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MANAGING LAW ENFORCEMENT PRESENCE IN THE EMERGENCY DEPARTMENT: HIGHLIGHTING THE NEED FOR NEW POLICY RECOMMENDATIONS

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☐ **Abstract—Background: The Emergency Department (ED) is the portal of entry to the health care system for a large percentage of patients. This is especially true for victims and perpetrators of interpersonal violence. Frequently, law enforcement personnel (LEP) accompany patients to the ED or seek access to patients during their ED stay or subsequent hospitalization. The time-sensitive nature of both emergency care and criminal investigation motivates both health care personnel and LEP, and can lead to potential conflicts of interest regarding access to patients in the ED. Objectives: We hope to examine the relationship among patients, providers, and LEP in the ED, and the potential impact these interactions have on patient care. This article presents a review of the relevant literature and policy consideration as well as provides guidance on the development of such policies for EDs. Discussion: Hospitals, EDs, and trauma resuscitation rooms are highly regulated environments, but LEP largely fall outside the ethical and institutional guidelines of health care institutions. Many potential areas of conflict exist when LEP are present in the ED that can have detrimental effects on patient care, provider liability, and LEP efficacy. Patients' perceptions of collaboration between ED personnel and LEP can compromise emergency patient care. Conclusion: There is a need for hospital policies to govern interactions among patients, emergency health care providers, and LEP in the ED.** © **2015 Elsevier Inc.**

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INTRODUCTION

Just over two years ago, the City of Boston was shocked by the heinous terror attack on one of it's premier large public events - the Boston Marathon. The bombing at the finish line killed three people and left hundreds more grievously wounded. The subsequent manhunt resulted in two more deaths including a police officer and one of the suspects. These events that gripped our national attention raised serious questions for politicians, policymakers, and health personnel. For many healthcare providers these traumatic events also illustrated the tensions posed by the presence of law enforcement personnel (LEP) in acute healthcare settings. Such interactions occur every day in less dramatic (but for patients similarly traumatic) fashion. The younger suspect in the case, 19-year-old Dzhokhar Tsarnaev, was critically injured and initially unable to speak due to a gunshot wound to the throat when he was taken into custody. As he lay sedated, LEP remained at his bedside, waiting to interrogate him. LEP were eventually allowed to question Tsarnaev for a total of 16 hours over the course of 3 days, before he was arraigned and read his Miranda rights under the direction of Judge Marianne Bowler. The pre-Miranda interrogation was allowed under the "public

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safety exception" to the Miranda ruling established by the case New York v. Quarles in 1980, which allows LEP to pursue questioning of a suspect when there is concern of imminent danger to officers or the public (1). Although there is much dispute over the extension of the public safety exception in terror cases, this case highlights important policy considerations for health care providers—specifically, Emergency Department (ED) personnel—dealing with more routine cases of criminal suspects under their care.

Patients presenting to the ED are often not well known to the provider caring for them. This lack of familiarity necessitates close collaboration with a wide variety of actors to gather information about a patient's health status and the events that led to their presentation to the ED (2). Such sources of information may include a patient's family, neighbors, primary doctor, emergency medical services personnel, nursing home staff, and even bystander reports. In theory, all parties involved are working with the motivation to improve the health of the patient and assist in their care. In this regard, all actors in the network have similar and overlapping interests.

Frequently, LEP are part of this information network, however, they have a different set of responsibilities and are not accountable to either the same ethical restrictions as health care providers or to hospital administration. Their primary interests lie in protecting public safety, not patient privacy. The presence of LEP in the ED presents a unique conflict of interest for patients, health care providers, and hospitals. It is important to recognize these different motivations when considering how to develop a policy response to govern this interaction between medical and law enforcement personnel.

Few health care institutions have clear guidelines regarding LEP presence in the ED. Under the Health Insurance Portability and Accountability Act, all covered entities, including health care providers and facilities, must adhere to strictly governed procedures about what health information may be shared, how, and with whom (2–7). Furthermore, ethical norms guiding health care providers and LEP differ in some important aspects. The goal of this article is to examine the ethical and legal ramifications of LEP in the ED, and to illustrate the need for a hospital-wide policy to govern the role of LEP in the ED. Finally, this article concludes with specific recommendations regarding the development of such policies.

Law Enforcement and the Emergency Department

The ED is the primary point of entry into the health care system for those affected by a variety of crimes, including episodes of domestic abuse, sexual assault, and gang-related violence (8). Frequently, victims of violence are accompanied to the ED by LEP as part of a prehospital emergency response. The primary objective of LEP is to rapidly initiate investigation of a crime by collecting information regarding the mechanism of injury and the role of the patient in the incident, as well as the patient's prognosis (5). The accuracy of such information degrades with time (9). For this reason, many jurisdictions allow LEP presence for rapid acquisition of information related to potential criminal activity. Although LEP presence in the ED has long-standing historical precedents, in only very rare instances is this presence governed by the law or hospital policy. It is a practice most often implicitly allowed rather than prescribed by law, and the position of professional societies point to adherence to local laws that many times are lacking (10).

Complicating matters are the varied interpersonal relationships that exist between emergency medicine (EM) providers and LEP. This includes the collegial camaraderie between EM providers and all first responders, or may even be of a more personal nature. For the proper function of the ED, its providers, and for the community as a whole, it is vital that these relationships be kept in good standing. However, providers must be careful never to do so to the detriment of their patients and the care they provide.

Patients may be unable (or unwilling) to speak with LEP during their initial evaluation, causing LEP to sometimes turn to ED staff to obtain the information they require (11,12). Hospital personnel are frequently caught between the desire, as a health care provider, to focus on patient care, and the desire to avoid obstructing a police investigation.

This conflict is further intensified as the presence of LEP in the ED can impact the quality of care provided. Patients may perceive that their health care team is collaborating with LEP, which can result in withholding information that is vital to their diagnosis and care. Alternatively, patients may feel implicit pressure to cooperate with LEP (even if they feel it is against their interest) if they perceive that their care will be dependent on such cooperation. Such conflicts can place emergency physicians in an untenable situation.

There are times when patients' personal health information must be shared with authorities without a patient's specific approval – for example, in the case of mandated reporting of domestic, child, or elder abuse; or of certain disease entities that must be reported to public health authorities (3–5). In these exceptional instances, physicians are required by law to subordinate patient confidentiality for a defined public good—when the importance of relaying confidential patient information outweighs the ethical obligation of maintaining patient privacy (4–7). Legislation clearly delineates in what instances such violations need take place, what types of information are reported, to whom this information may be