Featured Article

Health Care Providers Balance Patient Rights and Law Enforcement Authority in the Hospital Setting

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What is the issue? Interactions between law enforcement officers and heath care providers are common and necessary in the hospital setting, and can raise significant patient rights issues that may incite volatility when not considered and addressed in advance through adequate policies, education, and communication between and among stakeholders.

What is at stake? The protection of patient rights, hospital compliance with federal and state law, and employee safety are all at stake when hospital staff members are faced with balancing requests by law enforcement officers against their duty of care and patient protection.

What do you need to know? Implementation of effective hospital policies and ongoing training and collaboration between hospital staff and local law enforcement will help prevent and minimize disruption and conflict in the emergency department setting. Understanding the "what" and "why" behind a police officer's request and knowing what is required under the law and respective institutional policies will help health care providers strike the right balance when treating patients who are in police custody.

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Rogaliner, Rule, Schardt, Karam: Patient Rights and Law Enforcement

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Introduction

Last year, a social media firestorm erupted as video of an on-duty nurse's arrest and forcible custody went viral. Later reports identified the nurse as Alex Wubbels, a University of Utah Hospital nurse and a former Olympic athlete. Wubbels was arrested after refusing to draw blood from an unconscious patient when requested to do so by a Salt Lake City police officer who was investigating a motor vehicle accident. As captured on video by another police officer's bodycam, Wubbels consulted hospital policy and her supervisor before concluding that because the patient was neither under arrest nor subject to a search warrant, she would not draw a blood sample without the unconscious patient's consent. The resulting disturbing scene, shared on various social media and news websites, showed Wubbels being handcuffed and forcibly removed from the hospital. The video shows her still on the phone with her supervisor as she was manhandled by a Salt Lake City police officer. The audio captures her screaming in fear and protest.[1]

A similarly dramatic incident occurred in Houston several years ago when health system employees notified Harris County police that a patient awaiting care in their clinic had presented fraudulent identification when she checked in for her appointment. The patient, Blanca Borrego, was unaware that clinic staff had called the police who were en route to arrest her. Ms. Borrego was eventually called back to an examining room, only to be arrested and led in handcuffs back through the clinic waiting room in front of her two daughters. Once the dust had settled from the resulting negative publicity, the health system involved paid a $2.4 million fine as a result of an alleged violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[2] Though the initial police notification regarding Ms. Borrego's presence and actions at the clinic was permissible under HIPAA, the health system improp-

1 Erik Ortiz & Corky Siemaszko, *Utah Nurse Arrested for Refusing to Give Patient's Blood to Police*, NBC News (Sept. 1, 2017, 8:07 AM), *available at* www.nbcnews.com/news/us-news/utah-nurse-arrested-refusing-give-patient-s-blood-police-n798021.

2 45 C.F.R. § 160 *et seq.*

erly disclosed Ms. Borrego's name in a subsequent press release about the incident, which was an impermissible disclosure.[3]

Health care providers are subject to myriad local, state, and federal laws, regulations, and administrative rules that apply to and inform their decisions as they carry out their mission to care for each patient in their charge. Law enforcement officials are driven by a different set of guiding principals with the goal of public safety. Though they are well-versed and trained in criminal law and procedure, officers may not be aware of or focused on the laws, policy, or regulations that can impact their interactions with health care professionals. With these two groups of professionals operating under disparate duties and vastly different operating procedures and guidelines, there is ample opportunity for conflict when they interact in the hospital setting, particularly in a highly charged setting such as the emergency department.

Hospital staff and law enforcement must understand the legal duties and obligations imposed on each other as they interact in a hospital setting. This article will explore common legal issues raised by police presence in a hospital emergency department as health care providers try to balance their professional and legal obligations against requests for information and/or action by law enforcement officers. At the outset, this article will address the important issue of consent in the context of medical interventions, the role and applicability of the Emergency Medical Treatment and Active Labor Act (EMTALA), the challenge of addressing mental health issues and care for prisoners in the hospital setting, privacy laws including HIPAA, and the important role of hospital policies and procedures relative to the training, education, and community collaboration between health care providers and law enforcement officers.

3 Mike Hixenbaugh, *Memorial Hermann to Pay $2.4M After Sharing Patient Name in Press Release,* Houston Chronicle, May 10, 2017, *available at* www.houstonchronicle.com/news/article/Memorial-Hermann-to-pay-2-4M-after-sharing-11137038.php.

For a view from the front lines, the authors collaborated with John Peter Smith Hospital (JPS) in Fort Worth, Texas. JPS is a 589-bed acute care safety net hospital with a Level 1 trauma designation. A new patient presents to the emergency department (ED) at JPS every three minutes. Many of those patients (at JPS and at emergency departments throughout the country) are emotionally charged by fear, a sense of urgency, tension, and anxiety when they arrive because of their immediate need for acute medical care, whether from disease, trauma, or crime. As a result, the emergency department can be a flashpoint, and the sheer volume of patients can create a hectic environment if the volume is not handled efficiently and with proper handling of routine requests by law enforcement.

Consent

Alex Wubbels was correct when she refused a police officer's request for a blood alcohol test on an unconscious patient. Competent adult patients have the right to consent (or refuse to consent) to proposed medical care, treatment, and testing.[4] Police officers in the United States do not have the authority to demand that care, treatment, and/or medical testing be performed on an unconsenting individual without a search warrant.[5] This is true even when the individual is under arrest and in police custody.[6] On June 23, 2016, the United States Supreme Court ruled in *Birchfield v. North Dakota* that warrantless blood draws are unconstitutional. The Court held that both breath and blood tests constitute a search under the Fourth Amendment, but that blood draws are too extreme and intrusive to be supportable without a warrant.[7] Before the

4 This fundamental right has been emphasized in legal jurisprudence. Autonomy was recognized as a key aspect of medical law early in the case of *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92 (1914), *overruled on other grounds*, *Bing v. Thunig*, 143 N.E. 2d 3 (1957). *See also* Marwan Habiba, *Examining Consent Within the Patient-Doctor Relationship,* 26:3 J. of Med. Ethics 183, 87 (2000), stating "consent to investigations and treatment is considered a cornerstone in the doctor-patient relationship."

5 *See* Birchfield v. North Dakota, 136 S. Ct. 2160 (2016).

6 *See Id.*

7 *Id*. at 2165. While the Court did not strike down the concept of implied consent in other contexts, it held that implied consent was not supportable grounds for the performance of a blood alcohol test against a patient's consent. Specifically, the Court stated that there "must be a limit" and that motorists can only be deemed to have consented "to only those conditions that are 'reasonable' in that they have a 'nexus' to the privilege of driving." *Id.* at 2186.

Birchfield decision, many state laws permitted involuntary blood draws to test the blood alcohol level of persons in police custody. As seen with the Wubbels incident, however, the 2016 ruling may not have been fully appreciated or effectively incorporated into local police procedures and/or hospital policies in some communities as of the summer of 2017. This calls attention to the need for proactive study, policy updates, education, and training.

In light of the 2016 *Birchfield* decision and incidents that clearly show how quickly a situation can be ignited, hospital counsel and compliance officers should review current consent policies to ensure they do not permit warrantless blood draws on any patient without the patient's consent. If a hospital's current policy permits warrantless blood draws on any patient, the policy should be reviewed promptly by hospital counsel and revised to comport with the *Birchfield* decision. In addition, any policy revisions that will change the way emergency department personnel interact with local law enforcement officers should be brought to the attention of local law enforcement leadership before implementation in an effort to set expectations on all sides and avoid conflict in the patient care setting.

Scope of Services Requested

Even when an ED patient consents to medical intervention and/or evidentiary testing while in police custody, tensions can escalate when the scope of services requested by police differs from the scope of services health care providers deem necessary. For example, when a consenting patient is brought in for a routine blood alcohol test, the police officer may expect to be in and out of the emergency department within minutes; however, federal law mandates that health care providers perform screening examinations and stabilizing treatment in certain circumstances.[8] Thus, law enforcement officers often lose some level of control and authority. When any individual presents to the ED at a Medicare-participating hospital (whether on their own volition, in an ambulance, or by way of police custody) and a request is made for evaluation or care and treatment of that person, federal law requires that the hospital provide certain

8 *See generally,* 42 U.S.C. § 1395dd.

minimum screening and stabilization services, regardless of the presenting officer's preference or the scope of his/her request for services.[9]

Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. EMTALA's purpose is to ensure access to emergency care for all individuals, regardless of their ability to pay for services. EMTALA's scope is broad, however, and remaining in compliance with its mandates is a complex component of the operating policies and procedures in most hospital emergency departments throughout the United States.

Generally speaking, EMTALA requires that Medicare-participating hospitals[10] that have a "dedicated emergency department"[11] provide certain screening and stabilizing treatments to all patients who come to the hospital seeking evaluation or care and treatment of a medical condition, regardless of the patient's ability to pay for services. While that general concept may appear relatively straightforward, there are thousands of pages of regulatory expansion, broadened definitions and interpretive guidelines, rendering EMTALA

9 *Id.*

10 42 U.S.C. § 1395dd. Participation in the Medicare program is voluntary; however, the vast majority of hospitals in the United States are enrolled in and rely heavily upon the Medicare program. Medicare and Medicaid beneficiaries accounted for more than 60% of all care provided in the hospital setting in 2017. Am. Hosp. Assoc., Underpayment by Medicare and Medicaid Fact Sheet, December 2017 Update (Dec. 2017), *available at* www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf.

11 The term "Dedicated Emergency Department" is broadly defined under the law, and includes any area(s) of the hospital that meet one of the following three criteria: (1) is licensed by the state as an emergency department; (2) holds itself out to the public as providing emergency care; or (3) during the preceding calendar year, provided at least one-third of its outpatient visits for the treatment of emergency medical conditions, without requiring a prior appointment. 42 C.F.R § 489.24(b). As a result of this broad definition, many facilities will fall under EMTALA, whether or not they have formal or licensed emergency departments. In addition to traditional acute care hospitals with formal emergency departments, EMTALA applies to many critical access hospitals, physician-owned specialty hospitals and free-standing urgent care centers (if owned by a Medicare-participating hospital). *See* 42 U.S.C. § 1395dd(e)(5); 42 C.F.R. § 489.24.

relevant to circumstances well beyond the uninsured patient attempting to obtain emergency care.[12]

EMTALA applies to all individuals, not just Medicare beneficiaries or those who are indigent.[13] Race, religion, incarceration, and immigration status are all irrelevant. So is police custody. When EMTALA applies, the presenting officer will not have the authority to limit the scope of services to be provided to the person in custody, and the hospital will be required to provide (i) a medical screening examination to determine whether or not an emergency medical conditions exists; (ii) stabilizing treatment (if an emergency medical condition is found to exist); and (iii) a proper transfer to a higher level of care (if necessary to stabilize the patient's emergency medical condition).[14]

EMTALA's gating issue: evaluation or treatment?

A hospital's EMTALA obligations are not triggered by a person's mere presence in the emergency department. For example, medical screening examinations are not typically performed on visitors in the emergency department. A hospital's EMTALA obligations are triggered when a request is made for evaluation or treatment, which can occur in one of three ways: (i) the individual requests evaluation or care and treatment of a medical condition; (ii) a third party (including a police officer) makes a request for evaluation or care and treatment of the individual;[15] or (iii) the individual's appearance and behavior would cause a prudent layperson observer to believe that examination or treatment for a medical condition is needed, and the individual would make such request herself if she were able to do so.[16] It is the last component of this three-prong test that often sweeps patients who are in police custody into the hospital's EMTALA obligation, even when neither the patient nor the presenting police officer has requested evaluation or care and treatment for the person in custody.[17]

12 *See* Robert Wanerman, *The EMTALA Paradox*, 40:5 Annals of Emergency Med. 464, 466 (2002). "[T]he scope of EMTALA enforcement has been dramatically broadened by a confluence of case law, regulations, and informal agency policies." *Id.*
13 42 C.F.R. § 489.24(a)(1).
14 42 U.S.C. § 1395dd.
15 In the context of law enforcement presentations, this prong is met when an officer presents a person in custody requesting that the person be medically cleared before incarceration.
16 42 C.F.R § 489.24(c).
17 *See e.g.*, Evans v. Montgomery Hosp. Med. Ctr., No. 95-5039 (E.D. Pa. May 1, 1996).

Consider this relatively commonplace scenario: a police officer is presenting to the hospital with a person under arrest and in police custody and the officer requests a blood alcohol test (BAT). While strict application of the three-prong test would not suggest that a BAT presentation would invoke EMTALA screening obligations, there are countless scenarios in which it might, which is why health care providers must be cognizant of their EMTALA duties when presented with a non-emergent evidentiary request by a police officer. If the individual is exhibiting signs or symptoms of intoxication, hospital staff should consider the hospital's EMTALA obligations invoked and require a full medical screening examination on the individual, regardless of the scope of testing or treatment requested by the presenting police officer. Alcohol intoxication symptoms can mimic the symptoms of other emergency medical conditions, such as traumatic head injury, diabetic emergency, and stroke.[18]

In one instructive case out of Pennsylvania, local police arrested a man for allegedly driving erratically. The police brought him to the emergency department at Montgomery Hospital Medical Center and requested a BAT for evidentiary purposes.[19] No overt request was made for evaluation or treatment of a medical condition; however, the man in custody was processed as a patient and required to sign consent for treatment forms before the BAT was administered. Once the forms were signed, a nurse drew blood as requested by the police officer, but the patient was not otherwise evaluated. He was discharged without having received a Medical Screening Examination (MSE) and taken to jail, where he died the same night as the result of a stroke. The patient's family sued the hospital, alleging, among other things, that the hospital failed to meet its EMTALA obligations. The hospital argued that the man's presentation did not trigger EMTALA because the only request had been for an evidentiary BAT, not an evaluation or for care and treatment of a medical condition. The court ruled against the hospital, based in part on the patient's conspicuous symptoms while in the emergency department, which should have alerted staff to his apparent need for medical evaluation.

18 *See e.g.*, Evans v. Montgomery Hosp. Med. Ctr., No. 95-5039 (E.D. Pa. May 1, 1996); *see also* Robert A. Bitterman, Am. C. of Emergency Physicians, Providing Emergency Care Under Federal Law: EMTALA tbl. 1 (2000).

19 Evans v. Montgomery Hosp. Med. Ctr., No. 95-5039 (E.D. Pa. May 1, 1996).

Specifically, as the court described the evidence, the patient had severe lethargy and difficulty sitting up without assistance while the nurse drew his blood, which was enough, in the court's opinion, to trigger an EMTALA-mandated MSE.[20]

A different conclusion was reached in *Gooch v. West Virginia Department of Public Safety*,[21] when a Kentucky state trooper arrived at Raleigh General Hospital with a man in custody, requesting that a BAT be performed for evidentiary purposes. The hospital complied with the request and performed no other screening examination. The patient, Mr. Gooch, was discharged in police custody, but subsequently admitted to another hospital, where he died of streptococcal pneumonia. The BAT performed at Raleigh General Hospital was ultimately negative. Mr. Gooch's estate sued Raleigh General Hospital, alleging that the hospital had failed to meet its EMTALA obligation and perform an adequate MSE on Mr. Gooch, who was not intoxicated but severely ill. In review, the *Gooch* court found no evidence that Mr. Gooch's appearance in the emergency room was indicative of a need for medical intervention, and there was no evidence suggesting that the clinicians "knew or should have known" that Mr. Gooch was ill. Thus, while the *Gooch* court reached a different conclusion than the *Evans* Court, the analysis and rationale of the issue was consistent, with the relevant decision-point being whether or not the patient exhibited signs and symptoms suggesting that medical evaluation or treatment was necessary, not the scope of the presenting police officer's request for services.

To minimize conflict, emergency department providers and law enforcement officers need to effectively communicate regarding the presentation and ongoing status of each person in custody. For example, if a police officer presents with a person in custody, the officer must identify the purpose of the presentation. Most typically, the options include the following: (i) the person

20 When the *Evans* case was decided, the *Evans* Court was expanding the trigger for EMTALA presentations beyond the strict statutory language pertaining to a person's "request for evaluation or care and treatment" by incorporating a prudent layperson's observations as a trigger for a required MSE. *Id.* CMS subsequently issued formal rulemaking incorporating the *Evans* standard into the EMTALA definitions for what constitutes a request for care and treatment which will trigger an EMTALA obligation. *See* 68 Fed. Reg. 53222, 53234, codified at 42 C.F.R. § 489.24(c).

21 Gooch v. W. Va. Dep't of Pub. Safety, 465 S.E. 2d 628 (W. Va. 1995).

in custody is being presented for evidentiary testing only, and no medical evaluation or screening is requested; (ii) the person in custody is being presented for medical evaluation due to accident, injury, illness, or other symptoms that appear to require medical evaluation; or (iii) the person in custody is being presented for routine medical screening before incarceration. Once the presenting officer communicates to hospital personnel why the individual in custody has been brought to the hospital, it becomes the hospital's responsibility to appropriately respond to that patient presentation by evaluating and processing the individual in accordance with hospital policy and applicable law. If the hospital determines that evaluation or treatment beyond that requested by the police officer is necessary, the hospital's obligation to perform that screening exam is mandated by federal law and the person in custody will not be released by the hospital, even upon police request, until an MSE (and if necessary, stabilizing treatment) has been completed.

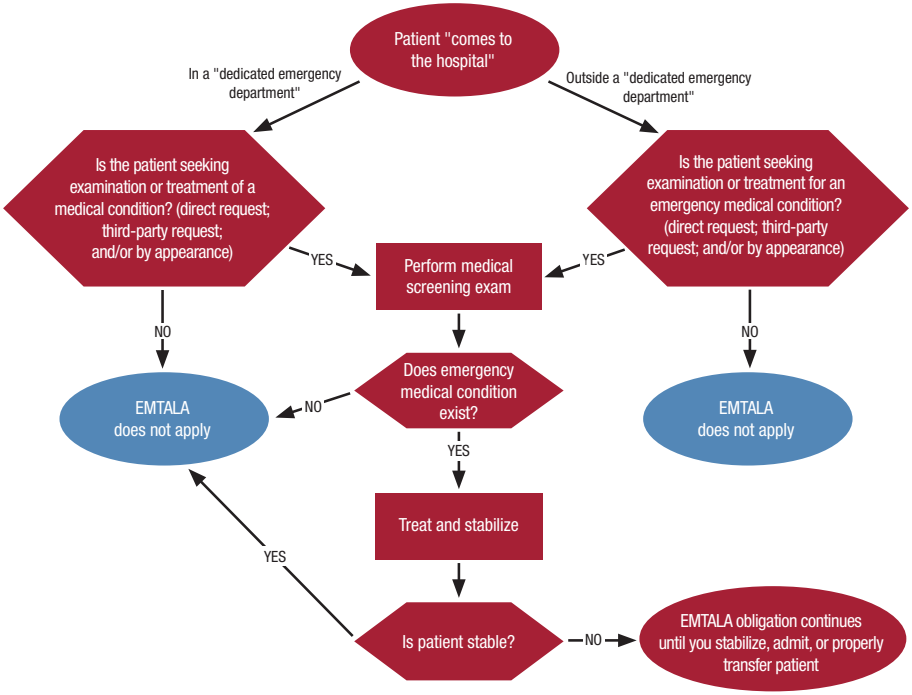
While EMTALA can be complicated, the first step to compliance is ensuring that hospital staff clearly understands which patient presentations trigger an EMTALA obligation in the first place. See Exhibit A for a quick reference decision tree regarding EMTALA's applicability.

The medical screening examination

Once an EMTALA obligation has been triggered, the hospital must perform a MSE on the presenting patient.[22] An MSE is a medical evaluation process performed for the sole purpose of determining with reasonable clinical confidence whether or not an individual has an emergency medical condition.[23] The MSE is not complete merely because a qualified clinician has seen the patient. Laboratory and other tests may be required to rule out an emergency medical condition, and the MSE process can involve more than a presenting law enforcement officer anticipated. Failure to perform a MSE would put the hospital in violation of EMTALA and implicate steep penalties—including potential fines of up to $103,139 per violation—and, more significantly, potential termination from the Medicare program[24] in addition to the risk of private causes of action.

22 42 C.F.R. § 489.20(l).
23 42 C.F.R. § 489.24(a)(1)(i).
24 42 C.F.R. §§ 1003 *et seq.*, 1005 *et seq.*

Exhibit A: EMTALA Decision Tree



Patient Privacy

A hospital's commitment to the privacy of its patients' protected information is never more acute than in an emergency situation involving law enforcement.[25] Confusion and haste can accompany a request for patient information from law enforcement, and it is therefore incumbent upon a hospital and its staff to have clarity and resolve regarding the use and disclosure of patient information

25 With respect to patient privacy rights, when any request for medical records is received, a hospital's obligation is caring for the medical needs and privacy of the patient. This is true regardless of whether the patient is also involved in a criminal investigation, either as a suspect, witness, or victim. It should be recognized by the hospital, however, that law enforcement officials have an important job that may require seeking access to patients, their medical information, or other evidence held by the hospital. Or. Assoc. of Hosp. & Health Sys., Hospital & Law Enforcement Guidance for Conducting Forensic Blood Draws (Mar. 2016), *available at* www.oahhs.org/sites/default/files/forensic_blood_draw_guidance_FINAL_March2016.pdf.

in these situations.[26] The following section will first identify the federal privacy standards and their relationship to state privacy laws, and then address federal guidance related to a hospital's response to requests from law enforcement, hospital-initiated disclosures to law enforcement, and the documentation requirements associated with these disclosures.

Federal privacy standards

The federal standards for the privacy of protected health information (PHI) derive from HIPAA, which dictates that in general, a hospital may not use or disclose the protected health information of a patient except as expressly permitted or required by HIPAA and applicable state privacy laws.[27] In the event a state privacy law is more stringent than what is mandated under HIPAA (e.g., a standard or implementation specification), a hospital must abide by the more stringent state law.[28]

Disclosures in response to requests from law enforcement

A hospital's principal obligation under federal and state privacy laws is the protection of its patients' health information; however, HIPAA's privacy standards establish several situations in which a hospital may—subject to

26 Each hospital may differ in their procedures for releasing information to law enforcement. That being said, every hospital should have a designated privacy officer pursuant to HIPAA who is available as a resource for when requests for information are received. For most institutions, the privacy officer may be the best place to start when law enforcement requests access to PHI and when the request is not a usual and customary experience. Wash. State Hosp. Assoc., Hospital and Law Enforcement Guide to Health Care Related Disclosure (8th ed. 2017), *available at* www.wsha.org/wp-content/uploads/Law-Enforcement-Guide-2017-11.20.17-FINAL.pdf.

27 45 C.F.R. § 160 *et seq*.

28 45 C.F.R. § 160.203(b).

compliance with an applicable exception—permissibly disclose a patient's PHI without authorization when requested by law enforcement.[29] First, a hospital may disclose PHI to a law enforcement official to comply with a court order, subpoena or summons issued by a judicial officer,[30] or a grand jury subpoena.[31] Hospitals must take care to limit such disclosures to the specific requirements of the order or subpoena and not exceed what is requested.[32]

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29 As a gating issue, when a request is received from an official authority, hospitals should have procedures specifying the requirements to verify if the requestor is a law enforcement official. For example, the requirement that individuals identifying themselves as members of law enforcement show their badge or other law enforcement identification. If the request is made by a law enforcement officer by phone, the hospital should have procedures to verify the identity of the requestor, such as a call-back process through publicly listed phone numbers. Am. Hosp. Assoc. & Nat'l Assoc. of Police Orgs., Guidelines for Releasing Patient Information to Law Enforcement (2006), *available at* www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf.

30 The term "judicial officer" is not defined under HIPAA, but has been interpreted in many jurisdictions to be limited to judges, magistrates, and administrative judges, while excluding attorneys for the parties and court clerks. Hospitals and their counsel will need to look to state law regarding treatment of the term "judicial officer" in developing and implementing policies and procedures in this area.

31 42 C.F.R. § 164.512(f)(1)(ii)(A)-(B).

32 In their *Guidelines for Releasing Patient Information to Law Enforcement (AHA Guidelines)*, the American Hospital Association and National Association of Police Organizations propose:

> "(I)f a hospital receives an administrative request, subpoena, or summons, a civil or authorized investigative demand, or other similar process authorized by law, patient information may be disclosed only if each of the following requirements in this "three-part test" are met: (i) Relevance. The information requested must be relevant and material to a legitimate law enforcement inquiry; (ii) Specificity. The request must be specific and limited in scope to the extent possible in light of the law enforcement purpose for which the information is requested; and (iii) Identifiable Information Necessary. De-identified information could not reasonably be used.
>
> The privacy rule says that a hospital may rely on statements in the administrative request, subpoena, or summons or other document in deciding that this three-part test is satisfied. However, a hospital is not required to rely on any document, and should not release the information if the hospital believes the three-part test is not met. Each hospital should develop its own procedures for handling these requests and ensuring the three-part test is met."

Am. Hosp. Assoc. & Nat'l Assoc. of Police Orgs., Guidelines for Releasing Patient Information to Law Enforcement (2006), *available at* www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf.

Outside of an official order or subpoena, a hospital may disclose PHI in response to a law enforcement official's request to identify a suspect, fugitive, material witness, or missing person. In the absence of an order or subpoena, a hospital may only disclose the following information about a patient for identification purposes: name and address, date and place of birth, social security number, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death (if applicable), and a description of the patient's distinguishing physical characteristics.[33]

In addition, hospital emergency department staff frequently encounter patients who present while under the custody of law enforcement. In these situations, a hospital can disclose the patient's PHI to the accompanying law enforcement officer if the disclosure is necessary for the health and safety of the individual or accompanying law enforcement.[34] Law enforcement, however, will often "de-arrest" or otherwise release an individual from custody for the duration of the individual's medical care, and then ask to be notified upon the individual's discharge. Once an individual is released from custody, a hospital may no longer make disclosures of PHI to the accompanying officials, including notice of discharge.[35] In other words, an officer may not release an individual from custody and still retain rights to receive protected details of the individual's care.

Finally, hospitals frequently interact with law enforcement when treating individuals who are suspected victims of crime. Hospitals may disclose information about the victim if the victim verbally agrees to the disclosure.[36] If the patient is incapacitated or other emergency circumstances exist, the hospital may proceed with a disclosure upon request if the following three

33 42 C.F.R. § 164.512(f)(2). Note, the hospital may not disclose for the purposes of identification any PHI related to the individual's DNA or DNA analysis, dental records or typing, samples or analysis of body fluids or tissue. Am. Hosp. & Nat'l of Police Orgs., Guidelines for Releasing Patient Information to Law Enforcement (2006), *available at* www.aha.org/system/files/2018-03/guidelinesreleasinginfo.pdf.

34 45 C.F.R. § 164.512(k)(5)(i).

35 *Id.* at (k)(5)(iii). The victim's agreement may be verbal, although any verbal agreement should be documented in the hospital's records.

36 *Id.* at (f)(3).

requirements are met: (i) the information is needed to determine whether someone *other than the victim* has committed a crime and the information will not be used against the victim; (ii) law enforcement represents that any delay in disclosure would have a material adverse affect on their enforcement activity; and (iii) the hospital, in the exercise of professional judgment, determines the disclosure would be in the best interest of the individual.[37] To ensure the requirements of this exception are satisfied and documented in the hospital's records, hospitals or law enforcement will often use a standard form which requires law enforcement to certify that the patient has agreed to the disclosure or the foregoing three requirements have been met in the event of a patient's incapacitation. Such a form should expressly state the requirements of the exception, the patient's name, the date, the information being requested, the law enforcement agent's name, ID number, agency, and contact informaiton. The form should be signed and dated by the law enforcement agent, and the hospital should retain this and any other documentation related to the request and disclosure in its records.

Disclosures initiated by the hospital

A hospital may encounter certain situations in which it must initiate a disclosure to law enforcement. First and foremost, a hospital emergency department providing care in a medical emergency may disclose PHI to law enforcement if that disclosure is necessary to alert law enforcement to the commission of a crime; the location of the crime or of the victims; and the identity, description, and location of the perpetrator of the crime.[38] Reporting a crime of abuse, neglect, or domestic violence may require additional procedures, and hospital staff should consult with their compliance team and privacy policies in making disclosures related to such crimes.[39] If a hospital suspects a patient has died as the result of criminal conduct, the hospital may disclose PHI to law enforcement in order to alert them of the patient's death.[40]

37 *Id.*
38 *Id.* at (f)(6).
39 Disclosure requirements for crimes of abuse, neglect, or domestic violence are found in 45 C.F.R. § 164.512(c).
40 *Id.* at (f)(4).

A hospital also may voluntarily initiate a disclosure of PHI to avert a serious threat to health or safety.[41] Such a disclosure may be permissible in two situations. First, disclosure is permitted if the hospital, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the general public.[42] Such disclosures must be directed to individuals reasonably able to prevent or lessen the threat, including the target of the threat.[43] Second, disclosure is permitted if the hospital, in good faith, believes the disclosure is necessary for law enforcement to identify or apprehend an individual.[44] A hospital would make such a disclosure if a patient admitted to a violent crime or if the hospital believed a patient had escaped from custody or a correctional institution.[45] Under HIPAA, the good faith belief in any of the foregoing situations must be based on the hospital staff member's actual knowledge or the credible representation of a person with apparent knowledge or authority.[46]

Documentation requirements

In order to navigate the intricacies of these disclosures and interactions with law enforcement, a hospital must implement and maintain effective privacy policies and procedures. HIPAA requires that a covered entity's policies and procedures be reasonably designed for the type of PHI-related activities undertaken by that entity.[47] For any hospital operating an emergency department, interaction with law enforcement is inevitable and hospital staff must be equipped to communicate with law enforcement in a compliant and effective manner.

41 *Id.* at (j).
42 *Id.* at (j)(1)(i)(A).
43 *Id.* at (j)(1)(i)(B).
44 *Id.* at (j)(1)(ii).
45 A use or disclosure pursuant to a statement by an individual admitting participation in a violent crime may not be made if the information in the statement is learned by the hospital: (i) in the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure, or counseling or therapy; or (ii) through a request by the individual to initiate or to be referred for the treatment, counseling or therapy. 45 C.F.R. § 164.512(j)(2). Any such disclosure to law enforcement must be limited to the individual's statement and the PHI identified in 45 C.F.R. § 164.512(f)(2)(i).
46 *Id.* at (j)(4).
47 45 C.F.R. § 164.530(i)(1).

As with any disclosure of PHI made by a hospital, the disclosures to law enforcement discussed above should be documented by the hospital in a manner sufficient to make an accounting of disclosures under HIPAA.[48] This includes documenting the date of the disclosure, the name of the entity or person who received the PHI, and, if known, the entity or person's address, a brief description of the PHI disclosed, and a brief statement of the purpose of the disclosure.[49] If the hospital receives a written request for PHI from law enforcement, such document should be included in the hospital's records and can obviate the need for a statement of the purpose of the disclosure. Also included in the hospital's records should be any formal documents or written notes verifying the identity and authority of the officials requesting or receiving PHI (e.g., credentials or other proof of government status, documents with government letterhead, written statements, subpoenas, warrants, orders, or other legal process).[50] All such documentation should be retained by the hospital in written or electronic form for six years from the date of its creation or from the date when the document was last in effect, whichever is later.[51]

Patient Egress and Confinement

Generally speaking, patients are free to come and go at will from a hospital emergency department. While a patient who decides to leave against medical advice (AMA) should be required to sign forms documenting the departure as being AMA, neither hospital staff nor hospital security has the authority to prevent a competent patient from leaving. This is not true, however, when a patient arrives in police custody, is a prisoner, and/or is being held for an involuntary psychiatric evaluation.

48 A hospital's disclosure to law enforcement of PHI related to an individual in custody is not subject to the same documentation requirements as other disclosures discussed in this article. Such a disclosure is not required to be included in an accounting of disclosures to a patient under 45 C.F.R. § 164.528(a)(1)(vii), and is therefore not subject to the same documentation requirements. For other disclosures not subject to documentation requirements, see 45 C.F.R. § 164.528(a)(1).

49 *Id.* at (b)(2).

50 45 C.F.R. § 164.514(h)(2)(ii-iii).

51 45 C.F.R. § 164.530(j)(2).

The hospital emergency department is often a necessary stop on the way to jail for individuals in custody. It is common practice for jails to prevent intake of medically unstable individuals and to require a medical clearance prior to incarceration. Some states require that any individual needing emergency medical attention receive a medical examination before incarceration.[52] Jails are permitted to require a medical clearance process in the interest of ensuring that detainees do not need immediate medical care, which may not be readily available.[53] The medical clearance may occur on-site at incarceration facilities, but with limited staff and resources, local authorities often choose to utilize EDs for screening purposes. Arrestees who initially arrive with obvious medical conditions, such as active seizures, broken bones, serious blood loss, unconsciousness, or breathing difficulties, are often first sent to an ED for evaluation and stabilization. The procedure may vary based on hospital policy as well as jail policy, but at a minimum, most jails require that an individual be screened by medical staff and monitored as necessary to ensure that any urgent health needs are met. Additionally, some hospitals have contracts and/or statutory obligations to care for incarcerated individuals.

Regardless of the reason for the presentation of the patient in police custody, when an individual arrives at a hospital emergency department in police custody, he or she will have consent, treatment, and privacy rights, but will not be free to leave the hospital while in custody. Police should remain with the patient, affording appropriate privacy for the patient as is necessary, while ensuring that the patient and individuals around the patient are kept safe at all times. In most instances, officers will remain just outside the patient's room or just outside the privacy curtain while a patient in custody receives medical care. The specifics regarding officer proximity and the patient's restraint (e.g., use of handcuffs) during medical evaluation will differ with each situation, depending on the officer's judgment regarding the likelihood of violence or disruption by the person in custody, as well as the officer's ability to react quickly and secure the area in the event an issue arises. Just as the judgment of clinical personnel trumps police authority in deciding what care is given and how long the patient

52 *See, e.g.*, 501 Ky. Admin. Regs. 3:120 (2017).
53 Estate of Allen v. City of Rockford, 349 F.3d 1015, 1020 (7th Cir. 2003).

remains under medical care and evaluation, the authority and judgment of police officers trump when it comes to making decisions regarding the safety and security of the patient and all persons nearby when a person in custody is in the hospital setting. Officers must be free to exercise their judgment and professional expertise in each circumstance. To the extent disagreements arise, requests for escalation to a supervisor can be effective on both sides of the equation; both clinicians and officers have chains of command that can and should be invoked when necessary to deescalate and resolve disagreements relating to the care and treatment of persons in custody.

Another instance in which individuals are frequently retained involuntarily, and will not have the freedom to leave after arriving at the hospital, involves what is commonly referred to as a "72-hour hold" authorized by state law. One of the most well-known examples of a law that allows for involuntary examination and institutionalization is Florida's Mental Health Act of 1971, commonly referred to as the "Baker Act."[54] Under the Baker Act, an individual may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and without care or treatment, the person is likely to suffer or cause certain adverse events. An adult may be held up to 72 hours for involuntary examination, and minors may be held for up to 12 hours only.[55] Many other states have adopted similar laws.[56] It is incumbent upon each hospital to consult local counsel if questions arise as to the supportability of a police officer's request to confine a patient to the hospital in situations where the patient is to be confined for mental health issues, and not because he/she is under arrest.

Law enforcement officers are key actors in a hospital's ability to safely process and treat patients whose rights of ingress and egress are limited.

54 Fla. Stat. § 394.451 *et seq.*
55 Fla. Stat. §§ 394.451–394.47891.
56 For example, California's Lanterman-Petris-Short Act authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes them a danger to themselves, a danger to others, a danger to property, and/or gravely disabled. Cal. Welf. & Inst. Code § 5000 *et seq. See also* Tex. Health & Safety Code § 573 *et seq.*

Hospital security officers[57] also may play a role, and it is critical that all participants in the process follow strict protocols for the safety and well-being of the patient, staff, and other nearby individuals. Vigilance is required, and frequent policy review, training, and collaboration with law enforcement may prevent tragedies from occurring in these potentially volatile circumstances.

Hospital Policies and Training

Throughout this article, the authors have recommended that hospitals ensure that appropriate policies are in place, updated regularly, reviewed with legal counsel as necessary, and most importantly, communicated to appropriate staff and other stakeholders (such as the local police force) in an effort to prevent or minimize disruption and conflict in the emergency department. Specifically, hospital compliance officers and legal counsel should review their hospitals' existing policies applicable to the following: (i) consent for treatment in the context of a patient in police custody; (ii) EMTALA and the hospital's screening procedures for patients who present in the custody of law enforcement; (iii) patient privacy rights while in the custody of law enforcement officers; and (iv) hospital security and patient confinement in the context of the emergency department. If the hospital does not have policies specifically addressing these topics, policies should be developed and implemented immediately. In the event such policies exist but appear to be in need of revision, revisions should be promptly initiated, including reviews by counsel familiar with the *Birchfield* case.

Once appropriate policies have been identified and drafted and/or revised, hospital administration should reach out to local law enforcement leadership

57 Hospital police provide services in their respective jurisdictions pursuant to specific enabling laws. To most patients, visitors, and staff, hospital law enforcement officers are out of mind because they are quietly and efficiently doing their job. Most days, serving in a hospital as a law enforcement officer is just being a friendly face in the hospital and answering questions for patients and visitors. At JPS, as is probably the case with many hospitals, law enforcement officers are provided a high level of customer service and dispute resolution training. Each hospital law enforcement agency determines its use of force standards, but it is understood most should employ the lowest level needed to achieve safety and compliance in a given circumstance.

to schedule a proactive face-to-face meeting to discuss any policy changes that will impact police procedures in the emergency department. This will allow law enforcement leadership to identify any points of disagreement in a candid but supportive environment where hospital leadership can answer questions in a thoughtful and deliberate manner, which should avoid later disruption and discord in the clinical setting. A specific date for rollout of the new polices/procedures should be clearly identified, with further discussion or collaboration offered, if necessary, to move forward under the new policies in a manner that will be efficient and non-disruptive for all concerned.

After hospital and law enforcement leadership have collaborated regarding emergency department protocols, the hospital will need to train relevant personnel and stakeholders on the new policies. Even the most up-to-date, well-written policies are of limited use if they sit on a shelf or are filed away and not correctly implemented through effective training programs. Effective training, communication, and education between the hospital and law enforcement are critical.[58]

While the issues of consent, EMTALA, privacy, and security are certainly already addressed on a regular basis in different forums throughout the hospital's education and training efforts, it would be most effective to introduce new policies and/or updated policies and procedures in an aggregated format that would address consent, EMTALA, HIPAA, and security in the specific context of interacting with police officers in the emergency depart-

58 HITECH and HIPAA require the training of staff regarding the safekeeping and disclosure of PHI. *See* 42 C.F.R. § 164.530. Similarly, EMTALA compliance requires that policies not only be in place, but that they be actively enforced by the hospital. U.S. Dep't HHS, CMS, State Operations Manual: Appendix V–Interpretive Guidelines–Responsibilities of Medicare Participating Hospitals in Emergency Situations, pt. II, TAG A-2-406/C-406 (July 16, 2010), *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf.

American Health Information Management Association (AHIMA) provides guidance for privacy and security training. Kathy Downing et al., *Privacy and Security Training (2013 Update)*, Am. Health Info. Mgmt. Assoc. (Oct. 2013), http://bok.ahima.org/doc?oid=107052#.Wr0swtTwbcs (last visited Apr. 6, 2018). The guidance reaffirms the necessity of training and recommends the training should be implemented through an organization's "normal or existing organizational educational operations," and ongoing updates and documented evidence of compliance in a written or electronic form should be retained for a minimum of six years.

ment setting. Context-specific training will be more effective than briefly and generally mentioning these issues throughout several different sessions that may cover a wide variety of subject matters. Training for emergency department staff, in particular, must regularly address issues that arise specifically in the context of interactions with law enforcement, including EMTALA scenarios specific to presentations for evidentiary tests, consent laws, the recent Supreme Court ruling against involuntary blood draws, HIPAA and state patient privacy rules, and how procedures will differ for incarcerated patients. Training should include education on the scope of authority granted to internal security as well as to police officers on the premises, and when and how staff members should escalate an issue if there is conflict between hospital policies and a request from law enforcement.

Staff in the ED must feel supported and educated as they face these issues, and training needs to be an ongoing process, not a static session that occurs once a year. Ideally, training will include regular updates through newsletters, email alerts, and pop-up screens that personnel will regularly encounter in carrying out their job duties at the hospital. The ideal training scenario also will include participation and input by local law enforcement in collaborative sessions regarding policy development and training of officers on resulting hospital policies.

Conclusion

While the authors were researching and writing this article, a man was brought to JPS by law enforcement for a psychiatric evaluation because he had been found incoherent and disoriented on the streets of downtown Fort Worth. While the circumstances suggested intoxication, a staff member noticed that the man was exhibiting signs specific to a stroke and life-saving interventions were initiated.[59] This presentation of a patient similar to that in the *Evans* and *Gooch* cases should serve as a reminder that such patients arrive in hospital

59 *See A Good Catch – Assumptions*, JPS Health Network (Jan. 2, 2018), www.jpshealthnet.org/news/good-catch-assumptions (last visited Apr. 6, 2018).

emergency departments every day throughout the country. It is incumbent upon those who provide legal counsel to hospitals to provide clarity for hospital policies, procedures, and training that are understandable and communicated clearly and frequently to the personnel who interact with officers in the clinical setting. Clear and understandable policies, procedures, and training will empower hospital staff to make potentially life-saving decisions, strive to work collaboratively with law enforcement, and successfully navigate potentially volatile situations in the emergency department, all the while safeguarding the patient's health, well-being, and privacy. J

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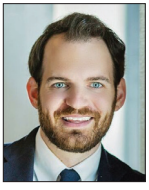

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