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Medical School Staff Perspectives on Sharing Sensitive Student Information.

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Abstract.

This study considered the duties and role dimensions of medical school staff in the context of how they deal with sensitive student information. It focused on exploring appropriate communications about learners in training for professional practice. The authors recognized the current legal and ethical dilemmas faced in managing academic, behavioural, and/or personal student issues and aimed to research how ongoing tensions and complexities manifest in relation to learner handover. The study aimed to inform future policy development around information-sharing practice to support student progress. A live audience-response survey was combined with a one-hour focus group session. Real experiences and opinions were focused through the use of scenario-based discussion and facilitator prompts to produce a transcript. Qualitative analysis, with inductive coding by the study team, identified themes; current values, processes, approaches and context to handover. Key quotes were highlighted and survey findings charted. Staff explained how they balance trying to best support the interests of learners whilst respecting their rights to privacy. Participants echoed an ongoing need for clear instruction and explored grey areas in communication strategy. Shared, evolving concerns were discovered about entrustment and traceability, with some consensus of opinion on written record-keeping/activity logs. The study contextualized perceived risks and benefits within learner handover and provided rich insights from a medical school shop floor around how sensitive student information is handled. The findings contribute to a wider, timely conversation within healthcare education and will be instrumental in tailored policy development. Learner perspectives will be sought as a key next step.

Keywords: Communication Strategy Learner handover; Sensitive Information.

1. Introduction.

Students all need longitudinal academic guidance and pastoral care. Many interactions with learners are informal (Humphrey-Murto et al., 2020) and undocumented, but they form a valuable part of the essential scaffolding of success. Medical school communities have a duty to deliver a collaborative, structured network of individualized academic support throughout their programs, nurturing wellbeing and resilience, especially at times of increased adversity (Bacchi & Licinio, 2017). They trust staff to foster a caring organizational culture (Sandars et al., 2014).

Any form of learner handover (whereby information about students is shared between staff) that occurs within this context must benefit stakeholders and incur minimal risk. As teachers and advisors we follow local University procedures, and also refer to recommendations from medical and higher education regulatory bodies (GMC, 2020; IMC, 2020).

In a 2020 survey, Gumuchian et al. summarized perceived handover risks and benefits. They discovered division amongst participants (educational supervisors, Canada), but a majority overall in favour of learner handover as a means of supporting academic progress to meet professional competency standards (Gumuchian et al., 2020). A current need to further enrich understanding was emphasized. These authors suggest gathering meaningful evidence from stakeholders so that leaders can optimize processes and improve learner outcomes, specifically recommending that "*future studies, using interviews or focus groups, could examine supervisors' beliefs about learner handover in more depth*" (p.295).

As an organization responsible for graduating new doctors, we recognize this need for collaboration and must ensure that professional standards for transition to clinical practice are met (IMC, 2020; GMC, 2020). We also note that 2018 changes in General Data Protection Regulation (GDPR) legislation emphasize the right of an individual to protect their personal data.

The risks and benefits of learner handover have been debated for at least two decades. Studies continue to reflect varied opinions and recommendations, with ongoing ambiguity around communication strategy (Gold et al., 2002) therefore procedures to report all types of issue are not easily established. Our staff handbook encourages all educators to contact the course director if any student concerns arise. At staff induction days, contact lists for student counselling and chaplaincy services are highlighted. Rules and procedures around serious misconduct are clear-cut, with a committee review process required for the creation of a formal 'Record of Unprofessional Behaviour'. No specific training course for academic advising is established, though written advice on conducting student performance reviews is provided to all tutors and teaching faculty active in this role *at* new staff induction (including senior faculty contact details).

Positive beliefs around handover efficacy include a greater ability to tailor individual learning over time, improved teaching efficiency, more accurate student assessment, and ultimate improvements to patient safety (Cleary, 2008; Gumuchian et al., 2020; Warm et al., 2017). Concerns about bias creation, however, are prevalent; Dory et al. (2021) discuss the controversy arising in the potential for biasing or stigmatizing learners by disclosing sensitive personal information and Shaw et al. (2021) reaffirm the risk of bias resulting from prior

performance information.

Humphrey-Murto et al. (2020) have recently highlighted polymotivation as a particular source of disparity in learner handover practice: The taboo of sharing student information as a self-defence mechanism to relieve angst, stress and insecurity. Staff wellbeing was considered an illegitimate (yet frequent) reason for information disclosure.

Several studies help to determine types (content and nature) of sensitive information that may surface during staff-student interactions: Sayer et al. (2002) describe causes of academic difficulties as widespread, from poor study skills to financial, social and emotional problems, and they conclude that similar difficulties are experienced. Sandars et al. (2014) state that 5-10% of medical students have specific learning difficulties, most often dyslexia. Many struggle to balance study with part-time jobs. International students, students with children and those from wider-access programs may need focused supports (Richardson & Skinner, 1990). Physical illness and disability may impact learning and assessment, and mental health challenges, such as high rates of anxiety, depression and burn-out (Ziring et al., 2018) are frequently described. Many medical students are known to experience Imposter syndrome (Villwock et al., 2016). Alcohol and drug abuse are also significant problems in the student population (Pickard et al., 2000).

All of these issues and more, can be the focus of meetings with staff and may result in the disclosure of sensitive information. Disclosures may be unexpected or may occur in the context of academic difficulty or lapses in professional behaviour (Koehler & McMenamin, 2014; Mak-van der Vossen et al., 2019; Mak-van der Vossen et al., 2020).

This study aims: 1) to generate case-based discussion amongst staff in order to emulate real-life handover practices; 2) to understand if and how medical school staff document sensitive student information and with whom they might share any detail, either written, electronic or verbal; and 3) to identify current concerns and recommendations as a foundation for learner-centred policy development.

2. Methods.

2.1 Overview.

Insights were gained from staff at the University of Limerick School of Medicine, Ireland. Our study design was a one-hour focus group session using three case-based scenarios (Appendix

1 – Cases). Realistic (but fictional) student scenarios were presented in a safe, simulated setting. An Audience Response System (ARS) survey was included at the start of the session to encourage/trigger topical discussion and debate. The authors were aware that case-based discussion and use of a live survey can encourage group reflection and help participants to relate to the subject matter (Doucet et al., 2009).

2.2 Materials.

In broad recognition of the types of sensitive information described above, our cases were designed around; the "*struggling" student, the "rude/disruptive" student and the "demanding student"* (Appendix 1- Cases). Case content was structured around familiar student behaviours experienced by the study team during small-group facilitation and academic advising. We acknowledged the diverse mix of potential background reasons for each typical presentation and an overlap in the way that various underlying difficulties can manifest. We realized that sometimes both academic and personal problems surface as professionalism issues, rather than requests for support.

2.3 Participants.

Following local ethics approval, all teaching, faculty and administrative staff involved in the pre-clinical phase of the University of Limerick Bachelor of Medicine/Bachelor of Surgery (BMBS) course were invited to participate. This included a mix of hourly-paid clinical tutors (mostly GPs with regular Problem-based Learning or Clinical Skills Groups) and faculty/admin staff on multiannual university contracts, age range approximately 25 - 70, with all ethnicities and gender identities included. We note that we have a high retention rate of tutors, so most have at least 3-5 years of experience in their roles. Faculty were known to students in the context of being regular small-group tutorial facilitators and/or lecturers. Both tutors and faculty act as academic advisors, with regular 1:1 student sessions scheduled. The Admin staff were Year 1&2 co-ordinators, closely involved in student and staff communications and often approached directly by students for guidance. No exclusion criteria were identified. 75 contact emails from approved staff lists were used to send invites, study information sheets and consent forms. 12 staff took part, with numbers split into 2 focus group sessions according to availability (7 and 5 respectively).

2.4 Procedure.

On-campus sessions were arranged for recruited staff on convenient dates (early March 2020). A gatekeeper (PF) was appointed to interact with potential participants, allowing anonymous engagement, and an independent facilitator was present at all sessions. The authors were not directly involved in the raw data collection process in order to avoid any potential compromise (independent facilitator DO'D). The study team know/work with many of the participants.

Participants all accessed the live ARS survey via their smartphones, with group results displayed in real-time on a large screen (for download by the study team). Focus group discussion was recorded using a set of standard facilitator prompts. A time allocation of 15 minutes per case was given and each session was audio-recorded. A reminder was given at the start to avoid use of personal identifiers during discussion. The written transcripts were pseudoanonymised to protect participant identity (in case voices proved recognisable on tape).

2.5 Analysis.

The survey responses were collected quantitatively in the form of Yes/No answers and Likert rating scales for evaluation.

An inductive approach was taken to qualitative analysis: Transcript data was independently interpreted and coded by two members of the study team. Emerging codes and themes were identified and reviewed as a group, iteratively as required to produce final results. Our data analysis provided perspectives on appropriate information-sharing (content, timing, location, methods).

3. Results.

3.1 Survey.

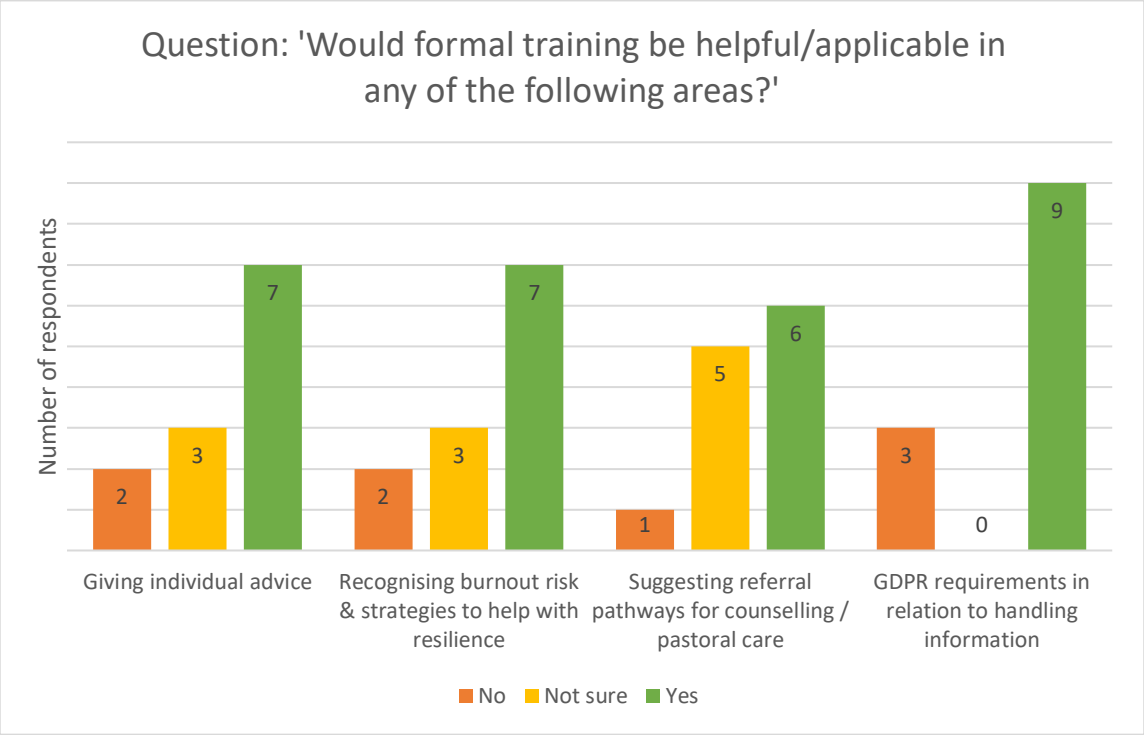
Key findings from the survey, including training needs, are summarized in Table 1 and Figure 1. The AR survey revealed that 7/12 participants were sure of a requisite for formal training around giving individual advice, recognising burnout risk and making strategies to help with resilience. The greatest need expressed (9/12 participants) was for GDPR training specific to information handling in the learner handover context. Whilst half (6 people) also voted for counselling/pastoral care referral training, the survey showed that 5 participants were less

certain about how helpful/applicable this might be.

Table 1: AR Survey Summary

Most participants (8/12) felt “reasonably” confident in giving students personal academic advice. 2 felt very confident, and 2 not at all so.
A majority of 5, however, were “not sure” when asked if parameters for recording concerns about students were clear. 4 people felt that parameters were not clear. 3 felt that they were.
Half of participants (6/12) felt well-supported, with 3 unsure and another 3 who did not feel supported in dealing with student issues.
10/12 did not see time as a barrier to managing this aspect of their role.

Figure 1: Training Needs, AR Survey



3.2 Focus Group Thematic Analysis.

Four main themes emerged from organisation of the identified codes: processes involved in advising, values underpinning these processes, personal variations in approach and contextual aspects to response (Figure 2).

Figure 2: Themes and codes illustrated as a Mind Map

Theme 1: Values

Staff voiced a respect for student privacy. They were unsure about whether they would be obliged to gain student consent to pass on concerns and raised queries over legislation:

D1P4 "*Do they have a right to refuse? ... I don't know what the GDPR is?*"

Admin, faculty and tutors all agreed that confidentiality could be upheld if performance issues were reported without being explicit about underlying causes. It was seen as important to report unprofessional behaviour in the context of mental health problems as long as details were not exposed:

D1P7 "*Behaviour yes, but the background to it maybe not?".*

Participants recognized a potential risk of creating prejudice or unconscious bias but emphasized the need help the student concerned. They were also aware of safeguarding, urging appropriate measures when meeting students on an individual basis (comments made by male participants, suggesting use of a chaperone / potential vulnerability).

Theme 2: Process

There was widespread agreement that concerns should be escalated to the course director, or in some cases to clinical skills leads. Everyone conveyed a sense of confidence in being able to approach senior staff. There was significantly less clarity and some debate over sharing information between tutors and the use of tutor meetings to discuss individual student issues:

D1P1 "*Is it wrong to have a quiet word with the next tutor*?"

D1P2 "*I think that has become more of an issue, it's a bigger issue with more GDPR, I'm more aware, but it's something I would have done previously*."

Some participants preferred to first go to the course director as a "default" option, but some tutors felt that meetings were a useful and appropriate setting in which to raise individual progress issues. Several tutors suggested that they would welcome a more structured team approach:

D1P7 "*Just more clarity on what issues should be reported and how, in what formats?"*

D1P3 "*I would have liked maybe to have been a little bit forewarned and forearmed in some way*".

Both groups generally favoured the creation of a standard logging method to ensure a coordinated response without creating a disciplinary record. Some tutors noted that contact time was variable with individual students depending on their role:

D2P4 "*It was suggested that we should make a note of it, but where to log it was the issue...*"

Administrators were familiar with professionalism guidelines for students, expressing awareness about how a formal record of unprofessional behaviour would be raised through the professionalism committee. They acknowledged how disruptive behaviour can impact on groups:

D1P4 "*No-one (students) wants to go in a group with them, and tutors won't want to engage with them*."

D2P2 "*It leads to a very negative teaching environment*".

The group emphasized that academic advisor meetings serve as a good opportunity to explore issues with students:

D2P4 "*If you didn't have that meeting, you might suspect it, but you'd have no vehicle to get the discussion going*."

Several tutors felt that earlier and more extensive access to academic records would help them to support specific needs from the outset. Although most staff were aware that they could direct students to counselling services, it appeared that there could be greater clarity over contact mechanisms.

Theme 3: Personal approach

It was interesting to note a potential grey area in the form of accidental role overlap (i.e. doctors referring to students as "*patients*" by mistake). Tutors were clear that student counselling, however, is conducted by a specialist service. Opinions over offering extra student support were wide-ranging. Some participants wished they had better personal boundaries for dealing with demanding students and gave examples of difficult situations causing excessive workload:

D1P5 "*It was very difficult to refuse…you start accepting in the beginning…like it was crazy! I really didn't handle it well*".

Others had a stricter approach to controlling student expectations. Most could relate to experiences with students persistently demanding extra tutorials and all had supported struggling students in some way. Many participants stated that they prefer to discuss matters verbally and may be reticent to write emails about students. Reluctance over written reporting appears to relate to fears over negative consequences for student progression:

D1P3 "*Yes, talk, keep it off the electronic record…I'd be afraid of putting things down on emails*".

There were reservations about documenting issues in terms of unknown implications for the student:

D2P2 "*With reporting issues in more traceable manner, the concern would be…whether this would have serious implication on the student or whether this would be step-wise*".

Theme 4: Context

None of the participants mentioned the role of the University chaplaincy in providing pastoral care, but both tutors and admin staff welcomed the idea of a "*student welfare person*" to connect with students outside the construct of the academic advisor role. Issues over access to mental health services were mentioned. Faculty were keen to ensure continuity of coordinated support and commented on school infrastructure (adjuncts vs rolling contacts):

D2P6 "*Tutors come and go as they all get moved (group switchovers) and the student then continues…*"

Although the group were unsure about reporting small incidents, they recognized that, cumulatively, incidents may warrant intervention. It was suggested that a written log may be helpful, along with a training package for staff:

D2P4 "*I'd be slower to put in a formal complaint, but if there was somewhere where we could log it as, you know, a minor misdemeanour, that isn't a written warning…*"

4. Discussion.

We identified four themes underpinning current learner handover practice; values, processes, personal approaches and contextual feedback. The codes encompassed within each theme provide specific areas for consideration as a basis for policy development (see Figure 2).

Focus group discussion revealed that participants could relate to potential dilemmas arising. Staff were confident in verbal escalation of academic concerns to the course director and showed respect for student privacy.

Staff were reluctant to create written records, particularly about minor concerns, fearing unknown implications for students. They raised the need for cumulative reporting of minor issues/incidents but were cautious about communicating student information between tutors. A verbal preference for communications was clear – any written or electronic procedures introduced in future would require explicit training and assurances about their purpose/consequences for students, with data security and gatekeeping essential aspects of design. We stress reluctance to record (in a traceable manner) as opposed to report verbal information due to a sense of unease around written evidence. Our participants shared anxieties around the potential uses of written records, with unintended/unforeseen consequences for students, see "*failure to fail*" (Yepes-Rios et al., 2016). They also felt that records conveyed an increased risk of resulting GDPR issues and/or accidental confidentiality breaches. Our findings resonate with Ziring et al. (2018) who found that perceived barriers to reporting professionalism lapses in medical students amongst faculty, included; "*uncertainty about the process*" and "*unknown effects on the learner*" (p.1700). We note that, in contrast to other study findings (Malik, 2000), staff involved in our survey did not report time constraints as a barrier to reporting.

Our results did reflect a recognized fear of binding students to excessive scrutiny (Sandars et al., 2014). Importantly, our staff stressed a wish to help rather than hinder their students, and valued the handover of a limited amount of information through appropriate channels as a means by which they could fulfil an obligation to ensure ongoing support. Their focus was on a holistic approach to continuous support without conscious bias. They did not connect any sense of bias creation with requesting access to existing academic records. Positive staff attitudes shown here act as a counter-claim to bias creation.

In describing current information-sharing practice, we note that many participants used the opportunity to air frustrations. Staff illustrated how adverse student behaviours can have a negative impact on small group dynamics during collaborative learning, an issue reported extensively in recent literature (Iqbal et al., 2016; Grey & Osborne, 2020).

Our results show that conflicts previously described around handover remain unresolved: "*Dilemmas arise in trying to balance rights and interests whilst causing the least harm…It is difficult to establish definitive policies and procedures. Schools risk both charges of invasion of privacy and withholding relevant information*."(Reeser & Wertkin, 1997, pp.347-362). More specifically, Sayer et al. (2002) questioned "*If documentation is to be made and fed back to the medical school, should boundaries and guidelines on confidentiality be drawn up to protect participants dealing with personal problems?*" (p.649) Our findings strongly support this idea, with our AR survey reflecting ongoing staff training needs. Staff showed particular interest in further training around advice-giving, risk recognition and information-handling procedures. To put this in context, the UK Advising and Tutoring Group (UKAT, 2020) report that 60% of institutions do not offer any form of training for tutors (no Irish data found).

Our focus group comments strengthen the evidence that individual student meetings with academic advisors (tutors/faculty) are a best practice point, crucial to training progress. Participants expressed the need for strong support infrastructure (including GP, counselling and chaplaincy services) and a coordinated response to student difficulties. Our findings inform policy developers that any protocol must include the flexibility to accommodate a range of circumstances.

Some participants (as qualified clinicians) expressed the need to avoid role ambiguity, aware of acting within their capacity as tutors/faculty, not doctors. They made reference to the current societal crisis over access to young people's mental health services, as described by Hill et al. (2020).

Staff have been given a chance to safely reflect on questions within their community of practice. Challenges may be magnified going forward, with the prospect of increased online / blended course delivery and a lack of face-to-face contact between staff working remotely. Positive

suggestions for improvement arising from open educator team discussion have been made, including the following key recommendations:

- An informal staff diary system/logbook for recording concerns about students would be welcomed if specific parameters for use were given.
- Participants agreed that early tutor access to academic records would be beneficial to all parties.
- Staff training sessions for student support should include; guidance around written reporting procedures (including adherence to the GDPR (2018) and Freedom of Information (2014) Acts), recognising burnout risk, welfare referrals and advice-giving.

We believe that our findings will be helpful to anyone reviewing medical school academic advising / reporting systems as we have described positive consensus on several topics, yet highlight gaps, especially in light of recent GDPR changes and evolving expectations regarding documentation. The themes generated in this pre-clinical phase study also link in to broader research that deals with transition from medical school to practice, where educational handover reflects lifelong learning and institutional responsibilities (Morgan et al., 2020).

We acknowledge that the staff who chose to participate may hold a greater interest in education, with more experience or qualifications, and that this study provides a small-scale snapshot. It cannot be proved that 12 focus group participants represent the mind-set of a greater staff body, and we note that we are a small faculty (75 invitees). A strength of the study was the use of a data gatekeeper and independent facilitator. AR survey results showed that five respondents were "*not sure*" whether training around suggesting counselling/pastoral care referrals would be helpful. As students self-refer to counselling, this question may have been misinterpreted and could have been worded better as "*equipping students to self-refer*" to these services. It would be useful to calibrate our findings with other institutions in order to widen participation, and the authors hope to gain learner perspectives as a future next step.

5. Conclusions.

This study has allowed us to acknowledge points of agreement from the 'shop floor' over good practice in sharing limited sensitive information about students. Staff aim to maintain student

privacy yet support performance, wellbeing and safety through handover practice. They have also voiced specific areas of concern and uncertainty to be addressed. We will explore the idea of developing a reporting algorithm with integration of an online, secure tutor diary/log system (perhaps an app/online tool designed specifically for the BMBS program). This study has illustrated the importance of good faith and clear process in learner handover, and has highlighted approaches that aim to be both protective and fair to all concerned.

Appendix 1

Case Scenario 1 – The struggling student

- It's tutor changeover time for Problem-based Learning (PBL) groups and you are aware that one student is consistently poor in their contribution to discussion. Their subject knowledge is clearly lacking across multiple topics. The group are frustrated by this student's inability to actively participate in sessions.
- At their Academic Advisor meeting, the student can't articulate any cause for their lack of engagement and failure to make progress. They don't wish to disclose any personal issues and can't identify any changes to improve their learning strategy. The results from their first year mock exams are poor.
- The admin team are aware that the student has sent in several emails to excuse themselves from various sessions (including several clinical skills topics).
- You recently noticed them working very early in the morning at the local 24hr garage.

Case Scenario 2 – The rude student

- You overhear a student at the reception desk shouting at staff in the office. They have issues with timetabling and blame the staff's organisational skills for their poor performance in a recent exam. They threaten to take formal action against individuals in the admin dept.
- Later that week, a simulated patient feeds back to you that the same student has told her "*she's not doing her job properly*".
- At a tutor meeting, you suspect that it is the same student whose behaviour is described by others as "*disruptive & irritating*" during small group sessions.
- The student has previously disclosed to you that she attends a mental health support group, organised via her GP, following problems with self-harm last year.

Case Scenario 3 – The demanding student

- This student often waits at the end of classes to ask you to demonstrate clinical skills 1:1 or to explain PBL content in more detail.
- They do every week, and when you suggest finding peers to work with, they say that others avoid them.

- You hear them approach different tutors to request regular extra sessions outside scheduled class time. They also send frequent emails, asking to be provided with extra written information online.
- Their parents phoned the medical school office this week, asking if they can pay for extra weekend tutorials.

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