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Q&A
WITH DR. MEDLAW

Just about everyone who works at our family practice office (PAs, an RN, and clerical staff) is also a patient there. Needless to say, many of them are accessing their own records. I have talked to my partners about this because I am really concerned that we would be hit hard about this in a HIPAA investigation, but they said that it is fine because people are only looking at their own records, which they have a right to do. Are they correct, or am I?

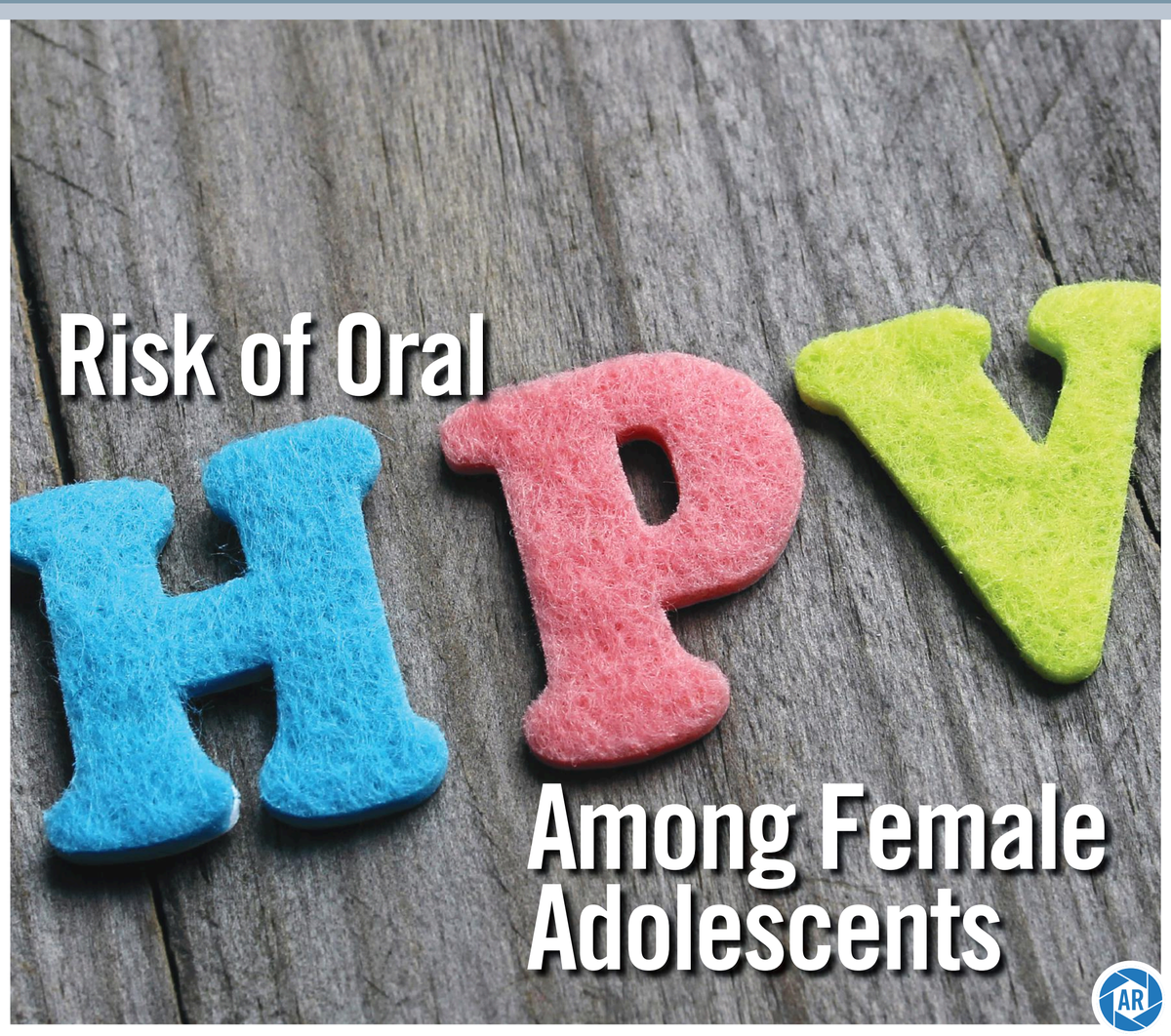
You are.

A patient has the right to see their records but could not just go to the receptionist's desk and start downloading them. The same applies if they happen to work at the practice. There are proper procedures to follow.

The real issue is that this conduct is a red flag for HIPAA laxity at your practice if you are ever investigated, even for another reason, because it shows that you are treating records as an open access matter to all staff, including non-medical staff, which is an invitation to improper use. When records access is unregulated, it is frankly inevitable that there will eventually be privacy violations, such as looking up the records of someone the staff member has a personal question about.

When a staff member wants their results, have them submit a request just like any other patient would or simply ask their treating practitioner to check for them. Include this as a set policy in your office's employee regulations that can be proffered to the OCR as proof that you deal with this properly if you are investigated or used as evidence in a lawsuit for a privacy breach under state confidentiality law.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



Contributor
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Recent studies indicate that the incidence of oropharyngeal cancers increased more than 200% in the US between 1988 and 2004. As the most common sexually transmitted infection in adolescent and young adult women, human papillomaviruses (HPV) are responsible for nearly all cervical cancers and most anal and oropharyngeal cancers. For a study published in *JAMA Network Open*, Nicolas Schlecht, PhD, Angela Diaz, MD, PhD, Robert Burk, MD, and colleagues sought to assess the risk factors for oral HPV, as well as the association of HPV vaccination with HPV prevalence in the oral cavity, in sexually active female adolescents receiving the quadrivalent (4vHPV) vaccine.

The researchers tested for HPV DNA through an oral rinse among more than 1,200 women who participated in repeated collection of oral rinse specimens over 10 years. Participants at time of enrollment were aged 13 to 21 (median age, 18) and planning to or already had received the HPV vaccine. Upon entry into the study, participants were asked about sexual behaviors, including number and type of sexual partners. The study authors also collected data on other sexually transmitted diseases, pregnancies, short- and long-term contraceptive use, tobacco smoking, and alcohol, marijuana, and other drug use. Follow-up visits occurred every 6 months until age 25 to obtain samples for HPV testing, and self-reported sexual history questionnaires. DNA from samples was tested for more than 40 types of HPV associated with infecting mucosal tissue.

HPV Numbers

Among participants, the average age of first sexual activity was 14. At the time of enrollment, 69.7% had at least three sexual partners. The HPV detection rate from initial oral rinse samples was 6.2%; 1.7% were oncogenic types and 0.2% were 4vHPV types. "While our study population had a higher average number of sexual partners and an earlier sexual debut on average compared with participants in previous studies, detection of 4vHPV vaccine types (HPV types 6, 11, 16, 18) was significantly lower among vaccinated women when compared with unvaccinated women," explains Dr. Schlecht. The highest prevalence of oral HVP detection was at age 16 (10.5% for all types, 3.9% for oncogenic types). "The majority of oral HPV that was detected was cleared within 12 months, reflecting the transient nature of these infections," adds Dr. Schlecht.

Detection of an HVP infection in the cervix increased the tendency for HPV identification in the oral cavity. Although no significant association was seen between giving or receiving oral sex and HPV detection, a strong connection was seen between years of sexual activity and HPV detection.

Prevalence of Vaccination & Infection

When enrolled, 15.3% of participants had not received the 4vHPV vaccine. To compare vaccinated versus unvaccinated participants, Dr. Schlecht and colleagues used a multivariable logistic regression approach, adjusting for years since first sexual activity and concurrent detection of 4vHPV types in the cervix (Table). Participants who had received at least one dose of the 4vHPV vaccine were 83% less likely to have a 4vHPV type detected in the oral cavity compared with unvaccinated participants.

"These findings parallel our earlier observations with cervical and anal HPV," notes Dr. Schlecht. "Detection of HPV in the oral cavity is not uncommon in sexually active adolescent females, but decreases with age and time since onset of sexual activity. Continued research is needed to determine whether the additional types targeted by the new 9-valent vaccine will also decrease, and whether vaccination reduces the incidence and persistence of oral HPV vaccine types. Similar studies in adolescent males are also needed."

Table Vaccine Dose & Detection of 4vHPV Vaccine Types in Oral Cavity

Vaccine Dose	Number of Participants	% HPV Positive	Odds Ratio
0 doses	192	2.1	1
1-2 doses	297	0.7	0.3
3 doses	770	0.3	0.12*

Odds ratios estimated by logistic regression adjusting for age and years since first sexual activity.

* Significant at $p<0.05$ threshold.

Source: Adapted from Schlecht N, et al. *JAMA Netw Open.* 2019;2(10):e1914031.

33 CHARTS

Doctors and the Culture of Permission

Recently, Richard Smith, editor of *BMJ*, called out *NEJM* for failing to publish critical letters. His post in the *BMJ* blog network calls out *NEJM* as elitist. If electronic space is unlimited, he asks, why limit letters?

Good point. But why assume that conversation is controlled by *NEJM*? This is a great illustration of what I have come to call medicine's culture of permission.

As physicians, we've been raised to seek approval before approaching the microphone. For hundreds of years, you could only say something if someone gave you permission. It used to be that the only place we could share ideas was in a medical journal or from the podium of a national meeting. Our ideas were required to pass through someone's filter.

The angry scientists cited by Smith are of a generation when someone else decided if their ideas were worthy of discussion. They are a generation trained to contain what they think and believe. They are the medical generation of information isolation. Our culture of permission has bred a generation of obsequious followers.

When I think about my peers, I think about the remarkable mindshare that exists. Each is unique and brilliant in the way they think and see the world. Each sees disease and the human condition differently. They carry stories and experiences that can ease minds and save lives. But their brilliance and wisdom is stored away deep inside. They are human silos of unique experience and perspective.

But the way the world communicates and creates ideas is changing. The barrier to publish is effectively non-existent. The democratization of media has given every physician and scientist a platform to the world. But, somehow, we still believe that *NEJM* is running the show. The assumption here is that the only place for dialog and publication is within the boundaries of a paywall-controlled platform.

The problem here is not the antiquated ways of *NEJM*, but the dated, permission-based thinking of the medical public.

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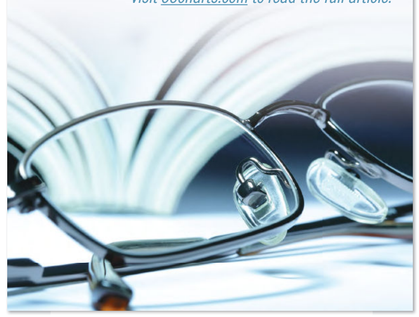

Sepsis & Infectious Disease Consultation

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Evidence indicates that the use of severe sepsis and septic shock (SS/SS) treatment bundles is associated with lower mortality when compared with no use. However, delivering successful SS/SS bundles can also increase risks for antibiotic overuse and higher rates of *C. difficile* colitis. For a study published in *Open Forum Infectious Disease*, Theresa Madaline, MD, and colleagues sought to determine a multidisciplinary approach that would provide patients the benefits of the SS/SS bundle while also providing the opportunity to optimize antimicrobial prescribing and diagnostic workup.

The study team investigated whether a collaboration between emergency medicine and infectious diseases that offered an early infectious disease consultation for patients with SS/SS could improve outcomes. Specifically, they analyzed whether patients who received an infectious disease consultation within 12 hours of arrival showed significant differences in mortality, 30-day hospital readmission, length of stay, and antimicrobial prescribing. Participants had received all components of the 3-hour bundle, in order to evaluate whether the benefits of early identification consultation beyond improving bundle compliance.

The study findings increase the body of evidence that infectious disease consultation, especially early in a patient's clinical course, are associated with lower mortality, according to Dr. Madaline. Indeed, the in-hospital mortality rates were 24.3% for the early consultation group, compared with 38.0% for the no consultation group. Early ID consultation was protective of in-hospital mortality (adjusted subdistribution hazard ratio (asHR), 0.60) and predictive of discharge alive (asHR 1.58) after adjustment. "We also demonstrated earlier de-escalation of antibiotics with early consultation, which could be a contributing factor for the observed difference in mortality," adds Dr. Madaline. "Data suggest the collaborative nature of the emergency medicine and infectious diseases service, and the benefits of team-based care, contribute to the lower mortality in the early infectious diseases group."

Further research is needed to understand the relationship between mortality and antimicrobial de-escalation, says Dr. Madaline. In the meantime, she emphasizes that "it is important to remember that diagnosing and treating SS/SS can be a challenge, and there is 'no one size fits all' model. Teamwork and clinical judgement are key."