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SPECIAL CONTRIBUTION

Ethics

Best practice guidelines for evaluating patients in custody in the emergency department

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Abstract

Patients in custody due to arrest or incarceration are a vulnerable population that present a unique ethical and logistical challenge for emergency physicians (EPs). People incarcerated in the United States have a constitutional right to health care. When caring for these patients, EPs must balance their ethical obligations to the patient with security and safety concerns. They should refer to their institutional policy for guidance and their local, state, and federal laws, when applicable. Hospital legal counsel and risk management also can be helpful resources. EPs should communicate early and openly with law enforcement personnel to ensure security and emergency department staff safety is maintained while meeting the patient's medical needs. Physicians should consider the least restrictive restraints necessary to ensure security while allowing for medical evaluation and treatment. They should also protect patient privacy as much as possible within departmental constraints, promote the patient's autonomous medical decision-making, and be mindful of ways that medical information could interact with the legal system.

KEYWORDS

autonomy, carceral, custody, incarcerated, law enforcement, prison, shackling

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1 | INTRODUCTION

In 1976, the Supreme Court ruled that deliberate indifference to an incarcerated person's serious medical needs was cruel and unusual punishment under the Eighth Amendment of the Constitution.[1,2] Nonetheless, this patient population faces significant barriers to accessing quality health care. Patients in law enforcement (LE) custody rely on officials to recognize serious medical need and to facilitate evaluation by healthcare professionals.[3,4] Correctional settings also often fail to ensure persons with chronic medical conditions continue to receive routine medical care.[5] Unique ethical and logistical challenges emerge when patients in LE custody are ultimately brought to the emergency department (ED), and the health care and criminal justice systems intersect.[6]

When caring for patients in custody, emergency physicians (EPs) balance duties to their patients, public safety, and the safety of the healthcare team. Many layers of policy and legislation influence interactions with patients in custody; however, these policies and statutes often lack clarity and vary based on geographic location and jurisdiction. In 2023, the American College of Emergency Physicians (ACEP) approved its first overarching policy on approaching care of patients who are in custody (Table 1).[7] This paper provides further practical guidance for treating adult ED patients in LE custody, including patients who have been arrested and are pre-trial and those who are incarcerated post-conviction.

2 | SECURITY CONSIDERATIONS AND DUAL LOYALTY

LE personnel are responsible for maintaining public order and managing public safety.[8] Their actions are governed by the internal protocols of the facilities they represent and relevant statutes, which differ depending on local, state, and federal jurisdiction. Actions or events that pose a security risk, such as the likelihood of potential escape or harm to the public, are of primary concern to LE. Simple actions routinely performed in the care of ED patients may compromise patient security. For example, contacting surrogate decision-makers could result in a security risk if the patient's location is disclosed.

EPs interactions with LE are complex and can be influenced by both positive and negative perceptions EPs have of the criminal justice system and LE presence in the ED.[9,10] "Dual loyalty" is an ethical framework used to describe the conflict healthcare professionals feel when their duty to the patient is at odds with their duty to a third party like the state.[11] In general, transparent communication between EPs and LE should be used to identify and meet the medical needs of the patient, the security needs of LE, and the safety needs of the healthcare team.[12,13]

3 | PRIVACY, CONFIDENTIALITY, AND RESPECT FOR AUTONOMY IN THE PATIENT ENCOUNTER

3.1 | History taking

Patients may not feel comfortable disclosing personal information with officers in the room. EPs may request that officers step out of earshot[14] during history-taking; however, officers may decline this request due to protocol or security concerns. If so, physicians may ask to speak to the LE supervisor to state the EP's reasons for their request or document that the request was made.

EPs may also request that officers turn off recording devices, such as body cameras, during history-taking.[15] Ideally, both the EP and the patient should consent to recording.[16]

The patient's history should be taken directly from the patient as much as possible. If necessary, it is appropriate to obtain collateral information from correctional officers or institutional paperwork understanding that these sources may be potentially biased. Documentation should make clear what information was provided by the patient and what information was provided from other sources. Patients with limited English proficiency should be offered a qualified medical interpreter to assist with history-taking.[17]

In some situations, knowing whether a patient has had violent behavior toward healthcare staff in the past can prepare EPs and other care professionals to be more vigilant during the patient encounter. Otherwise, soliciting or seeking information about the crime or offense a patient may have committed for any non-medical- or non-safety-related reason is inappropriate. Doing so can contribute to further stigmatization of this population and bias care.

3.2 | Physical examination

It is justifiable for healthcare staff to request adjustment or removal of restraints to deliver needed medical care, including an appropriate medical examination. If agreement cannot be reached regarding whether non-medical restraints can be adjusted or removed, and the restraints are judged to compromise care, speaking to a supervisor (such as a warden) or hospital legal counsel may be helpful.

EPs should use appropriate draping techniques for sensitive examinations such as genitourinary and rectal exams. To limit unnecessary exposure of the patient and protect patient privacy, EPs may request that officers step out of the room during the exam. If this is not possible due to safety and security concerns, alternatives include requesting that officers stand where they cannot view the exposed patient or requesting that only gender-concordant officers be present.

TABLE 1 American College of Emergency Physicians' (ACEP) recommendations for evaluating patients in custody in the emergency department.

1. Physicians have a responsibility to respect the autonomy, privacy, and dignity of patients in custody and to recognize the security and safety concerns of law enforcement, the care team, and the community. EPs should work with patients and stakeholders, including law enforcement, to evaluate each situation based on available information and act accordingly.
2. Under EMTALA, physicians are required to provide these patients with an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists.
3. Post-conviction patients who are incarcerated have a constitutional right to health care under the Eighth Amendment.
4. Patients in custody make their own medical decisions if they have decision-making capacity. They may also appoint a surrogate decision-maker using a written advance directive, medical power of attorney, or verbal designation. Physicians should communicate with law enforcement officers when surrogate or emergency contact information is needed.
5. It is ethically unjustifiable for wardens or other prison officials to serve as a patient's surrogate decision-maker unless explicitly chosen by the patient.
6. Considerations during the patient encounter:
   a. History-taking
      i. As much of the history as possible should be obtained from the patient. In situations where the patient only can provide limited history, collateral sources of information, including accompanying officers, may be helpful.
      ii. Consider asking officers to turn off recording devices (such as body cameras) and to step out of earshot (if caregivers' safety can be assured) while the history is being taken. Officers may decline this request due to relevant policy or safety concerns.
      iii. Unless directly related to medical decision-making or safety concerns, neither look up nor solicit information about the crime or offense these patients may have committed as it can further stigmatize them and bias care.
   b. Physical examination
      i. Use appropriate draping techniques during the physical examination. Examine sensitive areas such that they cannot be easily viewed by others in the room or request that only officers who are gender-concordant with the self-identified gender of the patient be present in the room during sensitive exams.
      ii. Communicate with law enforcement officers to facilitate necessary physical examination and delivery of care. This may involve requesting non-medical restraints be adjusted or removed, which may not be honored if a security risk is posed.
   c. Documentation
      i. Documentation of the patient encounter should accurately describe the chief concern, its related symptoms, and should justify medical decision-making.
      ii. Avoid using stigmatizing language.
      iii. Given variable recognition of physician–patient privilege in court and exceptions to HIPAA when law enforcement investigates criminal activity, EPs should not guarantee to the patient that information shared verbally by a patient or documented in the ED note will not be used as evidence in court.
   d. Disposition
      i. Share decision-making with the patient, if possible.
      ii. Absent a legal directive, court order, or patient consent, share with law enforcement officers only the personal health information necessary to ensure that the patient gets proper follow up and aftercare. The details of medical decision-making should not be shared with law enforcement.
7. Considerations from a law enforcement and security perspective:
   a. Law enforcement's main priorities are to maintain public order, manage public safety, supervise patients in custody, and ensure these patients remain detained.
   b. Recognize that sharing certain information with a patient, their surrogate decision-makers, or their emergency contacts (such as patient location and timing of follow-up appointments) may pose a security risk. Communication and consultation with law enforcement officers before sharing information may help mitigate this risk.
   c. EPs should make a reasonable effort to preserve physical evidence and maintain chain of custody.
8. Patients in custody may accept or decline interventions such as physical examination and diagnostic workup if they have decision-making capacity, but this is not an absolute right. Circumstances in which they may not refuse interventions include, but are not limited to, the following:
   a. They may not refuse testing or treatment for high-risk communicable diseases that pose a public health risk (such as tuberculosis and bacterial meningitis).
   b. They may not refuse involuntary treatment of agitation if they pose a danger to themselves or others.
   c. They may not refuse additional forensic testing on specimens that have already been collected for medical reasons.
9. If patients in custody do not consent to an intervention (such as diagnostic workup, physical examination, or a body cavity search) and there is no medical indication for the intervention, it should not be performed in the emergency department.
10. As stated in the ACEP policy Law Enforcement Information Gathering in the Emergency Department,[14] EPs may conscientiously object to complying with legal orders that violate the rights or jeopardize the welfare of their patients acknowledging that there may be legal ramifications to these actions.

Abbreviations: ED, emergency department; EMTALA, Emergency Medical Treatment and Labor Act; EP, emergency physician; HIPAA, Health Insurance Portability and Accountability Act of 1996.

3.3 | Disposition, care transitions, and information-sharing

EPs should use shared decision-making as would be done with any other patient. They should also inform patients about their results and future care plans unless laws or court orders dictate otherwise. Clear verbal instructions are imperative as patients in custody are generally not allowed access to paper discharge instructions. Accessing their own medical records, if permitted by law in the jurisdiction, can also take weeks and may involve significant expense. An important exception to what can be shared with patients in custody includes sharing the specific date, time, and location of scheduled follow-up appointments as this information can present a security risk. EPs can also ask LE officers for guidance on the types of discharge information that can potentially compromise security.

Sharing disposition-related information with LE officers is often necessary and involves balancing security concerns with the duty to protect patient confidentiality. Officers can be updated on a patient's clinical status (such as "stable" or "critical") and estimated timeline for results and disposition. Physicians are not obligated to describe to officers why certain tests or imaging are being done. If LE requests protected health information (PHI) such as specific test results, EPs may honor this request if the patient consents, applicable laws or regulations mandate reporting of the information, or LE officers produce a court order or subpoena requiring release of this information.[16] Requests for PHI from other entities, such as attorneys, can be filed using normal hospital procedures.[18] In general, any release of information should occur after consultation with hospital legal counsel. Rarely is there an emergent need to release information requested in a deposition or subpoena.

Care transitions require extra attention in this patient population given the uncertainty of their ability to follow up with outpatient healthcare professionals. If the patient is incarcerated in a correctional facility with an infirmary, communication with infirmary medical staff is vital in assuring continued care. Discharge instructions should provide specific recommendations for specialty or primary care follow-up, prescriptions (including over-the-counter medications that may not be easy for the patient to procure), and care instructions.

3.4 | Documentation

Documentation of the patient's history should be limited to the chief concern and an account of its related symptoms or injuries while avoiding stigmatizing language (such as "offender") or bias. Documentation of the physical exam should be an accurate and neutral depiction of what is found. For example, any wounds found should be described in terms of location and appearance without documenting their assumed origins. Like other ED patients, documentation should provide sufficient information to justify medical decision-making and communicate the disposition plan to other physicians. EPs may reassure the patient that they will document only information necessary for medical care. However, as described later, EPs cannot guarantee that information shared or documented will not be used as evidence in court.

4 | PATIENTS IN CUSTODY ARE THEIR OWN MEDICAL DECISION-MAKERS

Like any other patient, adult patients in custody who have decision-making capacity can provide informed consent and refusal for any medical intervention except in limited circumstances discussed below.[19] These patients have the right to be properly informed of their diagnosis, prognosis, and treatment options.[20–22] If an EP suspects a patient lacks capacity, they must perform a standard evaluation for decision-making capacity.[23] Some jurisdictions recommend that a psychiatrist be involved in capacity determinations, but doing so is at the EP's discretion. If a patient is judged to lack capacity, EPs must rely on legal surrogate decision-makers if they exist and can be reached.

4.1 | Surrogate decision-maker identification

Persons in custody can appoint a surrogate medical decision-maker using a medical power of attorney for health care (a form of advance directive) or by verbal designation.[24] Any contact, advance directive, or guardianship information that corrections or LE officials have for a patient should be provided to the ED as needed.[20] If LE officials do not appropriately facilitate access to this information, hospital legal counsel can be a useful mediator. In cases where a patient has not or is unable to identify a surrogate decision-maker, statutory surrogate hierarchy lists should be followed when possible. In the absence of any identifiable surrogate, EPs can seek advice from their institutional ethics committee by contacting the ethics consultation team or individual on call.[14,25]

Although frequently presumed to be appropriate by healthcare professionals,[26,27] it is ethically imprudent for wardens or other prison officials to serve as a patient's surrogate decision-maker unless explicitly and non-coercively chosen by the patient. Courts have repeatedly ruled that prison officials and LE officers are not court-appointed legal guardians and cannot make medical decisions for individuals in custody.[20,28] Moreover, correctional personnel have significant potential conflicts of interest if asked to serve as surrogate decision-makers for those in their custody, including making decisions based on the cost of treatment to a correctional institution.[25]

4.2 | Patient refusals

Generally, if patients have decision-making capacity, EPs should honor informed refusals of medical interventions out of respect for patient

autonomy. However, this is not an absolute right and may be overridden by an EPs' duty to protect public health and safety. These patients may not refuse, for example, testing or treatment of highly communicable diseases such as tuberculosis or bacterial meningitis.[29] In some states,[30] patients also may not refuse testing for blood-borne diseases like HIV in the setting of an occupational exposure. In these situations, it is justifiable to override the patient's autonomy given the risk of transmitting a potentially fatal illness. EPs also must balance these duties when having to treat those in custody with psychotropic medications. The US Supreme Court held that those incarcerated may be involuntarily medicated if they are a danger to themselves or others and the treatment is in their medical interest.[22,31,32]

If a patient in custody *without* decision-making capacity demonstrates either verbal or non-verbal refusal of interventions such as laboratory workup or physical evaluation, physicians may honor this refusal when proceeding is likely to cause more harm than benefit. It may be impractical, traumatizing to the patient, detrimental to the patient–physician relationship, and dangerous to staff to restrain a non-assenting patient to forcibly perform an intervention such as a blood draw or physical exam. Reasonable care should be provided until the patient regains capacity. Physicians can also utilize and recruit surrogate decision-makers for assistance if they are available. Asking the patient about their needs and other methods of conflict resolution may persuade the patient to assent to care.

5 | EXTENT OF MEDICAL EXAMINATION AND WORKUP

EPs are often asked to evaluate patients in custody for "medical clearance" prior to taking the patient to jail to be processed by the criminal justice system. EPs may also be asked to determine if a patient with a chronic medical condition without acute concerns is "fit for confinement." The Emergency Medical Treatment and Labor Act (EMTALA) of 1986 requires that physicians perform "an appropriate medical screening examination" to determine if a patient is suffering from "an emergency medical condition."[33] This federal statute requires EDs to provide as comprehensive an examination and workup as is dictated by the patient's clinical situation. This standard applies to evaluations of patients in LE custody.[34,35] If an emergency medical condition is found, physicians must stabilize it as well as they can with the resources they have. If unable to stabilize the condition, the person in custody should be transferred to a higher level of care that is better equipped for emergency stabilization. EPs are not obligated to comment on whether a chronic illness may be exacerbated while a patient is in custody.

6 | WHAT CAN BE USED AS EVIDENCE FROM THE PATIENT ENCOUNTER

Although there are ethical and legal obligations to protect patient privacy, limits exist to balance individual interests with government interests. "Physician–patient privilege" is the concept that information shared with a physician in a professional setting can be protected from disclosure in legal proceedings.[36,37] In federal courts in the United States, however, the Federal Rules of Evidence (FRE)[38] only afford this privilege to psychotherapists.[37] Some states recognize the privilege absolutely; others recognize the privilege but provide exceptions for evidence relating to serious crimes such as homicide. Therefore, in courts that provide exceptions to or utilize the FRE, physicians may be compelled to testify regarding the medical information of a patient regardless of whether a patient consents. Additionally, information shared by a patient that is not directly related to their medical care may not be privileged. If a patient admits something incriminating to a healthcare professional, and it is not relevant to the patient's medical care, this information can be used as evidence, and a physician may be compelled to testify.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is federal law that regulates disclosure of certain PHI. Under the Privacy Rule mandated by HIPAA, special circumstances permit covered entities (including hospitals and physicians) to disclose PHI to LE officials without a patient's written authorization.[39] As a result, medical records—including ED documentation—may be admissible as evidence. Records may be redacted to show only information relevant to the patient's medical care and diagnosis at the time of the encounter.[40]

In general, given the variability of recognition of physician–patient privilege and potential exceptions to HIPAA, EPs cannot guarantee that information shared with them verbally by a patient or documented in the ED note will not be used as evidence in court.

7 | OBTAINING FORENSIC EVIDENCE

In service of legal investigations, LE may request that ED staff gather forensic evidence from a patient actively undergoing emergency care. LE may produce a warrant or court order that directs EPs or staff to perform these interventions. LE may also request interventions to obtain evidence without a warrant or court order through implied consent laws. Implied consent laws provide that as a condition of driving on state roads or obtaining a driver's license, drivers give implied consent to testing— including breath, blood or urine tests—if suspected of driving under the influence. Conscious patients can refuse a blood draw for serum ethanol testing, but they may face civil or criminal sanctions for their refusal.[41] In unconscious patients, inadmissibility in court of a testing result depends upon state law. In one case, the US Supreme Court ruled that if a state's law determined that a blood draw in an unconscious patient was permissible under its law of implied consent, it is not unconstitutional to use that specimen for evidence.[42,43]

Performing more invasive procedures—such as retrieval of drugs, bullets, or other items—on patients in custody has been deemed to violate constitutional protections of the Fourth Amendment. An appellate court found that an EP intubating and sedating an incarcerated individ-

ual to retrieve rectal drug packets violated the patient's constitutional rights.[29,44]

EPs are presented with a difficult situation when LE officers request an intervention to obtain evidence—with or without a warrant—on a patient in custody who declines to have the intervention performed. ACEP's "Law Enforcement Information Gathering in the Emergency Department" policy articulates the complex competing obligations in these situations.[16,45] Ultimately, if a patient does not consent to an intervention (such as diagnostic testing, physical examination, or a body cavity search) and there is no medical indication for the intervention, it should not be performed in the ED. EPs may conscientiously object to complying with legal orders that violate the rights or jeopardize the welfare of their patients. EPs should also recognize that they may face legal repercussions for these decisions, including contempt of court or malpractice claims.[16] Thorough documentation regarding the situation and medical decision-making can be useful if an EP's decision is later called into question.

8 | SPECIAL POPULATIONS

8.1 | Pediatric patients

Pediatric patients are particularly vulnerable population that rely on parents or guardians to advocate and legally make medical decisions on their behalf. LE interfaces with pediatric patients in numerous ways: the patients themselves may be in custody, LE may be present for investigation of child abuse or neglect, or the patient's parent or guardian may be involved in the criminal justice system. Schultz et al recommend EPs advocate for these patients by ensuring that a parent or guardian is involved in the patient's medical care and aware of LE presence. They also recommend collaborative communication with LE to protect the rights of these patients.[13]

8.2 | Pregnant patients

Multiple professional organizations, including the American College of Obstetrics and Gynecology (ACOG), have advocated for the prohibition of shackling in this population because of the risk of falls, venous thromboembolism, and impediment to assessment and intervention.[46,47] In 2018, the First Step Act instituted a number of federal prison reforms, including the general prohibition (with limited exceptions) of shackling during pregnancy and up to 12 weeks postpartum.[48] This federal law, however, only applies to those incarcerated in federal facilities. The American Civil Liberties Union provides state-specific information on pregnancy-related health care and abortion care for those in prison.[49]

9 | CONCLUSION

Further advocacy and consultation with relevant stakeholders, including those who have experienced being an ED patient while in LE custody, will contribute to continual improvements in care delivery. Finally, the subject covered in this paper is vast, complex, and shaped by shifting cultural, political, and legal climates. The issues addressed here will need to be frequently revisited to meet the needs of the patients that EPs serve and the values of the profession of emergency medicine.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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