

COMMENTARY

Confidentiality and the Incarcerated Patient in the Community Setting

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Hippocratic Oath: “Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.”

It is rare that medical professionals are specifically trained about the ethical, legal, and practical aspects of caring for incarcerated patients despite the fact that it is not an uncommon occurrence. When faced with a patient dressed in a bright orange or red jumpsuit who is shackled in cuffs and chains, I often find that medical providers go about their business trying not to acknowledge that the patient is incarcerated. This is not the best approach as it ignores the role of the correctional officer that is ever present in the room. When people are incarcerated, they lose many rights, including the right to freedom of movement and the right to vote, but they do not lose the right to confidentiality except for certain exceptions mandated by federal and state law.

Disclosure of protected health information (PHI) to the correctional officer can occur in two distinct ways: 1) There can be the direct or active transfer of information to the officer, or 2) the officer can passively overhear the exchange of information. When is it appropriate to tell a non-medical professional PHI? The Health Insurance Portable and Accountability Act (HIPAA) privacy regulation makes allowances for a health care provider to disclose PHI if he/she believes that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the public and the disclosure is to persons reasonably able to prevent or lessen the threat. For example, an emergency room physician can report to law enforcement authorities the extent and location of injuries if a

patient has wounds consistent with being stabbed, shot, or involved in a crime in some way. However, it is important to note that not all disclosure laws create an *obligation* to make such a disclosure; some laws simply *allow* the disclosure without penalty. In most circumstances, a patient’s PHI has no relation to the public’s safety and therefore cannot be used as a reason to disclose to law enforcement authorities. The American Medical Association (AMA) states that when the law or a court order requires the disclosure of confidential information, physicians generally should notify the patient.

Laws usually also allow a health care provider to disclose PHI about a patient without the patient’s consent to the extent the recipient *needs* to know. The difficulty is determining when a law enforcement officer truly *needs* to know PHI. For continuity of care, disclosure can be made to an official of a penal or custodial institution where the patient is detained, but when possible it would be preferable to give the PHI to a medical professional from that facility. When a patient is discharged from a hospital back to a correctional facility, it is important that the receiving medical provider receive a summary of the patient’s hospital stay. Similarly, if a patient is sent out to the community for specialist consultation, the recommendations should be given to the correctional medical provider by calling them by phone or giving the officer the written information in a sealed envelope, but they should not be verbally given to the officer to pass on. Although it is appropriate to

disclose some PHI to the law enforcement officer who brought the patient to the medical center, disclosure should be limited to demographic information, clinical condition as opposed to diagnosis, estimated or actual discharge date, and extent and location of injuries when admitted. It can sometimes be necessary to disclose PHI about an inmate to a correctional officer if it impacts the health and safety of the staff at the correctional facility or the persons responsible for transporting the inmate. For example, if a patient is diagnosed with pulmonary tuberculosis, then the need for airborne precautions and a contact investigation is necessary to disclose. For most other diseases, universal precautions would be sufficient, and disclosure would not be necessary. No matter the reason for disclosure of PHI directly to a non-medical professional, only the minimal amount of PHI needed should be shared.

Alternatively, PHI can be passively disclosed to the correctional officer guarding the patient by speaking to or about the patient in his/her presence. Guarded patients can be maintained within line of sight of the officer but do not always need to be within earshot of the officer especially when the patient’s medical history is being obtained or the inpatient team is rounding. On the other hand, during an exam, incarcerated patients should be afforded visual privacy by standing behind a curtain or other barrier at which time the officer can be within earshot to maintain safety.

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There are several reasons why it is of utmost importance whenever possible to have non-medical professionals out of earshot when discussing PHI to avoid passive disclosure of confidential information. In medical school, we are taught that when taking a history of an adolescent, it is important to do so without a parent in the room to respect the privacy of the adolescent and increase the likelihood that accurate information is obtained. Similarly, when taking a history from a person in custody, it is equally important to take the history without the watchful eye of the legal system to obtain more accurate and important information that can impact health outcomes. The AMA specifically recommends that physicians avoid “situations in which an outside observer’s presence may negatively influence the medical interaction and compromise care.”

Respecting the patient’s privacy and autonomy works toward earning the patient’s trust, and the relationship between patient and physician is based on trust. Most incarcerated patients have had poor relationships with authority figures, often starting with their parents, then teachers, principals, and police officers. Medical providers are just another authority figure to many inmates—many of whom have never been engaged in regular medical care. Trust is something earned,

and asking an officer to stand out of earshot is an important first step in earning trust. Due to the innate unequal nature of the relationship between officer and inmate, asking the patient if it is okay for the officer to remain in the room is not valid as the inmate is not truly at liberty to make a free decision. It is better to have the default be that the officer step aside when discussing PHI. Although the safety of medical staff trumps the need for confidentiality, when incarcerated patients are seen in the community setting they are either in shackles and chains or cuffed to an inpatient bed. The safety concern is usually minimal in these circumstances, so confidentiality can almost always be honored.

The disclosure of information in a community setting can also have an impact on the patient’s care behind the walls of the correctional facility. Although officers guarding incarcerated patients in the community must legally uphold confidentiality to the same extent that medical professionals do, they are still seen as non-medical correctional staff in the eyes of the incarcerated patient. The concern about confidentiality is often exaggerated when the patient has a stigmatized diagnosis such as HIV. There is a real risk that officers will share information about blood-borne pathogens with their colleagues out of concern for the

health and welfare of their co-workers and not appreciate the greater benefit of abiding by universal precautions. The knowledge within an incarcerated setting that an inmate has HIV can create such an unpleasant environment for the infected individual that he/she may choose to be in solitary confinement for his/her own safety. I have had experiences with inmates returning from community appointments during which their HIV status was revealed to the accompanying correctional officer. To avoid any further unwanted disclosures of PHI to custody staff, some of these inmates refuse to go to any needed specialty follow-up appointments while others outright refuse any further care for HIV until after release back to the community.

Confidentiality laws and policies surrounding incarcerated individuals are laden with subjectivity. The information necessary to disclose directly to non-medical staff should be limited to only PHI that would avoid immediate harm to the individual or the public. It is equally important to avoid passive disclosure of guarded patients’ PHI while balancing confidentiality with safety. The Society of Correctional Physicians encourages “privacy of sight and sound to the degree possible without creating a risk to the provider or other individuals.” In general, the disclosure of PHI without consent should be the exception, not the rule. *SGIM*