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Do undergraduate heathcare students have to disclose their academic status to patients when involved in their care?

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DO UNDERGRADUATE HEALTHCARE STUDENTS HAVE TO DISCLOSE THEIR ACADEMIC STATUS TO PATIENTS WHEN INVOLVED IN THEIR CARE?

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Medicine in Bioethics and Health Law

Johannesburg, 2013

Candidate's Declaration

I, Martha Susanna van Niekerk, declare that this research report is my own work, except where I have explicitly indicated otherwise. It is being submitted in partial fulfilment of the requirements for the degree of Master of Science in Medicine in Bioethics and Health Law in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signed on this 17th day of September 2013:

_____

Student's signature

Dedication

I wish to dedicate this research report to my family who have made many sacrifices to allow me to follow my dream. Thank you!

Abstract

Using patients in the training of healthcare students is required by the World Federation of Medical Educators. South African legal instruments such as the Constitution and the National Health Act recognise patients' right to autonomy. This descriptive, analytical study investigated whether patients should be informed that the person involved in their care is a student. International studies and the ethical guidelines of regulating bodies support informing patients of the academic status of persons participating in their care. While patients are willing to participate in the training of healthcare students, they do not waive their right to informed consent. South African health care practitioners are increasingly required to disclose non-medical information to patients, such as treatment costs. Patients should be informed about the academic status of persons involved in their care and have the right to refuse to participate in medical education. The HPCSA should draw up guidelines to support this.

Acknowledgement

Foremost I would like to express my gratitude to my supervisors, Prof Ames Dhai and Adv Yolande Guidozzi, for their ongoing support and enthusiasm for this project. It is such a privilege to have been able to share this journey with people who are committed to professionalism and ethical behaviour, not only amongst practitioners, but also students.

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Chapter One: Introduction and Rationale for the study.

Using patients in the training of health care students is an entrenched practice, [1] with patient contact being one of the requirements of the World Federation for Medical Education [2] for medical training. Despite patient involvement in student education being an entrenched and necessary practice, ethical guidelines to protect the patients and guide the students have not paralleled this practice. Thus the ethics of using patients in the education of health care students continues to be debated in literature.

An important ethical concern related to patient involvement in the clinical training of health care students that is frequently raised in the literature centres around respecting patients' autonomy, right to self-determination and informed consent. [3] It is a well-established principle in biomedical ethics that patients' autonomy should be respected. [4] Respect for a patient's autonomy requires health care practitioners to give the patient information regarding the medical condition with which he/she has been diagnosed as well as all possible treatment options available to them and the risks involved therewith.

In practice, respect for autonomy is realised in three ways: 1) by providing sufficient information about the nature and inherent risks of a procedure so as to allow a patient (or his/her *curator*) to make an informed decision, [5] 2) by allowing patients to participate in decisions about their own health/body [6] and 3) by respecting a patient's decision in so far as it does not harm others. [7]

Thus, the self-directed behaviour of patients who are capable of making informed decisions should be honoured and respected. Importantly, patients with diminished capacity, such as

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[1] Jagsi, R, and Lehmann, L S. "The ethics of medical education." *British Medical Journal* 329 (2004):332; Blindless, L. "The use of patients in health care education: The need for ethical justification." *Journal of medical ethics* 24 (1998): 314; Salter, R H. "Learning from patients - unfashionable but effective." *Posgraduate Medical Journal* 72 (1996): 385

[2] World Federation for Medical Education. *Basic medical Education: WFME global standards for quality improvement.* Copenhagen, 2003:10-11

[3] Examples are Waterbury, J.T. "Refuting patients' obligations to clinical training: a critical analysis of the arguments for an obligation of patients to participate in the clinical education of medical students." *Medical Education* 35 (2001): 286-294, Lowe, M et al "Do patients have an obligation to participate in student teaching?" *Medical education*. 42 (2008):237-241, and Yentis, S.M. "The use of patients for learning and maintaining practical skills." *Journal of the Royal Society of Medicine*. 98 (2005):299-302. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1168911/ (accessed March 26, 2011).who argue the question whether patients have a duty to participate in medical education.

[4] Beauchamp, T L, and Childress, J F. *Principles of biomedical ethics.* Oxford: Oxford University Press, 2001:65

[5] Dada, M A, and McQuoid-Mason, D J. *Introduction to medico-legal practice.* Durban: Butterworths, 2001:35-36; Claassen, N J B, and Verschoor, T. *Medical negligence in South Africa.* Pretoria: Digma, 1992:62

[6] Health Professions Council of South Africa "National Patients' Rights Charter." May 2008:1; Pieterse, M. "The interdependence of rights to health and autonomy in South Africa." *South African Law Journal* 125, no. 3 (2008):555

[7] Dada & McQuoid-Mason 2001:35-36; Claassen and Verschoor 1992:60

those who are psychotic or with impaired intellectual capacity (and thus incapable of understanding that to which they may be consenting) should be protected. [8]

Patient autonomy and specifically the right to make an informed decision (informed consent), has been affirmed by the South African courts on a number of occasions. [9] It is important to note that all the standards applied by the courts when deciding about informed consent, relate to the provision of medical information. With the growing protection of patients' rights, including protection of their rights as consumers, increasing emphasis is placed on the disclosure of non-medical information (such as costs of procedures) in addition to medical information. [10] The question that arises is whether patients are entitled to know the academic status of all people involved in the various aspects of their care. [11] While the guidelines on Seeking Patients' Informed Consent: The Ethical Considerations, contained in Booklet 9 of the HPCSA mentions that patients may "want or ought to know" that students will be involved in their care as well as the extent of their involvement, the Ethical and Professional Rules of the Health Professions Council of South Africa as promulgated in Government Gazette R717/2006 also published in Booklet 2 of the HPCSA and the other guidelines of the HPCSA are silent on the procedures that should be followed in disclosing a student's academic status to a patient, as well as whose responsibility such a disclosure is. In addition, the National Health Act No 61 of 2003 also does not address this particular issue.

International literature has highlighted the need for ethical guidelines regarding disclosure of a student's academic status. However, few studies have been conducted regarding students' disclosure of their academic status to patients when involved in their care.

An alarming practice was reported by Beatty and Lewis [12] following a study they conducted at the University of Connecticut School of Medicine in 1992. [13] All the students who participated in their study had at some point in their career been introduced as "doctor" to

[8] Dada and McQuoid-Mason 2001:35-36
[9] See for example the cases of *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) and *Castell v de Greef* 1994 (4) SA 408 (C).
[10] Section 6(1)(c) of the National Health Act 61 of 2003 and item 2.8 of the National Patients' Rights Charter, Booklet 3 2008:2.
[11] For the purposes of this study, care entails any interaction with the patient for the purpose of making a diagnosis, or facilitating the patient's management (e.g. taking the patient's history, drawing the patient's blood or other fluids, and performing or assisting with procedures).
[12] Beatty, M E, and Lewis, J. "When Students introduce themselves as doctors to patients." *Academic Medicine* 70, no. 3 (1995):175
[13] The authors reported this study in the Letters to the Editor section of Academic Medicine, and thus it is not peer-reviewed.

patients and 5% of the student-participants had introduced themselves as “doctor” to patients. [14]

One of the reasons tendered by Beatty and Lewis for this misrepresentation on the part of clinicians and students is the fear that patients will refuse to consent to student involvement in their care. In a South African study on students’ views on wearing a white coat, [15] an alarming 63,4% (n=59) of the participants indicated that there is no need for students to wear a different colour coat or have some other form of identification in order to be distinguished from qualified doctors. [16] Of these 59 students, 6 indicated a fear that patients would not cooperate with them if they do not look like qualified doctors. [17]

Patients’ unwillingness to cooperate with students seems to be a real fear among students, but this fear is contradicted by the findings of a few studies. Jackson et al [18] found that patients in a community setting felt that it was important to participate and state their own viewpoints and lived experience to students. A study conducted in Sweden by Lynöe et al [19] reports that patients are positive towards participating in the training of health care students, but emphasized that they must receive information and the opportunity to decline participating. In a Turkish study 72 of 100 participants indicated that they will always consent to participate in clinical education, provided that they are asked. [20] In this study, only 3 participants indicated that they will never participate. Furthermore, participants in the Swedish [21] and Turkish[22] studies indicated that they were upset when they discovered that they were used in student training without being informed.

Literature reports that fewer patients are willing to participate in first time procedures or procedures performed by students in their earlier years of study, although patients will participate in these procedures as long as their autonomy is preserved by informed consent. [23] Interestingly, Başağaoğlu and Sari [24] found that 31 of their 100 participants were willing to

[14] Beatty and Lewis 1995:175
[15] McLean, M, and Naidoo, S S. "Medical students' views on the white coat: A South African perspective on ethical issues." *Ethics and Behaviour*, 2007: 387-402. .
[16] McLean and Naidoo 2007:393 and 395.
[17] Mclean and Naidoo 2007:395.
[18] Jackson, A, Blaxter, L, and Lewando-Hundt, G. "Participating in medical education:views of patients and carers living in deprived communities." *Medical Education* 37, no. 6 (2003):537-538.
[19] Lynöe, N, Sandlund, M, Westberg, K, and Duchek, M. "Informed consent in clinical training - patient experiences and motives for participating." *Medical education* 32 (1998):470.
[20] Başağaoğlu, I, and Sari, N. *Patient attitude about ethical issues confronted during the clinical education of medical students with emphasis on informed consent.* 2005:2. A different version of this article was published in 1998 in Turkish: Sari, I, Başağaoğlu I. “Ethical problems confronted during the clinical education of medical students.” *Journal of Medical Ethics, Law and History* 6(2)(1998): 61-68.
[21] Lynöe, N, et al. "Informed consent in clinical training - patient experiences and motives for participating." *Medical education* 32 (1998):470.
[22] Başağaoğlu and Sari 2005:2.
[23] N Lynöe et al 1998:470; Barnett et al "Informed consent from patient participating in medical education: A survey from a university hospital in Jamaica." *BMC Research Notes* 2 (2009):3-4.

allow students to perform first time procedures, or to perform examinations or procedures early in their academic career on them (as long as they were supervised), whereas Williams and Fost [25] found that 52% of patients were willing to permit students to perform a spinal tap for the first time on them, provided that the student was closely supervised during the procedure.

However, more often than not, the level of misleading information provided to patients is not as flagrant as that described by Beatty and Lewis. [26] In some cases, patients are simply not provided with any information. [27] The Jamaican study found that 74.8% of participants did not know the academic status of the medical professional who interviewed and/or examined them. [28] The results of the Turkish study indicated that although patients were admitted to a teaching hospital, "at least" [29] 70% of patients were unaware that students would be performing procedures on them for the first time. [30] In addition, while 87% of these participants were aware that it was an academic hospital, they were unaware (and not informed) that the students were absolutely inexperienced. [31] Also, only one third of these 87% of participants understood what it means to be treated in an academic hospital. [32] Başağaoğlu and Sari, [33] in interpreting their findings, state that they can only safely say that 28 of their 100 participants understood that an academic hospital "functions as a training institution and that patients are expected to contribute to training". [34] This creates the impression that while many patients know that a facility is an academic hospital, they do not necessarily understand that students are likely to be involved in their care, which is of concern as it undermines a patient's autonomy.

In other cases, patients were provided with information regarding the academic status of a person involved in their care, but it was not provided in a way that they could understand. The information conveyed proved to be inadequate, because patients were confused about the titles of practitioners caring for them, [35] whether these practitioners had told them their correct titles, or whether titles were printed on name tags. [36] Interestingly, Silver-Isenstadt

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[24] 2005:8.
[25] 1992:221.
[26] 1995:175.
[27] Williams, C T, and Fost, N. "Ethical considerations surrounding first time procedures: A study and analysis of patient attitudes toward spinal taps by students." *Kennedy Institute of ethics Journal* 2, no. 3 (1992)::217.
[28] Barnett et al 2009:3.
[29] This is the terminology used by the authors, but it is not clear what they mean by "at least" 70%.
[30] Başağaoğlu and Sari 2005:7.
[31] Başağaoğlu and Sari 2005:5-6.
[32] Başağaoğlu and Sari 2005:6.
[33] 2005:7.
[34] Başağaoğlu and Sari 2005:7
[35] Barnett et al 2009:3.
[36] Silver-Isenstadt A, and Ubel, P A. "Medical student name tags: Identification or obfuscation?" *Journal of general internal medicine* 12, no. 11 (1997):669-671.

and Ubel [37] found that most participants in their research identified “medical student” as being the least qualified and thus they recommend that name tags using this identifier be adopted by medical schools to reinforce students’ academic status. [38]

An important trend was found by Westberg et al [39] in a study to explore whether advance written notification of the presence of students during gynaecological examinations would influence patients’ consent to their presence. They found that, despite a standard practice of informing patients verbally of the presence of students and requesting consent, 9 of 39 patients who received verbal information, indicated that they were not informed of the presence of a student during their gynaecological examination. The study further found that receiving written information in advance had no effect on patients’ willingness to allow students to be present during gynaecological examinations. Importantly, none of the 71 patients who participated in the study refused to consent to participate in the students’ clinical training, although nine patients (one of whom was in the group that received advance written information) stated that they would have preferred not to have a student present. This is of interest, as 16 of the participants (of whom 4 had received advance written information) stated that they did not feel free to refuse to participate in student training. [40]

An issue raised by the Jamaican study relates to the question whether patients give implied consent to participate in the training of health care students simply by attending teaching hospitals. Barnett et al [41] and the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association (AMA) [42] emphasise that regardless of the fact that patients know that a hospital is a teaching hospital, they do not waive their right to autonomy. Admission to a teaching hospital should not be regarded as implied consent to participate in the training of health care students.

A further concern that arises is the lack of appreciation on the part of both teachers and students regarding the necessity for students to obtain consent to be present during examinations when the patient is under general anaesthesia, or for students to conduct these examinations themselves on the anaesthetised patients. Silver-Isenstadt and Ubel, in a study conducted in 1999, found that only 12% of preclinical and 28% of clinical students viewed it as important that patients be informed that a medical student will perform a rectal

[37] 1997:671.
[38] Silver-Isenstadt and Ubel 1997:671.
[39] Westberg, K, Lynöe, N, Lalos, A, Löfgren, M, and Sandlund, M. "Getting informed consent from patients to take part in the clinical training of students: randomised trial of two strategies." *British Medical Journal* 323 (2001):488.
[40] Westberg et al 2001:488.
[41] 2009:4.
[42] Council on Ethical and Judicial Affairs of the American Medical Association. "Medical Student Involvement in Patient Care." *Journal of Clinical Ethics* 12 (2000):111.

examination under anaesthesia. [43] Significantly, in contrast to the attitudes of the students and teachers, the studies of Başağaoğlu and Sari [44] and Barnett et al [45] found that all patients participating in their respective studies viewed giving their consent to the presence of students during examinations important to them, as well as giving consent to the performance of examinations on them while they were anaesthetised.

One particular concern in South Africa that differs slightly from issues raised in the international literature is that there are limited options available to patients who depend on the public health system, as in some areas the only public health care facilities are teaching hospitals. Should patients wish not to access these facilities, they may need to travel great distances at some cost to themselves to access other public health care facilities where there may not be an equivalent quality of care. Most patients who access public hospitals are unable to afford private health care and thus vulnerable because they have limited options available to them.

In the South African context, there is a large population of vulnerable patients. [46] Factors such as poverty, low literacy levels, geographic remoteness and limited education [47] all contribute to the vulnerability of patients who access public health services. [48] Medical students are only permitted to do fieldwork in public health care facilities by the rules of the HPCSA, but other students, such as occupational therapy students, may also be placed in private health care facilities. Placing health care students only in public facilities may result in an unfair burden on vulnerable populations to contribute to the education of health care practitioners. This is because of the inequities in access to health care resources in South Africa at present, where 84% of the population, consisting of mainly vulnerable persons who are dependent upon public health care only, merely have access to 50.6% health care resources, with the remainder of resources accessible to the remaining 16% of the population. [49] In addition, there is a more favourable ratio of practitioners to patients in the private sector than the public sector. [50]

[43] Silver-Isenstadt, A, and Ubel, P A. "Erosion in medical students' attitudes about telling patients they are students." *Journal of General Internal Medicine* 14, no. 8 (1999):487.
[44] 2005:7.
[45] 2009:3.
[46] McLean and Naidoo 2007:392-393.
[47] See the Preamble to the Consumer Protection Act No 68 of 2008.
[48] McLean and Naidoo 2007:392-393.
[49] McIntyre, D, Doherty, J, and Gilson, L. "A tale of two visions: the changing fortunes of Social Health Insurance in South Africa." *Health policy and planning* 18, no. 1 (2003):49.
[50] Department of Health "National Health Act, 2003: Policy on National Health Insurance." *Government Gazette* (Government Printer) 554, no. 34523 (August 2011): 10.

The studies conducted by Başağaoğlu and Sari [51] and Barnett et al [52] highlighted the need for guidelines regarding informed consent when patients participate in the training of health care students. Although the South African study on students' views on wearing the white coat also revealed an alarmingly high refusal amongst students to be easily distinguishable from qualified practitioners, [53] the authors of the study did not recommend guidelines regarding disclosure of academic status to patients, as disclosure was not the focus of the study.

In terms of the Constitution of South Africa [54] (Constitution) the following rights pertaining to autonomy and self-determination in the health care context are enshrined in the Bill of Rights:

- The right to equality and non-discrimination [55]
- The right to inherent dignity and the right to the protection and respect of their dignity [56]
- The right to freedom and security of the person, including the rights to be free from any form of violence from either public or private sources [57] and not to undergo any form of torture [58]
- The right to bodily and psychological integrity, which means *inter alia* that people should have control over their own bodies [59] and not be subject to medical or other experimentation without their informed consent. [60]
- The right to privacy. [61]
- The right to access [62] health care services and reproductive health care. [63]

Patients and consumers already enjoy some protection in South Africa, thus in order to establish guidelines regarding informed consent for patients participating in the training of health care students, an analysis of existing international policies and guidelines as well as South African legislation is necessary.

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[51] 2005.
[52] 2009.
[53] McLean and Naidoo 2007:392-393.
[54] Act No 108 of 1996.
[55] Section 9 of the Constitution Act No 108 of 1996.
[56] Section 10 of the Constitution Act No 108 of 1996.
[57] Section 12(1)(c) of the Constitution Act No 108 of 1996.
[58] Section 12(1)(d) of the Constitution Act No 108 of 1996.
[59] Section 12(2)(b) of the Constitution Act No 108 of 1996.
[60] Section 12(2)(d) of the Constitution Act No 108 of 1996.
[61] Section 14 of the Constitution Act No 108 of 1996.
[62] This right relates to adults, as children have the right to basic health care services (s28(1)(c) of the Constitution)
[63] Section 27(1)(a) of the Constitution Act No 108 of 1996.

Chapter Two: Methodology

2.1. Problem statements / research questions

Patients' right to medical information which allows them to make an informed decision is protected by various policies and legislation, including the National Patients' Rights Charter (published in Booklet 3 of the HPCSA), the National Health Act No 61 of 2003, Mental Health Care Act No 17 of 2002 and the Children's Act No 38 of 2005. Despite this protection, there are few South African guidelines regarding patients' right to informed consent in teaching hospitals, where students are involved under varying levels of supervision in the care of patients admitted to training hospitals.

The study investigated whether students, when involved in patients' care, have an ethical and legal obligation to inform patients that they are students and not qualified practitioners.

2.2. Objectives

The objectives of this research projects were the following:

- To describe international best practice guidelines regarding disclosure of the academic status of students who are involved in patient care.
- To analyse existing ethical guidelines in the South African context in an attempt to establish whether there are possible gaps in the ethical guidelines related to disclosure of the academic status of students who are involved in patient care.
- To analyse existing South African legal instruments with a view to ascertaining whether there is an existing legal obligation to disclose a student's academic status to patients when involved in their care.

Outcomes:

- To propose a framework to institutions and the HPCSA related to possible best practice guidelines regarding the disclosure of the academic status of students involved in patient care.
- Complete a discussion paper for dissemination to the Department of Health, health science institutions and other related entities (e.g. human rights organisations).
- Publish the research in a peer reviewed journal.
- Present the findings at national and international conferences.

- Submit the research report as partial fulfilment of the requirements of the MSc Med (Bioethics and health law) degree
- The research findings are to provide the basis of a PhD proposal.

2.3. Working definitions

A student for the purposes of this study is a student of any profession registered with the Health Professions Council of South Africa.

For the purpose of this study, care includes taking a history and/or performing an examination of a patient, performing procedures and executing aspects of treatment, or treatment in its entirety.

For the purpose of this study educational status means that the person in question is an undergraduate student, currently in training towards a health care qualification.

2.4. Methods

2.4.1. Study Design

This was a descriptive, analytical study of pertinent ethical and legal instruments and peer reviewed articles distributed in national and international publications.

2.4.2. Study methodology

Literature was identified by using electronic and research databases, such as ProQuest LexisNexis, JSTOR and SABINET. Search engines such as PubMed, Google Scholar and LexisNexis were used to identify pertinent literature to be used in the study by using the following search words:
Health care students, medical ethics, informed consent, education.

The following strings were used in addition:
“students disclose academic status”; “students inform patients”

In addition to the searches of electronic databases, the references of the articles found were also searched for relevant literature.

2.4.3. Study population and sampling

Literature pertaining to undergraduate students of all the different health care professions was used. Studies conducted on both under-and postgraduate students were included because of the paucity of research into the topic, but the results pertaining to postgraduate students were not included in this study. Papers not published in English were not included in this study.

2.5. Ethical issues

This study does not involve research with human participants. Ethics waiver was obtained from the Chair of the REC (Prof Peter Cleaton-Jones Peter.Cleaton-Jones@wits.ac.za).

2.6. Results

The results of the literature search are presented as an ethical-legal analysis toward formulating an opinion and recommendations which may influence public policy.

2.7. Funding

The research study was self-funded and no funding was obtained from other sources.

2.8. Limitations

This research report was limited to the study of general ethical issues facing undergraduate students of health care professions. Profession-specific issues were not dealt with in this report and should be the focus of future research studies. This study was limited to issues pertaining to student-involvement in the care of hospitalised adult patients and therefore the use of patients to present talks to, or to educate students on the lived-experience of specific medical conditions were not covered in this study. Children involved in clinical education of students were also not covered in this study.

A limitation of the international studies considered for this research report is that few of these studies had similar aims, making comparisons between studies difficult. For example the Jamaican study of Barnett et al [64] focused on surgical patients whereas the Turkish study [65]

[64] 2009

focused on patients in a public teaching hospital. Further, one of the studies [66] was only published in the "letters to the editor" section of a journal, thus limiting its value because it was not peer-reviewed. Most literature pertaining to patients being involved in student care are opinion-based pieces, either published as letters to the editor or as editorial comment, thus detracting from its scientific value.

[65] Başağaoğlu and Sari 2005.
[66] Beatty and Lewis 1995:175.

Chapter 3: International best practice guidelines

International literature has highlighted various ethical concerns regarding the training of student practitioners by means of using patients in health care student education. Many of these issues relate to the disregard for both the patient's autonomy and the pre-eminence of the patient's welfare.

Being honest with patients and empowering them to make decisions about their health care by providing pertinent information underlies the principle of autonomy. [67] This principle is disregarded when patients are unable to consent to or refuse treatment because insufficient or false information is provided to them. In such instances, patients cannot make an informed decision and therefore any choices they exercise may not be truly autonomous. [68]

Beatty and Lewis [69] and McLean and Naidoo [70] found that students are afraid that patients will not allow them to participate in the patients' care when they know their academic status. Although studies like Başağaoğlu and Sari [71] and Lynöe et al [72] indicate that patients are positive about participating in student training if asked, in the absence of ethical guidelines, patients' autonomy remains at risk of being undermined by withholding the academic status of people involved in their care from them.

Students and faculty may think that name tags are sufficient to identify students as such, but Silver-Isenstadt and Ubel in 1997 found that patients do not necessarily understand the titles given to different members of staff and thus are unable to consent, or refuse, to participate in clinical education, further undermining patients' autonomy.

Studies such as the one by Silver-Isenstadt and Ubel [73] highlight the need for clear guidelines regarding consent for students to participate in procedures that are performed under general anaesthesia. This is of concern, because these kinds of procedures are usually intimate in nature, such as gynaecological, urological and gastro-intestinal procedures.

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[67] Dada & McQuoid-Mason (2001:35-36), Medical Professionalism Project: ABIM Foundation, ACP-ASIM Foundation, and European Foundation of Internal Medicine. "Medical Professionalism in the New Millenium: a physician charter." *Annals of Internal Medicine* 136 (2002):243.
[68] Beauchamp and Childress 1994:121.
[69] 1995:175.
[70] 2007:393-394.
[71] 2005:7.
[72] 1998:470.
[73] 1999:481-487.

Although patients' participation in clinical education should be voluntary, there are reports of patients' well-being being undermined when they or their proxy refuse to participate in student education, resulting in discharge from the hospital in an extreme case as reported by Başağaoğlu and Sari. [74] Furthermore, patients have indicated a reluctance to not comply with practitioners' requests for fear of ill treatment. [75]

3.1. Ethical Policies and Guidelines regulating students' interaction with patients.

Internationally, there has been a wide call for ethical guidelines regarding patient involvement in student training. In the studies conducted by Başağaoğlu and Sari [76] and Barnett et al [77] the need for guidelines regarding informed consent when patients participate in the training of health care students was expressed. Despite this, few international regulatory bodies have taken up the responsibility to formulate ethical guidelines. For the purposes of this study, the guidelines published by the American Medical Association (AMA), [78] the Health and Care Professions Council (HCPC) of the United Kingdom, [79] and the set of policy guidelines developed by St Bartholomew's and the Royal London School of Medicine and Dentistry in 1996 as published in the British Medical Journal (BMJ) in 2001 [80] [81] will be analysed. A 2011 position statement by the Canadian Paediatric Society, the "Ethical participation of children and youth in medical education" will not be considered, as the issues pertaining to children and youth under the age of 18 years are unique and fall outside of the scope of this research report.

The guidelines of the General Medical Council (GMC) of the United Kingdom on student involvement in the health care of patients are fragmented. There are at least four documents that pertain to student practice to some extent: Tomorrow's Doctors; Clinical placements for medical students; Medical students: professional values and fitness to practice; and Consent: patients and doctors making decisions together. The GMC further

[74] 2005:2.
[75] Başağaoğlu and Sari 2005:7.
[76] 2005.
[77] 2009.
[78] American Medical Association. *AMA Code of Medical Ethics: Opinion 8.087 - Medical Student Involvement in Patient Care.* 2000.
[79] Health and Care Professions Council. "Guidance on conduct and ethics for students." 2012.
[80] St Bartholomew's and the Royal London School of Medicine and Dentistry. "Policy on the rights of patients in medical education." *British Medical Journal* 323 (2001). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119888/bin/bmj_322_7288_685__index.html (accessed November 27, 2012)
[81] Singer, P A. "Intimate examinations and other ethical challenges in medical education: Medical schools should develope effective guidelines and implement them." *British Medical Journal* 326, no. 7380 (January 2003):63 reports that because of the 2001 BMJ publication of policy guidelines on patient involvement in student training, the University of Toronto and the teaching hospitals associated with it, formulated ethical guidelines for clinical teaching.

describes different types of clinical practice for students, which differ from the South African context. The GMC guidelines for student behaviour are based on the guidelines to doctors, contained in its Tomorrow's Doctors document. [82] Because student guidelines are based on qualified practitioners' requirements, the different clinical practice models, and the fragmentation of guidelines pertaining to student practice, the GMC documents will not be included in the analysis of international instruments in this research report.

The AMA guidelines (see Appendix 1) consist of three items, whereas the HCPC guidelines (see Appendix 2) contain 13 guidelines with sub-items. The BMJ policy (see Appendix 3) consists of 7 points. The AMA guidelines and BMJ policy differ from the HCPC guidelines in one key respect: the AMA and BMJ emphasise that supervisors and students are responsible for ensuring that students practice ethically, [83] whereas the HCPC places the onus on the student. The AMA appears to approach their guidelines from a patients' rights perspective, whereas the HCPC guidelines are presented from a student conduct perspective. [84] The BMJ policy further differs from the AMA and HCPC guidelines in the respect that it is aimed at regulating situations where patients participate in clinical training purely for educational purposes that are not aligned with the patient's treatment. [85]

The provisions of the guidelines/policies relevant to this study can be grouped under the following ethical and professional principles, which will be discussed further:

- Benefitting the patient
- Acting in the best interests of the patient
- Informed Consent
- Confidentiality
- Honesty

3.3.1. Benefitting the patient.

The AMA guidelines emphasise that patients benefit from being treated by multidisciplinary teams, which include health care students. The Report of the Council on Ethical and Judicial Affairs, on which the AMA guidelines are based, explains that the benefit to the patient is in the "integrated care that is provided by health teams that include medical

[82] General Medical Council and Medical Schools Council. *Medical students: professional values and fitness to practise.* 2009:6.
[83] AMA Opinion 8.087 section 1. This is supported by the BMJ policy, as in the last bullet it is stated that "[e]ncouragement of students to ignore these guidelines is unacceptable".
[84] HCPC guidelines to educators/supervisors and students are contained in separate booklets, but only the student booklet will be discussed in this research report.
[85] BMJ 2001.

students". [86] The BMJ policy does not see participation in clinical education as primarily beneficial to the patient, though, because in terms of the BMJ policy, it appears that the primary purpose of participation in clinical education is educational.

The BMJ guidelines emphasise that patients should clearly understand that non-participation in clinical education will not compromise their care. This is important, because of the findings of studies such as the Turkish study by Başağaoğlu and Sari [87] where patients indicated a reluctance to refuse requests from health care practitioners for fear of compromised care. [88]

3.3.2. Acting in the best interests of the patient

The HCPC guidelines and BMJ policy prescribes a number of ways in which students should act in the best interests of their patients.

Firstly, students are required to respect a patient's right not to participate in clinical training. Students should respect patients by treating everyone equally and not abusing or exploiting their relationships with patients. [89] Patients' dignity should be protected by not performing potentially embarrassing examinations (either because of the nature of the examination or the number of students involved) without patients' express (verbal) consent. [90]

Students should act within the limits of their education and training. [91] They should ask for help from their supervisor or someone from the clinical placement [92] and only perform unsupervised tasks if they believe they have adequate skills to do so. [93] The BMJ policy requires "recorded evidence of competence" [94] before students perform unsupervised activities. [95]

Students should not expose patients to danger [96] and should deal safely with the potential of infection. [97] When students have health-related difficulties, they should cease their studies,

[86] CEJA 2001:111
[87] 2005.
[88] Başağaoğlu and Sari 2005:7
[89] HCPC 2012:9.
[90] BMJ 2001.
[91] HCPC 2012:10.
[92] HCPC 2012:11.
[93] HCPC 2012:9.
[94] Unfortunately "recorded evidence of competence" is not defined or further described.
[95] BMJ 2001.
[96] HCPC 2012:9.
[97] HCPC 2012:12.

especially when impairments in judgements may result as this could pose a risk to patients. [98]

Students are required to ensure that they keep patients' records up to date and that the information they add to a patient's file is correct and clear. [99]

3.3.3. Informed Consent

Patients should be informed of the identity and educational status of every person involved in their care [100] and should know that participation in clinical education is voluntary [101] and that they can refuse to participate in clinical education. [102] Patients have the right to choose their service provider and thus to choose to be treated by a qualified practitioner. [103]

The BMJ guidelines prescribe that verbal consent would be sufficient to allow student participation, except in those instances where students would perform actions while the patient is anaesthetised. In those cases, written consent should be obtained and kept in the patient's file. [104] Where verbal consent was obtained, the fact that the consent was obtained must be recorded in the patient's file. [105]

3.3.4. Confidentiality

All information about a patient is confidential. [106] Information obtained from patients should only be used for the purposes for which it was obtained. However, patients should be informed that students may be required to disclose information obtained from a patient to a responsible clinical supervisor, especially where others may be at risk. [107]

3.3.5. Honesty

The AMA and the HCPC emphasise that students (and supervisors) should be clear about the educational status of students and not inflate the skills of students. The BMJ policy

[98] HCPC 2012:10.
[99] HCPC 2012:12.
[100] AMA 2001.
[101] BMJ 2001.
[102] *Ibid.*
[103] HCPC 2012:9; AMA 2001; BMJ 2001.
[104] BMJ 2001. The AMA guidelines on the other hand require that student participation in procedures where patients will be anaesthetised, must be discussed prior to the procedure (AMA 2001).
[105] BMJ 2001.
[106] HCPC 2012:9; BMJ 2001.
[107] HPCP 2012:9; BMJ 2001.

states that students should be referred to by correct titles, and confusing [108] or misleading titles such as "'young doctors', 'my colleagues', or 'assistants'" may not be used by either supervisors, clinical teachers or students. [109]

Because the HCPC guidelines are student-centred, aspects related to plagiarism and academic honesty are included in their document. [110] These are beyond the purview of this research report and will not be discussed.

Whether a student-centred or a patient-centred approach is followed, the international instruments appear to agree that students should disclose their academic status to patients when involved in their care. An analysis of the South African position is necessary to establish whether the South African context may also require disclosure of academic status to patients.

[108] AMA 2001.
[109] BMJ 2001.
[110] HCPC 2012:12.

Chapter 4: the South African Perspective

4.1. Introduction

Provision of health care services in South Africa is regulated by *inter alia* the Constitution of South Africa Act 108 of 1996, the National Health Act 61 of 2003 (NHA), the Mental Health Care Act 17 of 2002 (MHCA) and the Health Professions Act 56 of 1974 (HPA) as amended. The Health Professions Council of South Africa (HPCSA) was created in terms of the Health Professions Act. [111] Its function is to "protect the public and guide the professions" which it achieves through the ethical regulations [112] and guidelines [113] it publishes in terms of section 49 read with section 61(2) and section 61A(2) of the Health Professions Act, [114] to regulate practice as well as its various tribunals. [115] In addition to the aforementioned legislation, the Consumer Protection Act 68 of 2008 which came into full effect on 31 March 2011 also impacts upon the provision of health care services and may qualify some of the rights and duties health care practitioners have in terms of the Health Professions Act and its regulations and guidelines. [116]

South Africa also does not have a codified set of ethical rules of conduct for students who interact with patients for educational purposes, or who perform assessments and/or treatment procedures on patients. For this reason it is necessary to analyse and consider all relevant legislative measures related to patients, in addition to the rights patients enjoy in terms of the common law to establish the full extent of rights and protection afforded to patients. Whether there is an existing legal obligation to disclose a student's academic status to patients when involved in their care will also be considered.

Before analysing the legislation, it is necessary to establish whether the legislator had student practitioners in mind when drafting legislation pertaining to the health sector. This may be done by reviewing the definition clauses found in s1 of the NHA and s1 of the MHCA. The NHA defines "health care providers" as people who provide health care

[111] Act no 56 of 1974.
[112] Booklet 2: Ethical rules of conduct for practitioners registered under the Health Professions Act 56/1974, published under Government notice R717 in Government Gazette 29079 of 4 August 2006 and amended by Government Notice R68 published in Government Gazette 31825 of 2 February 2009. It should be noted that a further amendment to the ethical rules to align it with the Competition Act 89 of 1998 is currently being drafted.
[113] Booklets 1, 3 – 12. These are not published in the Government Gazette and thus do not have the same legal standing as Booklet Two.
[114] Act no 56 of 1974.
[115] For example the Committees of preliminary enquiry of each Professional Board and the Conduct Committees.
[116] Other legislation, such as the Promotion of Access to Information Act No 2 of 2000 also has implications for practice but fall outside the ambit of this discussion.

services “in terms of any law”, including amongst others, the Health Professions Act, [117] while “Health workers” are persons involved in the provision of health care services, other than a “health care provider”. It can be extrapolated that student practitioners are included in the definition of health care providers, because they are involved in the provision of health care services through being trained in the hospitals with actual patients.

Interestingly the MHCA’s definition of “health care provider” differs substantially from the NHA’s corresponding definition, as the MHCA has not incorporated the definitions of other pieces of legislation such as the Health Professions Act into its definition. The MHCA merely defines “health care provider” as someone who provides health care services. The definition of a “mental health care practitioner”, on the other hand, is more specific, and includes

… a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services” [118]

Importantly, students (under- or postgraduate) are not mentioned in this definition. Students could possibly be included in the definition of “mental health care provider”, which is defined as:

… a person providing mental health care services to mental patients and includes mental health care practitioners.

The definitions of psychiatrist, psychologist and social worker found in the MHCA [119] relate to persons registered as such with the relevant regulatory body and thus do not seem to include students.

Contrary to the NHA and the MHCA, s1 of the HPA [120] includes students explicitly in its definition of a health practitioner. While it is good that students are included explicitly, their inclusion should be interpreted with the necessary caution, as their practice remains supervised until they graduate and register as independent practitioners. Importantly, the HPA is the only Act which explicitly includes not only all health care practitioners in its

[117] Act No 56 of 1974
[118] Section 1 of the MHCA No 17 of 2002.
[119] Act No 17 of 2002
[120] Act No 56 of 1974

definition, but also students, although it can be argued that the NHA [121] also includes students because of its reference to the HPA in s1.

The HPCSA's Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 contains its own definition clause and in rule 1 defines practitioner as "… a person registered as such under the Act". [122]

While the HPA [123] includes students overtly in its definition of health practitioners, the HPCSA's Ethical Rules [124] do not include students explicitly in its definition of practitioners. However, it could be argued that reference to the definition from the HPA [125] as amended, includes students in the ambit of the HPCSA's Ethical Rules by implication.

An analysis of the definitions of persons involved at some level in the provision of health care services highlights the lack of uniform terminology and the difficulties that may arise as a consequence when trying to establish which law applies to the regulation of students.

4.2. The Constitution of South Africa [126]

Sections 10 (right to dignity), 12 (right to freedom, security and control of one's body) and 14 (right to privacy) of the Constitution [127] have some impact on the provision of health care services and should be read together with sections 27 and 28(1)(c). Section 27(1)(a) of the Constitution [128] guarantees adults the right to access health care services. [129] Section 12 specifically includes the right not to be subjected to medical or other experimentation without providing informed consent. [130] The importance of these sections of the Constitution for the health sector is that patients' autonomy is constitutionally entrenched. Therefore, health care practitioners, regardless of their benevolence, may not undermine patients' autonomy and right to give informed consent (or refusal) for health care services. This would also apply to student practitioners.

[121] Act No 61 of 2003
[122] Booklet 2 2008:7.
[123] Act No 56 of 1974
[124] Booklet 2 2008:7.
[125] Act No 56 of 1974.
[126] Act No 108 of 1996.
[127] *Ibid.*
[128] *Ibid.*
[129] Section 28(1)(c) guarantees children the right to basic health care services, which is stronger than the right conferred upon adults. Ethical concerns around children participating in clinical education will not be addressed in this research report.
[130] Section 12(2)(d) of the Constitution Act No 108 of 1996.

4.3. The National Health Act [131] and Mental Health Care Act [132]

Health care providers must inform patients, [133] in a language and manner that they understand, [134] of their health status, [135] the range of procedures available to them [136] as well as the benefits, risks and costs thereof. [137] Patients must also be informed of their right to refuse treatment and the implications of refusal of treatment. [138]

Health services may not be provided without the patient's informed consent. [139] In addition, a patient –

…has the right to participate in any decision affecting his or her personal health and treatment. [140]

Nowhere does the NHA explicitly require disclosure of the academic status of a health care provider.

The MHCA [141] and NHA [142] do not have similar provisions regarding disclosure. The MHCA [143] only deals with issues peculiar to mental health patients and patients with diminished capacity due to mental illness, but does not address service provision by practitioners in training at all, although some psychiatric hospitals, e.g. Weskoppies Hospital and Sterkfontein Hospital, are teaching hospitals. This is a limitation of the MHCA which is likely to render patients more vulnerable and necessitates codified regulation of students.

4.4 The Health Professions Act, [144] the HPCSA and its Ethical Rules and guidelines.

The purpose of the HPA was to create the Health Professions Council of South Africa and Professional Boards as well as to control the education, training and registration of health

[131] Act No 61 of 2003.
[132] Act No 17 of 2002.
[133] The NHA Act No 61 of 2003 refers to patients as "health care users" and the MHCA Act No 17 of 2002 refers to patients as "mental health care users". The Health Professions Act as well as the HPCSA's booklets use the term patients. For the purposes of this report, the term "patients" will be used.
[134] Section 6(2) of the NHA Act No 61 of 2003.
[135] Section 6(1)(a) of the NHA Act No 61 of 2003.
[136] Section 6(1)(b) of the NHA Act No 61 of 2003.
[137] Section 6(1)(c) of the NHA Act No 61 of 2003.
[138] Section 6(1)(d) of the NHA Act No 61 of 2003.
[139] Section 7 of the NHA Act No 61 of 2003.
[140] Section 8(1) of the NHA Act No 61 of 2003.
[141] Act No 17 of 2002.
[142] Act No 61 of 2003.
[143] Act No 17 of 2002.
[144] Act No 56 of 1974.

professions and all related matters. The HPCSA, as part of its mandate to guide the professions, developed Ethical Rules (published as a schedule to the HPA as well as in the HPCSA's Guidelines for Good Practice, Booklet 2), and additional guidelines to the ethical rules, contained in Booklets 1 and 3 to 14 and 16. [145]

While the Ethical Rules are important for practitioners and therefore important for students to learn about, very few of these rules impact directly on student practice or address issues peculiar to students' interaction with patients. They are mainly targeted at qualified practitioners, for example touting, canvassing and signing medical certificates, whereas it is illegal for students to practise independently (as per the HPA). [146] On the other hand, the rules around exploitation, [147] professional confidentiality, [148] performance of professional acts, [149] and the reporting of a colleague's (or one's own) impairment, or unprofessional, illegal or unethical conduct [150] can easily also apply to student practice. The rules around maintaining confidentiality and performance of professional acts clearly relate to students' interaction with patients as well as the actions of qualified practitioners, but these rules are general and do not address issues peculiar to students' involvement in patient care.

The only rules that overtly refer to students are found in the annexures to the Ethical Rules. All the Professional Boards have published annexures to the Ethical Rules to cover profession-specific concerns. These documents are relatively similar, except for the annexure applicable to the profession of psychology, which document is more comprehensive and follows a different format to the other documents.

The Professional Board for Psychology, in its comprehensive annexure to the Ethical Rules, state that:

"When obtaining informed consent to therapy … a psychologist shall, as early as is feasible in the therapeutic relationship, provide the client concerned with appropriate information … and when the psychologist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client shall, as part of the informed consent procedure, be

[145] Booklet 2 of the HPCSA was promulgated as regulations and thus Booklet 2 carries slightly more legal weight than the remainder of the HPCSA's booklets. For the purposes of this report, the contents of Booklet 2 will be referred to as the Rules, whereas the other booklets will be referred to as guidelines.
[146] Act No 56 of 1974.
[147] Rule 22.
[148] Rule 13.
[149] Rule 21.
[150] Rule 25

informed that the therapist is in training and is being supervised and the client shall be given the name of the supervisor". [151]

This appears to be the only instance in the Ethical Rules where a student is required to disclose the fact that they are in training, although the emphasis here appears to be less on the fact that a patient should be able to make an autonomous decision about participating in the training of the psychologist and more on the fact that the patient should know who the supervisor is. [152]

The Professional Boards other than Psychology in the annexures to the Ethical Rules [153] require qualified practitioners, student practitioners, assistants and technologists to adhere to rules 2-27 contained in the main document, in addition to the Board-specific rules contained in the relevant annexure. Each annexure, except Annexure 12 pertaining to the Professional Board for Psychology, has a clause related to the performance of professional acts by a student, which states that students shall only perform acts under supervision, [154] and may only perform acts directly in keeping with their level of training. [155] [156]

The requirement of students to only perform acts directly in keeping with their level of training relates to skill. It is reasonable to assume that patients, upon entering health care facilities such as hospitals, expect to receive care at the standard of a qualified health care practitioner. However, students cannot measure up to the standard of a qualified health care practitioner, due to their limited training. Thus, a qualified practitioner should ultimately take responsibility for the care and treatment of the patients in whose care students are involved. Unfortunately, supervision is not clearly specified in either the HPA or the Ethical

[151] Annexure 12, Chapter 6 rule 57(b) of Booklet 2, *op cit*.
[152] Although not clarified, it is presumed to be implied here that the patient should be aware that information shared may be disclosed to the named supervisor.
[153] Annexures 1 to 11.
[154] Usually by a registered practitioner in the same profession, but some professions, e.g. occupational therapy stipulates that any registered practitioner may supervise occupational therapy students as long as supervision by a practitioner other than an occupational therapist does not exceed 6 moths (Annexure 7, rule 4(a)). Other professions, e.g. podiatry, could also be supervised by medical practitioners (Annexure 9 rule 6(a)).
[155] The Medical and Dental Professional Board in Annexure 6 specifies in addition that Interns (rules 6 and 7), Medical and Dental Students (rule 8) and clinical associates (rule 9) may not work in private practice, and may not act as a *locum tenens*.
[156] It should be noted that the nature and extent of "supervision" is not defined and may be specified in documents generated by the various Professional Boards' Education Committees. The nature of supervision is likely to vary from Professional Board to Professional Board. Acts directly in keeping with one's level of training may also be difficult to pinpoint and may vary from university to university, depending on how each university's curriculum is configured.

Rules and its annexures, which may render the patient vulnerable and the student, supervisor and teaching hospital exposed to unnecessary litigation. [157]

While eleven of the Professional Boards require students to act within the limits of their level of training and education, none of the Ethical Rules explicitly require practitioners to disclose their level of education to patients or patients.

The HPCSA has published 14 further booklets containing guidelines on the ethical rules, dealing with issues such as biological warfare, perverse incentives and reproductive health. Booklet 9, which deals with informed consent, contains the only reference to students other than that found in the Ethical Rules, in guideline 3.1.3, which deals with patients' right to information about their diagnoses. The guideline gives examples of information that patients may want to know, including:

…whether students will be involved, and the extent to which students may be involved in an investigation or treatment. [158]

This guideline is not specific as to the process of obtaining informed consent for student involvement or who must disclose information about student involvement.

It is important to note that patients have the right to refuse treatment, not only in terms of s6(1)(d) of the NHA, but also in terms of the National Patients' Rights Charter. [159] Further, patients may not be prevented from seeking a second opinion, or to be treated by another health care practitioner. [160] Non-disclosure of academic status is likely to unfairly limit this right.

4.5 The Common Law and Other Non-Medical Legislation

As discussed, one of the most important aspects affected by student participation in patient care is the patient's autonomy. The South African courts have protected the patient's right to make an informed choice about treatment in cases such as *Richter and Another v Estate Hammann* [161] *Castell v de Greef* [162] and the more recent case of *Louwrens v Oldwage.* [163]

[157] It should be noted that each Board prescribes the minimum standards of training for the respective profession(s) governed by the Board, and while supervision may be described in some of these documents, there is no uniform definition thereof.
[158] Health Professions Council of South Africa "Seeking Patients' Informed Consent: The Ethical Considerations." 2008:2, Guideline 3.1.3.9.
[159] Health Professions Council of South Africa "National Patients' Rights Charter." May 2008:2, Item 2.9.
[160] Rule 11 of Booklet 2 (2008:12).
[161] 1976 (3) SA 226 (C)

The South African courts appear to follow two different approaches in determining whether a patient's autonomy was impeded by a physician accused of medical negligence/malpractice. On the one hand, they apply a 'prudent doctor standard', [164] which evaluates a medical procedure from the perspective of the healthcare professional. According to this standard, the physician's duty to disclose those risks associated with the particular surgery or other procedure (which the physician may regard as remote), should be measured against the standard of the reasonable doctor facing the same problem. [165] This test was best formulated by Watermeyer J in the judgement of *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C), where he held at 232 G-H:

A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interest to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do.

The alternative, and probably better, standard applied by the courts is that of the prudent patient, [166] which entails that in order for consent to be informed, the patient needs to fully comprehend the extent of the risks involved in the procedure to which he is consenting (i.e. the patient needs to be informed of the material risks involved in the treatment/procedure). In the case of *Castell v de Greef*, [167] it was held that material risk is what a reasonable person in the plaintiff's position would have considered significant (and thus necessary to declare), or what the physician ought reasonably to have known that this specific patient upon whom he was about to perform a surgical procedure, would have considered noteworthy enough to necessitate disclosure. [168] Thomas (2007:188), with reference to the

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[162] 1994 (4) SA 408 (C).
[163] 2006 (2) SA 161 (SCA)
[164] See Claassen and Verschoor (1992:66-67) who discuss this standard with reference to the case of *Sidaway v Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1984] 1 All ER 1018.
[165] See Claassen and Verschoor (1992:67-68) for a discussion of this standard8.
[166] Claassen and Verschoor (1992:67-68) refer to this as the 'prudent patient standard'.
[167] 1994 (4) SA 408 (C).
[168] S*upra*, at 426.

Castell-case, [169] agrees that the standard of disclosure for informed consent (as explained in this judgement) is that of material risk, to which the patient must consent. [170] [171]

In the more recent case of *Louwrens v Oldwage*, [172] the court again applied the standard of the prudent doctor. The prudent doctor standard has been widely criticised [173] for denying a patient's right to self-determination. This standard seems to allow a paternalistic approach to persist and does not appear to fully appreciate the patient's autonomy and right to self-determination. Although the prudent patient standard is now considered to be the more appropriate test to apply because of its recognition of patient autonomy, the courts have been inconsistent in its application as can be seen in the *Louwrens*-case [174] which has caused confusion.

In all of the above-mentioned cases the issue at hand related to medical information, however patients increasingly require and are entitled to non-medical information such as the costs [175] related to procedures.

The Consumer Protection Act 68 of 2008 (CPA) provides two other important rights to consumers which are likely to impact on students rendering health care services, i.e. the right to select suppliers [176] and the right to be provided with information in a plain and understandable way so as to allow them to make an informed choice. [177] However, if patients are not informed that a person involved in their care is a student, they are unable to refuse treatment or to choose another service provider. Furthermore, s41 of the CPA [178] requires fair and honest dealing. "False, misleading or deceptive representations" are impermissible in terms of this section and thus it could be extrapolated that patients are entitled to know the academic status of persons involved in their care.

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[169] 1994 (4) SA 408 (C)
[170] In the *Castell*- case at 426 F-H 'material risk' was described as a risk which a reasonable person in the patient's position would find significant if they were warned about it, or that a doctor should reasonably know that this specific patient would find significant,. In the case of *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) it was held that remote risks or unusual risks that could not be reasonably foreseen are not material risks. In the case of *Louwrens v Oldwage* it was held that a 2% risk is too remote to be material, however, in view of the definition contained in the *Castell*-case, a particular patient may find a 2% risk significant and thus such a risk may not necessarily be negligible.
[171] In the modern information age patients can access information freely on the internet, thus possibly creating a greater duty on a physician to provide patients with comprehensive information and give effect to their right to self-determination.
[172] 2006 (2) SA 161 (SCA).
[173] See Claassen & Verschoor 1992:66-67.
[174] *Ibid.*
[175] Section 6(1)(c) of the NHA Act No 61 of 2003.
[176] Section13 of the CPA
[177] Section 22 of the CPA.
[178] Act No 68 of 2008.

Section 22(2) of the CPA [179] clarifies plain language as language that can reasonably be understood by the class of people for whom the notice, documentation or visual representation is intended, or those with average literacy skills and minimal experience as a consumer. [180] The question that arises is whether people with minimal experience as consumers of health care services at teaching hospitals understand what it means to seek health care services at a teaching or academic hospital. It can thus be argued that the presence of signboards designating a hospital as a teaching hospital is not sufficient to absolve a student or health care practitioner from disclosing the academic status of persons involved in a patient's care.

Although a patient's right to autonomy has been recognised by the South African courts and is protected to a limited extent constitutionally, in legislation and the common law, clear guidelines regarding students' interactions with patients are necessary.

[179] *Ibid.*

[180] Jacobs, W, Stoop, P, and Van Niekerk, R. "Fundamental consumer rights under the Consumer Protection Act 68 of 2008: A critical overview and analysis." *Potchefstroom Electronic Law Journal* 13, no. 3 (2010):330 indicate that this right does not require notices or documentation to be in official languages.

Chapter 5: Conclusion and Recommendations

The purpose of this study was to investigate whether health care students must disclose their academic status to patients when involved in their care, by analysing international policies and guidelines as well as South African legal instruments.

International studies, such as those conducted in Jamaica, Turkey and Sweden, found that patients are often not aware that students are involved in their care, but they want to be informed when students are involved. [181] While students are afraid that patients will not consent to participate in medical education, these studies also found that patients are willing to allow students to participate in their care, especially when they are supervised and the patients have given informed consent. [182] All of these studies have called for ethical guidelines specific to students' participation in patients' care, but few guidelines are available.

Three sets of international guidelines were analysed: AMA guidelines, the Policy on the rights of patients in medical education published in the BMJ, [183] and the HCPC guidelines. All of these guidelines confirm the patient's right to know the academic status of all persons involved in their care.

In the South African context, patients have rights that are often not well defined in relation to health care services, particularly regarding student involvement in the rendering of services. Patients' rights and their protection need to be applied to patient involvement in clinical education. One such example is the right to non-medical information, highlighted in the NHA. [184]

Traditionally, informed consent allows the patient to make a decision about a procedure based on the medical information around such a procedure. [185] The NHA [186] seems to expand the requirements of informed consent to also include non-medical information. Academic status can be argued to be non-medical information, as it does not pertain to the inherent medical aspects of procedures. Thus, because the NHA [187] requires the provision of costs of healthcare services, which is non-medical information, it can be extrapolated that

[181] Lynöe, Sandlund et al 1998:470; Başağaoğlu and Sari 2005:5-7; Barnett et al 2009:4.
[182] Lynöe, Sandlund et al 1998:470; Başağaoğlu and Sari 2005:8; Barnett et al 2009:3-4.
[183] Formulated by St Bartholomew's and the Royal London School of Medicine and Dentistry
[184] Section 6(1)(c) of the NHA Act No 61 of 2004.
[185] See for example the cases of *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) and *Castell v de Greef* 1994 (4) SA 408 (C).
[186] Act No 61 of 2004
[187] *Ibid.*

the NHA allows for the inclusion of other pertinent non-medical information, such as academic status, in informed consent.

There may be increased risks when procedures are performed by students rather than qualified practitioners, more so when the student performs these procedures for the first time. Thus, it could also be argued that academic status should be disclosed in any case, because the NHA [188] requires disclosure of the risks and consequences of procedures when extracting informed consent from a patient, as required by s6(1)(c) of the NHA. [189]

Furthermore, the NHA [190] confers on patients the right to participate in decisions affecting their health and treatment. If they are not provided with non-medical information or information about the risks surrounding procedures, they cannot participate effectively in decisions that affect their health and treatment.

The difficulty with patients not being informed about the academic status of the person involved in their health care is that, in the context of a society with strong paternalistic roots, low levels of literacy and limited experience as consumers, patients are likely to be vulnerable to exploitation or unfair practices without realising that they are allowed to refuse such treatment, because they may be unfamiliar with asserting their rights.

Patients in South Africa enjoy some protection of their rights because of the existing ethical rules and guidelines of the HPCSA. However, there are few guidelines and ethical rules that apply specifically to the interaction between student and patient. The three international instruments, i.e. the AMA guidelines, the Policy on the rights of patients in medical education published in the BMJ, [191] and the HCPC guidelines, differ from the HPCSA ethical rules and guidelines in one important respect: the three international documents address the interaction between patients and health care students separately, compared with the HPCSA which addresses the interaction between patients and qualified practitioners primarily.

The ethical rules of the HPCSA, while advocating that patients should know whether students will be involved in their care, [192] as well as the extent to which students will be involved, are not as comprehensive as the international instruments. The AMA guidelines, read together with the BMJ policy and HCPC guidelines explain the circumstances under

[188] Act No 61 of 2003.
[189] *Ibid*
[190] *Ibid*
[191] Formulated by St Bartholomew's and the Royal London School of Medicine and Dentistry
[192] Guideline 3.1.3. Booklet 9 (2008:2)

which written and verbal consent for student participation should be sought, as well as the manner in which consent should be obtained, i.e. verbally or written. The international instruments agree that explicit consent should be obtained for student participation in the care of patients, however, the HPCSA guidelines are not as clear.

The AMA advocates that the attending physician is best positioned to obtain consent for student involvement, whereas the HCPC guidelines require students to obtain consent from patients themselves to be involved in their care. A situation may arise where the student believes that the supervisor or attending practitioner has obtained consent for his or her involvement in the care of a patient and then may continue with involvement in the patient's care without the patient's express consent, or without indicating that he or she is a student practitioner. It seems prudent to require that the supervisor/attending practitioner AND the student to remain responsible for obtaining consent from the patient for participation. Furthermore, students should be required to inform and remind patients of their academic status, so as to avoid creating an expectation of a level of care that they are unable to deliver.

When patients are not provided with all the relevant information needed to give an informed consent to treatment, including knowledge of the academic status of persons involved in their care, health care practitioners and students fail to empower patients to make informed decisions about participating in their health care. This contravenes the autonomy of patients and cannot be seen to be in the bests interests of the patient.

The HCPC guidelines cover some of the aspects that are already covered by the HPCSA booklets, such as informing regulatory bodies when one's health becomes impaired. [193] In a student-focussed document, examples and scenarios that are specific to students can be used to illustrate ethical and professional principles, thus allowing students to better identify with the principles. This could allow students to remember and apply them more readily. A further advantage of a student-specific document is that it facilitates students becoming familiar with the other HPCSA ethical guidelines already published. This may ultimately result in a generation of practitioners that are more knowledgeable about ethical principles and guidelines of practice and who also know where to find some answers to ethical dilemmas when necessary, fostering better compliance with ethical rules and guidelines.

The international guidelines follow either a patient-centred approach (e.g. BMJ policy) or a student-centred approach (e.g. HCPC guidelines). The South African guidelines could develop both, because the existing National Patients' Rights Charter could easily be

[193] Booklet 2 2008:18; HCPC 2012:10.

expanded to incorporate patients' rights in relation to the teaching hospital environment. The HPCSA could then develop a separate student-specific document.

It is recommended that the existing National Patients' Rights Charter be expanded to include the right to be informed when students are involved in their care, as well as the extent of the students' involvement. The right to refuse student involvement in their care should also be included.

A student-focussed document containing student-specific guidelines when students are involved in patients' care should be developed. It is recommended that these guidelines encompass ethical principles such as autonomy, beneficence and legal principles such as the right to fair and honest dealing. Guidelines regarding autonomy must reinforce the patient's right to be informed of student involvement in a way in which they can understand. Students must be advised to respect patients' autonomy, to disclose their academic status to patients and to be truthful regarding their level of experience. Students, supervisors and faculty must respect patients' choices and patients should not be coerced into participating in student education. Guidelines related to beneficence should remind students to act always in the best interests of the patients and to maintain patients' confidentiality. Students must follow the instructions of their supervisors and may not perform examinations or procedures unsupervised unless there is evidence of their competence regarding the specific examination or procedure to be performed (see appendix 4 for a suggested set of guidelines).

In addition, it is recommended that patients give consent for student involvement in their care. Written and verbal consent should include information pertaining to the student's academic status, i.e. year and field of study. Written and verbal consent should further include consent to disclosure of the patient's information for academic purposes, as well as the specific procedures in which the student will be involved. Patients should acknowledge that they are aware that they can withdraw their consent at a later stage (see appendix 5 for a suggested consent form).

Consideration should be given to the timing of obtaining informed consent. It is recommended that the admitting practitioner should drive the process of obtaining informed consent for student participation from the patient, provided that the patient is in a frame of mind to give such consent. Obtaining informed consent for student involvement should not be left to administrative and clerical staff at the point of admission to the hospital.

The recommended guidelines and consent form flowing from this study will be submitted to institutions and the HPCSA for consideration to be included into policy documents. It is hoped that this will contribute towards the humanistic approach to patients in the practice of medicine and a greater respect of patients' rights.

Appendix 1

AMA Code of Medical Ethics

Opinion 8.087 - Medical Student Involvement in Patient Care

Available at: https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8087.page?

(1) Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves. Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students.

(2) Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfil this responsibility.

(3) In instances where the patient will be temporarily incapacitated (e.g., anesthetized) and where student involvement is anticipated, involvement should be discussed before the procedure is undertaken whenever possible. Similarly, in instances where a patient may not have the capacity to make decisions, student involvement should be discussed with the surrogate decision-maker involved in the care of the patient whenever possible. (V, VII)

Issued June 2001 based on the report "Medical Student Involvement in Patient Care," adopted December 2000 (*J Clin Ethics*. 2001;12:111-15).

hcpc health & care professions council

Information for students and education providers

Guidance on conduct and ethics for students

Appendix 3

Policy on the rights of patients in medical education

Compiled by: St Bartholomew's and the Royal London School of Medicine and Dentistry

Available from:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119888/bin/bmj_322_7288_685__index.html

Particular care must be taken to obtain the consent of patients for participation in educational activities not directly related to their treatment. Patients have a moral and legal right to exercise control over the circumstances in which they are physically touched and in which personal and clinical information about them is communicated to others. Therefore:

- Clinical teachers must ensure that patients understand that medical students are not qualified doctors and that cooperation in educational activities is entirely voluntary. Students should always be described as "medical students" or "student doctors" and not, for example, as "young doctors", "my colleagues" or "assistants".

- Clinical teachers and students must obtain explicit verbal consent from patients before students—for primarily educational purposes—take their case histories or physically examine them. Patients should be reminded of the primarily educational purpose of any physical examination or case presentation in which they participate. They should understand that their participation is entirely voluntary and resistance should be respected with reassurance that unwillingness to participate will not compromise their care.

- Clinical teachers and students should never perform physical examinations or present cases that are potentially embarrassing for primarily educational purposes without the patient's verbal consent—both for the physical examination itself and for the number of students present. When individual students are conducting such physical examinations, a chaperone must be present unless the patient explicitly agrees otherwise. Such agreement should only be obtained with the permission of the appropriate clinical teacher and should be recorded in the notes.

- Students should never perform any physical examination on patients under general anaesthetic for primarily educational purposes without their prior written consent, which should be placed within the notes. Patients who are unconscious or incompetent for other reasons must only be involved in primarily educational activity with the explicit agreement of their responsible clinician and after appropriate consent (with children) of someone with parental responsibility or (with adults) after consultation with relatives.

- Clinical teachers should obtain the explicit verbal consent of patients for students to participate in their treatment (suturing, taking blood, delivering babies, etc.). Where the procedure is normally written in the notes, the fact that such consent has been obtained should be recorded. Procedures that do not require supervision should only be undertaken if there is recorded evidence of competence.

- In conformity with the principles of the General Medical Council, students must respect the confidentiality of all information communicated by patients in the course of their treatment or participation in educational activity. Without prior authorisation, no written information about patients by which they might be identified should be removed from the place of treatment. Students should respect the confidentiality of personal information to which they are given access but which is not related to patients' condition or treatment. Patients should understand that students may be obligated to inform a responsible clinician about information which is so related.

- Clinical teachers are responsible for ensuring that the preceding guidelines are followed. If students are asked by anyone to do the contrary, they must politely refuse, making specific reference to these guidelines. Encouragement of students to ignore these guidelines is unacceptable.

Appendix 4

Suggested Guidelines for Students Participating in the Care of Patients.

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline
Autonomy	Patients should be informed of the academic status of health care personnel involved in their care.	• Students must be easily identifiable and distinguishable from qualified practitioners. This can be achieved by wearing uniforms, scrubs or white coats embroidered with their university's insignia as well as the word "student". • Students' name tags should clearly identify them as such.
	Patients have the right to give informed consent to participate in the education of health care students.	• Students should explain in simple language to patients – o That they are students o What they want to do with the patient o Whether the supervisor will be present at all times during the student's encounter with the patient o To what extent a supervisor will be participating

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline

	Students and supervisors should ensure that patients are informed (in a way that they understand) at the earliest opportunity that someone involved in their care is a student.
	
	Patients should be asked whether they consent to the student's involvement.
		• In most cases verbal consent will be sufficient, but for more invasive procedures, written consent will be required.
		  ○ For procedures that need to be performed under supervision, the supervisor should obtain informed consent for student-involvement.
		  ○ For procedures in which students have passed a competency test, e.g. taking blood pressure, performing simple sutures, etc. the student should obtain informed consent to perform the procedures.
		• Students should enquire whether the hospital has a form, if not, whether the University has a form. See Appendix 5 for an example of a consent form for student-involvement in patient care.

		• Where a patient is not proficient in English, the student should attempt to get an interpreter to ensure that the patient understands.
	Patients have the right to refuse to participate in the education of students and therefore to refuse to allow students to participate in their care.	• Students, supervisors and academic staff should tell a patient that they are under no obligation to work with students.

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline
	Students, supervisors and academic staff must accept a patient's refusal to participate in the education of students. Patients should not be coerced in any way into allowing students to participate in the care, even if they are just observing non-invasive procedures. Coercion undermines autonomy.	• If a patient refuses student-involvement in his/her care, it should be respected. • Students, supervisors and academic staff should not attempt to coax a patient into allowing student-involvement in their care.
	In instances where a duly authorised third party, such as a curator, guardian or superintendent of a hospital acting on behalf of a patient who is unable to make their own decisions, consents to student involvement in their care, the patient must assent to such involvement where possible.	• Patients with limited capacity, e.g. psychiatric patients, should be asked whether they will allow student-involvement in their care, regardless of whether such participation has been approved by a person with the necessary authority/capacity. • The wishes of patients with limited capacity should be honoured as far as possible.
		• At the end of the clinical block, students should give a comprehensive hand-over of the patient to ensure continuity of care and optimal care.

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline
Non-maleficence	Students' learning is dependent upon patients' participation in medical education. However, students should place the well-being of patients above their academic and learning interests.	• Students should not perform any action or procedure in which they are not sufficiently skilled without direct supervision.
		• Students should adhere to the instructions of their supervisors. If they are concerned about instructions, they should voice their concerns timeously, to the supervisor and/or academic mentor.
		• Students should disclose all information they have about a patient to the attending physician and/or supervisor, so as to ensure that the patient receives optimal care.
		• Students should ask for help timeously.

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline
Veracity/the right to fair and honest dealing	Patients must be informed in a clear, unambiguous manner of the academic status of someone involved in their care. This includes information on name tags.	• Students should not over-inflate their abilities or misrepresent their level of knowledge, skill or academic status.
		• Students must be introduced as students, and not by using misleading terminology, such as “young doctor” etc.
	Students, academic staff and supervisors must ensure that a patient understands what an academic or teaching hospital is as well as the likelihood of student involvement in their care at an academic/teaching hospital.	• A person who is admitted to a teaching hospital should be informed, in a way that they can understand, at the earliest possible opportunity that – ○ The hospital is a teaching hospital (and what it means if a hospital is a teaching hospital). ○ Students learn about various aspects of health care services at teaching hospital. ○ One or more members of the team involved in their care is likely to be a student. Where possible, the treating clinician should inform the patient on admission.

Overarching Ethical/Legal Principle	Exposition of ethical principle	Practical guideline
Confidentiality	All information about a patient is confidential.	• Where the patient is identifiable to a person supervising the student but who is not involved in the care of the patient, consent should be obtained for disclosures for academic purposes. • Students should only disclose relevant information about a patient for academic purposes. Relevance will be determined by the purpose of the disclosure. • Such disclosures should be anonymised as far as possible, e.g. by only using a patient's initials in written work handed in for marking, keeping non-pertinent personal information such as address, name of employer, etc. confidential.

Other aspects, related to academic honesty and plagiarism, which fall outside the scope of this research report but were included in guidelines such as the HCPC guidelines may also need to be included in South African guidelines.

Appendix 5

Informed consent form for student-involvement in the care of a hospitalised patient.

I _____ (name of patient) hereby consent to the participation of _____ (name of student) a student of _____(field of study) in the_____year of study ,in my care whilst hospitalised.

I understand that the person in question is a student and not a qualified practitioner. I understand that the student is supervised by _____ _____ (name of supervisor).
I consent to the student disclosing information about my background, condition and treatment for academic purposes. I understand that this information will be anonymised as far as possible.

I understand that the student will not take any independent decisions about my care, but will act under the instruction of the supervisor. I understand that I can withdraw my consent at any time without prejudice to me.

Signed:

_____	_____
Patient's signature	Student's signature
_____	_____
Date	Date

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