

## Part 6. Policies

### **Confidentiality**

Protecting the sanctity and confidentiality of patient information has been a cornerstone of medical practice for centuries. The Hippocratic Oath admonishes new physicians to swear that, “What I may see or hear in the course of the treatment . . . I will keep to myself.” Students embarking upon the exciting challenge and privilege of providing daily care to patients often need to be reminded of the pitfalls associated with hallway, dining room, and elevator conversations about patients and of their ethical and legal obligations to maintain patient confidentiality. Requirements may vary by state and by practice location, and requirements for some diseases or health conditions (e.g., HIV/AIDS, substance abuse, sexually transmitted diseases, etc.) may differ from the requirements for general health information. In addition to local requirements, federal law contains provisions that constitute minimum requirements to protect patient confidentiality.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, “HIPAA”) was signed into law in August 1996. One of the most substantial benefits arising from this law is the ability to maintain health insurance coverage for individuals who are changing employers. The law was also designed to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of administrative and financial data. Implementation has proceeded over several years, with those aspects of the law that most directly affect medical education arising in 2003 with the “Privacy Rule.”

Recognizing that the health information exchange requirements of HIPAA could potentially compromise patient confidentiality, HIPAA incorporates specific and detailed privacy protections. The Privacy Rule implements the first comprehensive federal privacy protections for health information, creating a federal “floor” of privacy protections. For states with more stringent protections, those stronger state-mandated protections remain in force.

The Privacy Rule is complex and detailed; readers are encouraged to seek additional information at the federal government HIPAA Web site at: [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) and at the AAMC HIPAA Web site at:

[www.aamc.org/advocacy/hipaa/start.htm](http://www.aamc.org/advocacy/hipaa/start.htm). The following discussion of key components and implications of the Privacy Rule for medical education should not be considered a definitive explication of this subject. Furthermore, this discussion considers only the ramifications for medical education and does not consider implications for patient care, research, and the other vital activities occurring within an academic health center.

The Privacy Rule incorporates several key concepts. "Individually Identifiable Health Information" is: 1) information, including demographic data, that relates to: a) the individual's past, present, or future physical or mental health or condition; b) the provision of health care to the individual; or c) the past, present, or future payment for the provision of health care to the individual; and information that 2) identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. This defines the information of interest and typically includes the patient's name, address, identifying numbers (e.g., Social Security number, medical record number), birthdate, and other information that could be used to identify the patient.

HIPAA also requires that the minimum information necessary be shared in order to perform an activity or accomplish a given task. In the course of clinical training, the "minimum necessary" information may be the entire medical record and will most likely include personally identifiable health information. On the other hand, non-clinical training (e.g., in a classroom setting) would typically not require personally identifiable health information. In the non-clinical setting, de-identified information would likely be sufficient.

De-identification requires that identifiers of an individual or relatives and employers or household members be removed, including: 1) demographic information, 2) locating information, and 3) elements of dates such as birthdate, admission date, discharge date, date of death, etc. If health information is de-identified, the information can be used without authorization from the patient.

HIPAA permits information exchange as a consequence of several different activities. Obviously, the multiple members of the health care team need to communicate information in the course of the patient's treatment. HIPAA defines "treatment" as the provision, coordination,

or management of health care by one or more health care providers, including consultation between health care providers or patient referrals. However, patient information discussed in the context of medical education typically falls under HIPAA's provision for information exchange as a part of "health care operations." Health care operations include quality assessment and improvement activities, *training*, accreditation, certification, credentialing, licensing, *reviewing competency*, and *evaluating performance* (emphasis added), and fraud and abuse detection.

HIPAA affects operations at clinical sites in many ways. Patients must receive notification of the facility's privacy policies. Sign-in sheets and wallboards, if used, must be HIPAA-compliant. All staff – from receptionists to students to physicians to medical assistants – are affected, and access to protected health information must be restricted consistent with the individual's job responsibilities.

Individual health care institutions are responsible for certifying that all individuals with access to health information have received training in HIPAA compliance. Some institutions have implemented classroom or Web-based programs requiring several hours of instruction and examination, while others have less extensive requirements and may simply administer a brief examination assessing an individual's knowledge. Students leaving their home medical school to complete away visiting clerkships typically must demonstrate some evidence of HIPAA training for the host institution, and they may be required to complete the host institution's training module. This is a subject of continued discourse within the GSA community at the time this brochure was written.

HIPAA contains provisions for both civil and criminal penalties. Civil monetary penalties can be imposed by the Office for Civil Rights, at \$100 per violation, with an annual cap of \$25,000 for each calendar year for each identical requirement or prohibition that is violated. Criminal penalties for wrongful disclosures arise from knowingly obtaining or disclosing identifiable health information relating to an individual in violation of the Privacy Rule. These penalties can be up to \$50,000 and one year imprisonment; or up to \$100,000 and five years imprisonment if done under false pretenses; or up to \$250,000 and 10 years in prison if the violator demonstrates intent to sell, transfer, or use the information for commercial advantage, personal gain, or malicious harm.

### Background Screening, Drug Testing, and National and State Laws Governing Licensure

The issue of background screening of medical school applicants and students has recently assumed heightened importance. At the time that this handbook was written, widely recognized guidelines had not been established to assist schools wishing to implement or modify screening procedures. While some medical schools have independently chosen to institute background screening, others are responding to requests or pressure from clinical training sites that wish to reduce their liability for students' actions. Institutions considering a program of background screening must consider:

- Who will be checked (all applicants, accepted applicants, or matriculants, as well as staff and/or faculty)
- The depth of detail and type of information desired in a criminal background check
- Thresholds for action (e.g., what types of information that might potentially be discovered that would constitute grounds for institutional action)
- The significance of any documented rehabilitation or restitution following the offense
- Decision-making and appeal processes resulting from the information discovered
- The timing and frequency of checks (upon application, upon acceptance, prior to matriculation, following matriculation, prior to initiation of clinical clerkships, annually, etc.)
- Sources of funding for checks
- Vendor selection and management of in-house processes
- Storage of, and access rights to, information generated by a criminal background check

The multiple complex issues associated with criminal background checks and other types of background screening were under discussion at the level of the AAMC governance at the time this handbook was written. The decisions made by the AAMC governance on these topics will be transmitted to Student Affairs officers and other GSA representatives as they are made.

Clinical training sites may have personnel policies and other requirements that differ from medical schools' requirements for acceptance, matriculation, and/or graduation. Some clinical sites already conduct criminal background checks for faculty and staff independent of medical school policies. Additional issues that arise when considering training at a non-medical school clinical site include:

- The types of information that may be shared between schools and clinical sites
- The locus of responsibility for determining actions to be taken in response to information of concern revealed in a criminal background check
- Policies and procedures for resolving the educational needs of students when schools and clinical sites differ in their policies and practices

One topic related to criminal background checks is that of drug testing of medical students. Again, standard guidelines or policies do not exist in this area. Issues to be considered when establishing, reviewing, or modifying drug screening policies include:

- Indications for testing (routine, at faculty discretion, with evidence of academic difficulty, upon reports of suspected substance abuse, etc.)
- Type of screening and agents covered
- Storage and use of, and access to, information collected
- Compliance with FERPA and HIPAA regulations
- Sources of funding for testing
- Availability of remediation and recovery programs for affected students
- The reporting of drug screening results in the MSPE

Finally, as medical schools strive to ensure a safe workplace for all participants and to protect the rights of patients, the protection of the privacy rights of students is also a concern. Schools hope to balance what may, at times, be competing interests so that they can provide reasonable assurances of students' trustworthiness and integrity to the individuals with whom our students interact in the clinical environment, while simultaneously protecting students against unreasonable intrusions into their personal privacy.

### Impairment and Disability

Policies regarding students affected by the abuse of alcohol or other drugs are typically included in a student handbook provided, either in a hard copy or online, to medical students upon their matriculation in school. Multiple mechanisms for identification, evaluation, treatment, and supervision exist. Each institution should have policies and practices specific to the requirements of the university and/or the state in which the school is located. Examples include:

- AIMS (Assistance for Impaired Medical Students): A student-sponsored peer support program that assists students who are experiencing problems with the abuse of alcohol or other drugs.
- Faculty observation and referral: Faculty directly observing a student who exhibits signs of impairment from suspected substance abuse may refer the student to the university or medical school mental health or counseling service for evaluation, treatment, or referral, as well as to the Student Affairs office if this observation takes place in the medical school environment.
- Faculty observation and reporting: Faculty directly observing a student who exhibits signs of impairment from suspected substance abuse may refer the student for consideration to the student promotions/academic progress committee. The committee may mandate that the student participate in evaluation, treatment, and/or ongoing monitoring and supervision.
- State medical board or medical association-sponsored Impaired Physicians Programs: Individual medical schools may have policies that mandate the reporting and referral of impaired students to the state medical board or state medical association for evaluation, ongoing monitoring and supervision, and participation in ongoing treatment and recovery programs.

### Mental Health

Individual students in need of mental health assessment and/or treatment should have access to confidential mental health services through one of the following sources:

- University Student Health Services
- University Mental Health Services or Counseling Center
- A community mental health provider who has contracted with the medical school to provide evaluation and triage services to medical students

### State Medical Boards

Student Affairs officers are being increasingly required by state medical boards to provide letters of explanation that address any gaps or delays in a student's progress through medical school. When a delay or gap in progress is the result of a course failure or the failure of a USMLE Step examination, the explanation is fairly straightforward. When a delay or gap is the result of a personal, family, or medical/mental health concerns, the explanation may be more complex. Some states also specifically inquire about prior mental health or substance abuse issues on the part of the student/graduate. In each instance, consent to release information should be received from the student/graduate prior to the completion of a form or letter of explanation for the state medical board.

### Handling of Exposures to Air/Blood-Borne Pathogens

Medical schools provide education and training to students to reduce the risks posed by infectious agents encountered in the clinical setting. These agents include HIV, tuberculosis, viral hepatitis, and other respiratory and blood-borne pathogens. Training may be provided during the initial orientation to the medical school, during the orientation to clinical clerkships, and/or as part of the preclinical curriculum in anticipation of clinical duties. Training may also occur during clinical training to reinforce lessons previously learned. Additional information about infection prevention can be found on the Occupational Safety and Health Administration's Web site at: [www.osha.gov/SLTC/bloodbornepathogens/index.html](http://www.osha.gov/SLTC/bloodbornepathogens/index.html).

In addition to providing training to reduce the likelihood of exposure and infection, medical schools should provide mechanisms for the timely management of accidental exposures experienced by students. The Centers for Disease Control and Prevention (CDC) has published "US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis." These guidelines are available on the CDC Web site at: [www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm).

Because the efficacy of post-exposure medications declines precipitously with increasing time between exposure and treatment, it is imperative that students know exactly where they should go in the event of an exposure and know to act as quickly as possible. Similarly, the Student Health Service or other individual(s) responsible for assessing and treating the

exposed student must be familiar with current protocols for post-exposure evaluation and treatment. In addition to online resources, health care providers caring for an exposed student may seek consultation with experienced clinicians 24 hours daily, 7 days a week, via the National Clinicians' Post-Exposure Prophylaxis Hotline at 1-888-448-4911. Additional information about this service is available at: [www.ucsf.edu/hivcntr/PEPLine/](http://www.ucsf.edu/hivcntr/PEPLine/).

One component of protection against infection is pre-exposure vaccination. Consideration should be given to requiring hepatitis B vaccination for non-immune students prior to their beginning clinical contact with patients.

### Standards of Conduct

Students should be provided with written documentation of the university's and medical school's standards of conduct. This document is typically included in a student handbook or academic bulletin and is often presented during orientation activities. These standards typically address the parameters of relationships between faculty members and students, including both limits on those relationships and expectations about the development and maintenance of a learning environment based on mutual trust and understanding.

### Students' Rights and Responsibilities and Disciplinary Procedures

Students must be informed, in writing, of their rights to "due process" and their responsibilities in any institutional action involving academic progress, disciplinary procedures, or potential dismissal from the medical school. Student rights and responsibility policies and procedures should be provided in an academic bulletin or student handbook made available upon initial matriculation at the school.

### Student Mistreatment

Student mistreatment policies and procedures outline the means for reporting, investigating, and following up on identified incidents of actual or perceived student mistreatment. An example of one university policy is provided below. Each institution should have school-specific policies and procedures in place for the investigation and adjudication of complaints of student mistreatment.

"It is the policy of Typical Medical School that student mistreatment, harassment, or abuse will not be tolerated. Student abuse may be verbal, psychological, or physical. It includes, but is not limited to, sexual harassment and discrimination based on age, racial or ethnic background, religion, national origin, or disability. It is understood that all personnel will treat students in a collegial and professional manner.

"Student abuse and sexual harassment are best defined functionally. Student abuse includes, but is not limited to, treating students in a harmful, injurious or offensive way; attacking in words; speaking insultingly, harshly, or unjustly to or about a student; reviling or demeaning a student; and/or undermining the self-esteem or confidence of a student. Sexual harassment includes, but is not limited to, offensive comments to or about the student; unwanted attention or unwelcome verbal advances; unwanted, persistent invitations; unwelcome explicit propositions; offensive displays; offensive body language; unwanted physical advances; and/or sexual bribery. Abuse and harassment create a hostile environment in which to learn. It is understood that incidents of abuse or harassment may cover a spectrum from flagrant to ambiguous and subjective. The abuser may be a member of the faculty, a resident, a nurse, another student, a member of administration, a hospital employee, or even a patient.

"The mechanism of reporting and investigating incidents of suspected student abuse is described below. An algorithm outlining the steps is included. The system and the plan for its implementation are designed to protect students from retaliation and to protect those charged with abuse from unfair accusations. The names of the student, the reporting individual, and the alleged abuser will be held in strict confidence on a need-to-know basis.

"An incident of abuse may be reported by the student or by an individual who witnessed the incident of abuse. An incident can be reported directly to the Dean's Office or to the Associate Dean for Student Affairs. An incident reported to a trusted faculty member, a class officer, a member of the academic administration, or a close friend may be reported to the school's Early Response Group or to the Associate Dean for Student Affairs.

“The Student Affairs dean will notify the University Legal Counsel of the incident, receive advice, if necessary, and gather information on the incident from the student, from any known witnesses to the incident, and from the accused offender. The communication and interaction involved in this process may lead to resolution of the incident. If the incident is resolved, no further action need be taken. The Associate Dean for Student Affairs will file a report describing any documented incident with a committee comprised of members of the faculty, student body, and administration (the Faculty/Student Relations Committee). The report of a resolved incident will contain no names. The Associate Dean for Student Affairs will follow up on the incident six to eight weeks after the report to assure that there has been no retribution.

“If the incident is not resolved, the Associate Dean for Student Affairs will consult with the Legal Department again, gather more information, if needed, and present the case to the Faculty/Student Relations Committee. The Faculty/Student Relations Committee will review the information and make a recommendation to the Dean for further action. Actions may include reprimand, loss of hospital privileges, suspension, dismissal, and/or possible criminal prosecution. In the strictest confidence, all reported incidents of abuse would be documented by the Early Response Group, including information regarding verification and resolution. During a follow-up assessment six to eight weeks after the process, the Early Response Group will determine if there has been any retribution to the student. Documentation will be forwarded to the Faculty/Student Relations Committee, which will compile an annual report on all incidents of student abuse for the Dean of the Typical Medical School.”

### **Standards and Procedures for the Evaluation, Advancement, and Graduation of Students**

Formal standards and procedures for individual evaluations and academic advancement should exist for each medical school and be provided to students upon initial matriculation. Policies describing the manner in which students' unsatisfactory academic performance will be addressed by a student promotions or academic progress committee should also be specified in a student handbook or academic bulletin provided to students upon matriculation. Similarly, the process of appeal should be specified to students. Each institution should have a formal route of appeal of student promotions or academic progress committee decisions. Students should have a clear understanding of the process, including a timeline for decision-making.

Furthermore, institutional policies describing the process by which unprofessional behavior will be addressed should be outlined in a student handbook or academic bulletin that is provided to students upon matriculation. Policies regarding the payment for remediation or repeated course work should also be provided to students upon matriculation.