Ethical and Legal Issues Impacting Medical Student Entries

An Introduction to the Ethical and Legal Issues Impacting Medical Student Entries in the Electronic Medical Record (StarPanel)

Prepared by the VUSM Honor Council

There are several ethical and legal considerations that influence what is and is not an appropriate use of documentation generated by medical students in the electronic medical record. What follows is a summary of the main issues to help you better understand your role as a member of the healthcare team.

1. **Transparency** – It is important for patient care and documentation that all entries made in the medical record are labeled clearly to indicate who the author is and what the author’s role is in the care of each patient.

2. **Accountability** – Each individual who makes an entry in the medical record accepts responsibility for the information contained in that entry.

3. **Plagiarism** – Copying another individual’s ideas or text and presenting it as one’s own without permission and attribution to the source is plagiarism, and is a serious academic and professional offense.

4. **Compliance** – There are multiple bodies, including the Center for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), who set legal or accreditation requirements for healthcare organizations. These regulations make specific statements about documentation by trainees. For example, CMS regulations specify how services must be provided by teaching physicians (attendings) in order for payment to be made for these services. They also specify very clearly how a student’s documentation may be used in relation to these services. Vanderbilt’s policies for all patients are structured to be in compliance with these regulations. The CMS document Guidelines for Teaching Physicians, Interns, and Residents states, “Students may document services in the medical record; however, the teaching physician may only refer to the student’s documentation of an E/M service that is related to the ROS (Review of Systems) and/or PFSH (Past Medical, Family, and Social History). The teaching physician may not refer to a student’s documentation of physical examination findings or medical decision making in his or her personal note. If the student documents E/M services, the teaching physician must verify and redocument the history of present illness and perform and redocument the physical examination and medical decision making activities of the service.”

5. **Security** – Access to the secured clinical computing resources at Vanderbilt is a privilege, and there are rules and conditions regarding this access. Each StarPanel user signs an agreement where, among other things, he or she commits to not share or allow others to use his or her access credentials.
6. **Integrity** – Just because an action is possible in StarPanel does not mean it is permissible. The functions that are used inappropriately all have appropriate uses. The burden falls on the individual user to use these tools responsibly.

**Key Points to Remember:**

- All student contributions to the EMR should be saved under the student's name.
- The ROS (Review of Systems) and PFSH (Past Medical, Family, and Social History) are the only parts of a student’s work that may be referenced (not copied) in a physician’s note (not the HPI, Exam, or Impression/Plan).
- Logging in or working under someone else’s user credentials is not permitted.

**Example Scenarios:**

Your resident asks you to write part or all of a note (H&P, consult note, discharge summary, etc) and “Save as Draft” for her to edit and finalize later.

What is wrong with this?

1. The School of Medicine explicitly does not approve of this practice (see 2005 Ad-Hoc Committee statement)
2. There is not adequate attribution in the finalized note—The final note will be recorded as the resident’s work, and your contribution to the medical record as a student will not be apparent. All student contributions to the EMR should be saved under the student’s name.
3. Any of your original work remaining in the finalized note will be presented as the resident’s own work (a.k.a plagiarism).
4. This note will not meet CMS standards for billing, as the ROS and PFSH are the only information composed by a student that may be referenced (not copied) in the official documentation of services. Signing someone else’s documentation as your own is considered falsifying documentation and submitting a false claim.

Your resident asks you to write a clinic note using the “Work as Transcriber” function so that he can sign it later.

What is wrong with this?

1. See example above—same issues apply here
2. This function exists to facilitate transcription (i.e. from dictation), and its presence does not mean that all possible uses are acceptable. If you are putting any independent thought into what is being written, you are not working as a transcriber.

A physician (resident or attending) asks you to write part or all of a note logged in under her user ID for her to edit and finalize later.

What is wrong with this?

1. See first example above—same issues apply here
2. This scenario is like the first, but is also inappropriate because it involves performing work under someone else’s access credentials. This is considered a Level 3 violation under the VUMC Sanctions Policy.

What should I do when this happens?

When these situations arise during a clinical rotation they can make you uncomfortable. You are a student, and as such are in a vulnerable position. Your residents and attendings are not only your supervisors, they are your evaluators, and the nature of your interactions with them is of understandable importance. In all likelihood, you will face scenarios like these numerous times during your clinical training. The following are some suggestions for how to handle this kind of circumstance.

1. **Be respectful and understanding at all times** – It isn’t always just about saving time; many residents view these tasks as additional ways for students to be meaningfully involved in patient care.
2. **Have solidarity with your classmates** – It is never good when one student on a team is willing to do what another student claims is not permitted. In being consistent throughout the year, your class has the power to help improve this situation for future students as well.
3. **Be familiar with the issues** – That’s why this handout was put together
4. **Focus on what you are not allowed to do** – In other words, avoid trying to convince residents or attendings that they are doing something wrong. However, it is appropriate to report a pattern of inappropriate behavior to Dean Fleming or within the VERITAS system.
5. **Try a response like the following:**
   1. “…The School of Medicine does not permit us to write notes which will not be saved or finalized under our name.”
   2. “…I am not allowed to work under another user’s ID and password”
   3. “…The School of Medicine requires that all work by students in the medical record be clearly attributed to the student”
6. **Offer to help the team and participate in any way that you are allowed.**
7. **Talk with your Clerkship Director if the problem persists. If necessary, contact Dean Fleming, Dean Lomis, or Dean Miller for guidance.**

If you have further questions or concerns about this topic or a specific situation, please feel free to contact Dean Miller, Dean Lomis, Dean Fleming, or any member of the Honor Council.

You may find the CMS Guidelines for Teaching Physicians, Interns, and Residents to be a useful document for understanding some of why resident and attending documentation is done the way it is. It can be found at: [www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf)

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