Clinical Practice: guidelines, policies & legislation

Contents

1. Ethical guidelines: involving patients in clinical teaching .......................................................... 1
  1.1. Introduction ........................................................................................................................... 1
  1.2. Medical Students and informed consent .............................................................................. 2
2. Policy - Smart phone and tablet technology and student learning ............................................. 14
  2.1. Use during formal learning sessions .................................................................................... 14
  2.2. Small group tutorials .......................................................................................................... 14
  2.3. Clinical ward rounds / bedside teaching .............................................................................. 15
3. Taking and sharing images of patients ....................................................................................... 15
  3.1. Generic principles ................................................................................................................. 15
  3.2. Photographs taken for the purposes of providing care ....................................................... 16
  3.3. Photographs taken for educational and professional practice purposes ............................. 16
  3.4. Using radiological and photographic images for educational and professional practice purposes ................................................................................................................. 17
  3.5. Apps facilitating sharing of medical information ................................................................. 18
4. Sensitive examination policy ........................................................................................................ 18
5. MBChB Guidelines for Students Requesting Investigations ..................................................... 19
6. Conflict of Interest and the Medical Programme .......................................................................... 20
7. Health Practitioners Competence Assurance Act 2003 ............................................................ 20
8. Medicine Regulations 1984, Section 41 ...................................................................................... 21
9. Code of Health and Disability Services Consumers’ Rights ..................................................... 22
11. Patient health information– Frequently Asked Questions ....................................................... 32

1. Ethical guidelines: involving patients in clinical teaching

1.1. Introduction

An effective health care system needs a continuing supply of qualified staff. An essential requirement for training health professionals is access to practical experience that is well planned and properly supervised.

Good quality practical experience for students is based on a four-way partnership with the patient who agrees to be part of the teaching/learning process; teaching staff; other qualified staff; and the student.

In this partnership, the paramount consideration must always be the welfare and interests of the patient. The present Guidelines address the issue of how to ensure such an ethical focus
when patient/student interaction is organised **primarily** for teaching purposes.

In some situations, different ethical codes or guidelines apply, e.g.:

a) When qualified personnel (e.g. doctor, nurse, physiotherapist, etc) are seeing patients for the purpose of their own continuing education, the normal ethical obligations appropriate to their own professional responsibilities will apply.

b) When students are involved with patients as providers of care, their supervision is the responsibility of the senior qualified professional involved, and the latter are therefore responsible for ensuring that the provision of care meets appropriate ethical standards.

All fully qualified staff, and not just teaching staff, have an obligation to facilitate the teaching of students in their own and related disciplines, and share a common responsibility to ensure adherence to the Guidelines.

As a junior member of a medical team your ethical responsibilities include those of qualified doctors as described and published by the New Zealand Medical Council of New Zealand as Cole’s Medical Practise in New Zealand. 2013 edition in electronic format available from:


If you are concerned in any way about ethical aspects of your clinical work, you should consult more senior members of your clinical team and/or the Head of the Academic Department concerned, the Phase Director, or the Head of the Medical Programme.

### 1.2. Medical Students and informed consent

A national consensus statement was developed to promote a pragmatic, appropriate and unified approach to seeking consent for medical student involvement in patient care. Please review article below:
Medical Students and informed consent:
A consensus statement prepared by the Faculty of Medical and Health Sciences of the University of Auckland and the University of Otago Medical School, Chief Medical Officers of District Health Boards, New Zealand Medical Students’ Association and the Medical Council of New Zealand

Warwick Bagg, John Adams, Lynley Anderson, Phillipa Malpas, Grant Pidgeon, Michael Thorn, David Tulloch, Cathy Zhong, Alan Merry

ABSTRACT
To develop a national consensus statement to promote a pragmatic, appropriate and unified approach to seeking consent for medical student involvement in patient care. A modified Delphi technique was used to develop the consensus statement involving stakeholders. Feedback from consultation and each stakeholder helped to shape the final consensus statement. The consensus statement is a nationally-agreed statement concerning medical student involvement in patient care, which will be useful for medical students, health care professionals and patients.

The Code of Rights establishes the rights of consumers, and the obligations and duties of providers to comply with the Code. It is a regulation under the Health and Disability Commissioner Act. Nevertheless, there is evidence that the practice of seeking consent for the involvement of medical students in patient care is presently very variable. This consensus statement is an attempt to promote a pragmatic, appropriate, and unified approach to seeking such consent.

The document aims to deal with the potential (and at times actual) tension between the fundamental requirement to respect patients and their rights, and the obligation on the health system and health professional educators to provide learning opportunities for students. While these two requirements are by no means mutually exclusive, thoughtful care is required on both sides. Medical students learn in clinical environments and are legitimate and integral members of healthcare teams. The student learning covers a continuum of experiences and responsibilities, ranging from directly providing care to an individual patient to being part of a team providing care. As medical students transition from novices to junior doctors, patient interaction becomes an increasingly important part of their learning. Senior students (Trainee Interns) are integral members of the healthcare team providing care in hospital and general practices, and consent requirements need to reflect this.

However, before becoming involved in any patient’s care, the consent of the patient must be obtained. Such consent should be informed; ie the patient (or another person as legally appropriate) should understand what he or she is granting permission for. This implies a conversation and communication, which includes listening to patients as well as giving them information. It is important to be sensitive to perceived or real imbalances in power between patients and healthcare providers. The process can usually be simple, verbal and
informal, particularly when the student's involvement is limited. When the risks are higher or the student's involvement greater, more information will be required and in some instances it would be prudent for explicit consent to be documented, or even obtained in writing, with a signature from the patient.

It is the spirit of informed consent that matters most; the important thing is to demonstrate respect and compassion for patients (and their families), in the context of their values, interests and vulnerabilities. Gaining and maintaining the consent of a patient is not a one-off event or simply an exercise in 'ticking boxes'. Rather, it is an ongoing process of communication and building trust, and patients must feel free to withdraw their consent at any time. Therefore, those involved (practitioners and students) should at all times remain sensitive to any change in each patient's sense of comfort over who is present or what is being done.

The aim of this consensus statement is to assist medical students, doctors and other registered health professionals responsible for supervising them to understand what is expected and required in relation to consent for students to be involved in patients' care.

**Background**

Medical students learn in an apprenticeship model under the supervision of registered healthcare professionals. Contact with patients occurs early in the journey towards becoming a doctor. Initially, this may be as an observer in a general practice, or in a class when a patient consents to being interviewed during a lecture. As learning progresses, students will be observers in surgical theatres, participate in the administration of anaesthetics, learn to undertake sensitive examinations, assist in the delivery of babies, and participate in many aspects of patient care in primary, secondary and tertiary care settings. The boundaries between observation and participation are sometimes blurred. Underpinning all these interactions is the trust of patients in those involved in their medical treatment and care. This trust is precious and must be respected.

Medical students become involved with patients in different ways, contexts and settings (see Table 1), and at different stages of their training. There are settings and contexts in which gaining consent is straightforward, and others where it is not. The relevant principles are not dependent on the setting or the context, but the way in which they are applied. These may vary and will require judgement.

**Table 1: Some of the diverse settings in which students may become involved with the care of patients**

<table>
<thead>
<tr>
<th>Hospital care</th>
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<tbody>
<tr>
<td>• Clinics</td>
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<tr>
<td>• Emergency departments</td>
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<tr>
<td>• Intensive care units</td>
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<tr>
<td>• Neonatal units</td>
</tr>
<tr>
<td>• Operating rooms – In a surgical or anaesthesia context</td>
</tr>
<tr>
<td>• Psychiatry units</td>
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<tr>
<td>• Wards, adult or paediatric</td>
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<table>
<thead>
<tr>
<th>Primary care or community care</th>
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<tbody>
<tr>
<td>• After-hours community clinics</td>
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<tr>
<td>• Air ambulances</td>
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<tr>
<td>• Ambulances</td>
</tr>
<tr>
<td>• Audiology clinics</td>
</tr>
<tr>
<td>• Community nursing clinics</td>
</tr>
<tr>
<td>• General practices</td>
</tr>
<tr>
<td>• Health care trusts</td>
</tr>
<tr>
<td>• Hospice</td>
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<tr>
<td>• Patients' homes</td>
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<tr>
<td>• Pharmacies</td>
</tr>
<tr>
<td>• Podiatrist clinics</td>
</tr>
<tr>
<td>• Private specialist clinics</td>
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<tr>
<td>• Rest homes</td>
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<tr>
<td>• Retinal screening clinics</td>
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</tbody>
</table>

On the whole, most patients welcome medical student involvement and understand the importance of training doctors (and other health professionals) for the future. The majority of patients say "yes" when they are asked about such involvement, and complaints about students are very rare. Thus, the process by which consent is obtained can and should be proportional to the involvement of the medical student and the nature of the interaction and consequent risk or inconvenience to the patient. It is not appropriate
to overstate the implications of the simple involvement of students, particularly as observers, and to do so may even have the perverse consequence of adding unnecessarily to the stress felt by some patients. Verbal consent obtained simply, politely and in the context of the general interactions between practitioners and patients is both adequate and appropriate for most situations.

The interactions between patients and medical students often occur in very busy settings in which clinical staff are under pressure, turnover of patients is rapid, and the opportunities to ask for consent are limited. Pragmatic solutions will be helpful in ensuring that the consent process is not unsettling or arduous for patients nor unworkably onerous for staff, but in the end the need to gain consent cannot be set aside on the grounds of inadequate time or resource. Irrespective of the context of the interaction, or the workload, patients should never feel coerced or pressured into providing consent.

There are some common principles about how consent should be obtained and by whom. These are outlined in the next section, and illustrated by examples and lists in boxes and tables.

Principles pertaining to informed consent for the presence of a medical student during the care of patients

1. Consent for the involvement of students in patient care is required by the Health and Disability Commissioners' (HDC) Code of Health and Disability Services Consumers' Rights (the Code)—see Rights 5, 6, 7 and 9. It is also an important aspect of building rapport with patients, and of maintaining the trust and goodwill that exists between patients and the health professionals who care for them—including medical students.

2. Organisations that care for patients have a responsibility to ensure that appropriate consent is obtained for all aspects of patient management, including the involvement of medical students in the care of patients. Therefore, the workplace environment should facilitate the gaining of such consent. To this end, general measures should be implemented to promote awareness that the organisation is involved with teaching and that medical students might be involved in patient care (see Table 2).

Table 2. Some general measures to promote awareness that students might be involved in patients’ care. Some or all of these may apply in various settings, including (for example), hospital wards, general practices, and outpatient clinics.

- Policies
- Signage
- Pamphlets for patients (available or given on admission)
- An appropriate section on forms for consent to anaesthesia and surgery
- Informed in letters sent to patients about other matters, such as confirmation of outpatient visits
- The practice, by doctors and nurses, of routinely mentioning to patients the possibility that students may be involved in their care (at least as observers) and of the possibility that patients can refuse student involvement

3. The primary responsibility for ensuring that consent is obtained for the involvement of a medical student in a patient’s care lies with the registered health professionals responsible for that patient at the time (see Box 1).

4. The HDC considers medical students who are providing care to be healthcare providers, and they are therefore also accountable for ensuring that consent has been given before they become involved in patients’ care.
Box 1. Patients on wards and the responsibility for seeking consent

On ward rounds, students should be introduced to patients as part of the team (explicitly as student members of the team) by the doctor conducting the round. Students may also initiate introducing themselves to patients where appropriate. Before students on wards seek out patients with educationally valuable presentations and take a history or perform an examination on them, they must seek permission from an appropriate member of that patient’s healthcare team (doctor, charge nurse or nurse caring for the patient) to approach the patient. Once permission has been obtained to approach the patient, the student should gain verbal consent from that patient for history taking and examination. It may be prudent for the student to record this in the patient notes with an entry such as: “Bill Smith, Year 4 medical student, examined Mrs Jones – verbal consent obtained”. An additional benefit of this approach is that the record would clearly indicate how many students had interacted with that patient, and be helpful in ensuring that a patient is not approached too often. It should often be possible for a senior doctor, interested in teaching and keen to encourage students to see patients, to obtain permission from patients at a convenient time (e.g., on a ward round) for students to seek consent to obtain histories or conduct examinations. Thus the burden of establishing which patients are open to such approaches need not be excessive.

5. Medical students should actively assess how comfortable patients and their family/whānau are with their involvement in care. If they perceive patients or their family/whānau to be uncomfortable, they should have a low threshold for disengaging. This is a matter of basic courtesy and ongoing sensitivity to the rights and comfort of patients.

6. Informed consent should be sought with respect and compassion for patients, taking into account their circumstances and vulnerabilities at the time (see Box 2).

Box 2. An example of a potentially difficult situation in seeking consent for a medical student’s involvement in the care of a patient

A patient is unclothed and surrounded by the healthcare team, and asked to consent to a student examining her abdomen, with the student in the room.

Patients differ in their assertiveness and in how empowered and robust they feel at any particular time. It might be quite difficult for a patient in this situation to decline in the presence of a student. It may be better for the consultant to ask the patient privately, if they consent to students being present and, if the patient consents, to then ask if one (or perhaps two) of them could examine her abdomen during the round.

7. Patients need to know that they do have a choice about the involvement of medical students, and that they are entitled to change their mind at any time about such involvement, without any negative consequences for their care. The patient’s right to refuse consent or withdraw consent takes precedence over the provision of training for students.

For many purposes, notably many instances of observation, it is appropriate to obtain (or confirm) consent verbally and informally; for other purposes it is prudent for the consent to be documented, or even obtained in writing, with a signature from the patient (see Point 16). Note that there is a legal requirement for signed consent for procedures under anaesthesia.

8. Language is key to communication: If a patient is not competent in English (e.g., because this is not his or her first language) then a competent interpreter must be used to obtain consent for the involvement of medical students; this can often be done during the more general processes of patient care, which will also require an interpreter.

9. Patients need to understand clearly what a medical student is (see Box 3).
Box 3. The need to explain what a medical student is

It may seem surprising, but many patients don’t seem to understand the term ‘medical student’ unless it is explained. The term ‘student patient’ is probably even less well understood, so ‘medical student’ is probably preferable. A brief clarification should be included in general informational material provided to patients, and this should be reinforced during conversations about medical students’ involvement in patients’ care. Name badges clearly indicating that the wearer is a medical student are also important.

10. As far as reasonably possible, patients should be informed about the proposed extent and nature of student involvement. There are three ways in which students may become involved in patients’ care, although in reality the distinction is blurred, as any interaction with a student contributes to a patient’s care (Box 4):
   a. Students may observe patients, or examine them, or carry out or assist with procedures on them for their educational benefit as students, or
   b. Bedside tutorials, when a senior doctor conducts a tutorial with a group of medical students, usually focused around examination of a patient the doctor may or may not be clinically involved with, or
   c. Students may contribute to the care of patients, under supervision (eg by taking blood, holding a retractor during a surgical procedure, or performing bag mask ventilation under anaesthesia).

11. Patients who are temporarily or permanently incompetent to make an informed decision are particularly vulnerable (see Table 3 and Boxes 5 and 6). In such circumstances, consent should be obtained from the patient’s legal representative if one exists and it is practical and possible. If no legal representative exists, then any views ascertained from the patient should be taken into account. If this is not possible, the views of other suitable, available persons who are interested in the patient’s welfare should be taken into account. When there is no practical opportunity to obtain permission, student involvement under supervision may entail observation, history taking and general examination, unless the treating doctor decides that greater student involvement remains in the best interests of the patient. Judgement and experience is needed in respect of children under 16 years old. The consent process with children is complex. In some situations, the child may be able to consent for themselves. In other cases, the child’s parent or guardian may need to make a decision for the child. Where this occurs, the assent of the child should also be obtained, as appropriate and possible. The principles remain the same, but in many cases eg, neonatal intensive care,

Box 4. Ways in which students may become involved with patients’ care, and how they might explain this

An interaction with a patient on a ward might begin by a consultant saying something like “I have spoken with Mrs Jones in bed seven and she is willing to have one student listen to her heart and another student take some blood.”

In case a) a student might say something like, “Hello Mrs. Jones. My name is Helen. I am a medical student. That means I am training to be a doctor. I am in my fourth year of medical training. I understand from Dr Smith that you have a medically important heart condition. Would you mind if I listened to your heart with a stethoscope and examined your heart and a few other things that might be affected by your condition, so that I can learn about it? Please feel free to say no if you prefer.”

In case b) a student might say something like, “Hello Mrs. Jones. My name is Bill. I understand from Dr Smith that you need a blood test taken. I am a medical student. That means I am training to be a doctor. I am in my fifth year of medical training and have been taught how to take blood for blood tests. Do you mind if I take your blood sample, instead of the phlebotomist?”

In either case the student should make a brief entry in the patient’s notes documenting his or her involvement.
there may be a parental perception that their child is too vulnerable to be examined by anyone other than an expert. This requires particular sensitivity and reassurance. Often the consent will be for the teacher to examine the child in front of students, rather than hands on, and it is obviously important to invite the parents to be present if possible.

Table 3. Some examples in which a patient might not be competent to make a decision or give consent.

- Under anaesthesia
- On a ventilator under sedation in an Intensive Care Unit
- During sedation (including so called “conscious sedation”)
- Very young patients
- Mentally or cognitively impaired patients or patients who are semi-conscious
- Patients impaired with alcohol and drugs
- Patients in shock, extreme pain or extreme distress
- Patients who are dying

Box 5. Patients in intensive care under sedation and/or on ventilators

It is important for intensive care units to have information available in the form of signage and pamphlets explaining that students may be present and may be involved in the care of patients. Given that most patients in intensive care units are very vulnerable, this is a situation where principle 11 applies. Except where it is possible and appropriate to obtain explicit consent for greater involvement, the role of medical students in intensive care units should usually be restricted to observation.

12. Some circumstances require a particularly high level of sensitivity to the potential vulnerability of patients and their families (See Table 4); in such circumstances meticulous care is required in seeking and documenting consent for the involvement of medical students.

Table 4. Examples of circumstances in which the potential vulnerability of patients or their families is increased, and in which extra sensitivity is appropriate regarding the need for informed consent for student participation

- Sensitive examinations (particularly under anaesthesia)
- Discussion of withdrawal of life support
- Discussion of organ donation
- The breaking of very bad news (which will be contextual for the patient)
- Catheterisation
- Patients with rare or particularly interesting conditions
- Patients who feel under obligation to their treating clinician
- Retrieval of patients from a referring hospital

13. Sensitive examinations (includes breast, rectal, vaginal examinations and those of the external genitalia) in competent awake patients require explicit consent. This can be verbal but should be documented in the patient’s notes. It is essential that there should be no possibility for the consent to have any element of coercion (eg, it may make it harder for a patient to refuse if the patient is asked after undressing or in front of student. See Box 2).

14. Sensitive examinations under anaesthesia require formal written consent obtained in advance and signed by the patient. It is essential that there should be no possibility for the consent to have any element of coercion (eg, asking in front of a student may make it harder for a patient to refuse). Without such consent a student cannot undertake such activity.

15. A section should be included on the forms used to document generic consent for the involvement of medical students in observing or contributing to surgery, anaesthesia and other basic procedures undertaken in operating theatres, under direct supervision of an appropriate
Box 6. Some practical points about anaesthesia attachments

Students allocated to an anaesthetic run may anticipate attending a particular list with a particular anaesthetist, and that anaesthetist may obtain consent from the relevant patients. However, on the day there may be scheduling changes such that there is little educational value in this list, while a much more educationally rewarding list is occurring in one of the other theatres. In fact, the best utilisation of time may come from moving between lists during the day as opportunities present. Generic consent obtained from all patients at the time of their consent to surgery will facilitate this. Therefore it is ideal for such generic consent to be obtained at the same time as consent for anaesthesia and surgery, as a matter of routine.

It is important to recognise that some patients may decline permission for students to be present, and a system will be needed to ensure that these patients are clearly identified, and that students do not inadvertently transgress their wishes.

Box 7. An unexpected surgical finding

Where a student on a surgical run is observing a surgical procedure, there may be an unexpected finding that he or she would benefit from scrubbing in and examining. It would be reasonable for generic consent to cover such a situation in most instances. However, it wouldn’t be appropriate for multiple students to examine the finding in a single anaesthetised patient, and any examinations of a sensitive nature must be the subject of explicit consent, which must be in writing.

Box 8. Primary or community care

Health care providers in primary or community care settings agree to undertake student supervision through Clinical Access Agreements. In each case there will be a primary supervisor who has completed the Clinical Access Agreement and is responsible for ensuring appropriate consent is obtained for students to be involved in the care of patients.

As always, signage and pamphlets are important for informing patients about the likelihood that they will meet medical students in a particular practice or setting. For example, in general practice, a notice should be placed facing the patient waiting room, stating words to the effect that this is a teaching practice and students may be involved in the delivery of health care. A member of staff (such as the receptionist) should be expressly asked to draw the sign to the attention of patients when they arrive, and to check with them on each visit that they are comfortable with the presence of students.

Before the start of the consultation, the GP should ask the patient if he or she is comfortable for the medical student to be involved in the interview, observation or procedure. Opportunity for the patient to decline this request must be given, so this request should take place without the student present.

The principles of consent related to patients undergoing sedation or sensitive examinations are the same as for any other setting.

Table 5. Examples of things typically included (under direct supervision) and excluded from general consent for students to be involved in surgery and anaesthesia; the latter require explicit consent.

<table>
<thead>
<tr>
<th>Included, basic procedures, such as:</th>
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<tbody>
<tr>
<td>Observation</td>
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<tr>
<td>Bag mask ventilation</td>
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<tr>
<td>Holding a retractor</td>
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<tr>
<td>Examining surgical pathology or normal anatomy</td>
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</table>

<table>
<thead>
<tr>
<th>Excluded, more substantive procedures, such as:</th>
</tr>
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<tbody>
<tr>
<td>Any sensitive examination</td>
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<tr>
<td>Endotracheal intubation (because there is a risk of damage to teeth or even of causing a sore throat)</td>
</tr>
<tr>
<td>Insertion of an IV line or arterial line</td>
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<tr>
<td>Closing wounds, including surgical incisions</td>
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registered health professional (note Right 7.6 of the Code). The important element of seeking such consent is, as always, the conversation between the doctor gaining consent and the patient.

16. Generic consent obtained under 15 should be understood as limited to observation and basic procedures and should not be taken as consent to conduct sensitive examinations while under anaesthesia or procedures with any material risk (see Table 5). Such examinations or procedures require explicit, and in some cases, including sensitive examinations, written consent.

17. In primary care settings (see Table 1 and Box 8), where students might accompany registered health professionals on visits to patients’ homes or their rooms in a rest home, verbal consent for the student to enter the room or house should be sought from the patient and/or family/whānau who might be present. Where possible this should be done before the visit.

18. Patients’ medical records are confidential and medical students should only access such records in line with a purpose that has been notified to the patient at the point of collection. There must be a genuine educational reason to do so, and with the permission of the health professionals responsible for the patient’s care. It is reasonable to construe consent for a student to be involved in a patient’s care as including consent for that student to read relevant patient records, but it would usually be courteous to mention this point to patients.

19. Students must respect the confidentiality of all information acquired by them in connection with patients. Under no circumstances should students disclose any information whatsoever on any form of social media about the patients they have been involved with, even in the absence of specific identifying information.

The above text is a consensus statement that was agreed by multiple stakeholders, after careful and considered consultation to provide a guideline. The paper is not intended to set standards but rather to outline New Zealand’s existing legal and regulatory requirements in a practical way.

The paper is intended to provide guidance to medical students and supervising doctors in clinical settings. We have limited its scope to medical students for pragmatic reasons. Similarly, we have not attempted to cover every possible clinical situation where consent is required in relation to the training of medical students, but instead have chosen examples to illustrate the principles in some settings that we think may be particularly challenging. Notwithstanding these limitations, we hope this consensus statement will prove useful in clarifying expectations for informed consent in this context in New Zealand today.

We hope that this consensus statement will engender discussion within our hospitals and universities, and in the correspondence section of the Journal. This will inform a planned revision of the statement after it has been in use for a year. It may also be appropriate to expand its scope at that time.
Competing interests: Nil

Note:
The NZMA Ethics Committee, MCNZ Consumer Advisory Group and HDC have been consulted.

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REFERENCES:
**Excerpts from the Code of Ethics of the New Zealand Medical Association (NZMA)**

**Code of ethics**

All medical practitioners, including those who may not be engaged directly in clinical practise, will acknowledge and accept the following Principles of Ethical Behaviour:

1. Consider the health and well-being of the patient to be your first priority.
2. Respect the rights, autonomy and freedom of choice of the patient.
3. Avoid exploiting the patient in any manner.
4. Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.
5. Protect the patient’s private information throughout his/her lifetime and following death, unless there are overriding considerations in terms of public interest or patient safety.
6. Strive to improve your knowledge and skills so that the best possible advice and treatment can be offered to the patient.
7. Adhere to the scientific basis for medical practise while acknowledging the limits of current knowledge.
8. Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient.
9. Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease.
10. Accept a responsibility to assist in the protection and improvement of the health of the community.
11. Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.
12. Accept a responsibility for maintaining the standards of the profession.

**Guide to the ethical behaviour of physicians**

The profession of medicine has a duty to safeguard the health of the people and minimise the ravages of disease. Its knowledge and conscience must be directed to these ends. Ethical codes have developed to guide the members of the profession in achieving them. The Hippocratic Oath was an initial expression of such a code. More recent codes have developed from this and from a consideration of modern ethical dilemmas and these are embodied in a number of important declarations, international codes and statements from the World Medical Association. These include:

3. The following statements by the World Medical Association which deal with particular issues:
- The Declaration of Venice which deals with terminal illness (1983, 2006).
- The Declaration of Delhi on health and climate change (2009)

For latest updates and new Declarations, regularly check the website of the World Medical Association, [www.wma.net](http://www.wma.net)

These have been endorsed by each member organisation, including the New Zealand Medical Association, as general guides having worldwide application.

The New Zealand Medical Association accepts the responsibility of delineating the standard of ethical behaviour expected of New Zealand Medical Practitioners.

An interpretation of these principles is developed in the following pages, as a guide for individual doctors.

**Responsibilities to the patient**

1. **Standard of care**
   Practise the science and art of medicine to the best of one’s ability in full technical and moral independence and with compassion and respect for human dignity.

2. Continue self-education to improve one’s personal standards of medical care.

3. Ensure that every patient receives a complete and thorough examination into their complaint or condition

4. Ensure that accurate records of fact are kept

5. **Respect for patient**
   Ensure that all conduct in the practise of the profession is above reproach, and that neither physical, emotional nor financial advantage is taken of any patient.

6. **Patient’s right**
   Recognise a responsibility to render medical service to any person regardless of colour, religion, political belief, and regardless of the nature of the illness so long as it lies within the limits of expertise as a practitioner.

7. Accepts the right of all patients to know the nature of any illness from which they are known to suffer, its probable cause, and the available treatments together with their likely benefits and risks.

8. Allow all patients the right to choose their doctors freely.

9. Recognise one’s professional limitations and, when indicated, recommend to the patient that additional opinions and services be obtained.

10. Keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient except when the law
requires otherwise.

11. Recommend only those diagnostic procedures which seem necessary to assist in the care of the patient and only that therapy which seems necessary for the well-being of the patient. Exchange such information with patients as is necessary for them to make informed choices where alternatives exist.

12. When requested, assist any patient by supplying the information required to enable the patient to receive any benefits to which he or she may be entitled.

13. Render all assistance possible to any patient where an urgent need for medical care exists.

Continuity of care

Ensure that medical care is available to one’s patients when one is personally absent. When professional responsibility for an acutely ill patient has been accepted, continue to provide services until they are no longer required, or until the services of another suitable physician have been obtained.

Personal morality

When a personal moral judgement or religious conscience alone prevents the recommendation of some form of therapy, the patient must be so acquainted and an opportunity afforded the patient to seek alternative care.

2. Policy - Smart phone and tablet technology and student learning

There has been a rapid increase in the ownership and use of electronic devices in society (smart phones, iPad / tablet devices, laptops) and this has been reflected within the medical student community. While this equipment has some use in the learning environment, it is important that it is used in a professional and respectful manner. Mobile devices can have adverse effects on doctor-patient communication. Inappropriate use of electronic devices (both the timing of the use and the content of the use) can be unprofessional, discourteous and can adversely affect student-patient and student-clinician interaction. The following examples are given and students are also referred to the document describing social media and the medical profession available on the MBChB portal.

2.1. Use during formal learning sessions

Laptop computers can be used to type notes during formal learning sessions, although you should be aware that this can be distracting to those around you. This is a permissible use of such equipment but the use of laptops (or tablet devices or smart phones) for any other purpose (e.g. to access social media sites, personal email accounts or to access information) is not permitted within a lecture theatre during formal sessions. There is rarely any reason to have a mobile phone switched on during a lecture. The act of texting within formal learning sessions is discourteous (to the lecturer and fellow students) and should be deferred until appropriate break times.

2.2. Small group tutorials

Sufficient preparation should be done prior to a tutorial in order to inform and improve discussion within the tutorial session. Electronic devices should not be used during a tutorial as a means of overcoming poor preparation. They should also not be used for
communication purposes during tutorials. In general modern communication devices are not to be used within small group tutorials unless with the express pre-agreed permission of the tutor.

2.3. Clinical ward rounds / bedside teaching

Attendance at all clinical situations such as ward rounds, emergency departments, operating theatres, outpatient clinics and community visits is a privilege and an important learning environment. This privileged learning experience with health professionals who are educating you should not be compromised by concurrent student use of smart phones, etc. Your attention should be focussed on communication and relationships with clinicians and patients and usually an electronic device should not be used. Smart phones, tablet devices, and laptops should not be used on a ward round, in the operating theatre, or in any learning situation unless instructed to do so by your teacher. If you wish to use such a device, permission should be sought from the lead clinician or teacher present.

Smart phones and cell phones are of use to help organise student group meetings and for the dissemination of instructions. During clinical attachments students will be assigned to small groups that work together to organise tutorials and clinical commitments etc. It is perfectly acceptable, but not obligatory, to use cell phones to convey messages between students and clinical staff to help organise tutorials and to aid time-keeping. However, even when used for this purpose, the cell phones should be used outside of a tutorial and outside of patient encounters.

3. Taking and sharing images of patients

There can be good reasons to take photographic and radiological images of patients. There can also be good reasons to allow certain others to view images. However, images are inherently sensitive parts of a patient’s medical record. They must be treated in a way that acknowledges that sensitivity and supports the trust that patients put in the medical profession. This guidance sets out the standards that the Faculty of Medical and Health Sciences (FMHS) expects students to meet when handling both photographic and radiological images of patients in all healthcare settings.

3.1. Generic principles

Images contain information about patients. Therefore, they are subject to the 12 Rules of the Health Information Privacy Code, which can be summarised as follows:

1. Only collect health information if you really need it.
2. Get it straight from the people concerned where possible.
3. Tell them what you are going to do with it.
4. Be considerate when you are getting it.
5. Take care of it once you have got it.
6. People can see their health information if they want to.
7. They can correct it if it is wrong.
8. Make sure health information is correct before you use it.
9. Get rid of it when you are finished with it.
10. Use it for the purpose you got it.
11. Only disclose it if you have a good reason.
12. Only assign unique identifiers where permitted.


Students must follow these rules in all their dealings with health information, including taking and handling images of patients. Students must comply with the policies of the healthcare
provider when taking and handling images of patients.

It is the responsibility of students to familiarise themselves with, and follow, relevant policies and to complete the paperwork that is required by the healthcare provider, noting that different policies may exist in different healthcare settings.

3.2. Photographs taken for the purposes of providing care

Photographs can be useful for diagnosis, treatment and review of a patient’s condition. As such, they can form an important part of a patient’s medical record. Students may be asked to assist a member of clinical staff in taking a photograph for clinical purposes.

Photographs should be treated like all other information contained within a health record: as confidential.

In addition, because the rules governing health information are complex and breaches have serious consequences, FMHS requires that students follow these rules:

1. Only take photographs of patients with the permission of a senior clinician with responsibility for a patient’s care.
2. In most situations, patients should consent to a photograph being taken of them and their agreement entered into the record. The treating clinician is responsible for the consent process. If a student is asked to take a photograph of a patient, he or she must ask the clinician about the arrangements for consent.
3. Wherever possible, use a device or camera belonging to the relevant treatment unit or the supervisor to take images. This is to ensure that images are stored and documented according to the healthcare provider’s policies.
4. If an image is taken with a student camera or device, it is the responsibility of the student to ensure that the image is downloaded and deleted from the camera or device before the student leaves the healthcare site. Where devices are set to synch with other devices, special care must be taken to ensure that images are deleted from all devices.
5. Where possible, ensure that images do not allow patients to be identified by a person not involved in their care.

3.3. Photographs taken for educational and professional practice purposes

Photographs of patients can have benefits beyond that involved in patient care. Students may learn from photographs; professional practice can be improved through auditing involving photographs; professional practice can be enhanced through dissemination of experience and discussion about cases. These are benefits that photographs can contribute to, but they may not be of direct benefit to patients. This, combined with their inherent sensitivity means that patient consent to a photograph’s use for one of these purposes is vital.

Patients’ trust that those providing them medical care would not ask to photograph them unless there was good reason to do so. They also trust that photographs will be treated sensitively and confidentially. In order to warrant this trust, FMHS requires students to follow these rules:

1. Only take photographs for an educational or professional practice purpose with the permission of a senior clinician with responsibility for the patient’s care.
2. Only take images for an educational or professional practice purpose with the consent of the patient.
3. It is the responsibility of the student taking a photograph to ensure that the following information is given to patients when a request is made to take a photograph of them and that the information is understood and agreed to by the patient:
- The purpose that the photograph will be used for.
- Who will have access to the photograph? This does not mean that patients need to know the names of individuals who will see photograph, but they should know the role in which individuals will have access (i.e. ‘my supervisor’, ‘my lecturers’; ‘my study group’; ‘attendees at a conference’).
- The arrangements for destroying the photograph once it has been used.
- Time frames for use and retention of the photograph.
- Arrangements for storing the photograph.

4. It is the responsibility of the student taking a photograph to ensure that consent is properly documented in the patient notes. This includes noting the information provided to patients.

5. The patient has the right to see the photograph(s) that will be used.

6. The patient has the right to change their mind, in which case the photograph should not be used and should be deleted. This should be noted in the records.

7. Where possible, ensure that photographs do not allow patients to be identified by a person not involved in their care.

8. It is the student’s responsibility to ensure that any photographs taken comply with DHB/PHO policy.

9. Photographs should only be shared selectively. Only those with whom it is necessary to share a photograph to meet the purpose for which consent was obtained should have access to the photograph.

10. A student who takes a photograph of a patient must take all reasonable steps to ensure that the image is treated in a respectful manner.

3.4. Using radiological and photographic images for educational and professional practice purposes

Students may wish to use existing radiological or photographic images (taken for the purposes of providing care) for educational or professional practice purposes. For instance, they may wish to include a copy of a scan or x-ray in a case report.

Radiological or photographic images are part of the patient’s health care record, and should be treated according to the same principles as the rest of the record. Health care providers are responsible for abiding by the Health Information Privacy Code.

FMHS expects students to follow the following rules:

1. Students must have the permission of a senior clinician responsible for a patient’s care before accessing and using a radiological image for educational or professional practice purposes.

2. Students must ask the clinician whether they should seek consent from the patient to use of the image. Whether an additional specific patient consent is necessary will depend upon factors such as the purposes for which the image was taken, and what the patient understood it might be used for. The clinician responsible for a patient’s care must make the determination about whether or not patient consent should be sought.

3. Students must remove identifying information (names and NHI numbers) from the image.
3.5. Apps facilitating sharing of medical information

Apps such as Figure-1 enable images of patients to be accessed by anyone else in the world who has the app. Figure-1 offers no way to ensure that images are treated appropriately by the persons who access them. Images can be disseminated beyond the scope necessary to ensure that a given benefit is obtained. They allow comments to be made on images that could be disrespectful, hurtful and degrading of trust between doctors and their patients. Images uploaded to Figure-1 may not be easily removed from public view or public record. Because Figure-1 is available to non-health professionals, it offers little if any means of controlling dissemination of an image.

For these reasons, students must not upload images to Figure-1, similar apps or other social media e.g. Facebook, Instagram, Snapchat. If a student has any questions or concerns in relation to the taking and sharing of photographs of patients, they should contact a University of Auckland clinical supervisor or MPD staff.

4. Sensitive examination policy

Sensitive examination of patients

Sensitive examinations include breast, rectal (PR), and vaginal (PV) examinations as well as those of male external genitalia.

There are certain steps to be taken before any sensitive examinations are performed by a medical student. These steps are:

1. You have received specific teaching on the examination technique by a University of Auckland teacher.
2. Apart from scheduled supervised teaching with full patient consent (e.g. GTA teaching in Year 5, examination under anaesthesia), there is a well-defined clinical indication to perform the examination.
3. If you believe that there is such an indication for a sensitive examination, you will first discuss the performance of this with the medical staff (or a midwife, in the case of obstetrics) responsible for that patient.
4. The examination is carried out with a qualified doctor (or midwife, in the case of obstetrics) present.
5. In the case of sensitive examinations on female patients, there must be a female chaperone present. This might be the supervisor, if female.
6. Gloves should be worn for all sensitive examinations except:
   - Examination of the breast.
   - In some contexts, examination of the male genitalia. These are:
     - When examining the male genitalia of a child under the age of 15.
     - When examining the scrotum of an adult when it is part of a routine abdominal examination, and where there is no sign of skin ulceration or infection.

Gloves will be made available for students to use at their discretion, in both clinical contexts and under university clinical assessment conditions.

On every occasion a discussion about the appropriateness of undertaking a sensitive examination must occur with a senior medical doctor (or midwife, in the case of obstetrics) prior to performing any sensitive examination.

Medical student training requires the goodwill of patients, health professionals (both university and non-university), and health authorities, with the maintenance of a high level of collaboration and trust among all parties. Maintaining this trust requires all parties to:

- Protect patients from inappropriate or unnecessary examinations.
- Ensure that patients are not unduly alarmed by incorrect interpretation of physical
findings.

- Protect you, your teachers, and the health authorities from the situation where a complaint may be laid.

**Policy pertaining to those who contravene these steps**

Any student who contravenes this protocol for sensitive examinations risks suspension from the Medical Programme while the situation is fully investigated. Depending on the outcome of this investigation, it is possible that the student may not be readmitted to the undergraduate medical programme following their initial suspension.

### 5. MBChB Guidelines for Students Requesting Investigations

**A Framework for investigation requests made by medical students**

**Scope**

The framework applies to students enrolled in Years 4 to 6 of MBChB. Students in Year 2 & 3 must not make requests.

The definition of ‘investigation’ is any request for a laboratory test, physiological test (e.g. lung function) or medical imaging.

The overriding principle is patient safety; with other considerations being protection for the individual student, clinical and academic supervisors, DHBs and the FMHS.

**Process**

District Health Boards (DHBs) and Primary Health Organisations (PHOs) are asked to consider the following guidelines when students are permitted to order investigations:

- Requests must include the name of a responsible doctor* who will receive the result of the investigation
- The result of the investigation must go to the requesting doctor* and where possible the student
- The act of student involvement must not delay action on results, compared with other routinely requested investigations

* Or other appropriate registered health practitioner

The ability to request investigations is at the discretion of the DHB/PHO and may be provided to students from Years 4 to 6.

The guidelines apply to all request systems; paper, electronic and blended.

Individual DHB/PHOs need to ensure that they apply the guidelines and must inform students of their local scope and process for ordering investigations (this includes not being able to make requests, if that is the local policy). This could be done during their orientation to site.

Students must never order investigations for themselves.
6. Conflict of Interest and the Medical Programme

The University has a conflict of interest policy covering staff and students and others, which includes a requirement that academic supervision must be carried out without bias or prejudice, free of a conflict of interest.

The full policy is viewable at:

Perceived conflicts of interest can arise from many different types of relationships including, family, contractual, professional, pecuniary and work relationships. These relationships may be known to the individuals only.

In the Medical Programme this means it is inappropriate for a student to be supervised or assessed by someone who may be perceived to be conflicted by their relationship with the student. Examples of this could be a family member, a former patient, professional advisor, colleague or employer.

It is the responsibility of the student to immediately notify the MPD or their Phase Director if they find they are assigned to a clinical attachment supervisor, clinical examiner or other supervisor or examiner who is a family member or with whom they have had a prior relationship or if it may be reasonably perceived or apprehended that there may be a conflict of interest of some sort.

Immediate efforts will be made to re-assign the student to an alternative supervisor or examiner.


This Act provides a framework for the regulation of all health practitioners where there is a risk of harm to the public.

**Purpose of the Act**
To protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. The Act provides a framework for the regulation of all health practitioners where there is a risk of harm to the public. There will be consistent processes for the registration and ongoing competence of practitioners who are currently regulated and a process for the inclusion of new health professions if appropriate. Registration authorities will certify that practitioners are qualified and competent to practise within a certain scope specifying conditions and time.

**Scopes of practice**
Each registration authority will develop scopes of practise describing the activities practitioners are qualified to perform, the conditions under which the activities may be performed and a date for review.

**Restricted activities**
Some activities, where there is a risk of serious or permanent harm, will be restricted to those who are competent to perform the activity according to their scope of practise.

**Ongoing competence**
Registration authorities will be required to put processes in place to ensure that practitioners maintain their competence throughout their careers.

**Complaints and discipline**
There will be consistent processes across the professions for handling complaints against health practitioners that are fair to both the complainant and the health practitioner.

**Protected Quality Assurance Activities (QAA)**
QAAs facilitate practitioners learning from patient outcomes, improving their competence
and reducing adverse outcomes. By declaring a QAA, the Minister of Health provides both confidentiality to information that becomes known as a result of the activity and immunity from civil liability to people who engage in the activity of good faith. It is important that you keep yourself informed of this Act and its implications for your ongoing professional development and competence.

8. Medicine Regulations 1984, Section 41

Every prescription given under these regulations shall –

a. Be legibly and indelibly printed; and
b. Be signed personally by the prescriber with his usual signature (not being a facsimile or other stamp), and dated; and
c. Set out the address of the prescriber; and
d. Set out –
   (i) The title, surname, initial of each given name, and address of the person for whose use the prescription is given; and
   (ii) In the case of a child under the age of 13 years, the date of birth of the child, and
e. Indicate by name the medicine and, where appropriate, the strength that is required to be dispensed; and
f. Indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription, and
g. If the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose; and
h. If the medicine is for application externally, indicate the method and frequency of use; and
i. If it is the intention of the prescriber that the medicine should be supplied on more than one occasion, bear an indication of –
   (i) The number of occasions on which it may be supplied; or
   (ii) The interval to elapse between each date of supply; or
   (iii) The period of treatment during which the medicine is intended to be used.

The MCNZ statements on prescribing also make reference to the following:

- The Medicines (Standing Orders) regulations 2002.
- PHARMAC subsidy requirements.
9. Code of Health and Disability Services Consumers’ Rights

1. Consumers have rights and providers have duties:

   1) Every consumer has the rights in this Code.
   2) Every provider is subject to the duties in this Code.
   3) Every provider must take action to -
      a) Inform consumers of their rights; and
      b) Enable consumers to exercise their rights.

2. Rights of consumers and duties of providers:

   The rights of consumers and the duties of providers under this Code are as follows:

   Right 1: Right to be treated with respect

   1) Every consumer has the right to be treated with respect.
   2) Every consumer has the right to have his or her privacy respected.
   3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

   Right 2: Right to freedom from discrimination, coercion, harassment, and exploitation

   Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

   Right 3: Right to dignity and independence

   Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

   Right 4: Right to services of an appropriate standard

   1) Every Consumer has the right to have services provided with reasonable care and skill.
   2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
   3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
   4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
   5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

   Right 5: Right to effective communication

   1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
   2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.
Right 6: Right to be fully informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including -
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   c) Advice of the estimated time within which the services will be provided; and
   d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   e) Any other information required by legal, professional, ethical, and other relevant standards; and
   f) The results of tests; and
   g) The results of procedures.

2) 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.

3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -
   a) The identity and qualifications of the provider; and
   b) The recommendation of the provider; and
   c) How to obtain an opinion from another provider; and
   d) The results of research.

4) Every consumer has the right to receive, on request, a written summary of information provided.

Right 7: Right to make an informed choice and give informed consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -
   a) It is in the best interests of the consumer; and
   b) Reasonable steps have been taken to ascertain the views of the consumer; and
   c) Either, -
(i) If the consumer’s views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

(ii) If the consumer’s views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.

6) Where informed consent to health care procedure is required, it must be in writing if –
   a) The consumer is to participate in any research; or
   b) The procedure is experimental; or
   c) The consumer will be under general anaesthetic; or
   d) There is a significant risk of adverse effects on the consumer.

7) Every consumer has the right to refuse services and to withdraw consent to services.

8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

10) No body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than –
    a) with the informed consent of the consumer or
    b) for the purpose of research that has received the approval of an ethics committee; or
    c) for the purposes of 1 or more of the following activities, being activities that are each undertaken assure or improve the quality of services:
       (i) a professionally recognised quality assurance programme:
       (ii) an external audit of services:
       (iii) an external evaluation of services.

Right 8: Right to support
Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights may be unreasonably infringed.

Right 9: Rights in respect of teaching or research
The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

Right 10: Right to complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

2) Every consumer may make a complaint to -
a) The individual or individuals who provided the services complained of; and
b) Any person authorised to receive complaints about that provider; and
c) Any other appropriate person, including -
   (i) An independent advocate provided under the Health and Disability Commissioner Act 1994; and
   (ii) The Health and Disability Commissioner.

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

4) Every provider must inform a consumer about progress on the consumer’s complaint at intervals of not more than 1 month.

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that:
   a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   b) the consumer is informed of any relevant internal and external complaints procedures, including the availability of -
      (i) Independent advocates provided under the Health and Disability Commissioner Act 1994; and
      (ii) The Health and Disability Commissioner; and
   c) The consumer’s complaint and the actions of the provider regarding that complaint are documented; and
   d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

7) Within 10 working days of giving written acknowledgement of a complaint, the provider must,
   a) Decide whether the provider -
      (i) Accepts that the complaint is justified; or
      (ii) Does not accept that the complaint is justified; or
   b) If it decides that more time is needed to investigate the complaint, -
      (i) Determine how much additional time is needed; and
      (ii) If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -
   a) The reasons for the decision; and
   b) Any actions the provider proposes to take; and
   c) Any appeal procedure the provider has in place.
3. **Provider Compliance:**
   1. A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
   2. The onus is on the provider to prove that it took reasonable actions.
   3. For the purposes of this clause, “the circumstances” means all the relevant circumstances, including the consumer’s clinical circumstances and the provider’s resource constraints.

4. **Definitions**

   In this Code, unless the context otherwise requires, -

   “Advance directive” means a written or oral directive -
   a) By which a consumer makes a choice about a possible future health care procedure; and
   b) That is intended to be effective only when he or she is not competent:

   “Choice” means a decision –
   a) To receive services:
   b) To refuse services:
   c) To withdraw consent to services:

   “Consumer” means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer.

   “Discrimination” means discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993:

   “Duties” includes duties and obligations corresponding to the rights in this Code.

   “Ethics committee” means an ethics committee
   a) established by, or appointed under, an enactment; or
   b) approved by the Director-General of Health:

   “Exploitation” includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.

   “Optimise the quality of life” means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances:

   “Privacy” means all matters of privacy in respect of a consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates:

   “Provider” means a health care provider or disability services provider.

   “Research” means health research or disability research:

   “Rights” includes rights corresponding to the duties in this Code:

   “Services” means health services, or disability services, or both; and includes health care procedures:

   “Teaching” includes training of providers.
5. Other enactments

Nothing in this Code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by an enactment.

6. Other rights affected

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.

What services are covered by these rights?

The Code of Health and Disability Services Consumers’ Rights applies to all health services and disability support services in New Zealand.

The Code gives rights to all consumers, and places obligations on people and organisations providing services. It covers a wide range of providers (whether public or private) including:

- hospitals
- rest homes
- doctors
- home care providers
- counsellors
- homeopaths
- nurses
- therapeutic masseurs
- optometrists
- midwives

The Code of Rights

If you believe your rights have been breached, it is best to talk or write directly to the person or organisation giving you the service.

Very often they will welcome your complaint as it helps them improve their standard of service or uncover a problem.

If you feel uncomfortable or unable to do this you can take a friend or relative with you as support. You can also have the support of an independent Health and Disability Advocate who is trained to help people in your situation. This service is free.

Your local advocacy service and the Health and Disability Commissioner can be reached on the following:

Phone 0800 555 050 Fax 0800 2787 7678  hdc@hdc.org.nz

This section contains the regulation known as the Code of Health and Disability Services Consumers’ Rights.

The Health and Disability Commissioner has produced a range of leaflets, posters and videos about rights, the Commissioner and the Advocacy Service.

| Health and Disability Commissioner |
| Level 10 Tower Centre               |
| P O Box 1791, Auckland 1010         |

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<th>(09) 373 1060</th>
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<tr>
<td>Free Phone</td>
<td>0800 11 22 33</td>
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<td>Fax:</td>
<td>(09) 373 1061</td>
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<td><a href="mailto:hdc@hdc.org.nz">hdc@hdc.org.nz</a></td>
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- updated 2003 and 2008

A. Privacy Act – applies universally
The Privacy Act establishes that information concerning an identifiable individual should be collected, stored, used and destroyed in a manner which ensures that the individual concerned (and in certain circumstances their relatives) are not either actually, or potentially harmed. Failure to comply with the 12 Information Privacy Principles in the Privacy Act (which became operative on 1st July 1993) can result in severe legal penalties for the individual and/or organisation breaching the principles.

B. Health Information Privacy Code
The following guidelines on the application of the Code to medical students are not exhaustive and do not replace the Code but indicate general approaches which should be adopted to comply with the Code and Directives from the DHBs.

The Privacy Act allows The Privacy Commissioner to promulgate Codes of Practise which tailor the Privacy Principles of the Act to a particular activity or occupation. Such a Code (The Health Information Privacy Code 1993 [Temporary]) came into force on 10th August 1993 and was replaced by a permanent Code on 28th June 1994. The reprinted 2007 Code incorporates 7 amendments made since 1994.

The Code applies to all “Health Agencies” (which include DHBs and General Practitioners) and individuals (including Students and Trainees) who use Health Information. Whilst under the supervision of a hospital or other health agency students must comply with the policies and regulations developed for staff of that agency and while under the supervision of the FMHS should comply with the School’s regulations and policy. The Code covers, for example, information about an individual’s medical and treatment history, any disabilities they may have or have had, their contact with any health or disability providers and information about donation of blood, organs etc. The Code does not apply to statistical or anonymous information which does not enable the identification of an individual.

Application of The Code and penalties for breaches
The Code does not supersede standards of Ethical and Professional Conduct of the Health Professions (which may be “higher”) but sets minimum standards with which all individuals and organisations have to comply.

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Failure to comply with the Code can result in severe legal penalties for both the organisation and the individual.

During your medical studies you must comply with the Code in all of your contacts with patients or patient information in all circumstances.
Contents of the Health Information Privacy Code 1994

The full Code is available for you to consult from:

The Code consists of 3 parts and an Appendix.

Part 1: Introduction

Part 2: The 12 Rules of the Code
  (based on the 12 Privacy Principles of the Privacy Act)

  (related to Charges for copies of Information, appointment of
   Institutional Privacy Officers, Complaints and Schedules)
  Appendix: Excerpts from the Privacy Act

The following guidelines on the application of the Code to Medical Students are not exhaustive and do not replace the Code but indicate general approaches which you should adopt to comply with the Code and Directives from the DHBs. Only the rules specifically applying to medical students have been mentioned.

In case of any doubt consult the full Code and/or your immediate Supervisor for guidance.

The Components of the Health Information Privacy Code

Rules 1 – 3: Collection of health information

This section outlines the essential points from each rule that is relevant for a medical student. It is not an exact copy of the rules.

Most health information is collected in a situation of confidence and trust and the manner of collection should reflect that confidence and trust by:-

Rule 1

Ensuring that health information is only collected from a person if it is for a lawful purpose connected with a function or activity of the health agency and is necessary for that purpose (eg. Care and Treatment, Administration, Training and Education, Quality Assurance).

Rule 2

Information shall be collected directly from the person concerned or from a person who he/she authorises or who is their legal representative. Non-compliance (under special circumstances) requires approval from your immediate supervisor and then specific explanation and consideration (this provision confirms the Informed Consent Principle).

Rule 3

All reasonable steps must be taken to ensure that the person knows: -

- That the information is being collected.
- The purpose for which the information is being collected.
- The intended recipients of the information.
- The name and address of the agency collecting and holding the information.
- Whether the supply of information is voluntary or mandatory, and if mandatory, the particular law under which it is required.
– The consequences to that individual and/or representative if all or any part of the requested information is not provided. [e.g. that failure to provide information for education and training purposes will not prejudice treatment]
– The rights of access to correction of health information

Rules 5 – 9: Storage, security, accessibility and retention of health information

Rule 5
The Health Agency shall ensure that the Patient Information is protected against loss, access, use, modification or disclosure or misuse, except with the authority of the agency. All efforts will be made to prevent unauthorised use or unauthorised disclosure of the information. Health information must be disposed of in a manner that preserves the privacy of the individual.

N.B. Patient notes/records must not be taken from the places specified for their secure storage.

Rule 6
The Health Agency shall provide to the patient on request confirmation of whether or not the Agency holds information about them and also provide access to that health information.

Rule 9
The Health Agency shall not keep information for longer than is required for the purpose for which the information may be lawfully used.

Rules 10 – 12: Use of health information

Rule 10
1) A health agency that holds health information obtained in connection with one purpose must not use the information for any other purpose unless the health agency believes on reasonable grounds:
   a) that the use of the information for that other purpose is authorised by:
      (i) the individual concerned; or
      (ii) the individual’s representative where the individual is unable to give his or her authority under this rule;
   b) that the purpose for which the information is used is directly related to the purpose in connection with which the information was obtained;
   c) that the source of the information is a publicly available publication;
   d) that the use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to:
      (i) public health or public safety; or
      (ii) the life or health of the individual concerned or another individual;
   e) that the information:
      (i) is used in a form in which the individual concerned is not identified;
      (ii) is used for statistical purposes and will not be published in a form that could reasonably be expected to identify the individual concerned; or
(iii) is used for research purposes (for which approval by an ethics committee, if required, has been given) and will not be published in a form that could reasonably be expected to identify the individual concerned;

f) that non-compliance is necessary:
   (i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or
   (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation);

**Rule 11**

1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds:

   a) that the disclosure is to:
      (i) the individual concerned; or
      (iii) the individual’s representative where the individual is dead or is unable to exercise his or her rights under these rules;

   b) that the disclosure is authorised by:
      (i) the individual concerned; or
      (ii) the individual’s representative where the individual is dead or is unable to give his or her authority under this rule;

   c) that the disclosure of the information is one of the purposes in connection with which the information was obtained;

   d) that the source of the information is a publicly available publication;

   e) that the information is information in general terms concerning the presence, location, and condition and progress of the patient in a hospital, on the day on which the information is disclosed, and the disclosure is not contrary to the express request of the individual or his or her representative;

   f) that the information to be disclosed concerns only the fact of death and the disclosure is by a [health practitioner], or by a person authorised by a health agency, to a person nominated by the individual concerned, or the individual’s representative, partner, spouse, principal caregiver, next of kin, whanau, close relative or other person whom it is reasonable in the circumstances to inform[; or]

   g) the information to be disclosed concerns only the fact that an individual is to be, or has been, released from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the disclosure is to the individual’s principal caregiver.
11. Patient health information— Frequently Asked Questions

Q 1 What are the key policies regarding the use of health information by medical students?

A The overarching policies regarding health information are the Health Information Privacy Code (1994), and The Code of Health and Disability Services Consumers’ Rights 1996. These are included in this policy guide.

The MCNZ has issued statements on Maintenance and Retention of Patient Records, Legislative Requirements about Patient Rights and Consent, and Use of the Internet and Electronic Communication.

Anyone (including medical students) working at a DHB is expected to observe that DHB’s policy with regard to the confidentiality of patient information at all times, and without exception, to ensure patient confidentiality is maintained. Most DHBs have Privacy Officers.

Please ensure you check the DHB’s policy at which you are working as they may differ.

All DHBs have policies on access to patient information. Those policies state that only those staff members involved in the care and treatment of a patient may have access to that person’s clinical records. In addition, any staff member wishing to view his/her own records should request to view their records following the processes designed by the DHB he/she is at.

Furthermore, parents and guardians do not have an automatic right to access their child’s clinical records and must officially request access to such records. Staff members who require access to their own or their child’s record should contact the Release of Information staff in the Clinical Records Department for assistance.

You should never share your logons/passwords with others.

You will be held accountable for all transactions that occur in any of the DHB’s patient information systems using your logon/password.

You must only ever access information in the DHB’s patient information systems (including CMS, CHiPS, PHS, CRIS, Concerto, Meddocs, PiMS etc.) for the purpose of performing the specific duties associated with your job.

If your job requires you to access the record of a patient with whom you have a personal relationship (e.g. a relative or a friend) it is recommended that you ask another staff member to perform the duties associated with accessing the record, rather than you accessing the record yourself. You should seek advice/support from your Manager regarding this.

DHB staff are strictly prohibited from accessing / browsing / viewing / printing patient information, unless they are required to do so for the purpose of performing the specific duties associated with their job. The same applies for medical students.

The DHBs conduct regular audits on patient information systems usage to identify potential breaches of the DHB Policy. Please note that all staff with access to patient information are subject to audit at some stage.

The DHBs regard any misuse of patient information systems as a breach of DHB policy. It is important that you realise that such breaches of patient confidentiality are taken very seriously, and have resulted in previous staff members having their employment terminated.
Depending on the severity of the breach, medical students might have their access rights to DHBs curtailed, and/or their actions considered under the Faculty’s “Fitness to Practise” process or the University Discipline Committee. This may result in suspension or exclusion from the Medical Programme. This would also have ramifications for access of future students to information systems, and DHBs.

Q 2 My login has expired but my clinical supervisor has given me her login to use indefinitely. I’ve used her login to look up a well-known TV presenter’s records not under our team’s care. What is the DHB’s view of this? What are repercussions for me? My supervisor?

A You should NEVER use another person’s login – this is against DHB policy at all the DHBs. The repercussions for you and the supervisor will be serious - see Q1 above. If you require access to clinical systems you need to follow the process required by the DHB you are at.

Q 3 I use my login to check the clinical results for a close relative who isn’t directly under my team’s care. The person has verbally consented to me. Is there any comeback?

A This is a breach of DHB policy as per Q1. To find out information about a patient who is not directly in your care, you must request the records following the process designed by the DHB at which you are located.

Q 4 I wish to look up a patient’s records for a case report/assignment/presentation. I recall examining this patient with a rare medical condition several weeks ago but the person has subsequently left the hospital and I have no way of getting their consent. Is there anything I can do?

A If you were involved in the team that was looking after the patient’s care, you will need to talk to your consultant and seek their approval to access the electronic record.

If you were not involved in the patient’s care, you will need to seek the approval of the consultant who was looking after the case. If they believe it is appropriate you then need to approach Clinical Records staff. You will need to provide appropriate identification, University ID and name badge, before the information is made available to you.

Q 5 I’m keen to get some additional clinical practise in preparation for a clinical skills assessment, so I turn up on the ward on a Saturday and look at the patients’ notes then log onto the patient record system. The Duty Nurse asks me what I’m doing. Do I have a right to access patient records in this situation?

A If you are practising for a clinical skills assessment you should not need to access the electronic patient record. It is not appropriate for medical students to view the case notes of patients that they are not involved with in a direct clinical sense. If you wish to view the patient’s paper record you do need the patient’s express permission. This can be discussed with the patient at the time.

The DHBs acknowledge rights of access for students for learning. You are reminded of the ethical guidelines covering the involvement of patients in clinical teaching and you must always:

- Be correctly attired, including the wearing of your university name badge.
- Identify yourself to the patient.
- Explain the purpose of your interview and examination and obtain verbal agreement
from the patient.
• Ensure the patient is able to consent and agrees to be interviewed.
• Respect a patient’s refusal to be examined.

If you are not formally allocated to a team in that ward, it is particularly important that you observe the following procedure in addition to the above:
• You explain the purpose of your visit, and seek permission from, the senior nurse on duty and the nurse looking after the patient before approaching the patient.
• If the clinical team is present, it is appropriate to speak to a member of that team.

Q 6 I am a Year 6 medical student working for the renal service; my colleague has a patient with an unusual urology syndrome that would provide valuable learning. May I meet with/examine the urology patient and access the urology patient’s records?
A See the answer to Q 5 regarding responsibilities to patients and access to their notes. It is preferable if one of the attending team asks the patient if they are prepared to see you.

Q 7 Do I have to log out of the main ward login and login under my username as this is slow and irritating?
A Every person has their own log-in and may only use that to access the patient information systems. You should log off when finished.

Q 8 May I complete an online patient discharge form? If so are there any caveats?
A You are reminded of the importance of the quality and accuracy of the information contained in the discharge form. This is the information the patient takes with them and provides important information for the GP for follow-up purposes. Extra care must always be taken to ensure that the information included is accurate. E.g. failure to document an allergy to medication can have serious consequences. You should follow DHB protocols and remember that you may not sign anything that needs to be signed by a registered medical practitioner.

Q 9 The IS Helpdesk has generated a username for me that has rude connotations. May I get it changed?
A All usernames are generally checked as they are created. However if the user name is problematic (e.g. it is offensive) a student should contact the relevant helpdesk of a DHB to request a change.

Q 10 I am doing a summer studentship, and have been asked to perform an audit. I would like to take the records home with me to save me coming into the hospital each day. How do I go about ordering these records?
A Even if paper records were available, you are NEVER allowed to take them home with you. You may only view the records that are relevant for audit purposes in a Clinical Records Department.