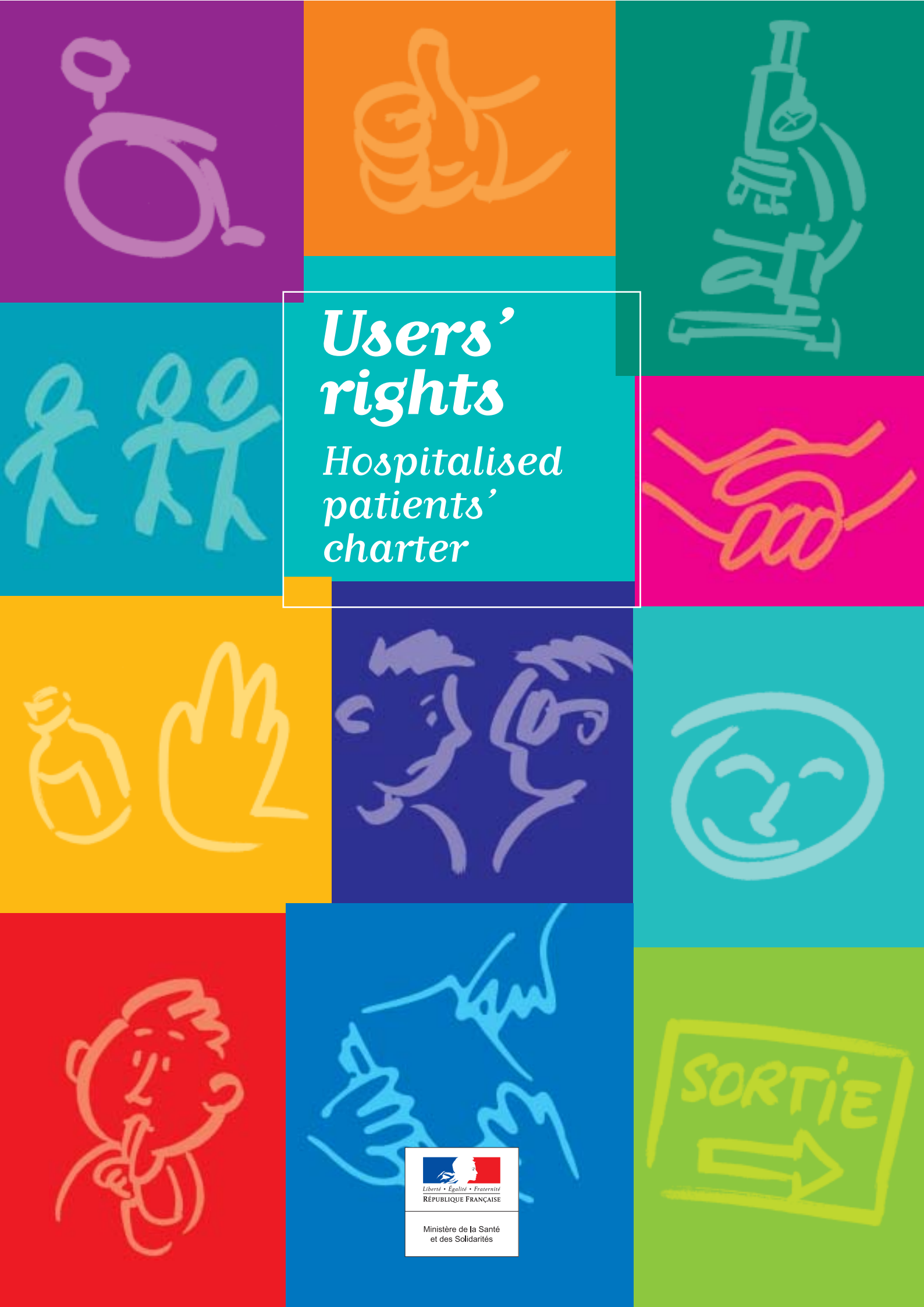

Users' rights

Hospitalised patients' charter

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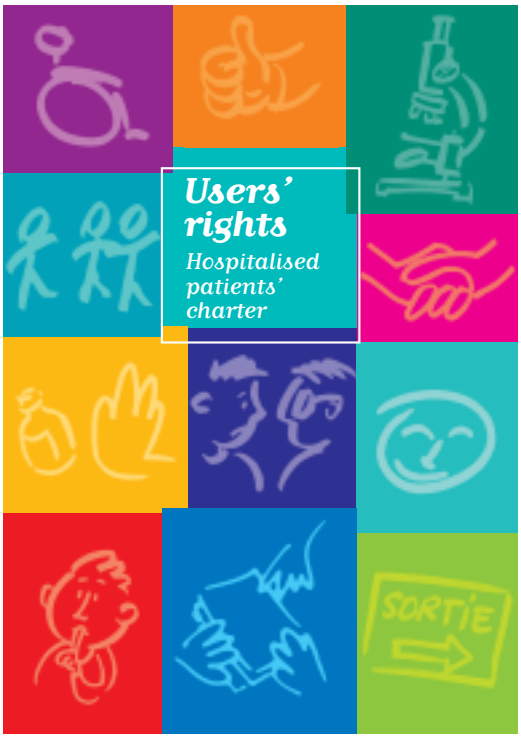
RÉPUBLIQUE FRANÇAISE

Ministère de la Santé
et des Solidarités



The purpose of this Charter is to inform patients admitted to health care institutions of their fundamental rights as set down in legislation – in particular the Act of 4 March 2002 relating to patients' rights and to the quality of the health system – and the principal decrees, orders, circulars and charters given in the appendix.

The expression "hospitalised patient" used in this Charter refers to all patients admitted to a health care institution, whether these patients are hospitalised (within the institution or in the context of home care), admitted for external consultation or emergency treatment.

The Charter is applied from the viewpoint of the obligations required for the smooth running of the institution and which must be met by the staff and hospitalised patients. The hospitalised patient must have access to the internal regulations setting out these obligations. The provisions which concern him and, particularly, provisions which apply to the institution, staff and patients, will, if possible, be included in the patients' handbook.

Each hospitalised patient admitted to the institution is given a summary of the Charter, as well as a leaving questionnaire and a formal commitment to relieving pain, appended to the patients' handbook. The complete Charter will be issued immediately, free of charge, on simple request from the admissions service.

1

Each person is free to choose the health care institution he wants to take care of him

Each person is **free to choose** the health care institution to which he wishes to be admitted. An institution can only object to this free choice if it does not have the means to ensure care can be provided that is appropriate for the condition of the person, or if it does not have a place available.

However, patients hospitalised without consent due to mental illness are only hospitalised in health care institutions approved for this purpose by the prefect.

Each person can also choose his doctor, on condition that this does not conflict with the institution's organisational methods.

In all cases, the person's choice of institution and/or doctor must be reconciled with certain expediencies linked to emergencies, the organisation of the service or the provision of care.

Conditions of reimbursement from which the person benefits may vary depending on the institution or the doctor chosen.

> *Provisions common to all health care institutions, whether public or private*

All health care institutions must contribute towards guaranteeing **equal access** of each person **to treatment** required by his state of health. No person must be discriminated against due to his state of health, handicap, origin, gender, marital status, political opinions, religion, race or genetic characteristics.

Institutions must make all the necessary provisions so that children of school age receive schooling adapted to their situation.

Special arrangements for receiving persons suffering from a physical, mental or sensory handicap must be provided for. The institution must take into account comprehension and communication difficulties of hospitalised patients and persons supporting them (the designated trusted support person, family or close relations).

Institutions must call on the services of interpreters or associations specialised in support for patients who do not understand French as well as deaf or hearing-impaired patients.

Health care institutions must facilitate the involvement of voluntary associations. The purpose of these associations is to provide help and support to any patient who requires it or to meet specific requests without hindering the provision of medical and paramedical care. An agreement must be reached with these associations specifying the conditions under which they work in the institution. The list of associations concerned should be displayed in the patients' handbook. Failing this, this list will be provided to hospitalised patients by the admissions service.

Any institution with an admissions service and **emergencies** department, which is unable to admit a person whose state of health requires immediate hospitalisation, must do all that is necessary to ensure he is admitted to another institution.

> *Provisions that are specific to the public hospital service*

Patients are admitted both day and night, possibly for emergencies.

Access to the public hospital service is guaranteed for the **most needy persons.** Persons who cannot provide proof of coverage by health insurance or State medical aid are admitted to public and private health care institutions participating in the public hospital service, for emergency treatment. This treatment is defined as treatment without which the patient's condition would be life-threatening or could lead to a serious and lasting deterioration in the patient's health or that of an unborn child. The institution constitutes a designated place where vulnerable persons are able to exercise their rights, including social rights. With this in mind, institutions must provide **continuous access to health care,** to assist persons in administrative and social procedures in order to guarantee their access to prevention, treatment and aftercare in hospital and in the care, admission and social support networks.

1 *Each person is free to choose the health care institution he wants to take care of him*

A social worker or, failing this, a charge nurse must be available for patients, their family or failing this their close relations[1] to assist them in resolving their personal, family, administrative or material difficulties resulting from their hospitalisation.

(1) The obligation of institutions to provide information also concerns the person designated as the trusted support person pursuant to Article L 1111-6 of the Public Health Code (see below).

2

Health care institutions must guarantee the quality of reception, treatment and care

Health care institutions must provide diagnoses, monitoring and treatment of patients, injured persons and pregnant women, while taking account of the psychological aspects of each of them. They must carry out preventative, examination and diagnostic procedures and provide the curative or palliative treatment required by the patient's condition and must not, within the context of the current state of medical knowledge, expose the patient to risks that are disproportionate to the benefit expected. Moreover, they must provide **continuity of care** at the end of the patient's admission or stay.

The painful, physical and psychological dimension of caring for hospitalised patients as well as relief of their suffering is an ongoing consideration for all parties. Every institution must be equipped with the means required to **provide pain relief** to the patients it admits. A leaflet outlining the institution's formal commitment to relieving pain must be given to each hospitalised patient. Progress in scientific and technical knowledge as well as the setting up of specific organisations enable pain to be relieved, in nearly all cases, whether chronic or not and whether experienced by children or adults. Particular attention must be paid to relieving the pain of persons at the end of their life.

When persons are nearing the end of their life, the institution does everything possible to ensure their **life is dignified until death.** It is essential to take account of their wishes in this respect (see below IV). They must receive supportive care, which meets their specific needs, both physical and psychological. They are supported, if they wish, by their family or close relations or persons of their choice (in particular the person they have designated as their trusted support person) and, of course, by the staff and volunteers working in the institution. In the event of impending death the institution will endeavour to inform the trusted support person, the family or, failing this, close relations, in good time for them to be able to be with the person during his last moments. Family members will also receive support[2].

In the event of death in the health care institution, the remains of the deceased person are placed in the mortuary of the institution or, failing this, in that of another institution. If there is no mortuary, the deceased can be transferred from the institution to a funeral chamber on the request of the family or on request of the director of the institution, if he has not been able to contact the family within a period of ten hours from the moment of death. When transfer to a funeral chamber has been requested by the director of the institution, the resulting transportation costs are charged to the institution as well as sheltering costs, up to the limit of the first three days following admission.

(2) The DHOS/O2/DGS/SD5D/2002/98 circular of 19 February 2002 constitutes a reference in this area with regard to organising supportive care.

3

Information given to the patient must be accessible and reliable

Institutions must ensure that **medical and social information** is provided to hospitalised patients and that the means used are adapted to any communication or comprehension difficulties experienced by the patient, in order to guarantee equal access to information.

It is the responsibility of the institution and health care professionals to prove that the information has been given to the party concerned.

Every person has the right to be informed about his state of health and medical confidentiality is not binding upon the patient. However, **a person's wish not to be informed** of the diagnosis or the prognosis concerning him must be respected, even if his state of health presents a risk of transmission to third parties.

The doctor must, during an individual assessment, provide the person with information that is **accessible, intelligible and reliable.** This information must be updated if necessary. The doctor must answer any questions tactfully and in an appropriate way. The information concerns examinations, treatments or preventative measures proposed as well as their possible alternatives. In the event of imparting information that is difficult for the patient to receive, the doctor can, insofar as possible, offer psychological support.

In the event that the medical information to be imparted partly falls within the remit of other health care professionals, **the doctor can refer** the person to these professionals for information or, failing this, recommend professionals that should be contacted to obtain more detailed medical information.

So that the patient can fully participate in the choice of treatment that concerns him and in its daily administering, the doctors and paramedical staff must inform and instruct him, each within his respective field of expertise.

When, after examinations, treatment or preventative measures have been carried out, new risks are identified, the person concerned must be informed, unless it proves impossible to contact him.

In order to ensure that **minors and adults under guardianship** are involved in the decision-making process concerning them, they are informed of the procedures and examinations required in order for their state of health to be taken care of, depending on their age and their ability to comprehend, independently of the vital information given to their legal representatives.

The doctor is bound by **medical confidentiality**, introduced to protect the patient. Under these conditions, the doctor must not disclose any medical information to any person other than the patient. However, in the event of a serious diagnosis or prognosis, and unless the patient objects, the family and close relations can be given information enabling them to directly support the patient and must have sufficient time to consult the doctors in charge of the patient. Moreover, in the event of death, and unless objected to beforehand by the patient himself, medical confidentiality does not present an obstacle to the disclosure of information to beneficiaries when the cause of death needs to be known, to protect the memory of the deceased or to enforce their rights.

The trusted support person (see below IV) must also be well enough informed to be able to legitimately give his opinion in the event that the patient is unable to express his wishes.

Only in the event that it proves impossible to inform the patient, it is an emergency situation or the patient does not wish to know, is the doctor released from his obligation to inform him.

The hospitalised patient must also be informed, on request, of the costs which he may be liable for with regard to his treatment. When this treatment is carried out by an independent health care professional, the latter must inform the person, before carrying out a procedure, of its cost and the amount of reimbursement he will receive from the health insurance organisations.

4

A medical procedure can only be carried out with the free and informed consent of the patient

The inviolability of the bodily integrity of each person and the inalienability of the human body are basic principles, which can only be overruled by medical necessity for the person and with his **prior consent.** For this reason, in particular, no medical procedure can be carried out without the consent of the party involved. When the person is not in a condition to express his wishes the doctor cannot carry out any examination or treatment without having previously consulted the trusted support person, the family or, failing this, a close relation, except in an emergency or should it prove impossible to contact them.

The consent of the person must be freely given, i.e. must not have been obtained under duress, and must be repeated for any further medical procedure. **Consent must be fully informed,** i.e. the person must have been informed beforehand of the procedure he is to undergo, the foreseeable normal or serious risks known within the context of the current state of scientific knowledge and the consequences of these. If new risks appear after examinations, treatment or preventative procedures, all measures must be taken to inform the person.

A further consequence of the principle of consent: any hospitalised patient, capable of expressing his wishes, can also refuse any diagnostic procedure or any treatment or request it be halted at any time. However, if by this refusal or this request to stop the treatment the person is putting his life in danger, the doctor, bound by his duty to assist, must do all that is possible to convince him to accept vital treatment. He may also call on another member of the medical profession. However, if the person reiterates his decision within a reasonable time (period assessed depending on the situation), this is binding upon the doctor. It should be specified that the decision taken by the patient to limit or stop his treatment, even if he is not at the end of his life, must be considered carefully. This is why the doctor's duty to assist must prevail over the refusal to be treated in emergency situations when the condition is life threatening, and when the patient does not have the minimum period required to reiterate his wishes with full knowledge of the facts.

End of life (i.e. when the person is in "an advanced or terminal phase of a serious or incurable disease"), if the person, duly informed of the consequences of his choice and capable of expressing his wishes, asserts his decision to limit or stop his treatment, this is binding upon the doctor.

In all cases, the decision to stop or limit treatment, taken by the patient, is recorded in his medical record.

When a person is not in a condition to express his wishes, whether at the end of his life or not, and preventative measures, examinations or treatment appear to be of no use, disproportionate or having no other purpose than maintaining life artificially, the doctor can make the decision to limit or stop them. However, this decision can only be taken after consultation with the medical team and **as part of a collective procedure.** Therefore, the doctor can only make his decision after consulting at least one other doctor with whom he has no hierarchical link. Moreover, he must take into account the wishes previously expressed by the patient as to the end of his life. These wishes must be sought particularly with regard to any **advance directives** (see below). He must also take account of the opinions expressed by the trusted support person, the family, or failing this, close relations. When a trusted support person has been designated, his opinion prevails over that expressed by the family or by close relations. The reasoned decision of the doctor as well as the stages of the procedure followed are recorded in the medical record.

In all cases where treatment is discontinued or limited, the person retains all his rights of access to palliative treatment. As previously stated (see above II), the doctor must relieve the patient's pain, alleviate his mental suffering, safeguard his dignity and support his family.

There are two procedures in place to guarantee the expression of the patient's wishes: the designation of a trusted support person and advance directives.

4 *A medical procedure can only be carried out with the free and informed consent of the patient*

At the time of his admission, any adult hospitalised patient is systematically informed of the option to designate **a trusted support person.** This designation is made in writing and is valid for the entire duration of the hospitalisation, unless the patient decides otherwise. The decision can be revoked at any time. The person chosen can be a spouse, companion, relative, primary doctor, etc. The trusted support person can be designated prior to hospitalisation. The institution must pay particular attention to recording the details of the person chosen and it is recommended that this information be recorded in the medical record. On the request of the patient, the trusted support person can provide support during procedures and attend medical appointments to assist him in his decision-making. In the event that the patient is unable to express his wishes, the opinion of the trusted support person must be sought, but is not binding upon the doctor.

Any adult person can draw up **advance directives,** for situations where he is no longer in a condition to express his wishes himself. The purpose of advance directives is to enable the person to make his wishes known with regard to the end of his life. Advance directives are presented in the form of a written document that can be authenticated. If the person cannot draw them up himself, two witnesses, including the trusted support person, attest that they correspond to the wishes clearly expressed by the person. They must be renewed every three years or have been drawn up less than three years before the person is no longer in a condition to express his wishes (for example in the event of a neurodegenerative illness). They can be revoked at any time. When advance directives exist, the doctor must take them into account. They are an essential document for making medical decisions. In fact they bear witness to the wishes of a person, while he was still able to express them and in a condition to do so. However, the doctor is not restricted by advance directives. He remains free to assess the conditions under which the directions expressed by the patient in this document should be applied taking account of the practical situation and any advances in medical practices. In any event, a patient who wants his directives to be taken into account must make them accessible to the doctor who will take care of them within the institution. For this purpose, but without it being a requisite for validity, the file held by the primary doctor is the best place to keep the directives.

At the time of his admission to the institution, the patient can draw attention to the existence of advance directives and give details of the persons to whom he has entrusted them.

When the hospitalised patient is a minor or adult under guardianship, if he is in a condition to express his wishes, his consent must be sought even if it falls to the holders of parental authority or to the guardian to consent to any treatment. However, when the health or the bodily integrity of a minor or adult under guardianship risks being seriously compromised by the refusal of the legal representative or by the impossibility of obtaining consent from the latter, the doctor can provide the required treatment. With regard to a minor, when there is a divergence between the holders of parental authority, one of the parents must file an application to the family court so that it can rule on the decision to be taken. In the event that this divergence involves a situation endangering the health or the safety of the minor, the doctor, being obligated to provide vital treatment, is, as with any other third party confronted by such a situation where a patient's life is in danger, authorised to notify the Public Prosecutor, who can refer the case to the juvenile court. With regard to an adult under guardianship, the guardian must seek an authorisation from the guardianship judge, in the event that he is called on to make a decision concerning the health of the protected person, in the absence of an opinion expressed by the latter or against his opinion when the decision presents a serious risk of affecting the bodily integrity of the protected person.

If treatment or an operation is vital to safeguarding the health of a minor but the minor does not wish his state of health to be brought to the attention of the holders of parental authority, the doctor can dispense with the consent of the holder(s) of parental authority after having done everything possible to persuade the minor to accept that they should be consulted. If the minor persists in his wish that confidentiality is kept, the doctor may intervene so that the minor is supported by an adult of his choice. The minor's refusal to allow the holders of parental authority to be consulted will be recorded in the medical record of the party concerned.

5

Specific consent is required for certain procedures

Besides the general principle of prior consent, certain medical procedures are the subject of specific guarantees with regard to consent.

In the area of medical assistance for procreation, the consent of both members of the couple, at the beginning of the parental project, is required (Article L. 2141-2 of the Public Health Code). For the **prenatal diagnosis,** only the consent of the pregnant woman is required (Article L. 2131-4).

Donation and the use of parts and products of the human body are also subject to specific provisions. Therefore, the removal of parts of the human body and the collection of its products, for any purpose whatsoever, cannot be undertaken without the consent of the donor. Consent can be revoked at any time (Article L. 1211-2 of the Public Health Code). When the initial purpose of the removal is changed, the person must be informed, unless this is impossible, so that he can object if he so wishes.

Consent to the **removal of an organ for a donation** is specifically subject to regulations: it must be recorded by the regional court or, in the event of an emergency, by the Public Prosecutor. This consent can be revoked at any time and without formal requirement (Article L. 1231-1 of the Public Health Code). As a general rule, no organ, tissue or cells can be removed, or any products taken from the human body for a donation from a living adult person who is subject to a legal protection order (Articles L. 1231-2 and L. 2141-2 of the Public Health Code). However, haematopoietic cells can be removed from the bone marrow of a minor or a protected adult for the benefit of his brother or sister, first cousin, uncle or aunt, nephew or niece, with the guarantees and under the conditions defined in Articles L. 1241-3 and L. 1241-4 of the Public Health Code.

Any person can express in his lifetime his opposition or his refusal to the removal of an organ after his death (whether for therapeutic or scientific purposes). This refusal can be recorded on the national register of refusals, but it can also be expressed by any other means. Therefore, in the absence of a refusal recorded in the national register, before any removal can take place, the doctor must check with the family or relatives that the person was not opposed, during his lifetime, in any way, to the donation of organs (Article L. 1232-1 of the Public Health Code). If the deceased person is a minor or an adult under a legal protection order, removal for the purposes of a donation can only take place on condition that each of the holders of parental authority – or the legal representative – expressly consent to it in writing. However, if it proves impossible to consult one of the holders of parental authority, the removal can take place on condition that the other holder consents to it in writing (Article L. 1232-1 of the Public Health Code).

Furthermore, **removals for scientific purposes from deceased persons,** can only be carried out within the framework of protocols sent, prior to their implementation, to the Biomedicine Agency and subject to the evaluation of the Minister for Research (Article L. 1232-3 of the Public Health Code). In all cases, the family or close relations are informed by the doctor of the purpose of the removals carried out on the deceased person for scientific purposes and of their right to be informed of the removals carried out (Article L. 1232-1 of the Public Health Code).

For the termination of pregnancy, specific provisions are provided for when it concerns **a minor.** If an unemancipated minor wishes to have a termination and is unable to obtain the consent of at least one of the holders of parental authority or if she wishes confidentiality to be retained, the termination and associated medical procedures and treatment can nevertheless be carried out on her request. In this case the minor can be supported by an adult of her choice.

Diagnostic, therapeutic and scientific removals of **embryonic or foetal tissues and cells** at the end of a termination of pregnancy can only be requested from adults (except in the event of examinations to discover the cause of the termination) and after they have granted their written consent. Furthermore, **removals for scientific purposes** can only be carried out in the context of the protocols sent prior to their implementation to the Biomedicine Agency and subject to the evaluation of the Minister for Research (Article L 1241-5 of the Public Health Code).

5 *Specific consent is required for certain procedures*

With regard to the performance of genetic characteristics examinations, the person must consent to them beforehand in writing under the conditions set out in Article L. 1131-1 of the Public Health Code. However, if it proves impossible to obtain the consent of the person or to consult the trusted support person that she has designated, her family, or failing this her relatives, the examination can be carried out when it is in her interests.

The performance of a sterilisation for contraceptive purposes must be the subject of specific information issued by the doctor on the risks and the consequences of the operation. This information is provided in a written document. Adult patients must express their free, reasoned and duly considered wishes taking into account the information imparted. Consent must be reiterated after a period of reflection of four months and confirmed in writing. Adults whose deterioration in mental faculties constitutes a handicap and has resulted in their placement under supervision or guardianship, benefit, for this operation, from an increased protective status. The operation is subordinated to the decision of the guardianship judge, in charge of obtaining the opinion of a committee of experts (Article L. 2123-2 of the Public Health Code).

Screening (for human immunodeficiency virus – HIV – for example) can only be performed with the prior consent of the person, except in certain exceptional cases where this screening is obligatory (for example: donations of blood, organs, tissues, cells and particularly sperm and milk). **No screening can be performed without the knowledge of the patient,** which would constitute an infringement of a person's privacy. Voluntary screening can be offered to the patient, in compliance with regulations pursuant to circular n° 684a of 28 October 1987 relating to HIV screening, including that of free consent, after information tailored to the individual is provided.

Moreover, any person infected with HIV must consent in writing to the computerised processing of his medical epidemiological file for statistical purposes.

6

Biomedical research cannot be conducted without the consent of the patient, after he has been specifically informed of the expected benefits, constraints and foreseeable risks

In order for advances to be made in the knowledge of how the body works and the cause, diagnosis and treatment of diseases, research needs to be conducted on human beings in the form of biomedical research strictly regulated by the law. This type of activity must not be confused with medical care; nor is it a right of patients. In any case, biomedical research cannot be conducted on a human being unless it meets **the criteria of scientific relevance, absence of risk disproportionate to the anticipated benefits and reduction of discomfort and constraints for the patient.**

In principle, biomedical research cannot be proposed to a hospitalised patient. However, it can be proposed in the following two cases: on the one hand, if the expected benefit for the hospitalised patient justifies the risk incurred; and on the other hand, if the research has potential use for other patients in the same situation, i.e. hospitalised, and insofar as there is no alternative method that is comparably effective.

Research cannot be conducted if it has not been **approved by an independent protection committee,** formed mainly from representatives of patients' associations and users of the health system. Furthermore, the research must be **authorised,** depending on the case, either by the French Health Products Safety Agency, or by the Ministry for Health.

The investigating doctor coordinating the research must provide the patient to whom the biomedical research is being proposed with **clear and comprehensible information.** The patient approached must, before giving his consent, be informed of: the objectives, method and duration of the research; the expected benefits, constraints and the foreseeable risks; alternative treatments; the medical care procedures provided for in the event that the research is discontinued for any reason; the procedure by which the participating hospitalised patient will be informed of the results after the end of the research. All of this information is summarised in a written document. Insofar as possible, the patient must have time to consider the proposal and to ask for any further explanations from the investigating doctor, to speak to any person of his choice (primary doctor, close relations, patients' association, etc.) before taking and making known his decision.

If the patient agrees to participate in the research, he must give his **consent in writing** by signing a document. If he does not accept the proposal made to him or if he withdraws his consent, this will have no effect on the care given to him by the institution and he will receive the same quality of care as if he had accepted to participate in the proposed research.

There are specific rules regarding consent for **minors, adults under supervision or guardianship or adults unable to express their wishes** as well as for patients considered as "vulnerable" – pregnant women or women in labour, breastfeeding mothers, persons in prison and patients hospitalised without consent - (Article L. 1122-2 of the Public Health Code).

It may be necessary to conduct research on hospitalised patients **in an emergency situation** who consequently are not in a condition to be able to give their consent. In this case, the approval of the designated trusted support person or of the family, if present, must be requested. The patient concerned is informed as soon as possible and his consent is then necessary to be able to continue the research. If the patient refuses, he can object to the use of the data on him, which have been collected before his refusal. During or at the end of research, the hospitalised patient has the right to be given the information that the investigating doctor has on his health. Hospitalised patients will not receive remuneration or indemnification for their participation in biomedical research.

Personal information for research purposes is processed under the conditions provided for by amended Act n° 78-17 of 6 January 1978, relating to data processing, files and personal freedom and privacy and to Article L 1111-7 of the Public Health Code. In accordance with these provisions, anyone can have access to information concerning him, and if applicable, request that this information be rectified or deleted, by applying to the persons responsible for the research. Anyone can also object to the processing of data concerning him.

The hospitalised patient can leave the institution at any time

A hospitalised patient can leave the institution at any time. When a request to leave is considered premature by the doctor and poses a risk to the patient's health, the latter must sign **an attestation** stating that he is aware of the risks to his health incurred by leaving. In the absence of an attestation, an internal document is drawn up.

A patient cannot be detained by the institution. Only patients having necessitated hospitalisation, due to **mental illness,** on the request of a third party or the administrative authorities, can be detained, subject to the provisions applicable to minors, and under certain conditions, applicable to adults subject to a legal protection order.

Any patient hospitalised with his consent for mental illness has the same rights with regard to exercising personal freedoms as those granted to other patients. Restrictions on the exercising of personal freedoms can be imposed on patients hospitalised for mental illness without their consent, within the limit of those necessitated by their state of health and the administering of their treatment. These patients must be informed on admission and then on their request, of their legal situation and their rights.

Imprisoned persons have the same rights as other hospitalised patients. However, imprisoned persons admitted to a health care institution continue to carry out their sentence; furthermore, persons indicted and remanded in custody remain in custody; therefore, prison regulations apply to them and, in particular, rules restricting freedom to come and go and to communicate.

8

The hospitalised patient must be treated with consideration

The privacy of the patient must be respected during treatment, washing, consultations and medical examinations, pre- and post-operative treatments, X-rays, transportation by stretcher, and, more generally, at all times during his hospital stay. The hospitalised patient must be treated with consideration.

If clinical teaching entails the examination of a patient in the presence of medical students, the prior consent of the patient is required. This cannot take place if the patient refuses. The same regulations must be respected with regard to the initial and continuing training of medical and paramedical staff.

The health care institution must **respect the beliefs and convictions** of admitted patients. In public health institutions, everyone must be able to exercise his religion (meditation, presence of a minister of his religion, food, freedom of action and expression, funeral rites, etc.).

However, the expression of religious beliefs must not infringe on the operation of the service, the quality of care, hygiene rules, or the peace and quiet of other hospitalised patients and their families. **Proselytism is not allowed,** whether it is by a hospitalised patient, a visitor, a member of staff or a voluntary worker.

The institution must take measures to ensure the peace and quiet of patients and to reduce noise and light pollution as much as possible, particularly during meal times and when patients are sleeping.

It must organise external consultations and complete the administrative formalities associated with hospitalisation, in such a way as to reduce transfers and waiting times as much as possible.

9

The respect of each patient's privacy must be ensured

Each hospitalised patient has the right to respect of his privacy.

Staff are bound by **professional secrecy** defined by Articles 226-13 and 226-14 of the Penal Code and by professional discretion defined by Article 26 of amended Act n° 83-634 of 13 July 1983, relating to the rights and obligations of public sector employees.

The institution must ensure **the confidentiality of information** that it holds on hospitalised patients (medical, civil status, administrative, financial information). However, information of a medical nature, insofar as it is necessary for the continuation of care and determines the best care possible, is deemed to have been entrusted by the hospitalised patient to all of the medical team treating him. This information may also be entrusted to other health care professionals, who are not part of the medical team treating the patient, insofar as the latter has been informed and does not object. Within the context of legal proceedings carried out in the accepted way, the judge or the person that he has appointed for this purpose, can have access to information concerning a patient who is hospitalised or has been hospitalised. However, these legal proceedings cannot entail the removal of anonymity guaranteed by the law.

The hospitalised patient can receive visitors of his choice in his room, while respecting the privacy and peace and quiet of other hospitalised patients. He has a right to confidentiality of his mail, his telephone conversations, and his discourse with visitors and with health care professionals.

Journalists, photographers, advertisement canvassers and sales representatives are only permitted access to hospitalised patients with the express agreement of the persons concerned, insofar as other patients are respected and subject to the written authorisation of the director of the institution. This access must be in moderation in order to avoid any abuse of the potential vulnerability of patients.

A hospitalised patient can refuse any visit and ask that his presence not be disclosed.

The hospitalised patient can bring personal belongings, insofar as other patients are respected and there is space in the room. Liability provisions in the event of loss, theft or damage of these objects, as well as objects authorised to be dropped off, are defined by Act n° 92-614 of 6 July 1992 and its implementing regulations (cf Articles L. 1113-1 to L. 1113-10 and R. 1113-1 to R. 1113-9 of the Public Health Code).

Any **hospitalised child** in a paediatric department must be able to be visited by his father, mother, or any other person who normally looks after him, at any time, including night time, insofar as the presence of the visitor does not expose the latter or the child to a health risk, in particular to contagious diseases.

10

The hospitalised patient (or his legal representatives) benefits from direct access to health information concerning him

All formalised medical information is included in **the medical record.** This information can be accessed by the hospitalised patient (under certain conditions, by his legal representatives or, in the event of death, by his beneficiaries), with the exception, however, of that concerning third parties or stating that it has been collected from third parties. The patient can access this information directly, if he wishes, or through the intermediary of a doctor whom he designates for this purpose. In the event that the patient wishes to consult his medical record on the premises, he can be accompanied free of charge by a member of medical staff recommended by the institution. The other conditions of being granted this access, particularly those concerning minors, and, in exceptional cases, those concerning patients hospitalised without their consent, are specified in the patients' handbook mentioned in Article L. 1112-2 of the Public Health Code.

Any admitted patient has access, on his request, to information concerning him and contained in the computer files of the institution pursuant to amended Act n° 78-17 of 6 January 1978.

In institutions offering a public hospital service, the user has a right to access administrative documents, under the conditions provided for by the amended Act of 17 July 1978. He must apply to the legal representative of the institution. In the event of express or tacit refusal of the latter, he can request the opinion of the Commission for access to administrative documents (CADA – 35, rue Saint-Dominique - 75007 PARIS - www.cada.fr).

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The hospitalised patient can express his views on his care and reception

Apart from the option of filling out the leaving questionnaire given to each patient with the patients' handbook, a hospitalised patient can express his views on the health care institution directly to the legal representative.
In each institution, a **commission for relations with users and the quality of care** (CRU) ensures that the rights of users are respected and that the quality of care and reception of patients and their families is improved. This commission particularly ensures that patients can express their grievances to managers of the institution.
The list of commission members (among which are two user representatives and two mediators, one who is a doctor and one who is not) as well as the conditions under which it examines complaints and claims are set out in the patients' handbook.

A hospitalised patient can also apply to **the regional or interregional commission for conciliation and compensation of medical accidents, drug-induced changes and nosocomial infections,** in the jurisdiction of which the health care institution concerned is located. The details of the competent commission are given in the patients' handbook.

With regard to conciliation the following cases can be referred to this commission by registered letter with acknowledgment of receipt:

> any dispute relating to the respect of the rights of patients and users of the health system (Article L.1114-4 of the Public Health Code),

> any dispute or difficulty between the patient or user of the health system and the health care institution arising from a preventative procedure, diagnosis or treatment (Articles L.1142-5 and R.1142-19 ff. of the same code).

The commission can either conduct the conciliation itself or delegate it to one of its members or an external mediator.
A document is drawn up in the event of total or partial conciliation.

With regard to amicable settlement, the patient (or his legal representatives, or, in the event of death, his beneficiaries) can refer a case to this commission, when he considers that he has been subjected to harm of considerable severity[3] and that the preventative procedure, diagnosis or treatment that caused the damage occurred after 4 September 2001.
For any information on the conditions of access to the compensation scheme go to the following site: www.oniam.fr or call the following local call charge number, from Monday to Friday between 2pm and 8pm: 0810 51 51 51.

A patient (or his legal representatives, or, in the event of death, his beneficiaries) who considers that he has been subjected to harm, can also **bring the case before the courts,** even, if he wishes, simultaneously to the proceedings before the above commission. This is possible whatever the severity of the damage. Depending on whether the offence occurred in a public or private health institution, it is either the administrative or ordinary court which has jurisdiction.

In all cases, **actions** aiming to implicate the liability of health care professionals or public or private health institutions, with regard to preventative procedures, diagnosis or treatment, **lapse after ten years, from consolidation of the damage.**

With regard to cases that are a matter for the administrative courts – and only these – it is necessary, **prior to bringing any case before the administrative court,** to lodge a request for compensation for harm (in the form of an amicable application) with the authority concerned.
If the application is refused, the claimant has a period of two months to bring the case before the administrative court. In the event of an application for damages and interest where the institution does not give a response within two months following the request (implicit rejection), the claimant is not bound by a deadline, but the institution can take advantage of the decennial provision mentioned above.

(3) In fact, only applications from persons for whom the damage suffered has caused permanent partial disability greater than 24%, or a temporary period of incapacity to work of at least 6 consecutive months or 6 non-consecutive months over 12 months are admissible. The application is also admissible, on an exceptional basis, if the person has been declared incapable of exercising his professional activity or if he has encountered particularly severe problems in his living conditions.

Hospitalised patient's charter
General principles

Each patient is free to choose the health care institution he wants to take care of him, subject to the limitations of each institution. The public hospital service is **accessible to everyone,** in particular to the most needy persons and, in the event of emergency, to persons without social security cover. It is adapted to handicapped persons.

Health care institutions must guarantee **the quality of reception, treatment and care.** They must be attentive to pain relief and do everything possible to ensure everyone is treated with dignity, particularly at the end of life.

Information given to the patient must be **accessible and reliable.** The hospitalised patient can participate in the choice of treatment. He can be assisted by a trusted support person that he freely chooses.

A medical procedure can only be conducted with **the free and informed consent of the patient.** The latter has the right to refuse all treatment. Any adult can express his wishes as to the end of his life in advance directives.

Specific consent is needed for patients participating in biomedical research, the donation and use of parts and products of the human body and for screening procedures.

A patient who is asked to participate in **biomedical research** must be informed of the expected benefits and the foreseeable risks. **His agreement must be given in writing.** His refusal will not have any effect on the quality of care that he receives.

The hospitalised patient can, unless otherwise provided for by the law, **leave the institution** at any time after having been informed of any risks incurred.

The hospitalised patient must be treated with consideration. His beliefs must be respected. He must be ensured privacy and peace and quiet.

Respect of privacy is guaranteed to every patient, as well as **confidentiality of personal, administrative, medical and social information** concerning him.

The hospitalised patient (or his legal representatives) benefits from **direct access to health information** concerning him. Under certain conditions, in the event of death, his beneficiaries benefit from the same right.

The hospitalised patient can express his views on the care and reception provided. In each institution, a commission for relations with users and the quality of care given ensures that the rights of users are respected. Every patient has **the right to be heard** by a manager of the institution to express his grievances and request compensation for harm to which he believes he has been subjected within the context of an amicable settlement procedure for disputes and/or before the courts.

Appendix to circular n° DHOS/E1/DGS/SD1B/SD1C/SD4A/2006/90 of March 2 2006 relating to the rights of hospitalised individuals and comprising a charter for hospitalised individuals

The list of legislation below is by no means exhaustive. It is simply a reminder of the main legislation used as a reference to draw up the Hospitalised Patients' Charter.

The legislation followed by (*) is accessible on the website: www.legifrance.gouv.fr
The legislation followed by (**) is accessible on the website: www.sante.gouv.fr

> Codes

- Penal code (*)
- Civil code (*)
- Public health code (*)
- Social security code (*)
- Code of social welfare and the family and social aid (*)
- General code of local government (*) (and, in particular, its Articles L. 2223-39, R. 2223-76, R. 2223-79 and R. 2223-91)

> Uncodified laws

- **Amended** Act n° 78-17 of 6 January 1978 relating to data processing, files and personal freedom and privacy (*)
- **Amended** Act n° 78-753 of 17 July 1978 providing for various measures to improve relations between the government and the public and various administrative, social and fiscal provisions (*)
- **Amended** Act n° 83-634 of 13 July 1983 relating to the rights and obligations of public-sector employees (*)

> Charters

- Hospitalised children's charter signed by the European associations in 1988 www.invivo.net/adarpef/article.php3?id_article=5
- Mental health users' charter of 8 December 2000 www.fnappsy.org/?page=charte
- Hospital voluntary associations' charter of 29 May 1991 www.ap-hop-paris.fr/site/benevolat/charte.htm
- Reception of families of victims of road traffic accidents in health care institutions charter www.famille.gouv.fr/dossiers/violences_rout/charte.htm
- Charte Marianne (**)
- European social charter www.coe.int

> Uncodified regulations

Legislation relating to care in health care institutions

- Order of 7 January 1997 relating to the content of the patients' handbook of health care institutions (JO [Journal Officiel – French government publication] n°9 of 11 January 1997, p. 496) (*)
- Circulars DH/DAS n° 93-33 of 17 September 1993 (BO [Bulletin Officiel – official listing of laws and decrees] 93/42) and n° 95-08 of 21 March 1995 (BO 95/16) relating to access to care for the most needy
- Circular DH/AF1/97/n°29 of 17 January 1997 for implementation of the order of 7 January 1997 relating to the content of the patients' handbook of health care institutions drawn up pursuant to Article L 710-1-1 of the Public Health Code (new Article L. 1112-2 of this same code) (BO 97/5)

- Circular DH/AF1/DGS/SP2/DAS/RV3 n°98-736 of 17 December 1998 relating to combating social exclusion in health care institutions participating in the public hospital service and to the access to care for the most needy (BO 99/1) (**)
- Circular N° DH/AF1/99/18 of 14 January 1999 relating to health care institution mortuaries (**)
- Circular DHOS/O1/2003/195 of 16 April 2003 relating to emergency care (BO 2003/20) (**)
- Circular N°DHOS/SDE/E1/2004/ 471 of 4 October 2004 relating to the convention defining the conditions for the involvement of voluntary associations in health care institutions and including a model convention (BO 2004/43) (**)

Legislation relating to care

- Circular DGS/DH n° 94-3 of 7 January 1994 relating to the organisation of care and the treatment of chronic pain (BO 94/5)
- Circular DGS/SQ2/DH/EO4 98-47 of 4 February 1998 relating to the identification of structures for treating persistent chronic pain (BO 98/9) (**)
- Circular DHOS/O2/DGS/SD5D/2002/98 of 19 February 2002 relating to the organisation of palliative care and support, pursuant to Act 99-477 of 9 June 1999, aiming to ensure the right to access to palliative care (BO 2002/12) (**)
- Circular DHOS/E2/2002/266 of 30 April 2002 relating to implementation of the national programme for pain relief 2002-2005 (BO 2002/21) (**)

Legislation relating to providing information to the hospitalised patient and his family

- Recommendations for clinical practice "Informing patients, recommendations for doctors", ANAES, March 2000 www.anaes.fr/
- Circular DGS/DHOS/E2 n° 645 of 29 December 2000, relating to the organisation of the fight against nosocomial infections in health care institutions (BO 2001/3) (**)
- Circular DHOS/E2/DGS/SD5C/2004/21 of 22 January 2004 relating to the particulars of nosocomial infections and informing patients in health care institutions (BO 2004/6) (**)
- Order of 9 January 2006 amending the order of 19 April 1994 setting out the list of authorities mentioned in Article L. 225-8 of the Labour Code, relating to representation leave for associations falling within the scope of the Ministry of Social Services, Health and Towns

Legislation relating to access to information contained in administrative and medical records

- Order of 1st October 2001 relating to the conditions setting out and determining the fees for a copy of an administrative document (JO [Official gazette] n° 228 of 2 October 2001) (*)
- Order of 5 March 2004 providing for ratification of the recommendations for good practice relating to the access to information concerning the health of a patient, and in particular the support of this access (JO n° 65 of 17 March 2004) (*)

Legislation relating to specific consent for certain procedures

- Order of 27 November 1991 authorising computerised processing of medico-economic and epidemiologic human immunodeficiency virus files in human immunodeficiency virus information and care centres and other hospital institutions. (JO of 17 January 1992) (*)
- Order of 22 December 2003 amending the order of 27 December 1991 authorising computerised processing of medico-economic and epidemiologic human immunodeficiency virus files in human immunodeficiency virus information and care centres and other hospital institutions (JO n° 38 of 14 February 2004) (*)
- Circular n° 684a of 28 October 1987 relating to screening for human immunodeficiency virus in hospitalised patients (BO 87/46)

Appendix to circular no DHOS/E1/DGS/SD1B/SD1C/SD4A/2006/90 of March 2 2006 relating to the rights of hospitalised individuals and comprising a charter for hospitalised individuals

- Circular DGS/DHOS/ n° 2001-467 of 28 September 2001, relating to the implementation of the provisions of the Act of 4 July 2001 relating to termination of pregnancy and contraception (BO 2001/43) (**)

Legislation relating to personal freedom

- Circular DGS/SP n° 48 of 9 July 1993 comprising a reminder of the principles relating to admittance and procedures for the stay of patients hospitalised for mental illness (BO 93/35)

Legislation relating to the respect of the patient and his privacy

- Circular n° DHOS/G/2005/ n° 57 of 2 February 2005 relating to secularism in health care institutions (BO 2005/2) (**)

Legislation relating to the right to privacy and confidentiality

- Circular DGS/DH n° 83-24 of 1st August 1983 relating to the hospitalisation of children (BO, specific section 83/9a)
- Circular DH/EO3/98 n° 688 of 23 November 1998 relating to the visiting system for children hospitalised in paediatric wards (BO 98/50) (**)
- Circulars DHOS/01/2003/195 of 16 April 2003 relating to emergency care (BO 2003/20) (**)
- Circular DHOS/SDO2003/238 of 20 May 2003 relating to emergency care of children and adolescents (BO 2003/26) (**)
- Circular DHOS/O1/DGS/DGAS/2004/21 of 28 October 2004 relating to the drawing up of Regional Health Organisation Plans (SROS) for children and adolescents (BO 2004/52) (**)

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