Prior to 1997, a minor, for the purposes of normal medical treatment was an individual below the age of 18. Since 1997, the provisions of section 23 of the Non-Fatal Offences Against the Person Act 1997 provides that a minor that has attained the age of 16 years can consent to surgical, medical or dental treatment.

Section 23 of the Non-Fatal Offences Against the Person Act, 1997:

The Section states that:

'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'.

For example, where an individual of 16 or 17 year of age requires an appendectomy, he/she can consent to such treatment and parental consent is **not** required. This includes consent to an anaesthetic, which is ancillary to the treatment and also includes any procedure undertaken for the purpose of diagnosis. The Act presumes that the minor has the capacity to consent and to understand the proposed treatment. However, as with adult patients, the patient's capacity must be assessed by the healthcare professional at the time consent is sought.

## **2.9 MINORS UNDER 16 YEARS OF AGE**

Children under the age of 16 years are presumed to be legally incompetent to make decisions about medical treatment and therefore such decisions must be made by parents/legal guardians.

There are circumstances where an individual under the age of 16 years may be able to give consent to medical treatment. In these circumstances, the individual under the age of 16 must have sufficient maturity, understanding and intelligence to enable them to fully appreciate the nature, purpose and likely consequences of undergoing or refusing to undergo the procedure that is being proposed.

However, it is important to note that the situation pertaining to the competence of the minor under the age of 16 has not been considered by Irish law and the courts in this country. It has been considered by the English courts and is known as the 'Gillick competence' test.

In the absence of Irish judicial consideration of this matter, it would be prudent practice on the part of the doctor/medical team to consider the views of the minor and to involve all relevant parties, i.e. the medical team, the minor and the parents/legal guardians, in the consent process.

In any situation where a parent or next of kin is entitled to make a decision in relation to medical treatment on behalf of a minor, their decision must be reasonable and in the best interests of the child, if it is not, the court has the power to override their decision. Confidentiality of patient records and treatment must be safeguarded at all times regardless of the age of the patient, unless the practitioner has cause for concern for the patients well being.

### **The Minor Parent**

In respect of children (i.e. any minor not competent to consent and those below the age of 16) it is the parent or legal guardian that will give consent on behalf of a child.

The special status of the family is recognised by Article 41 of the Constitution and will be protected by the courts. The Constitution however, also recognises that parents have duties towards their children and states at Article 42.5 that "...where parents for physical or moral reasons fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents..." Established statutory parental<sup>12</sup> duties are also recognised and are now stated in the Children Act 2001 which states at section 246(1) that:

It shall be an offence for any person who has the custody, charge or care of a child willfully to assault, ill-treat, neglect, abandon or expose the child, or cause or procure or allow the child to be assaulted, ill-treated, neglected, abandoned or exposed, in a manner likely to cause unnecessary suffering or injury to the child's health or seriously to affect his or her well-being.

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<sup>12</sup> *The Act defines parents as "parents', in relation to a child, means- (a) in case one parent has the sole custody, charge or care of the child, that parent, (b) in case the child has been adopted under the Adoption Acts, 1952 to 1998 (or, if adopted outside the State, his or her adoption is recognized under the law of the State), the adopter or adopters or the surviving adopter, and (c) in any other case, both parents".*

The Act goes on to state at section 246(5):

For the purposes of this section a person shall be deemed to have neglected a child in a manner likely to cause the child unnecessary suffering or injury to his or her health or seriously to affect his or her well-being if the person—

(a) Fails to provide adequate food, clothing, heating, medical aid or accommodation for the child, or

(b) Being unable to provide such food, clothing, heating, medical aid or accommodation, fails to take steps to have it provided under the enactments relating to health, social welfare or housing.

Section 246(6) states in subsection (1) the reference to a child's health or well-being "includes a reference to the child's physical, mental or emotional health or well-being."

In relation to medical treatment, where a parent refuses to consent to medical treatment on behalf of their child, which is in the best interests of the child, the refusal, if regarded as unreasonable can be overridden by a court and the provisions of the Child Care Acts can be invoked to protect the interests of a child whose health is at risk.

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

- (i) If the child of the parent requires **emergency** treatment – the formality of the consent process may be dispensed with and the doctor must treat the child.
- (ii) If a child requires **therapeutic** treatment (but not emergency), then normally the consent of the adult parent is sought. However, where the parent is a minor him/herself, obtaining 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. The 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 recent guidelines entitled Seeking Consent: Working with Children (Department of Health, 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.”

## **2.10 WARD OF COURT**

In circumstances where a person is a Ward of Court, the Ward of Court's Office issues a Certificate of Consent for medical treatment of the Ward on the basis of a medical opinion provided to the Office outlining the need for treatment. A certificate will normally issue if needed in a very short space of time. The Ward of Court's Office may be contacted at: 01-8725555. When a person (not a minor) has been taken into ward ship, it means that the President of the High Court has found, on the basis of medical evidence available to him, that the person is of unsound mind and incapable of managing his person or property.

## **2.11 RESUSCITATION**

Under Article 2 of the European Convention on Human Rights, every person has the right to life. A patient has the right to be resuscitated, if he/she has a reasonably good prognosis and if the procedure they are undergoing has a reasonable

possibility of success. Ideally, decisions about whether to attempt to resuscitate a particular patient should be discussed with the patient and made in advance, as part of their overall care planning, along with other aspects of future care. If a patient was asked before a procedure what their wishes would be in the event of a cardiac arrest, and it was established that the patient would not like to be resuscitated, then their wishes would prevail.

It should be established that the patient has the mental capacity to understand and make such a decision. Evidence of this should be entered into the patient's medical record.

◆ **Incapacitated Adult:**

No person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity. Relatives and concerned others should be assured that their views on what the patient would want will be taken into account in the decision making process but they cannot insist on treatment or non-treatment. Doctors cannot be required to give medical treatment, which is contrary to their clinical judgement.

◆ **Children and Young People:**

The views of children and young people must be taken into account in the decision making process about attempting CPR. Parents cannot expect doctors to provide treatment contrary to their professional judgement, but doctors can try and accommodate parent's wishes while protecting the wishes and the best interests of the child. If a disagreement regarding CPR arises between the doctor and the parents of a child, despite numerous attempts to reach agreement, legal advice should be sought. All communication regarding the issue of resuscitation must be documented in the medical notes.

The following points can lead to withholding cardiopulmonary resuscitation:

- ◆ The refusal of the mentally competent patient to medical treatment
- ◆ Patient's known or ascertainable wishes
- ◆ The likely event that CPR is likely to be succeeded by a poor quality of life, which would not be in the best interests of the patient

- ◆ If treatment was not in accordance with the professional judgements of medical staff.

A “not to resuscitate” order form / a “Do Not Resuscitate” (DNR) order should be completed and filed in the patient’s record. This order should be signed by the patient’s attending physician. The order form should state the patient’s condition and list the reasons why resuscitation is not an option.

## **2.12 ADVANCE CARE DIRECTIVES**

An “advance directive” or “living will” involves a patient specifying in advance how they would like to be treated in the case of future incapacity. Although now recognised in the English courts there is no legislation or case law in Ireland, which has considered advance care directives and therefore no indication of the extent, if any, to which they would be legally recognised. However, provided the advance directive was made voluntarily at a time that the patient had capacity and was specific to the circumstances under consideration then it may provide valuable evidence of the patient’s prior wishes and could be taken into consideration, together with any evidence available from other sources, such as close relatives, when deciding on treatment.

## **2.13 BLOOD TRANSFUSIONS**

In a situation where a patient requires a blood transfusion as part of medical treatment, verbal consent must first be obtained. In addition, written information on the procedure should be given to the patient. The accompanying information leaflet should contain the following:

- ◆ What the procedure is and what it entails;
- ◆ The purpose and the benefits associated with a blood transfusion;
- ◆ The risks associated with such a procedure;
- ◆ What are the safety measures to ensure uncontaminated blood;
- ◆ The reactions that may be experienced while undergoing a transfusion and the associated treatments;
- ◆ What are the alternatives to a blood transfusion;

## **2.14 CLINICAL PHOTOGRAPHY AND OTHER RECORDINGS**

Photographic, digital or video recordings, which have been made for the purpose of treating or assessing the patient, may not be used for any other purpose without the written consent of the patient. All clinical photography and other recordings must be stored in a secure manner and comply with the following legislation:

Freedom of Information Act 2000;

Data Protection (Amendment) Act 2003;

Copyright and Related Rights Act 2000;

Mental Health Act 2001;

Childcare Act 1991.

Any person undertaking patient photography does so on the understanding that all images that are produced will be regarded as medical records and are therefore protected by the same legal and ethical constraints. Each healthcare institution must have a policy dealing with this issue, which must be read and adhered to by all staff.

A full and detailed explanation of the purpose of the photographs and how they will be used must be given to the patient (in the form of a written leaflet) in addition to appropriate written consent being obtained before any photography takes place.

Section 23 of the Non-fatal Offences Against the Person Act, 1997 provides that a minor who has attained the age of 16 years can consent to surgical, medical or dental treatment. Provided the clinical photographs or images are taken for the purpose of assessment or treatment then a person who has attained the age of 16 can give valid consent. However, if the photographs or images have been taken for any other purpose, or it is intended to use them for any other purpose, such as teaching or research, then the consent of the minors' parent or guardian should be obtained. Likewise written consent must also be obtained from a parent or guardian when undertaking clinical photography of a minor under the age of 16 and must only be carried out by a senior member of medical or nursing staff. If a child is not willing for a recording to be used, it must not be used, even if consent from a parent or guardian has been obtained.

There are special circumstances where the attending consultant may not require consent. Examples of these circumstances are the following:

- ◆ Suspected non-accidental injury to a child
- ◆ Deceased patients whose next of kin is not known

In case where the doctor suspects non-accidental injury to a child and clinical photographs are required for the child's treatment, diagnosis or as part of the clinical records as documentary evidence, the doctor can agree to photographs being taken in the best interests of the child. Such photographs should not be kept for research or training purposes.

### **The Making and Use of Photographs and Recordings for Purposes other than the Patient's Treatment or Assessment**

You must obtain the patient's separate and specific consent to use any photographs or recordings that are made, or are to be used, for reasons other than the patient's treatment or assessment, for example teaching or research purposes. Before the recording, you must ensure the patient

- ◆ Understands the purpose of the recording, who will be allowed to see it, the circumstances in which it will be shown and whether copies will be made
- ◆ Understands that withholding consent for the recording to be made, or withdrawing consent during the recording, will not affect the quality of care they receive.
- ◆ Are given time to read Patient Information Leaflet material and to consider the implications of giving their consent.

After the recording, you must ensure that:

- ◆ Patients are asked if they wish to vary or withdraw their consent to the use of the recording.
- ◆ Recordings are used only for the purposes for which patients have given their consent.

- ◆ Recordings are given the same level of protection as medical records against improper disclosure.

Consent must also be obtained in the case of an unconscious patient. Photographs may be taken but should not be used until signed consent has been obtained. In the event of recovery the physician must inform the patient that photographs have already been taken and the reason why they were taken. In the event of the patient refusing to sign a consent form for the release of recordings that have not been made for the purpose of the patient's treatment or assessment, then the images must be destroyed.

The patient's confidentiality must be safeguarded. It is not sufficient that black bands be used across the eyes in facial images to conceal identity. Any clues from which a patient may be identified must also be removed. Patients have the right to withdraw consent at any time during the recording, after which the images must be destroyed. Patients must be made fully aware of the implications of the recording entering the public domain, including the fact that it may not be withdrawn.

## **2.15 PROVISION FOR PATIENTS WHOSE FIRST LANGUAGE IS NOT ENGLISH**

These patients must receive the appropriate written and oral information they need in order to make a rational decision. Provision must also be made for staff to communicate appropriately with patients. Each hospital must draw up an institutional policy on how to manage and alleviate the situation. It is recommended that relevant governing bodies or embassies be contacted to assist in organising an interpretation service to assist both the patient and staff. Interpreters must be informed of the obligation of confidentiality and if deemed necessary and desirable be asked to sign a confidentiality agreement. The signing of such an agreement will ensure that the healthcare provider has discharged its duty by protecting as best it can the patient's confidentiality and demonstrating that it has done so.

## **2.16 DEAF PATIENTS**

Deaf patients should expect to be provided with appropriate communication support in every consultation and at every stage of their treatment process. The use of a properly trained interpreter is important in order to ensure the quality of the service. Such interpreters must adhere to a strict code of ethics and confidentiality.

## **2.17 BLIND PATIENTS**

Provision must also be made for blind patients to communicate appropriately in order to obtain informed consent. 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 proposed procedure must be given in audio form in order for the 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 patient must be entered into the medical record.

## **2.18 STEPS TO BE TAKEN BY STAFF FOLLOWING INJURY WITH A SUSPICION OF HIV/ AIDS**

In the event of a healthcare professional sustaining a needle-stick injury from a patient and you consider it necessary to test the patient for a serious communicable disease, the patient may be asked to give his/her consent to the donation of a sample of blood for investigation, namely for HIV or Hepatitis testing. Written consent must first be obtained. In such a situation counselling must also be undertaken and all relevant information given to the patient.

If the donor (patient) is competent but withholds consent despite careful counselling and a sample of his or her blood has not already been taken for other purposes, then no further action is possible. A blood sample should not be taken against the patient's wishes. In these circumstances the injured party is followed up and treated as if the donor is unknown.

If the patient is unconscious when the injury occurs consent should be sought once the patient has regained full consciousness. If appropriate, the injured person can take prophylactic treatment until consent has been obtained and the test result is known.

If the patient refuses testing, is unable to give or withhold consent because of mental illness or disability, or does not regain full consciousness within 48 hours, you should reconsider the severity of risk to the injured health care worker, or to others. You should not arrange testing against the patient's wishes or without consent other than in exceptional circumstances, for example where you have good reason to think that the patient may have a condition such as HIV for which prophylactic treatment is available. In such cases you may test an existing blood sample, taken for other purposes, but you should consult an experienced colleague first. It is appropriate to explain to the donor (patient) that this will be carried out and they should be offered the opportunity to be informed or to refuse information relating to the test result.

It is possible that a decision to test an existing blood sample without consent could be challenged in the courts, or be the subject of a complaint to your employer or the Irish Medical Council (IMC). You must therefore be prepared to justify your decision.

If you decide to test without consent, you must inform the patient of your decision at the earliest opportunity. In such cases confidentiality is paramount. Only the patient, should they wish to be informed, and the injured party's treating physician may be told about the test and its result. In these exceptional circumstances neither the fact that test has been undertaken, nor its result, should be entered in the patient's personal medical record without the patient's consent.

It is however advisable that an admission policy be drawn up to include general information on consent guidelines, incorporating the possibility of having to donate a blood sample in the event of a staff member sustaining a needle-stick injury. To some extent the patient will then be prepared in the event of such an incident.

## **2.19 PATIENT INFORMATION SHEET**

On admission for elective procedures, the patient should be presented with an admission information sheet, which will be individualised for their particular case. The language should be easy to understand and consist of 'lay man' terms. The print should be large to aid those who are visually impaired.

## **2.20 PROTECTION OF MEDICAL RECORDS**

The healthcare professional must ensure that his/her patients' medical records are protected from improper disclosure while in his possession. Medical information must only be disclosed in accordance with the conditions of the patient's consent. The patient is also owed a duty to be informed whenever confidential information will be disclosed to third parties i.e. other healthcare professionals as part of multi-disciplinary team. The healthcare professional may not disclose any medical details concerning a patient's condition to a third party, without the consent of the patient. For example disclosing details to his/her family or preparing a medical report for his/her solicitor or an insurance company.

There are exceptions to the Medical Profession's duty of confidentiality to the patient:

Where a patient gives consent to the disclosure of information to third parties
When disclosure is required by a judge in a court of law
When disclosure is necessary to protect the interests of the patient
When disclosure is necessary to protect the welfare of society
When disclosure is necessary to safeguard the welfare of another individual or patient.

The Data Protection Act 1988 protects the individual's right to privacy. Doctors and other healthcare professionals holding data concerning patients must register with the Data Protection Commissioner. A person has the right under the Act to establish the existence of this information and also has the right of access to this information. This information must be provided to the individual within a specified time frame and in intelligible form. The person can exercise the right to rectify or erase any information held that is incorrect or misleading. Such information may not be

disclosed to any third party without the prior consent of the individual unless it falls under the exceptions discussed above.

The Data Protection (Amendment) Act, 2003, which commenced on 1 June 2003, amends the Data Protection Act, 1988, by extending data protection rules to certain manual data relating to living individuals which is recorded as part of a relevant filing system. The extension to include manual data applies to new data obtained from the date of commencement of the Act. However, the full application of the Acts to existing manual data, that is manual data already in existence at the date of commencement of the Act, does not come into force until 24 October 2007.

The Act sets out conditions for processing personal data, including more stringent conditions in relation to sensitive personal data, and strengthens data subjects' rights, in particular the right to be informed about the processing of data relating to them. The new section 2A of the Act sets out additional conditions for the legitimate processing of personal data. It provides that in addition to satisfying the conditions, which must be complied with in section 2, at least one of the listed conditions in Section 2A(1) are met. One of the conditions listed is that consent has been obtained from the data subject or an appropriate person (e.g. if the data subject, by reason of his or her physical or mental incapacity or age, is likely to be unable to appreciate the nature and effect of such consent<sup>13</sup>). Other conditions are listed in section 2A(1) but it should be remembered that it is only necessary for one of them to be met to comply with the Act.

The new section 2B relates to the processing of sensitive personal data and provides for a prohibition on the processing of sensitive personal data, unless the criteria set out in sections 2 and 2A are satisfied and in addition at least one of the listed conditions contained in section 2B(1)(b) is met. The conditions listed in this section include:

- ◆ Where the data subject has given his/her consent to the processing unless prohibited by law (subsection 2B(1)(b)(i))
- ◆ Where processing is necessary to prevent injury or other damage to the health of the data subject, or another person or serious loss in respect of,

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<sup>13</sup> *Data Protection (Amendment) Act 2003, Section 4 Subsection 2A(1) (a)*

or damage to, property or otherwise to protect the vital interests of the data subject or of another person in a case where consent can not be given by or on behalf of the data subject (subsection 2B(1)(b)(iii))

- ◆ Where processing is necessary for the establishment, exercise or defence of legal claims (subsection 2B(1)(b)(vii))
- ◆ Where processing is necessary for medical purposes and is undertaken by a health professional or another person subject to an obligation of professional secrecy (subsection 2B(1)(b)(viii)).

The new Section 2C deals with security of processing and it provides that data controllers must implement the most appropriate measures to protect personal data and that having regard to the cost of their implementation, such measures must ensure a level of security appropriate to the risks presented by the processing and the nature of the data to be protected. The data controller must also ensure that anyone in his/her employment or anyone else who has access to the workplace is aware of and complies with such security measures.

The provisions of the legislation should be given careful consideration.

The Freedom of Information Act 1997 also enables individuals a general right of access to information in the possession of public bodies so as to enable individuals' access to and correction of personal information. Public Bodies includes health boards, public hospitals, the Department of Health, the Blood Transfusion Board and the Irish Medicines Board. The issue of third party access to publicly held records, which contain personal information, such as clinical details in medical records, is also governed by the Act. The CEO shall refuse such a request if access would involve the disclosure of personal information. The Act provides that the patient may access medical records through a healthcare professional that has relevant expertise in regard to the subject matter of the medical record.

## **2.21 RETENTION OF TISSUE**

It is common practice to retain tissue/samples, removed (of necessity), during a procedure for the purposes of diagnosis and treatment. Patients should be advised in advance of this practice and their consent should be obtained. Retained tissue/samples can also be valuable in education and research; however, the

patients' consent should be obtained if the tissue/sample taken from them is to be used for these purposes

## **2.22 POST MORTEMS**

The Report following the Organ Retention Inquiry recommends that legislation should be introduced to ensure that no post mortem is carried out on a deceased child and no organ will be retained from a post mortem examination for any purpose whatsoever without the authorisation of the child's parent/guardian, or the authorisation of the coroner in an appropriate case. The Report suggests that the principles that underpin these recommendations are equally applicable to all post mortems.<sup>14</sup>

Until the recommended legislation is enacted, the advice contained in the guidelines for post mortem consent and retention of samples (which includes organs) issued by the Faculty of Pathology of the Royal College of Physicians of Ireland should be adhered to.

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<sup>14</sup> *Report of Dr. Deirdre Madden on Post Mortem Practice and Procedures; 21 December 2005*

## **APPENDIX ONE**

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**Circular from the Department of Health and Children to all Health Boards and Voluntary Hospitals on consent to medical treatment for foster children, dated 30<sup>th</sup> November 1999.**



2 November, 1999

Chief Executive Officer  
Each Health Board



DEPARTMENT  
OF HEALTH AND  
CHILDREN  
AN ROINN  
SLÁINTE AGUS LEANAÍ

Shaping a  
Healthier Future

Consent to Medical Treatment for Foster Children

Dear Chief Executive Officer

I am directed by the Minister for Health and Children set out the position in regard to the above matter as follows:

Urgent Medical Treatment

The advice of the Attorney General's Office has been sought on the matter. That office has indicated that foster carers have the capacity to consent to **urgent medical treatment** which, in the clinical judgement of the medical practitioner, is necessary in the interest of the patient's welfare. In any event, 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 treatment be given urgently, the child's rights to prompt medical treatment and, more generally, to have his or her welfare considered is paramount.

The consent of the foster parent to urgent treatment may be deemed to extend to ancillary procedures which, while they may not be of themselves necessary to preserve the life or health of the child, are nevertheless a necessary part of the treatment of the child. For example, the application of an anaesthetic to a child before setting a broken bone or extracting a tooth.

Non Urgent, Elective Procedures

(a) The Child in Voluntary Care

In relation to children under 16 years, consent should be sought from the child's natural parents. If this is not forthcoming, it may be appropriate to seek directions from the court under section 47 of the Child Care Act, 1991.

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. This section provides that a minor who has attained the age of 16 years can consent to any surgical, medical or dental treatment. There may be circumstances, either because it is in the best interest of the patient or because of a doubt the medical practitioner may have as to the competency of the child to give consent, where the consent of the child over 16 may need to be accompanied by the consent of the child's parent or guardian.

L.AM/PCO/FOSTER/MEDCOONS/SAM

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If this consent from the parent or guardian is not forthcoming it may be appropriate to seek directions from the court in the matter.

A refusal of treatment by a child over 16 does not override the consent of a parent or guardian to that treatment. However, where there is such refusal, it may be appropriate for the Board to apply to the court for directions in the matter. If there is any doubt as to how section 23 should be applied, in relation to the particular circumstances of a case legal advice should be sought.

(b) *Emergency Care Order or Interim Care Order*

In relation to children who are under 16 years of age, the health board can seek directions under section 13(7) or section 17(4) of the Child Care Act, 1991, as appropriate. Directions can also be sought by the health board or by any person under section 47 of the Child Care Act, 1991. If a child is 16 years of age or over, section 23 of the Non Fatal Offences Against the Person Act, 1997 will apply as set out above. If there is a doubt about the competency of the child to consent, directions should be sought from the court.

(c) *Care Order*

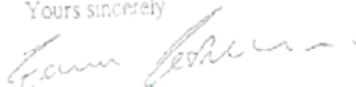
In relation to children under the age of 16 in respect of whom a care order has been made, the health board can consent to elective treatment if it is in the best interests of the child. It may be prudent however to consult the child's natural parents and in appropriate circumstances seek directions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

In relation to children of 16 years and over, in respect of whom a care order has been made, the provisions of section 23 of the Non Fatal Offences Against the Person Act, 1997 apply. If there is a doubt about the competency of the child to consent, such consent may need to be accompanied by the consent of the Board. It may also be prudent to consult the child's natural parents or guardian. Where there is refusal of treatment by a child over 16, it may be appropriate for the board to apply to the court for directions in the matter.

Finally, whenever an issue in relation to the welfare of the child arises, consideration should be given to the provisions of section 3(2)(b)(ii), of the Child Care Act, 1991.

I would appreciate if you could bring this circular to the attention of all relevant staff. Please note that this circular supercedes this Department's circular of 27 November, 1998 in this matter.

Yours sincerely



Eamon Corcoran  
A/Principal Officer  
Child Care Policy Unit

cc: Each Programme Manager, Each CEO/Secretary/Manager each Voluntary Hospital

LSMHPROFOSTERMEDCONS.LAM