Te Kaunihera o Ngā Kāreti Rata o Aotearoa
COUNCIL OF MEDICAL COLLEGES
NEW ZEALAND

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Morag McDowell
Health and Disability Commissioner - Te Toihau Hauora, Hauātanga
By email to morag.mcdowell@hdc.org.nz

Cc: Helen Stokes-Lampard
Chief Medical Officer – Health NZ
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Health New Zealand | Te Whatu Ora Waitematā (formerly Waitematā District Health Board) (Case 19HDC01260)

Tēnā koe Morag

The Council of Medical Colleges is the collective voice for eighteen medical colleges in Aotearoa New Zealand. Medical colleges are not-for-profit educational bodies responsible for the training, examination and recertification of medical practitioners. The colleges support over 9000 specialist medical practitioners working in a range of disciplines in the Aotearoa New Zealand health system.

We have considered your conclusions and recommendations in relation to patient information material and informed consent at Health New Zealand | Te Whatu Ora (Health NZ) Waitematā.

In response, we:

- agree patients should not be involved in teaching without giving informed consent, providers of health and disability services must have a robust system and culture to obtain that, and senior clinicians and teachers must model good transparent consent processes to their colleagues
- support your recommendation for Health NZ to report back on progress in developing a national policy on informed consent and associated documentation, informed by the findings of your report
- note your specific recommendations to remedy the situation at Health NZ Waitematā.

There are three broad types of training that come under the HDC's ruling on informed consent:

1) **Medical students:** this group has clear guidance on consent with wide agreement on best practice
2) **Trainee doctors who are receiving active teaching:** consent should be sought when a trainee doctor is learning a new skill or enhancing a new skill outside of their competency, which would most likely be under the supervision of a senior doctor
3) **Trainee doctors practicing under their scope of practice for part or all of a service:** this is where consent guidance needs nuance and clarity as in some circumstances this is considered part of 'teaching' although it is not 'active teaching' as they are performing a service within their skillset. This group forms a significant part of Health NZ's service delivery.

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We would also like to bring to your attention a category of trainee doctor that also fits under the groups mentioned in 2 and 3, are fellows (usually from overseas) undertaking sub-specialty training here in New Zealand.

It is our view that trainee doctors delivering services under their scope of practice and competency need to have clear and defined guidance around consent so as not to have disruptive effect on health service delivery in Aotearoa New Zealand.

We have gone to some length in providing detailed comments for your consideration, and to inform the more work ahead of Health NZ and the medical colleges to ensure patients give informed consent to be involved in teaching.

Key points are:

- There will be implications for medical colleges' training programmes
- We will offer to Health NZ the expertise and experience of members of the medical colleges to contribute to developing a national policy on informed consent and associated documentation, and will expect to be consulted as the work progresses
- The proper emphasis on patient choice, with the implication that patients can choose not to have a trainee involved in their care, is likely to have a significant impact on the design and viability of the Health NZ service provision model which is currently significantly reliant on doctors in training. Changes will require collaboration across the healthcare system
- A possible disruption mitigation could be obtaining consent at pre-admission before a patient goes into a teaching hospital /training site.

Medical students

We fully support the updated Consensus Statement jointly authored by the Auckland and Otago Medical Schools in 2023.[1] For medical students there is a responsibility and requirement that all involvement with patient care has explicit consent, and this consent should be sought on behalf of the student by the responsible/teaching registered clinician. Ensuring student participation in patient care occurs only with the necessary consent requires coordinated and consistent efforts across the healthcare systems.

Student involvement in obstetrics and gynaecology requires special vigilance because this care and treatment frequently involves intimate examinations at a time when the patient is particularly vulnerable. The consent in these circumstances should be well documented.

The guidance for medical students is clear with wide agreement about best practice. Ongoing vigilance is required by the universities, teachers and the healthcare system to ensure compliance with best practice. We need to actively teach and develop the skills required to consent patients for student involvement. These skills include being able to clearly explain the role of the student and seek patient consent for student involvement without the patient feeling under duress. When this occurs skilfully and empathetically the likelihood of the patient giving full and informed consent is optimised.

[1] Simon Walker et al. *New Zealand Medical Journal* 2023 Jul 21; 136(1579). ISSN 1175-8716 https://journal.nzma.org.nz/

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Doctors in training

As you recognise, consent for doctors in training is a complex and nuanced matter with best practice still evolving. The work you have recommended will be helpful in advancing a better and consistent approach.

Consumer Code of Rights (CCOR) Right 6(2) states: *Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.*

We note [and agree] with your interpretation of CCOR as not implying a junior doctor or trainee must identify themself as being 'in training' in every interaction with a patient.[2]

Rather, practice should be guided by 6(3): *Every consumer has the right to honest and accurate answers to questions relating to services, including questions about the identity and qualifications of the provider.* This means '*the identity and qualifications of the provider*' need be given only if a patient asks, and simply identifying themselves as a 'doctor' will likely be sufficient information in those patient interactions that form part of the trainee's scope of practice and competency.

Trainee scope of practice and competency

Coming to this conclusion hinges on the idea of a trainee's scope of practice and competency. On face value this is sensible, appropriate and the lens through which to decide the level of information that should be provided to 'a reasonable consumer'. However, determining a trainee's scope of practice and competency is often far from straightforward.

Every doctor in training will have a set of skills in which they have achieved the level of competency to deliver care using those skills without direct supervision. Some of these skills will be formally documented and evaluated, particularly when they form part of the skills necessary for speciality training. For example, in the RANZCOG (O & G) training program:

- the core competencies that need to be acquired during training are detailed together with the experience that needs to be gained to achieve competence and the method of assessment
- the greater the skill required to safely deliver the competency the more likely the competency will be formally specified and verifiable; for example, surgical competencies include documenting surgical numbers and being formally signed off by a supervising consultant
- other skills are acquired more organically in the course of service delivery and not formally assessed or documented; for example, vaginal examination is not documented as a formal competency and not directly assessed
- As doctors train, their tool kit of skills grows until they have met the requirements for registration within the special scope of their specialty. Even then there will be areas of practice where competencies are still evolving. For example, a generalist O & G specialist may require distance supervision to deliver a vaginal breech (level C competency) or direct supervision to do a hysterectomy (level A).

[2] Para 146, Opinion 19HDC01260.

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All clinicians will continue to learn throughout their careers as they hone their skills and expand their competencies. This means it can be challenging to know at system level the competencies of any individual clinician, and even more challenging when a clinician is in training mode. We consider:

- when direct supervision is provided active training is most likely happening
- if supervision is off site and the clinician is consolidating existing skills, this is likely to be training.

Trainee doctors as service providers

Trainee doctors have competing responsibilities for service delivery and for learning and developing their craft. The public health system depends on doctors in training providing care with varying levels of supervision. The more experienced the trainee, the greater their competencies and the more they can (or will be expected to) provide care relatively independently. Much of the provision of affordable afterhours care depends on trainees without on-site support or supervision.

As you recognise, during one procedure a trainee may move between providing a service role, such as assisting or doing some part of a procedure that is **within the trainee's scope of practice and competency** and being in an active learning role where they perform part of the surgical procedure for which is **outside of the trainee's scope of practice and competency.**

When the trainee is providing services which they are paid to deliver, including to assist a more senior clinician at surgery, this is not considered active teaching. In practice explicit patient consent for teaching is only sought when then intention is for the trainee to acquire a new skill or enhance a skill under the direct supervision of a senior doctor.

Obtaining consent from a patient before they enter a teaching hospital/training site informing them that they are likely to receive services from a trainee would provide an earlier opportunity for the patient to refuse services. This would not negate the need for doctors to explain the following information to the patient.

We agree a reasonable patient would (in the context of teaching during surgery) expect:

- a doctor's role and status, and reason for their presence, to be made clear
- 'a frank explanation of the qualifications, responsibilities and the status of the surgeons who were to be involved'
- to be told who will be performing their surgery and who will be present, including those who are part of the treatment team and those who are not.

It seems likely that this level of consent does not occur consistently.

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MCNZ guidance on informed consent [3] aligns with the CCOR and your views. MCNZ guidance on delegation of responsibility is also relevant in the training environment where trainees provide care under

[3] Informed Consent: Helping patients make informed decisions about their care. https://www.mcnz.org.nz/assets/standards/79e1482703/Statement-on-informed-consent.pdf

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the supervision and responsibility of a senior doctor. Doctors are required to consider whether the person to whom they delegate responsibility:

- has the right skills and experience to treat the patient
- understands the risks and benefits of the treatment they are providing
- understands the patient's needs and their clinical history
- recognises that, in some situations, they should contact the doctor who delegated them the responsibility or a senior colleague for advice
- be clear about which doctor or health practitioner is responsible for obtaining consent from the patient and for checking that the patient is clear about their decision.

Implications for Health NZ

Health NZ must provide a safe and supported training environment which enables trainees to gain the experience they need. This is a requirement for certification of a hospital as a specialty training site. The guidance and processes in place regarding consent for teaching and training must be clear and widely understood and enabled by the wider health system for trainees to be compliant with regulatory authorities.

The Health NZ Waitematā case highlights areas for focus and ongoing improvement as a whole system.

- Consent forms need to be designed in such a way as to ensure all matters relevant to the consenting process are easily captured. This includes capturing who will be involved in the procedure/surgery, their role and any proposed teaching component
- Trainees' scopes of practice and competencies should be clearly documented and available for the supervising senior doctor (and potentially other clinical staff) to access. This will assist a more comprehensive and nuanced approach to procedural consenting
- Alongside focus on providing safe and competent patient care, the consenting process provides an opportunity to proactively consider the teaching goals that could be met during care. For example, for a trainee with basic pelvic surgical skills to become more skilled at pelvic sidewall dissection
- When an active teaching component is part of the ideal care plan, the teaching/supervising doctor (usually, but not always, the senior doctor) should be involved in obtaining patient consent. The directive from Health NZ to RMO's in 2019 referenced in this case shows this approach is not actively encouraged ('I'm Dr Jones, I'm the doctor who will be undertaking your surgery today. I'm an advanced trainee in surgery and will be undertaking this procedure with the supervision of Dr Smith who is the consultant operating with me').

The proper emphasis on patient choice, with the implication that patients can choose not to have a trainee involved in their care, is likely to have a significant impact on the viability of the Health NZ service provision model which is significantly reliant on registrars. Health NZ will need to consider clinical governance, management and funding implications in developing a national policy on informed consent.

As we have mentioned earlier, any guidance around patient choice could look at informing opportunities early in the care pathway e.g. pre-admission when a patient is entering or likely to enter a teaching hospital/training site which will have the significant likelihood of a trainee doctor delivering care.

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Patients who do not give consent to be taught upon when they are scheduled to be on a teaching theatre list, or equivalent such session, would ideally be rescheduled on a list where teaching is not expected to take place, to not disrupt and reduce teaching opportunities. As this is likely to delay their surgery, communications and guidance will need to be provided by relevant agencies to ensure that patients are informed of the process.

Implications for medical [speciality] colleges

Colleges need to be explicit about the skills and levels of proficiency trainees need to achieve to provide care with offsite supervision.

As part of their credentialing of teaching sites colleges need to ensure good processes are in place within the training site to document, update and appropriately share individual trainees' skills and levels of proficiency with the senior doctors who will be providing supervision and other relevant members of the healthcare team.

Care delivered by a trainee which falls within a trainee's competency and scope of practice will not require proactive disclosure as a teaching activity. This does not mitigate the need for trainees to introduce themselves to the patient and explain their role in patient care, nor to answer specific questions about their experience and training should a patient ask.

Doctors have been hesitant to explicitly disclose the level of training and experience of trainees involved in patient care. This topic is not widely discussed within the profession.

Informed consent does not seem to be an area of active research. What little evidence there is suggests that disclosure, particularly when a trainee is providing surgical care with distant supervision, is likely to lead to withdrawal of consent.

A 2004 British study [4] found:

- in men undergoing transurethral resection of the prostate only 15% said they would be happy for a competent junior doctor to operate unsupervised
- if given the choice, 57% said they would wait and have a consultant operate
- but 74% of patients also said that they would not mind a junior doctor operating on them unsupervised if it meant the operation could be done sooner.

While further study it needed in this area it seems likely that the quality of the communication and consenting process will influence patients' willingness to be involved in teaching.

Colleges need to include within their curriculum a competency for informed patient consent for involvement in teaching. It is very important that this competency is highly developed to maintain the possibility that patients will agree to have a trainee actively learn on them by performing a high risk (surgical) procedure.

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[4] Campbell B. (2004). New consent forms issued by the Department of Health. Annals of the Royal College of Surgeons of England, 86(6), 457–458. https://doi.org/10.1308/1478708041082

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Conclusion

In summary, the Council of Medical Colleges:

- agrees patients should not be involved in teaching without giving informed consent, providers of health and disability services must have a robust system and culture to obtain that, and senior clinicians and teachers must model good transparent consent processes to their colleagues
- draws attention to the difference between teaching medical students where guidance is clear, and teaching doctors in training which is tricky and nuanced with best practice still evolving
- supports your recommendation for Health NZ to report back on progress in developing a national policy on informed consent and associated documentation, informed by the findings of your report.

We will offer to Health NZ the expertise and experience of members of the medical colleges to contribute to developing a national policy on informed consent and associated documentation and will expect to be consulted as the work progresses.

In particular, we note that the proper emphasis on patient choice, with the implication that patients can choose not to have a trainee involved in their care, is likely to have a significant impact on the design and viability of the Health NZ service provision model which is currently significantly reliant on doctors in training.

Changes to address the issues you have raised will require collaboration across the healthcare system.

We are available and would like the opportunity to discuss this submission.

Nāku noa, nā

Dr Samantha Murton

Chair