

Coming to consensus: developing a framework for medical student consent

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Consent is a fundamental part of medical practice.¹ In New Zealand the Code of Health and Disability Services Consumers' Rights enshrines in law the right to informed consent. This right is underpinned by ethical considerations, which reflect the importance of valuing and respecting the choices made by autonomous individuals in determining what is important to them regarding their medical care.² This includes the right to know who will be involved in providing that care, and in what way, including having access to their confidential information.

Medical students are an integral, legitimate, and important part of the medical team. They need to be involved with the care of patients if they are to learn, and to become the doctors of New Zealand in the future. One of the things they need to learn is the importance of respect for their patients, in general and specifically in respect of consent. The influence of role models, and the so called "hidden curriculum",^{2,3} is strong, and will substantially determine the type of doctors that will be caring for us, as New Zealanders, in the future.

Our opinion, albeit anecdotal, is that the vast majority of the clinicians who teach medical students in New Zealand are excellent role models. Unfortunately, a few appear to fall short of the mark. Medical students at the University of Auckland, have written about their experiences with patients⁵ and some of the ethical challenges they have faced during their preceding months of learning in clinical environments.⁶ A number have identified situations where they considered that practices failed to meet acceptable ethical standards, and consent was often the central ethical issue.

The nature of students' clinical interactions with patients varies greatly within an apprenticeship model of training. They may simply be observers, for example as part of the team accompanying a consultant on a ward round. Sometimes they will be involved in the operating room, perhaps scrubbed and assisting a surgeon, or perhaps learning to manage a patient's airway under the supervision of an anaesthetist. Ideally they will have met the patient prior to surgery (in the ward or in the theatre suite), who will have given consent (at least verbally) for the student to be involved in the procedure, but at times this may be impractical. If the appropriate consent has been given to the clinicians responsible for the patients care, this will suffice. But what should be done about the "interesting" patient in the operating room next door who provides a great opportunity for learning, but who has not given consent to anyone for a student to be involved in his or her care, and is now anaesthetised? Is it acceptable under these circumstances for a student to observe? To assist? To undertake an intimate examination?

To be clear, the answer is emphatically and definitely not in the last of these examples, and in the strict interpretation of the Code, arguably not in any of them. Lest it be thought that this is the only potentially tricky situation that arises, consider patients in intensive care units on ventilators, babies on paediatric wards, patients being visited at home in primary care, patients receiving bad or embarrassing news - how and when should consent be obtained for students to be present and involved in a way that is sensitive and leaves open a genuine opportunity for the patient to decline? And conversely, how are medical students to learn if the burden of obtaining consent for them to do so is too onerous?

Concern over these difficult questions led to a meeting in 2011 between senior staff and the then Health and Disability Commissioner, Mr Ron Paterson. This meeting probably raised more questions than it answered - it became increasingly obvious that the settings in which questions of consent for the involvement of medical students in patients' care could arise are varied and complex. A paper was taken to a meeting of the Chief Medical Officers (CMOs) of the District Health Boards, who welcomed a national initiative to develop consensus and provide clarity and guidance for clinical staff and medical students about how these issues ought in fact to be handled in New Zealand. In due course a working group was formed that included representatives from the CMOs, the University of Otago, The University of Auckland, The New Zealand Medical Students' Association, and the Medical Council of New Zealand. An extensive process of consultation and consensus building followed. Discussion was detailed and prolonged. There was no agenda to set standards, simply to interpret the standards already pertaining in New Zealand and apply them in a practical way to an indicative range of possible scenarios in which students might become involved in patient care, or at least in observing patients or reading patients notes, viewing X-rays or interpreting the results of other investigations.

All the authors shared the belief that most patients are willing to facilitate the training of students and that the process of obtaining consent should be proportionate to the proposed involvement of the students. Generic measures on the part of hospitals (by way of signage and information sheets, for example) are one way in which the whole process can and should be facilitated. At the same time, all the authors also shared the belief that the opportunity to learn is a privilege, and that the generosity of patients in this respect ought unquestionably to be acknowledged and respected.

An advanced draft was shared with the current HDC, and the feedback from his office taken into consideration. The views of patient advocacy groups, and the NZ Medical Association were also sought.

The result of this process appears in this edition of the Journal. It is a consensus statement from the people listed as authors, and as such it has been carefully, sometimes almost pedantically, crafted. Reaching agreement

on detail proved more difficult than one might expect. It is one thing to say that everyone agreed in the principle that informed consent should be obtained in this context, quite another to pin down what that should actually involve, as a minimum, in each particular scenario that was considered. If these questions were easy to answer, arguably the document would not have been needed.

Have we got it right? To some extent the answer to that question is that expectations in relation to informed consent are not static and continue to evolve. Our impression, in light of a recent editorial in the BMJ,⁷ is that New Zealand is somewhat in advance of the UK in this evolution. We have certainly come a long way since the times of the Cartwright enquiry⁸ – as we needed to. To our knowledge this is the first ever effort to develop a national consensus on how consent should be obtained for the involvement of medical students in the care of patients. There may be important situations that we have not thought of, and there may be recommendations in the document that are either unworkable, or too permissive (the point that New Zealand has legal requirements in this context should not be missed). A revision is planned after a year, so feedback is welcomed. In the meantime, we hope the document will prove of value to medical students and their teachers – and therefore to patients in New Zealand, which is what really matters.

[Ed] This editorial draws from an original article, to be published in the New Zealand Medical Journal later this month.

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