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.

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.

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.

Broad consent can be used for basic clinical activities, e.g.: • Observation • Maintaining a patient's airway • Bag mask ventilation • Holding a retractor • Cutting sutures • Examining surgical pathology or normal anatomy (excluding sensitive examinations)
Specific consent is needed for more substantive procedures, e.g.: • 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.1[6]

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.