



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Te Kaunihera Tapuhi o Aotearoa | Nursing Council of New Zealand

By email: enreview@nursingcouncil.org.nz

Tēnā koe

Health and Disability Commissioner's submission on the proposed changes to the EN education standards (including amendments to the RN education standards)

Thank you for the opportunity to provide feedback on the proposed changes to the EN education standards and the amendments to the RN education standards.

As you are aware, the role of the Health and Disability Commissioner (HDC) is to promote and protect the rights of people using health and disability services as set out in the [Code of Health and Disability Services Consumers' Rights](#) (the Code). The Code places corresponding obligations on service providers.

Change to the EN scope of practice reflected to the EN education standards

The change to the EN scope statement reflects the broadened role of the EN as an independent practitioner in care delivery. I am pleased that this significant change in the EN's scope necessitated changes to their educational preparation. The strengthened requirements around cultural safety with a focus on Te Tiriti o Waitangi and application of kawa whakaruruhau is particularly pleasing to see.

However, whilst we value the role of ENs within the health and disability sector, I reiterate our comments about the impact this change as it applies to patient safety. This is especially noted in residential aged care settings where a significant number of ENs practise and multidisciplinary/collegial support can be limited. Complaints to HDC about ENs primarily relate to the adequacy of assessment, including appropriate and timely escalation. I trust that the change to their education program will sufficiently support them to develop appropriate skills in these areas, particularly in regard to decision-making, delegation and seeking appropriate guidance from other members of the healthcare team when necessary. It would also be prudent to develop formal guidance for the health and disability sector on the EN's new practice parameters and their relationship with other health practitioners (especially, with the RN).

The Code of Rights

The Code sets the benchmark for good practice and the provision of consumer-centred care in Aotearoa New Zealand. It is important to recognise that when providing care to patients, students on clinical placements are considered providers under the Code and therefore have a duty to uphold people's rights. Education programs must therefore ensure that they are providing students with the tools they need to meet their obligations, and EN graduates must be supported to develop and display an in-depth understanding of the application of the Code in practice. I suggest that the standards would be strengthened by enhancing the visibility of EN's obligations under the Code (especially, in *Standards Two and Four*).

The Code clearly sets out that rights apply on those occasions where a consumer is participating in teaching. In addition, Right 6(1)(d) requires that all consumers are provided with the information they need to make an informed decision and give informed consent, including the right to be notified of any proposed participation in teaching. HDC has been concerned by recent lapses across professions in ensuring that informed consent is obtained to student involvement in care, including a lack of awareness among students and supervisors of the requirements under the Code in this respect. I suggest that there may be some value in requiring educational institutions to develop procedural guidelines with service providers on informed consent, including consent for student involvement in care. In this respect I have **attached** the recently published consensus statement on informed consent for medical student involvement in clinical care which you may find useful.

Finally, you may be interested in HDC's online education modules for providers on the Code, informed consent and complaints management which can be found here -

<https://www.hdc.org.nz/education/online-learning/>

Please do not hesitate to contact us again if you wish to discuss this further.

Nāku iti noa, nā



Dr Vanessa Caldwell

Deputy Health and Disability Commissioner

Enc Informed consent for medical student involvement in patient care: an updated consensus statement

Informed consent for medical student involvement in patient care: an updated consensus statement

Simon Walker, Papaarangi Reid, Lynley Anderson, Susan Bull, Monique Jonas, Joanna Manning, Alan Merry, Suzanne Pitama, Sarah Rennie, Jeanne Snelling, Tim Wilkinson, Warwick Bagg

ABSTRACT

Enabling patients to consent to or decline involvement of medical students in their care is an essential aspect of ethically sound, patient-centred, mana-enhancing healthcare. It is required by Aotearoa New Zealand law and Te Kaunihera Rata o Aotearoa Medical Council of New Zealand policy. This requirement was affirmed and explored in a 2015 Consensus Statement jointly authored by the Auckland and Otago Medical Schools. Student reporting through published studies, reflective assignments and anecdotal experiences of students and teachers indicate procedures for obtaining patient consent to student involvement in care remain substandard at times. Between 2020 and 2023 senior leaders of Aotearoa New Zealand's two medical schools, and faculty involved with teaching ethics and professionalism, met to discuss these challenges and reflect on ways they could be addressed. Key stakeholders were engaged to inform proposed responses. This updated consensus statement is the result. It does not establish new standards but outlines Aotearoa New Zealand's existing cultural, ethical, legal and regulatory requirements, and considers how these may be reasonably and feasibly met using some examples.

It is a moral requirement that health systems in Aotearoa New Zealand and healthcare professional training institutions uphold principles of equity and social accountability, give effect to Te Tiriti o Waitangi and support patients' rights. Medical students are expected to adopt these commitments. They are made aware of this during their sustained programme of medical ethics and law teaching and in clinical placements. Understanding and respecting the concept and process of consent is a central aspect of their professional development.¹

The legal requirement for consent is set out in the Code of Health and Disability Services Consumers' Rights (hereafter "the Code").² The Code specifies 10 patient rights, including the right to be treated with respect (Right 1), the right to effective communication (Right 5), the right to be fully informed (Right 6) and the right to make an informed choice and give informed consent (Right 7). Consent is important for several reasons. It is an essential aspect of respecting patients and their autonomy, establishing rapport, building trust and promoting a positive doctor-patient relationship.^{3,4} When managed well it empowers patients to actively engage with healthcare services and can increase patient participation in treatment.⁵

It can also support cultural safety,^{6,7} vital for good patient care and emphasised in two recent Te Kaunihera Rata o Aotearoa Medical Council of New Zealand (MCNZ) statements.^{8,9}

Links between informed consent and Te Tiriti o Waitangi are evident in the Te Manatū Hauora – Ministry of Health's Whakamaua: Māori Health Action Plan, which reiterates the role of Te Tiriti o Waitangi within health service systems and delivery.¹⁰ The positioning of article two of Te Tiriti o Waitangi within this document aligns with the concept of mana motuhake, the "*right for Māori to be Māori (Māori self-determination), to exercise authority over their lives and live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori*" (p. 14).¹⁰

Involvement in patient care is essential in learning to be a doctor. The Code extends to circumstances when a patient is participating in the teaching and training of providers, including medical students. It specifies patients have the right to be notified of any proposed participation in teaching (Right 6[d]). The MCNZ statement on informed consent includes a requirement to obtain patients' consent if students attend consultations or participate in their care (see Box 1). Specific consent for student involvement in care is neces-

sary because it is important for patients to know who will be involved in their care and why. This is particularly significant in the case of student involvement because students are not registered health professionals. Failing to obtain consent to student involvement could seriously undermine patient trust and confidence and cause considerable distress. An indicator of mana motuhake within the health system is Māori patients having relevant and appropriate information to support confidence in providing informed consent, including who is involved in their care and the purpose for which they are involved.

In response to concerns about the adequacy of informed consent to student involvement in patient care,¹¹ a National Consensus Statement on Informed Consent specifically for medical students and supervisors was published in 2015.¹² It aimed to promote and guide a pragmatic, appropriate and consistent approach to seeking patients' consent when medical students are to be involved in their treatment and care. Anecdotally, students find this consensus statement helpful and empowering. Nevertheless, some deficiencies persist in processes for obtaining consent for medical students' involvement in patient care.^{13–16}

Addressing challenges

Medical students learning in clinical environments assume a range of roles and responsibilities, from passive observation through to directly providing care to an individual patient under supervision (in this statement "involvement in care" includes all such roles and responsibilities). As students transition from novice to senior, patient interaction becomes an increasingly important part of their learning. Senior students (trainee interns) are integral members of healthcare teams providing care in hospitals and general practices. Interactions between patients and medical students often occur in busy settings: clinical staff are under pressure, turnover of patients is rapid and opportunities to ask for consent are limited.

The variations in where and how students are involved in patient care affect how consent to their involvement can be obtained. Realising patient rights in such circumstances is not always straightforward. Policies to uphold patients' rights regarding student involvement need to be tailored to each kind of learning environment, the different ways students interact with patients, and their increasing participation in healthcare

provision as their learning progresses. Policies should centre on positive and engaging experiences for patients and their whānau, and be proportional to their needs and priorities. Overstating the impact of student involvement can have the perverse consequence of adding unnecessarily to patient stress. Pragmatic solutions are needed to ensure the consent process is not unsettling or arduous for patients, or unworkable for staff.

During 2020–2023 senior leaders of Aotearoa New Zealand's medical schools, and faculty involved with teaching ethics and professionalism, met to discuss these issues. The aim was to gather expertise and reported experiences of peers working across a range of contexts, to identify factors influencing substandard practices and consider how these could be addressed. Various stakeholders were engaged at different stages to evaluate possible solutions and provide feedback on draft versions of the statement (these included chief medical officers, the Health and Disability Commissioner, the Medical Council of New Zealand, the New Zealand Medical Students' Association and the Council of Medical Colleges). This updated consensus statement is the outcome. It contains a list of key principles and considerations, including responsibilities for obtaining consent, the consent process and disclosure of information, documenting consent, sensitive examinations and procedures, patients who may not be able to consent, health information, care at home and remote care.

This statement does not establish new standards but outlines Aotearoa New Zealand's existing cultural, ethical, legal and regulatory requirements, and considers how these may reasonably be met in some selected practical ways. It affirms proper consent processes as essential for culturally safe and Tiriti-informed care, incorporates recent MCNZ guidance, describes responsibilities of institutions and individuals to ensure consent processes are adequate and clarifies the level of information that should be provided and the processes that should be followed across the range of contexts in which medical students learn.

Key principles and considerations for obtaining consent for student involvement in patient care

1. Responsibilities for obtaining consent

Ensuring that student participation in patient care always occurs with the necessary consent requires coordinated efforts in healthcare systems.

Box 1: Selected extracts from the 2021 Te Kaunihera Rata o Aotearoa I Medical Council of New Zealand (MCNZ) statement on informed consent.⁶

What is informed consent?

Every time treatment is provided, a doctor must have permission to provide that treatment. The process of obtaining that permission is called “informed consent”. Without informed consent, the treatment may be unlawful. To help the patient decide whether they want a treatment, they first need to be given information, such as the risks and benefits of their treatment options.

In this statement, we use the words “treat” and “treatment” to refer not just to one-off or specific clinical encounters and procedures, but also to ongoing care.

When care is provided in a teaching environment

You must have a patient’s permission in advance, if students or observers attend a consultation or participate in a patient’s care. Pay particular attention when sensitive issues are discussed. You must obtain explicit consent for any intimate examination.

Explain to the patient:

- a) the status and clinical experience of those attending;
- b) the role and involvement of those attending (such as whether they will be observing, or participating in the care by taking a clinical history or examining the patient);
- c) what is expected of those attending;
- d) at any point in time, they have the right to refuse the involvement of those attending.

The levels of responsibility are outlined below.

1.1 The primary responsibility for ensuring consent is obtained for student involvement in a patient’s care lies with the registered health professionals responsible for that patient at the time.

1.2 Organisations providing healthcare have a responsibility to ensure appropriate consent is obtained for all aspects of patient management, including the involvement of medical students in the care of patients. The workplace environment should facilitate the gaining of consent and promote awareness that the organisation participates in teaching and that medical students might be involved in patient care. Healthcare organisations have responsibility:

- a. for the overall healthcare system and ensuring consent processes can be carried out and patients’ rights to decide are respected;
- b. for taking institution-wide measures to inform patients about teaching activities and their rights;
- c. for ensuring processes for seeking consent are appropriate and proportionate; consent processes should be streamlined in so far as this supports patient rights, for example by including standard language in consent forms about

proposed student involvement.

1.3 Students are classified as healthcare providers under the Code, and assume relevant obligations, including being accountable for ensuring consent has been given before they observe or become involved in a patient’s care (see Boxes 2 and 3). While many patients are ready to support students in their learning and are willing for them to be involved in their care, most expect to be asked, and some are less comfortable.^{4,17-19} Medical students should actively assess how patients and their whānau feel about their involvement (see Box 3). If they perceive discomfort, they should have a low threshold for disengaging. This is a matter of basic courtesy, sensitivity and good practice. As part of supporting cultural safety, staff and students need to be aware of how implicit or explicit biases, values or assumptions may hamper their ability to identify a patient’s concerns.

2. The consent process and disclosure of information

The essential elements of consent are well established: patients who are competent must be given sufficient information and time to reach

Box 2: Patients on wards and the responsibility for obtaining consent.

Ward rounds: Patients should be made aware students are participating in ward rounds, and that they have a choice about whether or not students are present when a doctor attends them. Students should be introduced to patients unless it is inappropriate in the circumstances.

Teaching on wards: Permission should be obtained from patients at a convenient time (for example on a ward round) for students to seek consent to obtain histories or conduct examinations.

Before students approach patients, e.g., to take a history or measure blood pressure, students must seek permission from an appropriate member of that patient's healthcare team (doctor, charge nurse or nurse caring for the patient). Once permission has been obtained to approach the patient, the student should introduce themselves to the patient, explain they are a student, and re-gain verbal consent from that patient before proceeding further. Where reasonably practicable, the student should make a record in the patient notes e.g.: "Mr/s/x Smith, Year 4 medical student, examined Mr/s/x Jones—verbal consent obtained". An additional benefit of this approach is to indicate how many students have interacted with the patient, and ensure individual patients are not approached too often.

voluntary decisions regarding their healthcare. Patients whose competence is compromised must still be given information in a way they can understand and the opportunity to decide for themselves where possible. Here we lay out some ways these essential elements apply to consent to student participation in, and observation of, care.

2.1 Patient consent should be appropriately informed, i.e., the patient (or another person as legally appropriate) should understand what they are granting permission for. This requires conversation and communication, which includes listening to patients, appreciating how their cultural background may influence their decision making, as well as giving them information. It is important to be sensitive to and recognise perceived or real imbalances in power between patients and healthcare providers, and patients and others involved in their care, including whānau, friends, carers or employers. The most important element of obtaining consent is the two-way conversation between the doctor and the patient. Whānau may also need to be involved.

2.2 Consent from the patient should generally be obtained before a medical student is involved in any patient's care, including observation of consultations and clinical procedures.^{4,20} In almost all circumstances, students should only undertake an examination, provide treatment or perform a procedure when the patient has explicitly consented to this. The exceptions to this are very limited, e.g., time-critical situations where a patient is unconscious and the student's involvement is urgently needed to provide or contribute to life-saving treatment. (See also 5.2 and 6.)

2.3 Where possible, patients (and those

involved in their care) should be informed about the proposed extent and nature of student involvement. There are many ways in which student involvement might occur, ranging from reviewing notes and X-rays, observing on a ward round, taking histories and performing examinations, assisting in operations and conducting procedures under direct supervision or independently. Conducting a necessary procedure may be primarily for educational benefit if there is no shortage of trained clinicians to do the procedure. Conversely, students may contribute to care in ways that are primarily for the patient's benefit, and yet the student will still gain valuable learning.

2.4 Patient consent is not a one-off event or simply an exercise in "ticking boxes". Rather, it involves a process of building and maintaining a relationship, whether brief or sustained, based on communication and trust.³ Those involved should always remain sensitive to changes in each patient's comfort with the presence of students and their involvement in care.

2.5 The consent process can and should be proportional to the involvement of the medical student, the nature of the interaction, and consequent risk or inconvenience to the patient. Proportionality entails assessing what a reasonable patient, in that patient's circumstances, would expect to be informed about, and how. Consent can usually be simple, verbal, informal and taken in the context of routine verbal interactions between practitioners and patients, particularly when student involvement is limited.

2.6 When student involvement will be limited to observation or carrying out routine, low-risk procedures under supervision, broad patient

consent can be sought. When the risks are higher for patients, or where student involvement is more significant or invasive (e.g., performing a sensitive examination or procedure), specific consent is required. More information about the proposed student involvement must be given, and the patient should have more time to consider their response. Broad consent must not be taken as consent to conduct sensitive examinations while under anaesthesia or procedures with material risk (see Table 1 and Boxes 4 and 5).

2.7 Consent can be sought verbally or in written form depending on the context. For instance, surgical consent forms could indicate proposed student observation of a procedure and minor participation, and enable a patient to indicate their decision.

2.8 In order to consent to student involvement, patients must understand what a medical student is and how their involvement might differ from that of registered doctors. Many patients do not understand the term “medical student” or “student doctor” unless it is explained. The former is preferable, and a brief clarification should be included in general informational material provided to patients. This should be emphasised during conversations about medical students’ involvement in patients’ care. Name badges clearly indicating the wearer is a medical student are also important.

2.9 Patients need to know they have a choice about the involvement of medical students, and they are entitled to change their mind at any time.

Patients should never feel coerced or pressured into providing consent. Supervisors and students need to be considerate of the ways a patient may feel pressured to consent (e.g., a supervisor asking in front of a student may make it harder for a patient to refuse).²⁰

3. Documenting consent

3.1 Where reasonably practicable, verbal consent to (or refusal of) student involvement should be documented along with any limitations to the kinds of student involvement consented to. Written consent is required for student involvement in more substantive procedures performed under anaesthesia (including sensitive examinations).

3.2 Procedural consent forms should include a section to document broad patient consent to the involvement of medical students in observing or contributing to surgery, anaesthesia and other basic clinical activities undertaken in operating theatres, under direct supervision of an appropriate registered health professional (note Right 7.6 of the Code).

4. Sensitive examinations and procedures

4.1 Sensitive examinations bring students into contact with patients in ways that can make patients feel vulnerable. They require trust and attention to the patient’s responses to perform safely. If not performed with care, sensitive examinations can be experienced as violations. Examinations of certain areas of the body (breast,

Table 1: Examples of activities in surgery and anaesthesia (with direct supervision) typically included under broad consent for student involvement, and others requiring specific consent.

<p>Broad consent can be used for basic clinical activities, e.g.:</p> <ul style="list-style-type: none"> • Observation • Maintaining a patient’s airway • Bag mask ventilation • Holding a retractor • Cutting sutures • Examining surgical pathology or normal anatomy (excluding sensitive examinations)
<p>Specific consent is needed for more substantive procedures, e.g.:</p> <ul style="list-style-type: none"> • Sensitive examination • Catheterisation • Endotracheal intubation (because of the risk of damage to teeth or causing a sore throat) • Insertion of an IV line or arterial line

Box 3: Questions medical students can ask themselves or the patient to determine if appropriate consent has been sought.

- Does the patient understand my involvement in their medical treatment and care?
- Does the patient understand how long I will spend with them and the sorts of activities I will undertake?
- Does the patient know they can refuse to have me involved in their care?
- Has the patient had time to ask questions?
- Does the patient want whānau, a support person, or a chaperone involved in any discussions, examinations or procedures?

Box 4: Some practical points regarding intensive care and anaesthesia attachments.

It is important for intensive care units (ICU) to provide information in the form of signage and pamphlets explaining medical students may be present and involved in the care of patients. Most patients in ICU are very vulnerable. Except where it is possible and appropriate to obtain explicit consent for greater student involvement from the legal representative, the role of medical students in ICU should usually be restricted to observation.

Students allocated to an anaesthetic run may anticipate attending a particular list with a named anaesthetist/surgeon, and the anaesthetist/surgeon may obtain consent to student involvement from the relevant patients. However, schedule changes may mean the best utilisation of a student's time comes from moving between lists. Seeking broad consent from all patients for medical student participation at the time of consent to surgery facilitates this.

A core skill medical students need to learn under close supervision during their anaesthesia attachment is basic airway management and bag-mask ventilation. This carries little risk if well supervised and could reasonably be seen as integral to a broad consent for a student to be involved in anaesthesia care. In contrast, intubation is not a core competency for medical students, and carries risk to the patient. For a medical student to learn this skill, specific patient consent is appropriate.

A system is required to ensure patients who decline permission for students to be involved in their care are clearly identified, and students do not inadvertently transgress their wishes.¹⁶

vagina, rectum, external genitalia) and procedures pertaining to those areas (e.g., catheterisation) are by their nature sensitive. Specific and documented consent is required for student involvement in such exams and procedures. However, sensitivity is not restricted to these areas of the body. Cultural groups and communities hold differing criteria for cultural safety, and with respect to what comprises a sensitive exam. For instance, the concept of tapu dictates within Te Ao Māori a person's comfort with and acceptance of physical examinations. For people who have experienced assault or abuse, contact with parts of the body that may not be widely regarded as sensitive (such as the upper arms or wrists) may be traumatising. Clinical supervisors and students should be aware of the cultural and experiential nature of sensitivity and approach each patient encounter with due care.

4.2 Consent for sensitive examinations (including breast, rectal, vaginal or external genitalia examinations) and procedures (e.g.,

catheterisation) in competent awake patients can be verbal, but should be documented in the patient's notes.^{21,22} Extra care needs to be taken to avoid undue pressure (e.g., it may be harder for a patient to refuse if they are asked after undressing) (see Box 6).

4.3 Sensitive examinations under anaesthesia require written consent obtained in advance and signed by the patient. Without such consent, a student cannot undertake an examination or intervention on a patient under anaesthesia (see Box 5). In some instances where there are unexpected complications and a patient under anaesthesia needs more investigation or more extensive treatment than was anticipated, the student must consult their supervisor about whether to remain involved.⁶

4.4 In situations where patients or their whānau are particularly vulnerable, meticulous care is required in seeking and documenting consent for the involvement of medical students. These may include discussion of sensitive examinations

Box 5: Example of a student declining to perform a sensitive examination.

“A 53-year-old New Zealand European woman with abnormal uterine bleeding was in theatre for hysteroscopy and dilation and curettage to be performed under local anaesthetic and sedation. I had not met the patient prior to the procedure so the registrar on the team gained verbal consent for me to be present. I introduced myself as a medical student and read her medical notes to familiarise myself with her situation. Once she was prepped, sedated and ready to proceed the registrar began by performing a bimanual examination. He then asked me if I would like to perform a bimanual exam. I had not had the chance to confirm that the patient had given written consent for this, and the registrar didn’t know, so I declined to perform the examination. The registrar continued with the procedure.”

– Modified extract from 5th Year medical student’s “Ethics Report”; used with the student’s permission.

Box 6: Illustration of the need for students to assess how comfortable patients are with their involvement for teaching.

“During one clinic, both the consultant and I were seated in the consultation room. After the patient entered, the consultant then asked the patient, ‘Are you happy for the medical student to be here?’ Consent was given at that stage. The patient required a sensitive examination and was asked to get ready on the bed behind the curtain. The consultant then entered the examination space, bringing me, and asked the patient, ‘Would you be happy for the medical student to look over my shoulder while I do the exam?’ By now, the preparation for the clinical examination was already underway and the patient was partially exposed. In fact, it wasn’t until the sheet was lifted exposing the woman’s genital area that the consultant asked whether the patient would be happy for me to observe. Although the patient consented, she seemed to be in a vulnerable position. My presence in the clinical room both at the beginning of the consultation and at the bedside for the procedure may be considered an external pressure. This woman may have felt like she couldn’t say no because I was already present in the room and may have been scared about the consequences of saying no.”

– Extract from 5th Year medical student’s “Ethics Report”; used with the student’s permission.

(particularly under anaesthesia), withdrawal of life support, organ donation, catheterisation and the communication of bad news (which will be contextual for the patient).

5. Patients who may not be able to consent

5.1 Consent processes with children are complex and require judgement and expertise. In some situations, children can consent for themselves. Alternatively, the child’s parent or guardian may need to provide consent. Where this occurs, the assent (agreement) of the child should also be obtained, where appropriate and possible. The principles remain the same, but in many cases, e.g., neonatal intensive care, there may be a parental perception their child is too vulnerable to be examined by anyone other than an expert.¹⁹ This requires special sensitivity and reassurance. Often consent will be only for student observation of a staff member examining a child. It is important to invite the parents to be present if possible.

5.2 Where a patient temporarily or permanently lacks decision-making competence, consent should be obtained from the patient’s legal representative. If no legal representative exists, the patient’s view should be sought to the extent possible in the circumstances, as well as the views of suitable others interested in the patient’s welfare (this may include whānau members, a support person or carer). When there is no practical opportunity to obtain consent from a legal representative, the treating doctor should determine what, if any, student involvement is in the patient’s best interests. If the patient indicates discomfort with the student’s involvement, the student should immediately discontinue.

6. Health information

6.1 As part of the healthcare team, students will have access to patients’ health information. In some contexts, it is most practicable for students to review the patient’s health information prior to seeing the patient, and before the patient

has had the opportunity to decide about student involvement. This could be required for educational reasons, but also as part of preparing students for a particular clinical situation. These factors must be weighed against potential harms relating to the patient's privacy, and this balance may depend on context. This should be made explicit to staff and students. If a patient declines students access to their health information this must be respected.

6.2 One way to mitigate risks is to ensure staff are aware of the possibility some patients may decline student involvement or access to their information because of particular sensitivities or privacy needs, and in those situations, students should not have access to the patient's information before receiving consent. Students must also be mindful of the need to treat health information as confidential and staff need to support them in meeting this responsibility.²⁰

7. Care at home and remote care

7.1 In primary care settings, students might accompany registered health professionals on visits to patients' homes or residential aged care facilities. Verbal consent for the student to enter the house or room should be sought from the patient and/or whānau who might be present. Where

possible, this should be done before the visit.

7.2 Students may have the opportunity to attend telehealth appointments. Verbal consent for the student to join the call should be sought prior to the student sitting in. Where possible, consent should be sought in advance of the appointment.

Conclusion

This statement outlines Aotearoa New Zealand's existing cultural, ethical, legal and regulatory requirements for consent to students' observation and involvement in patient care. It offers guidance about how these requirements can be appropriately met. The principles and considerations it contains are designed to guide policies, processes and practices of healthcare providers, clinicians and students to ensure patients' rights are respected in relation to student participation in healthcare. Ongoing attention, training and review is required to ensure Aotearoa New Zealand's legal and professional standards and societal expectations are consistently met. The authors call upon those involved in healthcare to work together to address the practical challenges in obtaining such consent for the betterment of patient care and medical training.

COMPETING INFORMATION

Nil.

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