



Institute of  
Medical  
Illustrators

# A Code of Professional Conduct for Professional members

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*Copies are available on the IMI website ([www.imi.org.uk](http://www.imi.org.uk))*

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## **Introduction**

All IMI professional members are bound to practice within the terms of IMI's "A Code of Professional Conduct for Professional members". This code details the standards required to maintain professional practice.

Within the text, the Code refers to professional members, and where specifically appropriate, to Clinical Photographers. IMI also includes Medical Artists, Graphic Designers and Illustrators.

The title, Clinical Photographer, is used where the code applies to professional members practising Clinical Photography and/or Clinical Videography. These individuals are registered through the Committee for the Accreditation of Medical Illustration Practitioners (CAMIP).

The Code refers to some professional national guidelines. These guidelines inform the development of procedure within the practice of Clinical Photography. The following guidelines are pertinent and available on the IMI website: -

Clinical Photography and Cultural Diversity<sup>1</sup>

<http://www.imi.org.uk/document/cultural-diversity-guidelines> Consent to Clinical Photography<sup>2</sup> Patient Confidentiality, Use and storage of digital clinical images and Clinical Illustrative Records<sup>3</sup>, The Use of Chaperones in Clinical Photography<sup>4</sup>

### **The purpose of "A Code of Professional Conduct for Professional members"**

The Code of Professional Conduct aims to inform and guide the professional practice of all IMI professional members. It is a statement of the values and principles that IMI regards as fundamental to maintaining the highest standards of professional conduct. The Code requires that professional members practice in an ethical and professional manner.

The Code may be used in IMI disciplinary procedures as evidence of the requirements of fitness to practice. IMI Council may impose reasonable penalties on professional members who are found in breach of any requirements within this Code.

## **Summary of Statements**

### ***Statement 1 - Responsibilities and scope of practice***

Professional members should recognise their responsibilities to maintain professional standards and an appropriate scope of practice.

### ***Statement 2 - Duty of care***

Professional members shall avoid causing harm or distress to patients; protect their rights and dignity while recognising their beliefs and cultural practice.

### ***Statement 3 - Reporting concerns or risks to appropriate person(s)***

Professional members must report to an appropriate authority, circumstances that might put patients or others at risk.

### ***Statement 4 - Collaborative practice***

Professional members shall work collaboratively with other healthcare professionals in the interests of patient care, teaching and research.

### ***Statement 5 - Health and safety***

Professional members must identify and employ safe working practices and ensure compliance with legislation and health and safety policy.

### ***Statement 6 - Identifying limitations of knowledge and skills***

Professional members must continually evaluate personal skills and knowledge. Maintain Continuing Professional Development to ensure that training and learning processes address the specific requirements of practice.

### ***Statement 7 - Confidentiality, security and copyright***

Professional members must protect the confidentiality, security, and copyright of images and information to conform to legislation and protect the rights and dignity of patients.

### ***Statement 8 - Remuneration and payment for services***

Professional members should not accept unrecognised forms of payment or remuneration from patients, patients' relatives or commercial organizations.

### ***Statement 9 – Employers policies and procedures***

Where Professional members are employed by NHS and University organizations they must adhere to the local policies and procedures and standing financial orders of their employing organizations.

## ***Statement 1 – Responsibilities and scope of practice***

“Practitioners should recognise their responsibilities to maintain professional standards and an appropriate scope of practice.”

### ***1.1 Clinical photography, clinical videography***

Professional members must consider the requirements of their individual job description and scope of practice.

They must adhere to protocols, employ evidence based practice and amend practice where audit outcomes and relevant research indicate best practice.

Professional members will always be accountable for their actions, omissions and behaviours and need to be able to justify any decisions taken within their scope of practice. They should recognise any deficiencies in practice and take appropriate action to rectify them.

Professional members should seek to develop and maintain their abilities using a programme of CPD.

Professional members must practice within the limits of their competence. Where evidence of competency is required, this must be assessed formally and documented.

### ***1.2 Development of the profession***

Professional members should endeavor to ensure that the profession of Clinical photography continues to develop across all fields and specialities and to look for opportunities to pursue development.

### ***1.3 Individual role development***

Organisational and individual career progression plans should provide opportunities for individual role development. Practitioners should engage in development and educational planning relevant to individual, organisational and service needs as identified within clinical practice. Adoption of reflective, self-directed learning should ensure the appraisal of contemporary research evidence leading to sharing of best practice within teams. Professional members should encourage colleagues and other professional members of the Medical Illustration workforce to pursue role development.

### ***1.4 Medical artists, graphic designers and illustrators***

As professional members of IMI, practitioners are required to work in accordance with principles in the Code that relate to maintaining professional standards. In addition, Medical Artists who work with patients must follow principles relating to the Duty of Care to patients.

All IMI professional members must maintain skills and knowledge that meet the requirements of their clients and employing organisations. Medical Artists, Graphic Designers and Illustrators should participate in an appropriate Continuing Professional Development scheme.

### ***1.5 Delegation of duty***

Practitioners who delegate duties to others, such as students, support workers or volunteers, must be satisfied that the person is competent to undertake that duty and provide, where necessary, an appropriate level of supervision. Practitioners delegating duties will retain responsibility for the patient or client at all times.

Clinical Photography Departments employing or providing clinical placements for students should attain IMI Quality Assurance Level 1.

### ***Footnotes:-***

***1. IMI National Guidelines -***

***Clinical Photography and Cultural Diversity*** <http://www.imi.org.uk/document/cultural-diversity-guidelines>,

***2. Consent to Clinical Photography***

<http://www.imi.org.uk/document/consent-in-clinical-photography>

***3. Patient Confidentiality and Clinical Illustrative Records***

<http://www.imi.org.uk/document/patient-confidentiality>

***4. The Use of Chaperones in Clinical Photography***

<http://www.imi.org.uk/document/chaperones>

## ***Statement 2 – Duty of care***

**“Professional members shall avoid causing harm or distress to patients; protect their rights and dignity while recognising their beliefs and cultural practice.”**

Unlike many health care records and diagnostic medical images, clinical photographs and video recordings can be easily understood by the general public. The practitioner must ensure that patient’s rights and interests, with regard to dignity and confidentiality, are safeguarded within working procedures.

Professional members shall employ interpersonal skills and working practices that avoid causing harm or distress to patients to ensure that fundamental human rights, personal beliefs and cultural practices and personal dignity are not compromised

Clinical Photographers have a duty of care (Bolam Test).<sup>5</sup> to ensure that while they are undertaking any procedure with a patient, they maintain that duty and do nothing which could cause physical or psychological harm. This is especially true of invasive procedures such as dental and paediatric cleft lip and palate photography, which require the introduction of dental mirrors and retractors into the oral cavity.

This duty of care extends to harm which may be caused by disclosure of images as a result of inappropriate consent, handling and or storage procedures. The Institute of Medical Illustrators (IMI) has developed guidelines for Confidentiality and Consent.

### ***2.1 Informed consent***

The process of gaining informed consent for clinical recordings is something that hospitals throughout the United Kingdom have now recognised as conforming to ‘best practice’ and most hospitals will have organisational policies to support this including a requirement to obtain a signature from the patient/legal representative as evidence that an informed consent process has taken place.. Examples of such policies can be found on the IMI website.

The key aspect of informed consent is that any proposed procedure and the intended use of clinical photographs has been explained to the patient, in language or a form that he/she can understand so that the patient is able to make an appropriate informed decision. Often hospitals’ consent forms will vary to include different levels of consent that are easily understood.

The responsibility of obtaining informed consent and assessing the capacity of the patient to understand rests with the treating clinician and is not a function of the Clinical Photographer. However, the clinical photographer has a duty to ensure that such informed consent has been obtained prior to undertaking clinical photography and in all cases of recording, care must be taken to respect the dignity, ethnicity and religious beliefs of the patient. Patients have the right to withdraw consent for use of their recordings at any time. If a patient decides to withdraw consent, the records must not be used (and, if made in the context of teaching or publication, quarantined). However in the case of electronic publication, it should be made clear to the patient that once a recording is in the public domain, there is no opportunity for effective withdrawal of consent.

### **2.1.1 Refusal to consent**

A patient has the right to refuse to consent to any procedure and it must be made clear that doing so will not prejudice their future care. This right extends into the imaging session. The practitioners should stop the recording if the patient expresses this wish or if it is having an adverse effect on the consultation or treatment.

### **2.1.2 Recordings without consent**

In the case of procedures where recording is implicit (e.g. endoscopy, non-interventional radiology, ultrasound, fluorescein angiography), consent to the procedure should provide implicit consent to recording under the normal conditions set above. Health professionals must ensure that they make clear in advance that photographic or video recording will result from the procedure.

Illustrative Recordings without consent may be prescribed in certain circumstances, provided the authority of the consultant in charge of the case is obtained and the consultant is satisfied that this is in the vital interests of the patient to do so. Examples of where this might occur include:

Suspected non-accidental injury of a child, where it is unlikely that the parent or guardian will give consent and the recording of injuries is demonstrably to the patient's benefit and in cases of adult protection.

### **2.1.3 Children's consent**

In the case of minors, the patient or guardian should sign the consent form however there are some exceptions to normal consent procedures involving children. In addition to this there are also legislative variations between different parts of the United Kingdom.

In England & Wales a person who has attained the age of 16 years has the legal capacity to consent to treatment (Family Law Reform Act 1969).<sup>7</sup>

In Scotland a person under the age of 16 years has legal capacity to consent (Age of Legal Capacity (Scotland) Act 1991).<sup>8</sup>

Records of children should be taken only if there are specific features that need recording for clinical (e.g. assessing the progression of a skin lesion) or teaching (e.g. an important clinical sign that might only be seen rarely). Records should only include the specific areas of interest. Whole body shots should not be taken unless completely necessary.

In Northern Ireland, a minor who has attained 16 years shall have effective consent to treatment (Age of Majority Act (Northern Ireland) 1969).<sup>9</sup>

The Children Act 1989 does not deal specifically with consent, but makes provision for a minor to refuse medical or psychiatric examination.<sup>10</sup>

In addition to legislation, there is case law which determines if a minor is competent to consent to treatment (Gillick v West Norfolk and Wisbech AHA, 1985).<sup>11</sup> This case law led to the establishment of Gillick Competence. However, this has subsequently been updated following a ruling by Lord Fraser.

The assessment of a child's competence is now referred to as Fraser

Competence.<sup>11, 13</sup>, This assessment is clearly the responsibility of the requesting clinician. In a court of law, any decisions regarding competence are potentially open to challenge. It is debatable whether Medical Photography can be defined as a treatment.

The child may decide, after consent has been obtained, and prior to or during the photography session, that he or she does not want to be photographed. In this situation, the photographer must refer back to the requesting clinician.

Non Accidental Injury (NAI) cases involving a minor may be photographed without consent, where it is unlikely that the parent or guardian will give consent and the recording of injuries is demonstrably to the patient's benefit of care.

#### ***2.1.4. Mental Capacity***

Capacity relates to the persons ability to be able to make a specific decision at the time it needs to be made. Capacity can fluctuate and any individual has the potential to lack capacity at times during their lives. Factors that could potentially affect capacity can either be temporary. If a patient is deemed to be lacking in mental capacity, whether temporary or permanent, any photography undertaken must be done so only when carried out in the patient's best interests.

In the absence of capacity to give consent the healthcare professional requesting the recording must make the decision in the best interest of the individual under section 1(5) of the Mental Capacity Act (2005), an example of which would be to positively promote an individuals right, providing evidence in relation to suspected abuse.

In cases of temporary incapacity where it is impossible to obtain consent prior to the recording (e.g. photography of an unusual finding in the course of an operation where the patient is under anaesthetic or where the patient is otherwise unconscious), the recording can be made but should be quarantined in the department until consent is subsequently obtained when the patient regains capacity.

The patient must be told that the recordings have been taken. If such a patient does not consent retrospectively then the records must be quarantined for the same retention period as the patient's health record (i.e. the images will be removed from the individual's medical record and retained within the archive but not be accessible to view.

#### ***2.1.5 Vulnerable adults***

Vulnerable adults may be defined as those who are not in a position to make judgments and/ or consent on their own behalf regarding medical treatment or procedures.<sup>12</sup> These may include certain categories of psychiatric patients and those suffering from dementia.

In Scotland patients can be photographed without consent providing they have an active incapacity certificate (Adults with Incapacity (Scotland) Act 2000).<sup>14</sup> However, no healthcare worker, other than a registered medical practitioner, has the power to complete and sign the certificate.

In England, Wales and Northern Ireland, no one can legally give consent by proxy if a patient over 18 years lacks mental capacity. Treatment, however, may be given

in the best interests of the patient, provided that a body of responsible medical opinion agrees. Preferably, decisions on treatment would include a relative or guardian.

### ***2.1.6 The Deceased Patient***

The duty of confidentiality survives the death of the patient and the terms of the original consent should be honoured. However in instances where a patient dies before retrospective consent can be obtained, material can only be released with the consent of the deceased's personal representatives. In addition, wherever possible the consent of the next of kin or near relatives should be obtained, particularly where the personal representatives are not relatives of the deceased.

In cases as defined above any such recording should not be used if recordings of patients who are able to give or withhold consent could equally well meet the purpose of the recording.

## ***2.2 Cultural / religious / ethnic beliefs and issues***

Respect for the patient as an individual is fundamental to the ethical practice of Clinical Photography. In addition, the rights of the patient are protected in law (Human Rights Act 1999, Disability Discrimination Act 1995, Sex Discrimination Act 1998 and Race Relations Act 1976).<sup>15-17</sup>

Clinical Photographers must be sensitive to cultural and lifestyle diversity and ensure that services respond to the needs of multicultural society. The IMI National Guidelines – Clinical Photography and Cultural Diversity, seek to identify best practice in this area. All Clinical Photographers should be familiar with these guidelines.<sup>18</sup> Photographers should appreciate the importance of appropriate personal attitude, effective communication, maintaining eye contact and ways of addressing language barriers.

### ***2.3 Contact with patient***

The Clinical Photographer must approach the patient in a professional manner and must not undertake any practice that may cause physical or psychological distress.

It is advisable to avoid unnecessary physical contact with the patient. However it is inevitable that, during some photographic sessions, close contact will occur. The photographer should carefully explain his intentions prior to contact. Poor communication might contribute to patients and their carers misunderstanding and misinterpreting the actions and intentions of the photographer. The potential for allegations of assault might arise.

In many cases, it is essential for the patient to remove clothing in order to record the entire area requested by the clinician. However, some patients may have valid reasons for not wishing to remove clothing and clinical photographers need to be sensitive to this possibility. In these cases, it is possible to preserve the patient's dignity by allowing garments to be worn during photography. Although the session may result in the production of records that do not match the clinician's preferences regarding the removal of distracting clothing, the needs of the patient must be respected at all times.

It is the duty of the Clinical Photographer to exercise professional judgement and common sense and to recognise the unspoken signals from the patient that might demonstrate their feelings during the photographic session.

### ***2.4 Chaperoning***

It may sometimes be necessary to invite a chaperone in to the photographic session. All Clinical Photographers should be aware of the issues surrounding the use of chaperones;

- **When to use a chaperone?**
- **Who may or may not be used and what to do when a chaperone is unavailable?**

The IMI National Guidelines - The Use of Chaperones in Clinical Photography addresses these issues and should be familiar to all Clinical Photographers.<sup>19</sup>

**Footnotes:-**

5. *Bolam Test* <http://www.sma.org.sg/smj/4301/430111.pdf>

There is no legal requirement for consent to be in writing, but it is considered 'best practice' to do so and may well be stated in local hospital policy documents. However, a patient's consent may not be required if he/she has certain notifiable diseases. In such circumstances the clinician is legally bound to disclose information for the greater good of the public. The patient must be told about the disclosure under the Data Protection Act 1998.<sup>6</sup>

Attempts to make clinical photographs anonymous (e.g. by blacking out eyes) should never be undertaken in place of obtaining informed consent.

6. *Data Protection Act 1998* <http://www.legislation.gov.uk/ukpga/1998/29/contents>

7. *Family Law Reform Act 1969*

<http://www.legislation.gov.uk/ukpga/1987/42/contents>

8. *Age of Legal Capacity (Scotland) Act 1991*

<http://www.legislation.gov.uk/ukpga/1991/50/contents>

9. *Age of Majority Act (Northern Ireland) 1969*

<http://www.legislation.gov.uk/apni/1969/28/contents>

10. *Children Act 1989*

<http://www.legislation.gov.uk/ukpga/1989/41/contents>

11. *Gillick and Fraser Guidelines*

[http://www.nspcc.org.uk/inform/research/questions/gillick\\_wda61289.html](http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html)

12. *The Mental Capacity Act 2005.*

[http://www.nspcc.org.uk/inform/research/questions/gillick\\_wda61289.html](http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html)

13. *Families Link International, Law - End of Gillick Competence, Competent children, medical consent and their best interest.*

[http://www.familieslink.co.uk/pages/law\\_gillick\\_competence.htm](http://www.familieslink.co.uk/pages/law_gillick_competence.htm)

14. *Adults with Incapacity (Scotland) Act 2000* <http://www.scotland-legislation.hmsso.gov.uk/legislation/scotland/acts2000/20000004.htm>

15. *Human Rights Act 1998*

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

16. *Sex Discrimination Act 1986*

<http://www.legislation.gov.uk/ukpga/1986/59/contents>

17. *Race Relations Act 1976* <http://www.legislation.gov.uk/ukpga/1976/74>

18. *The IMI National Guidelines – Clinical Photography and Cultural Diversity*

<http://www.imi.org.uk/document/cultural-diversity-guidelines>

19. *IMI National Guidelines - The Use of Chaperones in Clinical Photography*

<http://www.imi.org.uk/document/use-of-chaperones>

### ***Statement 3 – Reporting concerns or risks to appropriate person(s)***

“Practitioners must report to an appropriate authority, circumstances that might put patients or others at risk.”

Professional members have a duty to report, to an appropriate authority, circumstances that might put patients or others at risk.

Clinical Photographers work within a variety of environments, within and outside the clinical setting. All environments can present risks for the patient, staff or visitor. Professional members should make sure that any procedures undertaken are safe for the patient, visitors, staff and self.

Any risks identified in the course of practice must be reported to the appropriate authority within their organisation.

Professional members should ensure that they maintain their own competence and assist colleagues to maintain their standards and levels of practice and to report incompetent practice to the appropriate authority.

### ***Statement 4 – Collaborative practice***

“Professional members shall work collaboratively with other healthcare professionals in the interests of patient care, teaching and research.”

It is widely recognised that working within multi-disciplinary teams improves the quality and effectiveness of the work of all practitioners within the various disciplines. Sharing of information and collaboration contributes to improving and maintaining services that support patient care, teaching and research.

Professional members must co-operate and communicate effectively with colleagues and other healthcare professionals to ensure that patients receive the highest possible standards of care. Professional members have a responsibility not to undermine or bring the reputation of other staff into disrepute. However, when working within a multidisciplinary team, professional members must only undertake those tasks for which they are competent within the scope of the remit of their professional practice or for which competency has been assessed and documented.

## ***Statement 5 – Health and safety***

“Practitioners must identify and employ safe working practices and ensure compliance with legislation and health and safety policy.”

Professional members have a responsibility to maintain safe working practices and a safe working environment and to understand the extent of that responsibility. Professional members are expected to be aware of health and safety rules, local infection control policies and procedures, and relevant legislation. Professional members must work in compliance with health and safety law and organisational policy, in order to protect patients, relatives, colleagues, carers and the general public.

Employing organisations have a legal obligation to protect their employees as well as the general public who access the organisation’s property. Employees must report, to an appropriate person and/or appropriate authority, circumstances that might appear to put patients or others colleagues at risk.

It is a member’s duty, while at work, to: -

- Take reasonable care for his / her own health and safety and that of anyone else who may be affected by his / her acts or omissions at work. All professional members are required to conform to the standards demanded within their organisation.
- Co-operate with Heads of Department and anybody else with specific safety duties, so that they can comply with relevant health and safety legislation and the organisation’s Health and Safety Policy.
- Not interfere with or misuse anything provided in the interests of health, safety or welfare.

### ***5.1 Relevant legislation***

Control of Substances Hazardous to Health Regulations 2002 (COSHH)

<http://www.legislation.hmso.gov.uk/si/si2002/20022677.htm>

Electricity at Work Regulations 1989

[http://www.hmso.gov.uk/si/si1989/Uksi\\_19890635\\_en\\_7.htm](http://www.hmso.gov.uk/si/si1989/Uksi_19890635_en_7.htm)

Fire Precautions (Workplace) (Amendment) Regulations 1999

<http://www.legislation.hmso.gov.uk/si/si1999/19991877.htm>

Health and Safety (Display Screen Equipment) Regulations 1992

[http://www.hmso.gov.uk/si/si1992/Uksi\\_19922792\\_en\\_1.htm](http://www.hmso.gov.uk/si/si1992/Uksi_19922792_en_1.htm)

Health and Safety (First Aid) Regulations 1981

<http://www.hse.gov.uk/pubns/books/l74.htm>

Management of Health and Safety at Work Regulations 1999 (Management Regulations) <http://www.hmso.gov.uk/si/si1999/19993242.htm>

Manual Handling Operations Regulations 1992

[http://www.hmso.gov.uk/si/si1992/Uksi\\_19922793\\_en\\_1.htm](http://www.hmso.gov.uk/si/si1992/Uksi_19922793_en_1.htm)

Noise at Work Regulations 1989 (Noise Regulations)

[http://www.hmso.gov.uk/si/si1989/Uksi\\_19891790\\_en\\_1.htm](http://www.hmso.gov.uk/si/si1989/Uksi_19891790_en_1.htm)

Personal Protective Equipment Work Regulations 1992 (PPE)

[http://www.hmso.gov.uk/si/si1994/Uksi\\_19942326\\_en\\_1.htm](http://www.hmso.gov.uk/si/si1994/Uksi_19942326_en_1.htm)

Working Time Directive and Working Time Regulations 1998 (amendment 2002)

<http://www.legislation.hmso.gov.uk/si/si2002/20023128.htm>

## ***Statement 6 – Identifying limitations of knowledge and skills***

“Professional members must continually evaluate personal skills and knowledge. Maintain Continuing Professional Development to ensure that training and learning processes address the specific requirements of practice”.

Being a professional requires recognition of personal limitations and maintenance of appropriate National Occupation Standards and standards of proficiency and CAMIPs Code of Conduct.

It is an individual’s responsibility to achieve and continuously maintain a high level of professional competence. Maintaining professional competence helps to maintain the confidence of patients, clinicians, healthcare professionals and the general public.

Clinical Photographers have a duty to identify and comply with the standards, policies, procedures, professional guidelines and legislation relating to medical photography practice.

Clinical Photographers should practice to the best of their ability, while exercising professional judgment, skill, and care.

### ***6.2 Undertaking Continuing Professional Development (CPD)***

All Professional Members of IMI are required to undertake mandatory CPD. Members should adopt an attitude of lifelong learning. The integration of CPD into day-to-day practice benefits the individual by enhancing and developing his/her own performance. Enhanced personal performance will benefit the service and ultimately the patient.

The practice of Clinical Photography is subject to constant development and rapid change. In order to keep up with these changes it is important that Clinical Photographers undertake CPD. They should engage actively in a constant process of learning and development.

The maintenance and development of professional standards is a requirement of continued practice.

Individuals should take personal responsibility for actively maintaining and developing their professional competence. IMI has published a statement of its CPD requirements on its web site. (20)

#### ***Footnotes: -***

##### ***20. IMI CPD***

***<http://www.imi.org.uk/document/continuing-professional-development>***

## ***Statement 7 – Confidentiality, security and copyright***

“Professional members must protect the confidentiality, security, and copyright of images and information to conform to legislation and protect the rights and dignity of patients”.

Detailed guidance can be obtained from these IMI guidelines: -

- Consent to Clinical Photography
- Patient Confidentiality and Clinical Illustrative Records <sup>2,3</sup>

### ***7.1 Confidentiality***

Clinical Photographers shall ensure the confidentiality and security of information and images acquired in the course of their professional practice.

Audiovisual records of patients will be made only in accordance with local procedures for obtaining informed consent.

The disclosure of confidential information should be on a ‘need to know basis’ in line

with the six key Caldicott principles. <sup>21</sup> Records will normally only be shared with the knowledge and consent of the patient.

### ***7.2 Security***

All records shall be kept securely in accordance with national legislation, policies and guidelines, and local policies and protocols. Records will only be made available to those who have a legitimate right to see them.

Access to the records by the patient will only be made in accordance with current statutory provision. Reference should be made to current codes of practice and other national and local guidance on access to personal health records.

### ***7.3 Copyright***

The Copyright, Designs and Patents Act (1988) makes it clear that copyright in any artistic work is vested in the original creator, e.g. photographer, videographer or artist. However, for those working as employees, the copyright remains with the employer. <sup>22</sup>

The copyright of patient record material cannot be assigned to another party, such as an external contractor and remains with the authority responsible for the patient’s care. This is not, itself, a provision of the 1988 Act, but is a reasonable assumption because of the need of the authority to retain control over confidential medical material. <sup>22</sup>

### ***7.4 Relevant legislation***

Access to Personal Files Act 1987, London: HMSO. Access to Medical Reports Act 1988 [http://www.hmso.gov.uk/acts/acts1988/Ukpga\\_19880028\\_en\\_1.htm](http://www.hmso.gov.uk/acts/acts1988/Ukpga_19880028_en_1.htm)

Access to Health Records Act 1990

[http://www.hmso.gov.uk/acts/acts1990/Ukpga\\_19900023\\_en\\_1.htm](http://www.hmso.gov.uk/acts/acts1990/Ukpga_19900023_en_1.htm)

Data Protection Act 1998

<http://www.legislation.gov.uk/ukpga/1998/29/contents>

Human Rights Act 1998

<http://www.legislation.gov.uk/ukpga/1998/42/contents>

Freedom of Information Act 2000

<http://www.legislation.gov.uk/ukpga/2000/36/contents>

Also applicable are: -

The Cabinet Office. 1991. Citizen's Charter. HMSO. Department of Health.  
Patient's Charter. HMSO.

<http://www.publications.parliament.uk/pa/cm200708/cmselect/cmpublicadm/411/41105.htm>

Data Protection (Subject Access Modification) (Health) Order 2000

<http://www.legislation.hmso.gov.uk/si/si2000/20000413.htm>

**Footnotes: -**

*2. Consent to Clinical Photography*

<http://www.imi.org.uk/document/consent-in-clinical-photography>

*3. Patient Confidentiality and Clinical Illustrative Records*

<http://www.imi.org.uk/document/patient-confidentiality>

*21. The Caldicott Report 1997*

[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4068403](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4068403)

*22. Copyright, Designs and Patents Act (1988)*

[http://www.hmso.gov.uk/acts/acts1988/Ukpga\\_19880048\\_en\\_1.htm](http://www.hmso.gov.uk/acts/acts1988/Ukpga_19880048_en_1.htm)

### ***Statement 8 – Remuneration and Payment for Services***

Professional members should not accept unrecognised forms of payment or remuneration from patients, patients' relatives or commercial organisations. Employees should conform to employers standing financial procedures.

Professional members should not accept favours, gifts or hospitality from patients or patients' families. Professional members should abide by their employing organisations' policies when considering accepting benefits or hospitality provided by commercial organisations.

Professional members should not be influenced by commercial or other interests that might conflict with carrying out their duty.

Employing organisations may have local standing financial instructions that govern financial accountability and responsibility. Management procedures should ensure that financial transactions conform to these instructions.

### ***Statement 9 – Employers policies and procedures***

Where Professional members are employed by NHS and University organizations they must adhere to the local policies and procedures and standing financial orders of their employing organizations.

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## ***Appendices for Scottish professional members.***

### **Statement 2 – Duty of Care**

“Clinical Photographers shall avoid causing harm or distress to patients, recognise their beliefs and cultural practice and protect their rights and dignity.” Reference is made to the ***Bolam Test*** pertaining to the Clinical Photographer’s duty of care and the potential to harm a patient in the execution of their duties as well as encompassing all aspects of consent and confidentiality. This guidance does apply in Scotland.

*“The Bolam test has previously been used to judge medical practice but would apply to all healthcare professionals. Negligence is determined by whether the healthcare professional acted in accordance with accepted practice as recognised by a responsible body of professional opinion.*

*A duty of care encompasses avoiding actions and omissions that are reasonably likely to cause harm to the patient.”*

[http://www.advancedpractice.scot.nhs.uk/legal-and-ethics-guidance/accountability/public-\(owing-a-duty-of-care\).aspx](http://www.advancedpractice.scot.nhs.uk/legal-and-ethics-guidance/accountability/public-(owing-a-duty-of-care).aspx).

The Bolam Test in Scotland only differs from that of England and Wales at the point of actual litigation:

“The rules by which civil cases are conducted are the Civil Procedure Rules (CPRs) and doctors giving evidence as expert witnesses have to follow Part 35 of those rules in the submission of medical evidence.

The most important rule here is that 'experts' have to understand that they are there to advise the court and not to take the side of the party who is paying their fees. They have to remain impartial and should not, for instance, enter into fees being paid conditional to the outcome of a case.

These rules apply strictly in England and Wales but not in Scotland or Northern Ireland.”

<http://www.patient.co.uk/doctor/clinical-negligence>

#### **2.1.5 Children’s consent**

Under Scottish law a person under the age of sixteen years has legal capacity to consent (Age of Legal Capacity (Scotland) Act 1991). There are some changes pending to this Legislation but none of which will affect consent to clinical recording.

<http://www.legislation.gov.uk/ukpga/1991/50/section/2>

[https://www.lawscot.org.uk/media/726657/fam\\_extending\\_the\\_rights\\_of\\_children\\_with\\_capacity\\_response.pdf](https://www.lawscot.org.uk/media/726657/fam_extending_the_rights_of_children_with_capacity_response.pdf)

## ***Appendices for Republic of all Ireland professional members.***

These appendices are to assist Irish professional members in applying the code of Professional Conduct to their practice, while making reference to many of the points of UK statute and common law in the code, to those of statute and common law which exists within the Republic of Ireland.

### **Statute**

An Act of Parliament is a statute enacted as primary legislation by a National or sub-National parliament. In the Republic of Ireland the term Act of the Oireachtas is used, while an Act of Parliament is used in the UK. In the case of the UK, such acts are authorized by the Parliament of the United Kingdom at Westminster, or by the Scottish Parliament at Edinburgh.

### **Common Law**

Irish common law originates from English Common-law. Indeed both legal systems place an emphasis on previous court decisions or 'Stare decisis' than to 'civil-law' jurisdictions which are those used predominantly in countries such as France and Germany where the legal systems originate from Roman Law. More recently the legal framework put in place by Napoleon Bonaparte in the case of France.

#### **1.5 Delegation of duty**

Makes reference to the Bolam test

Bolam Test (Bolam v Friern Hospital Management Committee (1957)).<sup>1</sup> or the Bolam test as it became known, has been the benchmark test for medical negligence in the UK since 1957 and is used by Courts to determine the existence of a breach of duty in clinical negligence cases in England and Wales. In The Republic of Ireland the case of (Dunne (an infant) v the National Maternity Hospital and Jackson (1989) IR 91),<sup>2</sup> sets out the law on the appropriate standard of medical care within the ROI which are now referred to as the Dunne principles

#### **Footnotes:**

1, Bolam v Friern Hospital Management Committee (1957) 1 WLR 582  
<http://www.sma.org.sg/smj/4301/430111.pdf>

2, William Dunne (an infant suing by his mother and next friend Catherine Dunne), Plaintiff, v The National Maternity Hospital and Reginald Jackson, Defendants  
<http://www.houseofrussell.com/torts/exam-prep-cases/dunne-v-national-maternity.pdf>

#### **2.1 Informed consent**

The process of gaining informed consent for clinical recordings is something that hospitals throughout the Republic of Ireland now recognize as conforming to 'best practice'. Doctors therefore should inform the patient fully of the advantages or disadvantages, of having clinical Photography taken. The landmark cases of (Walsh v Family

Planning Services Ltd. & Ors )<sup>3</sup> and (Geoghegan v Harris([1992] 1IR 496)

<sup>4</sup> concluded that any risks must be disclosed to the patient. As is the case

in the UK Certain Diseases are notifiable under the (Infectious Diseases (Amendment) Regulations 2011)<sup>5</sup>

Footnotes:

3. Walsh v Family Planning Services Ltd. & Ors

[http://books.google.ie/books?id=OtPwqIDHdiQC&pg=PA68&lpg=PA68&dq=walsh+v+family+planning+services&source=bl&ots=ZAtguvnK8M&sig=btDjihIO1BbNmGo h1CIK\\_KPjUF8&hl=en&sa=X&ei=-dWQU46-BOMw7QbA64DQAQ&redir\\_esc=y#v=onepage&q=walsh%20v%20family%20planning%20services&f=false](http://books.google.ie/books?id=OtPwqIDHdiQC&pg=PA68&lpg=PA68&dq=walsh+v+family+planning+services&source=bl&ots=ZAtguvnK8M&sig=btDjihIO1BbNmGo h1CIK_KPjUF8&hl=en&sa=X&ei=-dWQU46-BOMw7QbA64DQAQ&redir_esc=y#v=onepage&q=walsh%20v%20family%20planning%20services&f=false)

4. Disclosure of risks in proposed medical treatment - new development

[http://www.hayes-solicitors.ie/archive%5Cnews\\_19\\_2003\\_June\\_3.htm](http://www.hayes-solicitors.ie/archive%5Cnews_19_2003_June_3.htm)

5. Infectious Diseases Regulations 1981

[www.irishstatutebook.ie/1981/en/si/0390.html](http://www.irishstatutebook.ie/1981/en/si/0390.html)

### 2.1.5 Children's consent

In the ROI a person who has reached the age of 16 years is deemed to have legal capacity to consent. (Section 23, of Non-Fatal Offences Against the Person Act 1997).<sup>6</sup> This Act deals specifically with consent by a minor of 16-17 years to surgical, medical and dental treatment. Although section 23 gives a minor the right to consent it is not clear if it provides the right of a minor to refuse treatment.

In the UK, the case of (Gillick v West Norfolk and Wisbech AHA, 1985)<sup>7</sup> led to the establishment of what is referred to as a test of Gillick Competence. This was later updated by Lord Fraser upon appeal to the House of Lords, following reversal of the decision by Justice Woolfe in the Court of Appeal. Lord Fraser subsequently upheld the original ruling by Justice Woolfe in dismissing the case taken by Mrs. Victoria Gillick. Lord Fraser went on to further add a set of guidelines to establish the competence of a minor. These are known as the Gillick competence and the Fraser guidelines. In the Republic of Ireland the situation surrounding consent of a minor remains unclear. The Medical Protection Society Booklet on consent (Who can consent on behalf of a minor?)<sup>8</sup> states "There may be circumstances in which a person under the age of 16 who demonstrates the maturity to understand the implications of a particular treatment does not wish his or her parents to be involved in that decision. In these circumstances, the patient's confidentiality should be respected."

Footnotes:

6. Non-Fatal Offences Against the Person Act 1997, section 23

<http://www.irishstatutebook.ie/1997/en/act/pub/0026/sec0023.html>

7. Gillick and Fraser Gillick v West Norfolk & Wisbech Area Health Authority [1985] UKHL 7 (17 October 1985)

8. (Who can consent on behalf of a minor?)

<http://www.medicalprotection.org/ireland/booklets/consent/who-can-consent-on-behalf-of-a-minor>

### 2.1.6 Vulnerable adults

Vulnerable adults may be described as those who are not in a position to make judgments or give consent on their own behalf in regard to medical treatment or medical procedures. In the ROI as is the case in England, Wales and Northern Ireland, no one can give consent by proxy for an Adult over 18 years of age who lacks mental capacity, unless the person is a ward of court or subject to an enduring power of attorney. The judgment and subsequent guidelines delivered by Miss Justice Lefoy in the case of (Fitzpatrick & Anor v K & Anor [2008] IEHC104)<sup>9</sup> clarifies a medical practitioner's responsibilities regarding informed consent and sets out the test of capacity that should be applied.

Of particular note is a bill (Assisted Decision-Making (Capacity) Bill 2008)<sup>10</sup> currently before the House of the Oireachtas. This, if enacted, will change the law relating to persons who require assistance in a decision making now or into future.

#### Footnotes:

9. (Fitzpatrick & Anor v K & Anor)

[http://www.codices.coe.int/NXT/gateway.dll/CODICES/full/eur/irl/eng/irl-2008-1-003?fn=document-frame.htm\\$f=templates\\$3.0](http://www.codices.coe.int/NXT/gateway.dll/CODICES/full/eur/irl/eng/irl-2008-1-003?fn=document-frame.htm$f=templates$3.0)

10. Assisted Decision-Making (Capacity) Bill 2013

<http://www.oireachtas.ie/documents/bills28/bills/2013/8313/b8313d.pdf>

### 2.2 Cultural / religious / ethnic beliefs and issues

Equality in the ROI is governed by The (European Convention of Human Rights Act(2003)<sup>11</sup> the (Equal Status Act, 2000)<sup>12</sup> and the (Equality Act 2004).<sup>13</sup> Under the equality legislation, discrimination based on any one of 9 distinct grounds is unlawful. These grounds are:

- Gender
- Civil status
- Family status
- Sexual orientation
- Religion
- Age (does not apply to a person under 16)
- Disability
- Race
- Professional membership of the Traveller community.

## **Footnotes:**

11. The (European Convention of Human Rights Act 2003)  
<http://www.irishstatutebook.ie/2003/en/act/pub/0020/>

12. Equal Status Act 2000  
<http://www.oireachtas.ie/documents/bills28/acts/2000/a800.pdf>

13. Equality Act 2004.  
<http://www.oireachtas.ie/documents/bills28/acts/2004/A2404.pdf>

### **5.1 Relevant Health and Safety legislation and guidelines:**

**SAFETY, HEALTH AND WELFARE AT WORK ACT 2005**  
[http://www.hsa.ie/eng/Legislation/Acts/Safety\\_Health\\_and\\_Welfare\\_at\\_Work/SI\\_No\\_10\\_of\\_2005.pdf](http://www.hsa.ie/eng/Legislation/Acts/Safety_Health_and_Welfare_at_Work/SI_No_10_of_2005.pdf)

**Fire Services Act 1981** <http://www.irishstatutebook.ie/1981/en/si/0430.html>

**Guide to the Safety, Health and Welfare at Work (General Application) Regulations 2007**  
[http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/General\\_Application\\_Regulations/Display\\_Screen.pdf](http://www.hsa.ie/eng/Publications_and_Forms/Publications/General_Application_Regulations/Display_Screen.pdf)

**Guide to the Safety, Health and Welfare at Work (General Application) Regulations 2007**  
[http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/Retail/Gen\\_Apps\\_Control\\_of\\_Noise.pdf](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Retail/Gen_Apps_Control_of_Noise.pdf)Guide

**Managing Health and Safety**  
[http://www.hsa.ie/eng/Topics/Managing\\_Health\\_and\\_Safety/](http://www.hsa.ie/eng/Topics/Managing_Health_and_Safety/)

**Organisation of Working Time Act, 1997**  
<http://www.irishstatutebook.ie/1997/en/act/pub/0020/>

**Personal Protective Equipment**  
[http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/General\\_Application\\_Regulations/Personal\\_Protective\\_Equipment.html](http://www.hsa.ie/eng/Publications_and_Forms/Publications/General_Application_Regulations/Personal_Protective_Equipment.html)

**Guide to the European Union (Prevention of Sharps Injuries in the Healthcare Sector) Regulations 2014**  
[http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/Healthcare\\_Sector/Guide\\_to\\_the\\_European\\_Union\\_Prevention\\_of\\_Sharps\\_Injuries\\_in\\_the\\_Healthcare\\_Sector\\_Regulations\\_2014.html](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/Guide_to_the_European_Union_Prevention_of_Sharps_Injuries_in_the_Healthcare_Sector_Regulations_2014.html)

**Tuberculosis - Protecting Healthcare Workers From Workplace Exposure**  
[http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/Healthcare\\_Sector/](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/)

**Guidance on Lone Working in the Healthcare Sector**  
[www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/Healthcare\\_Sector/Guidance\\_on\\_Lone\\_Working\\_in\\_the\\_Healthcare\\_Sector.pdf](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/Guidance_on_Lone_Working_in_the_Healthcare_Sector.pdf)

Get A Grip - Stop Slips and Trips in Healthcare [http://www.hsa.ie/eng/Publications\\_and\\_Forms/Publications/Healthcare\\_Sector/Get\\_A\\_Grip\\_Stop\\_Slips\\_and\\_Trips\\_in\\_Healthcare.pdf](http://www.hsa.ie/eng/Publications_and_Forms/Publications/Healthcare_Sector/Get_A_Grip_Stop_Slips_and_Trips_in_Healthcare.pdf)

## Statement 7 - Confidentiality and Security and Copyright

### 7.1 Confidentiality

In 1997, the Caldicott Committee in the UK presented its report on patient confidentiality and laid out six main principles protecting patient privacy. In the Republic of Ireland there are no Caldicott Principles or guidelines. However, the Constitution of Ireland offers the protection of the right to privacy as an aspect of personal rights under (Article 40.3.1,).<sup>14</sup> Notwithstanding this there is no specific reference to confidentiality in the medical field. Privacy is also protected by the (European Convention On Human Rights Act 2003)<sup>15</sup>. The confidentiality of the patient record is protected under The (Data Protection Act 1988)<sup>16</sup> which gave protection to information stored on computers only, this was later updated in the (Data Protection (Amendment) Act 2003)<sup>17</sup> to include among others, manual files, while the same amendment gave power to Data Controllers and the Data Commissioner. Section. 2.17 of the act outlines a number of duties for a Data Controller which are similar to those of the Caldecott principles in the UK.

### 7.2 Security

Access to personal medical records is provided for through The (Freedom of Information Acts 1997 & 2003).<sup>18. 19</sup> As is the case in the UK, in The ROI all records shall be kept in accordance with National and local guidelines. It should be noted that the (Data Protection (access Modification) (Health) Regulations 1989)<sup>20</sup> provides for circumstances where health data may be withheld where it is considered to be harmful to the patient both mentally and physically.

A bill currently before the Houses of the Oireachtas the (Freedom of Information bill 2013)<sup>21</sup> will, if passed into law will change the law on Freedom of Information.

### Footnotes:

14. Constitution of Ireland <http://www.irishstatutebook.ie/en/constitution/>

15. European Convention on Human Rights Act 2003<sup>16</sup>,  
(<http://www.irishstatutebook.ie/2003/en/act/pub/0020/>)

16. Data Protection Act, 1988  
<http://www.irishstatutebook.ie/1988/en/act/pub/0025/index.html>

17. (Data Protection (Amendment) Act 2003) section  
4. <http://www.irishstatutebook.ie/2003/en/act/pub/0006/sec0004.html>

Freedom of information Act 1997  
<http://www.irishstatutebook.ie/1997/en/act/pub/0013/index.html>

19. Freedom of Information (AMENDMENT) ACT  
2003 <http://www.oireachtas.ie/documents/bills28/acts/2003/a903.pdf>

20. Data Protection (access Modification) (Health) Regulations 1989)

21. Freedom Of Information Bill <http://www.oireachtas.ie/documents/bills28/bills/2013/8913/b8913d-memo.pdf>

**Also applicable are:**

Health Service Executive Standards and Recommended Practices for Healthcare Records Management  
[http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality\\_and\\_Patient\\_Safety\\_Documents/v3.pdf](http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/v3.pdf)

MPS Confidentiality of records  
<http://www.medicalprotection.org/ireland/booklets/medical-records/confidentiality-of-records>

Data Protection Breach Management Policy  
[http://www.hse.ie/eng/services/Publications/pp/ict/Data\\_Protection\\_Breach\\_Management\\_Policy.pdf](http://www.hse.ie/eng/services/Publications/pp/ict/Data_Protection_Breach_Management_Policy.pdf)

Data protection is everyone's responsibility An Introductory Guide for Health Service Staff  
<http://www.hse.ie/eng/services/list/3/hospitals/ulh/staff/resources/pppgs/dp/DPstaffguide.pdf>

Section C of the Ethical Guide: Medical Records and Confidentiality  
<https://www.medicalcouncil.ie/News-and-Publications/Videos/Section-C-of-the-Ethical-Guide-Confidentiality/Section-C-of-the-Ethical-Guide-Medical-Records-and-Confidentiality.html>

Confidentiality - general principles  
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### 7.3. Copyright

In The ROI copyright is covered by the (Copyright and Related Rights Act, 2000)<sup>22</sup>

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