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Teaching and learning moments: Burial in completion

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Commentary: **Criminal Background Checks for Entering Medical Students: History, Current Issues, and Future Considerations**

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Abstract

In this commentary, the authors aim to contextualize the history and rationale for what has become the Association of American Medical Colleges–facilitated criminal background check process for entering medical students. As the process was being considered, many issues with a standardized process were identified. There were concerns that demographic or socioeconomic factors might unfairly burden certain applicants or discourage them from applying to medical school. On the other hand, a unified, national program would minimize cost and enhance quality assurance. The authors discuss these issues. Lessons learned in the first three years of the program are also addressed, including some unexpected and favorable consequences such as the identification of accepted applicants with at-risk behaviors (e.g., substance abuse), who would have otherwise gone undetected. Several challenges remain, including the fact that the criminal background check process creates an enhanced role for prehealth advisors and encourages undergraduate institutions to establish standards and processes relating to professionalism. While this is, no doubt, an evolving program which needs continued oversight and ongoing reevaluation, the authors support the continued advancement of the criminal background check process for entering medical students.

Editor's Note: A Point-Counterpoint on criminal background checks upon acceptance to medical school appears on pages 807 and 808.

Medicine exists as a largely self-governing profession, in part as a reflection of our willingness to accept responsibility for ensuring that patients, frequently the most vulnerable members of society, are safe in our hands. This notion was taken on faith for many years, as individuals, organizations, and governments assumed that physicians would be trustworthy. In the early part of the 21st century, this began to change, as concerns about the behavior of physicians were raised in legislatures and by regulatory agencies around the United States. These concerns were in response, at least in part, to high-profile events such as the conviction of Michael Swango for impersonating a physician and committing multiple homicides.[1] With very little evidence to confirm the efficacy of doing so, state legislatures, hospitals, and the Veterans Affairs Health Care System began requiring that health care workers undergo criminal background checks as early as 1985. By 2006, 36 states and the District of Columbia required such checks.

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The History and Rationale for the Development of the Criminal Background Check Process

In response to growing concerns that state legislatures and hospitals were moving toward mandating criminal background checks on medical students, the Association of American Medical Colleges (AAMC) convened a Criminal Background Check Advisory Committee in February 2006. The committee was composed of 18 representatives from AAMC Councils (Deans, Teaching Hospitals, and Academic Societies), Groups (Resident Affairs, Educational Affairs, and Student Affairs), the Group on Student Affairs (GSA) Minority Affairs Section, the AAMC Organization of Student Representatives (OSR), the American Medical Association, the Federation of State Medical Boards, the Educational Commission of Foreign Medical Graduates, the National Association of Advisors for the Health Professions (NAAHP), the American Hospital Association, and the Department of Veterans Affairs. This group was charged with the responsibility, in concert with AAMC staff, of evaluating the evolving call for criminal background checks on entering medical students. The group completed a detailed assessment of the types of criminal background checks that could be performed, the resources required, the potential negative consequences of conducting such checks, and the likely response of the public and the regulatory authorities should the profession choose not to proceed. This process included open discussions at regional and national meetings of the AAMC GSA and the NAAHP, and within the advisory committee. After considering all of the information available at the time, the advisory committee recommended the creation of a national program for criminal background checks on all conditionally accepted applicants to U.S. medical schools, to be operated under the

auspices of the American Medical College Application Service (AMCAS). Subsequently, an AAMC GSA Criminal Background Check Implementation Advisory Committee, composed mainly of medical school directors/associate deans of admissions, an associate dean for student affairs, a registrar/student records specialist, and representatives from the OSR and NAAHP, was then appointed and charged with the creation and initial oversight of this national program.

The recommendation to move ahead with a national program reflected multiple factors, including the expectation that if the schools did not, in some way, accept this responsibility, it would be imposed by an outside authority with little guidance from those with a vested interest in protecting patients, students, medical schools, and the profession of medicine. Furthermore, a single, comprehensive, national program with high standards of integrity and a unified format would minimize the cost, the work, and the emotional ordeal for applicants and medical schools and would avoid unwarranted costs by focusing only on accepted applicants. It was anticipated that only a small percentage of applicants would have a criminal history and that these could be identified in advance by requiring applicants to self-report misdemeanor and felony convictions in the medical school application (AMCAS). These self-reports would be validated during the subsequent criminal background check.

There was great concern that race, gender, and income-based inequities in the U.S. criminal justice system would disproportionately burden underrepresented minority applicants and further discourage them from considering careers in medicine. Performing background checks after conditional acceptance, under the auspices of AMCAS, the GSA national Committee on Admissions (COA) could monitor these factors and structure the reviews to minimize the risk to vulnerable applicants. In addition, the GSA COA, in concert with AMCAS staff, could create training materials, guidelines, and effective practice documents to assist medical schools in the development of policies and procedures for the handling of criminal history information at individual schools.[2]

This unified, national program commands resources for the support of oversight and quality assurance that no single school-based program could match. Because medical schools start clinical rotations at different times (including during year one), and many hospitals require prior criminal background checks, this program reduces confusion and delay at individual schools by ensuring the criminal background check is completed before students begin their studies. The GSA COA has continued to monitor the program, ensuring that searches are carried out in as fair and accurate a manner as possible while also assisting participating schools in developing mechanisms for handling criminal history information as it becomes available.[2]

Current Issues and Lessons Learned

The criminal background check process has expanded to 113 medical schools over the past three years; 92 schools use the AAMC-facilitated process, and 21 schools use an independent process. As anticipated, only a small number of conditional acceptances have been reconsidered based on the results of criminal background checks. For classes entering medical school between 2008 (the first year of the AAMC criminal background check pilot) and 2010, 58,108 out of 127,242 applicants were accepted by at least one medical school.[3] AAMC-facilitated criminal background checks were conducted on 24,085 of these accepted applicants, and only 3% of these applicants did not matriculate for a combination of reasons, including withdrawals, deferments, and rescinded offers of acceptance. Detailed information on the very small number of rescinded offers of acceptance is not yet available.

Applicants with a criminal history must consider the impact this information may have on their ability to enter medical school. In some cases, this may provide applicants with an opportunity to reflect on past behavior and consider their future responsibilities as physicians. This requirement may also affect behavior during the early college years of students considering careers in medicine.

Because misdemeanor and felony convictions should be self-disclosed in the AMCAS application, the criminal background check provides validation of applicant forthrightness. Applicants' explanations for criminal offenses have ranged from dismissive to acceptance of responsibility for an event that served as a life-altering experience resulting in personal growth. Some applicants have used these situations to demonstrate the maturity to overcome isolated lapses in judgment and the tenacity to escape negative influences. What was unanticipated to some degree was the number of applicants who failed to self-disclose incidents that appear in their criminal history for reasons ranging from misunderstanding complexities of the legal system (e.g., not realizing that payment of a fine constitutes a guilty plea or assuming that records would be expunged without further intervention) to apparent lapses in memory.

Medical schools adopting checks have developed policies and procedures for reviewing criminal history that ensure confidentiality and due process for applicants while adhering to applicable state law. This has often led to new relationships with legal counsel and other members of the faculty who would not otherwise be involved with the admissions process. Criminal history review committees have encountered a broad spectrum of criminal activities, from minor infractions to serious violations. Case-by-case contextual considerations have been a necessity in review committees' work toward complex decisions that are fair and equitable. For example, the state of adjudication may impact how an incident is reported; a speeding ticket is a misdemeanor in some states but not in all states. The nature and severity of offenses need to be considered. Although there is likely to be consensus about avoiding perpetrators of violent crimes, what about alcohol-related offenses? Should a charge of "minor in possession of alcohol" be considered in the same way as "driving under the influence"? Does it matter whether either of these was a single incident that occurred years ago or was a repeat and/or recent offense? Does the timing or pattern of offenses warrant probationary deferment of matriculation to demonstrate "good behavior," or is evidence of rehabilitation required in lieu of rescinding an offer of acceptance? Do

concerns about past behavior impacting the safety of the medical school and hospital environments warrant monitoring or mandatory drug testing while the student is enrolled in medical school? What impact might incidents in the criminal history have on the ability of the prospective student to acquire licensure? If further incidents of a similar nature occur while a student is enrolled in medical school, what impact will these have on the public trust of the institution and profession? Complexities of the legal system and variations between jurisdictions can be confusing for applicants and for institutions. Unintended lapses in truth telling can be uncovered early in the criminal background check process and dealt with in a reasonable and timely manner. In addition to providing clarification for applicants and medical schools in the short term, resolution of these matters ensures that applicants can accurately answer such questions in the future, when incorrect answers may have severe consequences.

Participating schools have encountered a number of unanticipated and favorable consequences from criminal background checks and have developed policies and procedures for responding to information derived from the searches. For example, criminal background checks have identified accepted applicants with patterns of at-risk behavior (such as substance-abuse-related incidents) that would have gone undetected without the background check. In response, some schools offer these applicants conditional matriculation that may require either periodic counseling or monitoring, including random drug testing, throughout enrollment in medical school. Other schools require these applicants to have a face-to-face meeting or telephone conversation with the admissions dean prior to matriculation. Such practices afford opportunities for behavioral modification and provide an opportunity to discuss values of the school, expectations of students, and professional responsibilities.

Even though few accepted applicants have been affected by the criminal background check process, it is important to have this process both to validate disclosures and to determine whether there have been omissions of criminal incidents from AMCAS applications. Lessons learned by the students and schools suggest that the investment of time and resources has been worthwhile.

Future Considerations

Through the criminal background check process, it has become clear that every action that violates some law, rule, or standard may put a student's future medical career at risk. Applicants need guidance on navigating the increasingly complex regulatory climate of medicine. This need will create an enhanced role for prehealth advisors. For example, students should be informed that current behaviors may impact future considerations for medical school admission, licensure, and hospital credentialing and privileging. Students should be advised in advance to fully disclose any criminal history in accordance with guidelines on medical school, licensing, and employment applications. Conditional offers of acceptance may be rescinded for breach of truthfulness if an incident is not disclosed, even if the actual events are relatively minor. Because the prehealth advising offices of many undergraduate institutions provide a single composite letter of evaluation for applicants from their school, they may need to revise processes and set standards that alter the strength of their recommendation for a medical school applicant based on his or her criminal history. At the same time, medical schools have started to develop very structured processes to review findings disclosed on criminal background checks. It is essential to have standards to ensure that all applicants are treated fairly. Medical schools and their criminal history review committees will need to make judgments about the severity of incidents and whether a particular incident would be considered a "fatal flaw."

The discussion of criminal background checks highlights the need to further evaluate other "institutional actions" reported on the AMCAS application. Some incidents do not reach the level of misdemeanor or felony simply because they are handled internally, but are these incidents any less significant than those in an applicant's criminal history? Because some incidents handled at the institutional level are comparable to incidents that appear in criminal histories, there may be a need for institutional documentation and verification of outcomes. There needs to be a national discussion about how such events may or may not predict a physician's future behavior. How should applicants with multiple events be viewed? Currently, each medical school considers both criminal background checks and institutional actions in its own way. A set of national guidelines about institutional actions might improve consistency and equity. The issue of "expunged" records also remains unresolved in that applicants cannot always be certain about what will be revealed on the criminal background check. Additionally, some school disciplinary records may be removed from the permanent record at graduation, which may prevent undergraduate institutional actions from being reported during the medical school application process. These actions are handled differently across undergraduate institutions and provide a risk to any attempt at standardization among schools.

Finally, the criminal background check is captured at a particular time in the prematriculation process for schools participating in the AAMC-facilitated program. Even though applicants are instructed to self-report any misdemeanor or felony conviction after the initial disclosure, a routine method of follow-up and validation is lacking. Thus, there is no consistent approach to the reporting of any events that may occur after the initial review.

The AAMC may consider reconvening the GSA Criminal Background Check Implementation Advisory Committee or formally establishing another group to periodically review the criminal background check process and outcomes. We view this as an important recommendation because the criminal background check process is playing a role in determining who will become a physician, and that role is likely to be expanded in the future.

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Teaching and Learning Moments

Burial in Completion

The smell was an unforgettable mixture of preservation and decay that stung my nose as I walked into the laboratory. I felt a mix of insecurity and excitement as the rows of cadaver benches came into my view—dull gray metal with bodies wrapped in layers of fabric, plastic, and preservatives. I learned quickly that everything has a purpose and a flow. Each nerve has a function and each vessel a destination. Anatomy is a systematic science. Working layer-by-layer, the student comes to an understanding of the whole by learning the details of the parts.

While I sat at home one afternoon attempting to memorize innervation and blood supply, I heard a loud thud and walked onto my balcony, expecting to see construction in the area that could explain the sound. Finding no explanation, I returned inside only to hear another sound. This time, I could hear the vibration of air whooping up against the doors and windows of my apartment. I felt a tiny ball of sickness grow in my stomach. I heard the sirens next, one after another in a symphony of wails. I rushed to my bedroom window to see a nightmare unfolding across the street. At the main intersection of town stood two buses with gaping black holes in their centers and smoke shooting out. Before long, individuals wearing white vests were collecting the remains of the victims off the same street that I walked on my way to school each day.

When I learned about the details of Jewish burial practices in my anatomy course, I was surprised to hear how similar they were to the Muslim rituals I remembered from my childhood. Both traditions originated in the temperate climate of the Middle East. Both incorporate traditional burial clothing, both throw handfuls of earth on the dead body, and both sit for well-defined periods of mourning.

In the Jewish tradition, a strong emphasis is placed on burial in completion. Organ donors are difficult to recruit because of the common belief that the body should be buried in an undefiled state, as complete as it was at birth. The men and women in the white vests searched the site for any pieces that could be considered human remains. They meticulously covered the scene with no other job than to ensure that the greatest possible respect be paid to the victims.

Their bags reminded me of the containers that I had used in the anatomy lab the day before. As we were dissecting our cadavers, we were encouraged to place every piece of human waste in a special container to be returned to the body upon completion of the dissection for the eventual burial. Both their bags and our containers served the same purpose but in entirely different circumstances.

Each morning after the bombing, I walked the same street to class, pushing aside questions of faith, life, and death as I focused on my studies. My anatomy course continued as expected, despite the tragedy that I had witnessed, and we moved on to studying the anatomy of the chest. We worked our way through the mediastinum to reach the heart. Learning about the chambers and valves of the heart was nothing compared to the day when I reached into the thoracic cavity and held a human heart in my own two hands. The anatomy of the heart was a poignant reminder of the fragility of the human experience.

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