

Consent:

A guide for health and social care professionals



Acknowledgement

Acknowledgement

The general principles of consent and the processes for seeking consent outlined in this guide have been adapted from the HSE *National Consent Policy* which is the definitive reference for all HSE staff.

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Part One: Adults

Part One—Adults

1. Introduction

If your work involves treating or caring for people (this involves anything from helping people with dressing to carrying out major surgery), you must make sure you have that person's consent to what you propose to do. This respect for people's rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement. It is also important to note that nobody else can consent on behalf of an adult, unless they have formal legal authority to do so.

This booklet provides a brief guide to some of the common issues regarding consent that may arise in practice. It is not a substitute for the HSE *National Consent Policy* which is the definitive reference for HSE staff and which sets out in detail the general principles of consent and provides good practice guidance including reference to current Irish law.

2. When is consent required

The need for consent, and the application of the general principles in this policy, extends to all interventions conducted by or on behalf of the HSE on service users in all locations. Thus, it includes social care as well as health care interventions and applies to those receiving care and treatment in hospitals, in the community and in residential care settings. It includes, for example:

- Physical examination
- Provision of intimate personal care
- Blood tests
- Radiological examinations

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- Surgical procedures
- Anaesthetic procedures
- Chemotherapy and radiotherapy treatment
- Administration of medications
- Use of blood products
- Clinical photography and video/audio recording
- Assessment of need for health or social care
- Provision of social care
- Psychological interventions
- Sharing of personal information
- Provision of day or residential care
- Participation in social or educational activities as part of social care provision.

How the principles are applied, such as the amount of information provided and the degree of discussion needed to obtain valid consent, will vary with the particular situation. For example, a minor risk-free procedure, such as changing a dressing, may require only a brief explanation and a warning about possible discomfort. On the other hand, extensive discussion will be required for a major decision involving significant risks, such as whether or not to have surgery.

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3. What is valid consent?

Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention. Seeking consent is part of good practice in communication and decision-making and should usually occur as an on-going process rather than a once-off event.

For consent to be valid, the person must:

- have received sufficient information in a comprehensible manner about the nature, purpose, benefits and risks of an intervention or service;
- be acting voluntarily (that is, not under undue pressure or duress from anyone); or
- have the mental capacity (be 'competent') to make the particular decision at that time.

4. What information do people need?

The amount of information to be provided about an intervention will depend on the urgency, complexity, nature and level of risk associated with the intervention and on the preferences of the person. Many decisions require the person to balance potential risks and benefits of the intervention and, in order to do so, he or she will need adequate information about:

- Their diagnosis and prognosis
- Options for treating or managing the condition, including the option not to treat
- The purpose of any proposed intervention and what it will involve
- The potential benefits, risks and the likelihood of success of a proposed intervention, as well as that of any available alternative.

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Provision of health and social care to a service user during a single episode often involves a number of interventions. For example when people are admitted to hospital it is important that they understand the scope of any decisions to be made, especially if treatment will be provided in stages, with the possibility that changes or adjustments might be needed, or that different professionals may provide particular parts of an investigation or treatment, such as anaesthesia and surgery. Similarly when someone is admitted to a nursing home or other form of residential care, there is a requirement to understand the nature and multiplicity of interventions that might be provided while a resident.

5. How and when should information be offered?

It is essential that the relevant information is provided in a form that the particular person can understand. This is particularly important with those who may have difficulty making decisions including those with communication difficulties, intellectual disability or cognitive impairment. Helpful measures to support the person's ability to understand may include offering information in a variety of forms depending on the person's needs (for example if they have any sensory impairment) and preferences. Use of simple, clear and concise language and avoidance of jargon and medical terminology are also important.

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Are information leaflets helpful?

Standardised information leaflets can supplement but should never replace discussion with an individual patient. General information about the benefits and risks for the average patient may not always be applicable to a particular patient. Literacy and numeracy difficulties are common and many people find it hard to understand medical terminology. It is important that leaflets are written in clear simple language. You may also consider referring the patient to reputable health related websites for further information.

The manner in which information is presented is also important. You should ensure that information is provided in a respectful way, for example by finding an appropriate, private place to discuss confidential matters. You should also ensure that people have the time and support they need to make their decision. This is referred to again later at page 22.

Example 1

Mrs A, who has fallen recently, has been referred to community services for assessment for provision of physical therapy and appropriate supports. The referral letter notes that she is originally from Poland but has just moved to live with her son in Ireland; she speaks Polish and doesn't speak any English.

When the community team meet to consider her referral, they note that effective communication, including obtaining consent for assessment and any interventions, will require an interpreter proficient in Polish; using her son as an interpreter will not be appropriate. The best approach will be to arrange for a professional interpreter to attend with Mrs A at an initial meeting where each member of the team can explain their particular role and get Mrs A's consent for a process of care likely to extend for some weeks.

6. What information about risks and side effects of an intervention should be provided?

In providing medical care, a general rule is to provide information about risks that a reasonable person in the patient's situation would expect to be told or would consider significant. This is in line with ethical and professional standards as well as the legal standard applied by the Irish courts. Factors such as someone's occupation or lifestyle may influence those risks that they consider significant or particularly undesirable. For example, a person whose occupation involves manual work would be more likely to attach significance to a risk of nerve damage to his hands which might impair his ability to continue in work; similarly, for a person used to living independently who values being on their own, communal living might be very challenging, and this potential disadvantage should be raised if admission to residential care is under consideration.

In general, such information includes the likelihood of:

- side effects or complications of an intervention;
- failure of an intervention to achieve the desired aim; and
- the risks associated with taking no action or with taking an alternative approach.

Common, even if minor, side effects, such as transient nausea or discomfort, should be disclosed as should rare but serious adverse outcomes. The latter include death, permanent disability (such as paralysis or blindness), permanent disfigurement and chronic pain.

In an emergency life-threatening situation, treatment that is immediately necessary to save the life or preserve the health of the person should be administered even if there is no time for the health care professional to provide a full explanation or if the person is unable to provide consent.

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My patient is particularly anxious. It doesn't seem reasonable to worry him with a lot of information about unlikely risks. He might even opt not to have the treatment he needs!

or

My service user, who has a learning disability, is very anxious about a potential change of residential placement and if I explain everything to him he is likely to refuse to the move.

Unfortunately health and social care often involves difficult or worrying information or decisions, and it is understandable that health and social care professionals or family or friends may wish to shield a patient from anxiety. However, it is essential that a patient or service user receives sufficient information to know what is involved in an intervention or decision and to be able to consent or withhold consent. The fact that somebody might be upset or refuse treatment or services as a result of receiving information as part of the consent process is not a valid reason for withholding information that they need or are entitled to know.

It is often helpful in these circumstances to ask the service user if they would like a relative, partner, friend or advocate to be present at the consultation as a support and to spread out the time over which information is given to better enable someone to come to terms with it. It is also important that information about risk should be given in a balanced way: a 1 in a hundred risk of a complication also means that 99 out of a hundred patients will not experience that complication!

'The fact that somebody might be upset or refuse treatment or services as a result of receiving information as part of the consent process is not a valid reason for withholding information that they need or are entitled to know'.

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7. Is the person's decision made voluntarily?

It is very important to ensure that the person's decision is their own and that they understand that they have a choice. Health and social care professionals have a role to play in discussing treatment and care options and may have a recommendation to make or may need to point out the likely consequences of choices the person may make. Nevertheless, care should be taken that people do not feel forced into making a particular decision.

People may also be subject to pressure from family and friends to accept or reject a particular intervention. Again, care should be taken to ensure that the person ultimately makes his or her own decision, for example by discussing treatment and care options with the person in the absence of family or friends if the person is comfortable with that.

Example 2

Mrs B, who lives alone, has, despite optimal medical care, become increasingly frail due to arthritis. She now requires home help and meals-on-wheels. Ms C the local Public Health Nurse discussed the option of long-term residential care with her on a number of occasions, but Mrs B was always clear, while acknowledging the inevitable risks, that she would prefer to remain at home. Mrs B's daughter Mary has recently come home for a visit and contacts Ms C insisting that her mother should go into a nursing home. Ms C explains that, while she understands Mary's concern, Mrs B must be the one to make that decision. When Ms C talks to Mrs B alone, it is clear that the latter, despite considerable pressure from her daughter, prefers to remain at home. Ms C arranges, with Mrs B's permission, to meet Mary to seek to allay her concerns.

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8. Has the person the capacity to make the decision?

‘Adults are always presumed to have capacity to make healthcare decisions, unless the opposite has been demonstrated’.

There are a number of important principles related to mental capacity to make a decision.

- i. Capacity should be judged in relation to the particular decision to be made, at the time it is to be made. This is sometimes called the ‘functional approach’, and recognises that, some people may have capacity to consent to some interventions but not to others. The fact that a person has been found to lack capacity to make a decision on a particular occasion does not mean that they lack capacity to make any decisions at all, or that they will not be able to make similar or other decisions in the future.
- ii. Capacity to consent requires that:
 - a. the person understands in broad terms the nature of the decision to be made;
 - b. the person has sufficient understanding of the main benefits and risks of an intervention and relevant alternative options after these have been explained to them in a manner and in a language appropriate to their individual needs; and
 - c. the person understands the relevance of the decision and is able to retain this knowledge long enough to make a voluntary choice.

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- iii. Adults are always presumed to have capacity to make healthcare decisions, unless the opposite has been demonstrated. It must not be assumed that somebody lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including intellectual disability, mental illness, dementia or scores on tests of cognitive function).
- iv. Capacity should not be confused with the reasonableness or wisdom of the person's decision. People are entitled to make a decision based on their own religious belief or value system, even if that decision is perceived by others to be irrational, as long as they understand what is entailed in their decision.
- v. People who lack capacity to make a decision will nevertheless very often be able to express a preference to receive or forgo an intervention. Even in the presence of incapacity, the expressed view of the person carries great weight and, except in emergencies, it may often be impractical or undesirable to try to impose care, treatment or investigation on someone who resists it. Legal advice should be sought in respect of refusal by a person lacking capacity of any major intervention including surgery, prolonged detention or other restrictions on liberty.
- vi. Health care professionals have a duty to maximise capacity. This requires that efforts must be made to support individuals in making decisions for themselves where this is possible.

Part One—Adults***Example 3***

Mr B who is 70 years old was diagnosed with early Alzheimer's Disease 6 months earlier. He has been taking aspirin for some years because of ischaemic heart disease. At a routine clinic visit, his doctor, Dr Y, found that Mr B was in atrial fibrillation. He explained to Mr B that his irregular heart beat meant that he was at increased risk of having a stroke, and that the blood thinning agent warfarin would provide better protection against stroke than would aspirin. He also explained the risks and disadvantages associated with warfarin – the increased risk of serious bleeds and the need for regular blood tests to ensure that the dose is neither too high (risking bleeding) nor too low (risking clots including stroke). He concluded that his advice was that warfarin would be the best treatment but asked Mr B for his views.

Mr B declined warfarin. Although he accepted that warfarin would give better protection against stroke, he hated the idea of having blood tests regularly and pointed out that he had been doing very well with the aspirin. Dr Y replied that while he still thought warfarin was the best option, he would go along with Mr B's preference and continue to prescribe aspirin.

Although Dr Y was aware that Mr B had cognitive impairment (the diagnosis of early Alzheimer's Disease), he felt that Mr B's responses did demonstrate a broad understanding of the issues and that his decision, while not in accordance with medical advice, was reasonable in light of his preferences.

9. What should be done if somebody lacks capacity to make a decision?

In making decisions for those who lack capacity, you should determine what is in their best interests. Factors that you should take into account include:

- Evidence of the person's previously expressed preferences, wishes and beliefs
- Whether the lack of capacity is temporary or permanent
- Which options for treatment or care would provide overall clinical benefit for the person
- Which options, including the option not to treat or provide care, would be least restrictive of the person's future choices
- The current views of the person if ascertainable.

'No other person such as a family member, friend or carer (and no organisation) can give or refuse consent on behalf of an adult who lacks capacity to consent unless they have formal legal authority to do so'.

Should the patient's family be asked to give consent?

The views of those who have a close, on-going, personal relationship with the person such as family or friends are often helpful in the discussion and decision-making process for those who lack capacity particularly with regard to providing greater insight into the person's previously expressed views and preferences. However, no other person such as a family member, friend or carer (and no organisation) can give or refuse consent to a health or social care service on behalf of an adult who lacks capacity to consent unless they have formal legal authority to do so. The designation of a family member as 'next-of-kin' does not confer any legal decision-making authority. In the absence of a person with legal authority to make decisions on behalf of the service user, the health and social care professional must make the relevant decision on the basis of his or her assessment of the best interests of the service user.

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Emergency situations

In emergency situations where a patient is deemed to lack capacity and there is no valid advance refusal of treatment, you should act in the best interests of the patient bearing in mind the principles outlined above. This usually means providing any treatment immediately necessary to save the life or to prevent a serious deterioration of the condition of the patient. While it is good practice to inform those close to the patient, nobody else can consent on behalf of the patient in this situation.

Example 4

Mr N was shopping in town when he suddenly developed weakness in his right arm, leg and face side and difficulty speaking. A passer-by rang for an ambulance and he was brought to the local hospital within a few minutes. Investigations confirmed that he had had an ischaemic stroke. Mr N's past history was obtained from his family doctor. Unfortunately, Mr N's wife was not at home and did not answer her mobile phone.

The consultant physician Dr C was called to determine if administration of thrombolysis (clot-dissolving medication) was indicated. Dr C agreed that Mr N seemed a suitable candidate for thrombolysis. Dr C explained to him that thrombolysis reduces long term disability in stroke – about one out of every 7 people will have an excellent outcome that they wouldn't have had otherwise. However, about one of every 17 people treated with thrombolysis will have an immediate symptomatic brain bleed they wouldn't otherwise have had and in one of every 37 people treated that bleed will be fatal. Although Mr N nodded his agreement to proceed with thrombolysis, Dr C was unsure how much of this Mr N could understand since he had a significant speech impairment affecting his ability to express himself and possibly his comprehension also. Attempts to contact Mrs N continued to be unsuccessful.

The benefits from thrombolysis diminish with each passing minute, and the decision to treat or not could not be deferred. Despite his uncertainty as to whether Mr N's apparent agreement represented a valid consent and since he was of the opinion that treatment was in Mr N's best interests, Dr C decided to proceed with treatment. He documented the reasons for this decision including his efforts to obtain consent from Mr N and to contact Mrs N.

10. Who should seek consent from a service user or patient?

If you are the person providing a particular intervention or treatment, you are ultimately responsible for ensuring that the person consents to what is proposed. If different aspects of care are to be provided by different professional disciplines, each should usually obtain consent for their particular intervention. Thus, for example, the different members of a multidisciplinary rehabilitation team should each seek consent before providing treatment to a patient with a stroke.

You may delegate the task of providing information and seeking consent to another health care professional provided that person is suitably trained and qualified and has sufficient knowledge of the proposed intervention and of the benefits and risks in order to be able to provide the information the service user requires. Inappropriate delegation (**for example where the seeking of consent for a surgical procedure is assigned to a junior doctor with inadequate knowledge of the procedure**) may mean the “consent” obtained is not valid. However, the seniority of the person seeking consent is of less importance than their knowledge of the intervention and their ability to convey that knowledge effectively.

The person seeking consent should have sufficient knowledge of the intervention and be able to convey that knowledge effectively

Part One—Adults*Example 5*

Mr K had just been admitted for an elective hip replacement and was seen by Dr G, the orthopaedic Senior House Officer. The case notes showed that the consultant had explained the advantages and disadvantages of the procedure to Mr K in the outpatient clinic 2 months earlier, and Mr K confirmed that he recalled that discussion. Dr G explained again to Mr K that serious complications of a hip replacement are uncommon, occurring in less than one in a 100 cases. Blood clots in the leg can occur despite the preventative measures that are always used. Less commonly, a pulmonary embolism – a blood clot in the lungs can develop and these can be fatal. There is always a small risk that bacteria can get into the tissue around the artificial hip joint and cause infection; this can require further surgery to remedy. Dislocation or loosening of the joint can occur often many years after surgery and require another operation. Dr G emphasised that, despite these risks, the vast majority of those having a hip replacement had an uneventful surgery and an excellent outcome.

Mr K asked if the general anaesthesia for his operation would be risky. Dr G said that the risk of death with modern anaesthetic techniques in a generally healthy patient would be much less than one in 50,000 cases, in other words much less than the annual risk of having a fatal accident as a driver or pedestrian. He also explained that the anaesthetist would be along later to see Mr K and would be glad to explain further about the anaesthetic. Finally, Dr G checked that Mr K was happy to proceed with surgery and both Mr K and Dr G signed the written consent form. Dr G also made a note of his discussion with Mr K in the case notes.

11. How should consent be documented?

It is essential for those who provide health and social care to document clearly the person's agreement to the intervention and the discussions that led up to that agreement particularly if:

- the intervention is invasive, complex or involves significant risks;
- there may be significant consequences for the service user's employment, or social or personal life;
- providing clinical care is not the primary purpose of the intervention e.g. clinical photographs or video clip to be used for teaching purposes or blood testing following needle stick injury to staff; or
- the intervention is innovative or experimental.

The service user's agreement can be documented by their signature (or mark if unable to write) on a consent form or through documenting in their notes that they have given verbal consent.

While it is important to document consent adequately, the process and quality of communication are of equal importance.

'How important is it to get the service user's signature on the Consent Form'?

A signature on a form is evidence that a process of communication has occurred and that the service user agrees to an intervention: it is, however, not proof that an adequate process of communication has occurred or that the consent is valid. On the other hand, if a person has given valid verbal consent, the fact that they are unable to sign the form is no bar to treatment. Thus, while it is important to document consent adequately, the process and quality of communication is of equal importance.

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12. When should consent be sought?

For a major elective intervention such as a surgical procedure, it is good practice where possible to seek the patient's consent to the proposed procedure well in advance, for example in the out-patient clinic, when there is time to respond to the patient's questions and provide adequate information. Clinicians should then check, before the procedure starts, that the patient has no questions or concerns and still consents to proceed. Asking a patient to give consent just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, or seeking consent from someone who is sedated, in pain or anxious, creates doubt as to the validity of the consent. In particular, patients should not be given routine pre-operative medication before being asked for their consent to proceed with a treatment.

'How Long does Consent Remain Valid'?

Some services may opt for pragmatic reasons to set a maximum fixed time period for which consent remains valid in their particular service. However there is no legal authority to support the validity of any particular time period.

In general, if there is a significant time-lapse between the initial seeking and giving of consent and the actual date of an intervention, it is helpful to check if the patient can remember the treatment information given previously and if they have any questions in relation to that information. If the patient isn't satisfied that he or she can remember the earlier information or if there is a change in the patient's condition or in the information about the proposed intervention which may result in a change in the nature, purpose or risks associated with the procedure, a fresh consent following provision of appropriate information should be sought.

13. What if the patient refuses to give their consent?

If an adult with capacity to make an informed decision makes a voluntary and appropriately informed decision to refuse a proposed treatment or service, this decision must be respected, even where the decision may result in his or her death. In such cases it is particularly important to accurately document the discussions with the patient or service user, including the procedure that has been offered, their decision to decline and the fact that the implications of this decision have been fully outlined. If you are unsure about the patient or service user's capacity to make a decision, the guidance provided earlier at pages 14-18 should be followed. However, there are some circumstances in which a valid refusal of consent raises complex legal and ethical issues and it may be advisable to seek legal advice:

- Refusal of treatment in pregnancy where the refusal creates a risk to the life of the foetus
- Refusal of isolation for infectious disease
- Refusal of the taking of blood and urine samples for the purposes of Garda investigations into driving under the influence of alcohol and/or drugs.

Patients admitted involuntarily under the Mental Health Act 2001 have the same right as other patient to refuse treatment for all conditions except for treatment for a mental disorder, which must be provided in accordance with the requirements of the Mental Health Act 2001. If in doubt about whether treatment can be categorised as treatment for a mental disorder, legal advice should be sought.

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'Can Consent be Withdrawn'?

A person with capacity is entitled to withdraw consent at any time, including after signing a consent form or even during the performance of a procedure. Where a patient or service user does object during a treatment or service, it is good practice for the practitioner, unless this would genuinely put the life of the service user at risk, to stop the procedure, establish the service user's concerns, and explain the consequences of not completing the procedure. If the service user confirms that they wish to withdraw consent, this should be respected and the episode documented.

14. Advance refusal of treatment

Sometimes service users may wish to plan for their medical treatment in the event of future incapacity, including advance refusal of medical treatment. There is no Irish legislation confirming the enforceability of such advance refusals. However, such an advance plan should be respected on condition that:

- the decision was an informed choice, according to the principles discussed earlier;
- the decision specifically covers the situation that has arisen, and
- there is no evidence that the service user has changed their mind since the advance plan was made.

If there is reasonable doubt about the existence of an advance treatment plan, the service user's capacity at the time of making the treatment plan or whether it still applies in the present circumstances, treatment decisions should be made according to the principles discussed earlier. Legal advice may be advisable in such circumstances if the decision will have a significant impact on the service user's health.

Part Two – Children and Minors

Part Two– Children and Minors

1. Introduction

In any matter relating to children, the child's best interests are of paramount importance. In providing health and social care services to children, it is important that their autonomy is respected. This means that the child's own voice should be heard and respected as far as possible in decision-making about their care.

Involving children in decision-making may be different from seeking consent from adults due to the age or ability of the child to understand the relevant information and decision to be made. The role of the parents and/or legal guardians to make decisions for the child is of course also very important.

Even where children are not able to give a valid consent for themselves, they still have the right to be involved in the decision-making process as even young children may have opinions about their healthcare and they have the right to have their views taken into consideration. It is always important to give children information about their care in a form and language that they can understand.

2. Who can give consent for a child?

Parents and legal guardians are generally considered best placed to safeguard the health and wellbeing of their children. Legal guardianship refers to the right and responsibility of a parent to be involved in all major decisions affecting the child including education, health and moral concerns. Under Irish law the following rules apply:

- Where the parents are married, both mother and father are legal guardians
- Where the child has been jointly adopted by a couple, the adoptive parents are both legal guardians

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- After separation or divorce, both parents remain legal guardians
- If the parents are not married, the child's mother is the only automatic legal guardian but the child's father may also be legal guardian by agreement with the mother effected by way of a statutory declaration or by virtue of a court order.

Where a child accesses a health or social care service with an adult, the adult should be asked to confirm that they are the parent or legal guardian. This should be documented in the child's record. If they are not the parent/legal guardian, contact must be made with the appropriate person to seek consent.

If the child's parent is a minor, he or she is nonetheless presumed to be the best decision-maker for their child. If their decision is not considered to be in the best interests of the child, then you should engage in dialogue with them about their decision, including an assessment of their maturity as outlined below. If appropriate, another person such as the child's grandparents might be involved in this process with the consent of the minor parent. If agreement cannot be reached, legal advice should be sought.

3. Can I get consent from a parent over the phone?

Sometimes it can happen that a child is brought for treatment by a grandparent or babysitter who does not have legal authority to give consent for the child. In such circumstances consent may be obtained by telephone if the parent is unable to attend, and should be documented. The same standard of informed consent set out in Part One applies to consent obtained this way.

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4. Do I need to get consent from both parents?

This is a very difficult question to answer as the legal position is unclear. Some people argue that the consent of both parents is legally required where both are recognised as legal guardians. However, seeking joint consent may cause delays in children receiving necessary care and services and there may be logistical difficulties in ensuring that both parents attend to give consent.

Seeking the consent of one parent is widely recognised as sufficient in health and social care practice both in Ireland and elsewhere and is considered more practical for safe, timely and effective service provision in the interests of the child.

If both parents have indicated a wish to participate in decision-making for the child, you should accommodate this as far as possible. It is the parent's responsibility to make sure they are contactable at the time when decisions have to be made for the child.

In circumstances where the decision to be made for the child will have profound and irreversible consequences, both parents should be consulted if possible. However, if urgent care is required and the second parent cannot be contacted, you must act in the best interests of the child.

5. What if neither parent is contactable?

In emergency circumstances where neither parent is contactable, you may provide care if this is necessary in the best interests of the child. If urgent care is not required, you should postpone treatment until a parent is in attendance to give consent.

Part Two– Children and Minors

6. Age of consent

Irish law generally defines a child as a person under the age of 18 years, other than someone who is or has been married. However, section 23 of the Non-Fatal Offences against the Person Act 1997 provides that a person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to seek consent from the parents. This also covers any procedure undertaken for the purposes of diagnosis and any procedure ancillary to treatment such as anaesthesia.

A 16 or 17 year old can give their own consent to surgical, medical and dental treatment as if they were an adult.

For those under 16, it is good practice to involve them in decision-making and to seek their assent to the proposed intervention or care.

'I have sometimes heard reference to 'the mature minor' test. What does this mean?'

In some countries a person can give consent when he or she reaches a stage of sufficient maturity to enable them to understand fully what is proposed and the consequences of their decision. In England, this is called the *Gillick* test.

Since the Irish courts have not yet addressed this issue in this jurisdiction, the application of the mature minor test in Ireland is unclear. It is possible that an Irish court may adopt this test or the court may take the view that parental consent must always be sought for a person under the age of 16 years.

The *National Consent Policy* adopts the position that it is usual to involve parents in decision-making for persons under the age of 16 years. However, sometimes a person under 16 may seek health or social care without the parent's knowledge or consent.

Part Two– Children and Minors

7. What should I do if a 15 year old seeks treatment without their parent?

Firstly you should try to encourage and advise the young person to involve their parent. In exceptional circumstances where you consider that the service is in the best interests of the minor you may provide the service if you are satisfied that

- the minor has sufficient maturity to make an informed decision;
- the minor's views are stable and a true reflection of their beliefs taking into account their physical and mental health;
- the nature, purpose and usefulness of the intervention is in keeping with the minor's best interests;
- the benefits outweigh the risks of the proposed treatment; or
- you have met any legal requirements under child welfare and protection law or guidelines.

8. Should I tell the parents?

Confidentiality is a cornerstone of medical ethics and fundamental to the trust between you and your patient. It is essential that the minor patient is not deterred from seeking healthcare services by a fear of disclosure to their parents. However, in medical ethics and law there are circumstances in which a breach of confidentiality may be justifiable where, for example, you reach the conclusion that disclosure to the parents is necessary to prevent harm to your patient or someone else. In those circumstances it is best practice to warn the patient that you intend to make such a disclosure.

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It is also important to be aware that under Irish law a minor under 16 cannot be assured confidentiality due to the provisions of the Freedom of Information Act 1997 which may entitle the minor's parents to access their medical or other records. You should tell the minor that if their parents seek such records, you are obliged by law to release them.

9. Should I inform anyone if my patient informs me of underage sexual activity?

If your minor patient seeks sexual health advice or treatment, you should consider the patient's age and any legal obligations you may have to report underage sexual activity to the HSE or an Garda Síochána. It is critical in such circumstances that you consider the possibility that the sexual activity may have been abusive, exploitative or non-consensual. You should document the result of your assessment of this possibility and any actions you decide to take as a result. You should encourage the minor to involve their parents in such matters.

10. Refusal of services by children, minors or their parents:

- If a **young child** refuses treatment despite parental consent, they should always be given the opportunity to explain the reasons for their refusal. You may be able to provide sufficient explanation and reassurances to the child to allay any fears or worries they may have.
- If a **mature minor under 16**, acting in the absence of a parent, refuses a health or social care service, you should encourage them to involve their parent in the decision. If they do not want to involve the parent and you are of the view that the service is in the minor's best interests, you should inform the parent despite the minor's refusal.

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- If a **person between 16 and 18** refuses a treatment or service, in general you should respect this refusal. However, if it relates to life-sustaining treatment or other serious decisions, you should make reasonable efforts to discuss the decision with all relevant parties. You may seek the assistance of the HSE advocacy services or a mediator in order to try to reach consensus. Failing agreement, an application should be made to the High Court to adjudicate on the refusal.
- If **parents refuse** on behalf of the child or minor, you should recognise the right of the parents to participate in decisions about what is best for the child. It may be advisable to call a case conference involving the parents and all relevant care providers to try to reach consensus. If the parents seek a second opinion, this should be facilitated wherever possible. In exceptional circumstances where consensus cannot be reached, you may consider applying to the court for an adjudication of the matter.
- **What if parents are in dispute with each other about the treatment?** The parents should be advised that they have a responsibility to discuss the matter and reach an agreement between themselves as quickly as possible, with the assistance of HSE advocacy services and a mediator if required. If agreement cannot be reached, you should generally not provide the treatment unless you are of the opinion that it is necessary to safeguard the child's best interests. It may be necessary to seek court approval for any such action.

11. Children in the care of the HSE

It is the responsibility of the HSE to ensure that there is an appropriate care order in place for a child in respect of whom consent is required to be given for the provision of health or social care services. Further detail on this is available in the *National Consent Policy*.

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12. Mental health services

The provision of mental health services to children follows the same general principle as other services.

- For children under the age of 16, consent from their parents is generally required
- For those between 16 and 18 who seek mental health treatment on an outpatient basis, the same provisions apply in relation to an assessment of their maturity to make their own decision
- For children admitted under the Mental Health Act 2001, the requirements of the Mental Health Act 2001 must be followed.

In all situations involving the provision of mental health services it is important to take account of the child's right to participate.

