Medical students and informed consent—response to “Consent for Teaching”

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The authors of this letter are currently engaged in revising “Medical Students and informed consent: A consensus statement prepared by the Faculties of Medical and Health Science of the Universities of Auckland and Otago, Chief Medical Officers of District Health Boards, New Zealand Medical Students’ Association and the Medical Council of New Zealand”.1 We disagree with Dr Gray’s2 proposal that the consensus statement is flawed. Gray argues the consensus statement is couched in ethical terms that prioritise patient autonomy, which is inconsistent with the approach of balancing the quadruple aim of quality medical practice.3 The quadruple aim encompasses improving population health, patient experience, healthcare team wellbeing and reduced costs.3 What Gray does not acknowledge is the Code of Health and Disability Services Consumers’ Rights,4 as set out in the Health and Disability Commissioner Act 1994,5 is the law in Aotearoa New Zealand. Thus, the consensus statement on medical students and informed consent was written to reflect the law in the most pragmatic way possible. In particular, Right 6, the “right to be fully informed”, and Right 7, the “right to make an informed choice and give informed consent”. We make no apology for supporting patient autonomy in the consensus statement. Patients have an ethical and legal right to understand “who, how and why” will be engaged in their healthcare—particularly if it is for learning. Gray does not acknowledge the distinction made in the consensus statement between involvement of students primarily for the benefit of their education, and involvement that may occasionally be necessary for the care of patients, such as when a qualified clinician is unavailable at a cardiac arrest. Doctors have an ethical and legal duty to ensure patients and their whānau are fully informed to the extent practicable in the circumstances. A student’s need to be educated does not trump this duty. Patients should understand what their healthcare will involve, by whom and for what purpose, and have an input into these decisions. Such informed shared decision making will result in better patient outcomes, reduced costs, improved population health, patient experience and team wellbeing—the process of obtaining consent, done well, is consistent with the quadruple aim of quality medical practice and has the potential to enhance it.

Informed consent encompasses much more than the alternative term “agreement” proposed by Gray. Consent is a word commonly used in both professional and lay settings and has meaning. Informed consent, rather than just assent, must be gained by supervising clinicians for student involvement in teaching. It encompasses the nuances involved in both patient and whānau agreement to patients engaging in student learning—this naturally will be influenced by the relationship the clinician has with the patient and their whānau. As is stated in the consensus statement, informed consent is an ongoing process that patients can withdraw at any stage, however, agreement is simply an outcome of a discussion.

Gray makes two factually inaccurate comments. First, that in requiring students to obtain consent for teaching, the CS recommendations are asking students to do something not required of graduate doctors. Indeed, this requirement for informed patient consent when trainees are involved in the provision of patient care has been unequivocally reinforced in Health and Disability Commissioner opinions.6,7 Second, Gray suggests that while the CS refers to the apprenticeship model, the requirement for consent for teaching runs counter to the use of this model in other settings. However, it is registered healthcare professionals, not students, who are required to obtain consent for teaching and any aspect of patient care. Students instead have the responsibility for consent that lies with the healthcare professional.
We agree that greater attention should have been paid to cultural safety within the consensus statement. Doctors essentially hold the power in the doctor–patient relationship and must consider how this reflects on the way they engage with the patient. It is important for doctors and medical students to reflect on the impact of their own culture and attitudes, and not to impose their own values onto patients and their whānau. The consensus statement is currently being revised to ensure that cultural safety in Aotearoa is properly encompassed in the consent process. The principles of patient and whānau involvement and autonomy remain central. Good communication with a focus on doctors reflecting on their own views and biases is a vital part of the consent process—not separate to it, and it doesn’t negate the need for consent. The days of applying health and teaching of health to patients without their understanding and consent are gone. This outdated approach is simply not acceptable within current medical education frameworks or practice, or within New Zealand law as reflected by the HDC code of patient rights. A recent publication from the University of Auckland indicates that consent for student involvement in teaching by patients can and is being obtained well for most patients in obstetrics and gynaecology. However, the results for patient consent for medical student teaching in other sensitive exams are disappointing, and the reports of students being coerced into conducting sensitive exams on patients without consent is deeply concerning. We can and must do better, even in busy, rushed clinical environments.

In summary, apart from the important matter of cultural safety, we disagree with Gray and think that all clinicians in Aotearoa can uphold the law, which in this matter we also believe to be ethically appropriate.
COMPETING INTERESTS
Nil.

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REFERENCES