

**EVALUATING THE INEBRIATED:
AN ANALYSIS OF THE HIPAA PRIVACY RULE
AND ITS IMPLICATIONS FOR INTOXICATED
PATIENTS IN HOSPITAL EMERGENCY
DEPARTMENTS**

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I. INTRODUCTION

Consider a hypothetical accident involving an intoxicated driver. A father places his daughter into her car seat and makes sure she is safely buckled in before he settles into the driver’s seat. He stops at a red light and turns to watch his daughter playing in the backseat. After the traffic light turns green and he continues to drive home, a car weaves through the median and slams into the driver’s door. Within moments, the father succumbs to his injuries, and his toddler, now in critical condition, is rushed to the hospital. The police officers’ investigation reveals the driver of the second car had a blood alcohol content far surpassing the legal limit. This hardly comes as a surprise to the officers; every fifty-one minutes that tick by, another person will die in an accident involving an intoxicated driver.²

Complicating this situation even further is the fact that fifteen minutes

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² *Traffic Safety Facts 2012 Data: Alcohol-Impaired Driving*, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN. (Dec. 2013), <http://www-nrd.nhtsa.dot.gov/Pubs/811870.pdf>.

earlier the intoxicated driver had been in a hospital emergency department (“E.D.”). While some may blame the emergency physician for not preventing the intoxicated man from leaving, consider the hypothetical plight of the physician.³ A child with a blocked airway could not be revived, a seemingly healthy forty-year-old woman died of cardiac arrest, and an elderly man slipped into a vegetative state. With no time to dwell on the losses, the physician immediately goes to the next trauma room. A young man in his mid-twenties, with what appears to be a minor injury, is sprawled across the bed, shouting vulgarities and being aggressive toward staff.⁴ The toxicology screen confirms that the patient’s blood alcohol content is over the legal limit. The physician informs the young man that someone will be in shortly to further evaluate him. Shortly thereafter, a nurse informs the physician that the young man has eloped from the E.D.

The physician, in the throes of a life-saving medical procedure with another patient, is stumped. Should she call the police? After all, the patient was considered intoxicated only fifteen minutes prior. If she calls the police, would she be violating the patient’s privacy rights by disclosing personal information? There is not enough time to call the hospital’s legal department, and the physician must focus on the critical situation currently in front of her. Unbeknownst to the physician and hospital staff, the patient who fled the E.D. quickly got into his car and drove haphazardly until ultimately striking the vehicle containing the child and her father.

As this vignette illustrates, emergency physicians who treat and interact with intoxicated patients must walk the line between confidentiality and protecting a third party.⁵ “Traditionally, the physician–patient bond is considered as sacrosanct as that between parishioner and priest. . . . [But], this bond is muddied somewhat when potential for harm to other innocents rests on it.”⁶ Emergency physicians are charged with treating patients expediently and effectively—but as the E.D. is increasingly used as a de facto holding tank for intoxicated individuals, these physicians must also battle to treat all patients in the E.D. without sacrificing public safety.⁷

On December 28, 2000, this conflict between patient privacy and public safety became vastly more confusing: the Health Insurance Portability

³ Peter Tyson, *One Night in an E.R.*, NOVA (Mar. 27, 2001), <http://www.pbs.org/wgbh/nova/body/one-night-emergency-room.html> (“[Dr.] Finkel tells me how busy it normally is. On a recent night[] . . . she charted a patient on average every 11 minutes.”).

⁴ Rob Orman, *Art of the Chemical Takedown*, ERCAST.ORG (June 27, 2014), <http://blog.ercast.org/art-chemical-takedown/> (“An unruly, intoxicated and violent patient rolls into the ED. The situation and the patient are both in need of control.”).

⁵ Chris Cotton et al., *Ethics Roundtable Debate: Is a Physician-Patient Confidentiality Relationship Subserving to a Greater Good?*, 9 CRITICAL CARE 233, 233 (2005), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1175898/>.

⁶ *Id.*

⁷ David W. Ross et al., *EMS Triage and Transport of Intoxicated Individuals to a Detoxification Facility Instead of an Emergency Department*, 61 ANNALS OF EMERGENCY MED. 175, 181 (2013).

and Accountability Act (“HIPAA”) was expanded to establish the Privacy Rule, effectively increasing emergency physicians’ level of trepidation.⁸ As one physician muses, “It is easy to become caught up in obstacles and hurdles that HIPAA can impose on physicians trying to care for patients. Sometimes we long for a no-holds-barred environment unencumbered by rules.”⁹ Though its intent is to safeguard patients’ personal information, the Privacy Rule also compels physicians to identify what information must be kept in the proverbial vault of secrecy and what must be shared for protection purposes.¹⁰ Many providers struggle with this situation.¹¹ This Comment argues that the HIPAA Privacy Rule must be amended to make a physician’s duty to warn of intoxicated patients mandatory in order to provide guidance to physicians, as well as to protect innocent third parties.

First, this Comment will discuss the nuances of the HIPAA Privacy Rule and explain to what extent physicians are able to disclose Protected Health Information (“PHI”). This discussion will examine the current protections of the Privacy Rule and the repercussions for physicians who violate HIPAA.

Second, it will analyze how the situations surrounding intoxicated patients leaving the hospital apply to the Privacy Rule. This examination will elaborate on the need for mandatory disclosure to authorities related to intoxication and will compare this need with physicians’ mandatory duty to disclose information related to the mentally ill.

Lastly, this Comment will propose an amendment to the Privacy Rule to remedy the quandary many physicians feel. This section will define the provision’s scope and will examine how the current Privacy Rule is an inadequate resource for emergency physicians.

II. BACKGROUND

It is well established that drug and alcohol intoxication is a large problem in the United States.¹² Though much of our society recognizes the

⁸ *The Privacy Rule*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacypolicy/index.html> (last visited Mar. 23, 2015); see also Daniel J. Solove, *HIPAA Turns 10: Analyzing the Past, Present and Future Impact*, AM. HEALTH INFO. MGMT. ASS’N (2013), http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050149.hcsp?dDocName=bok1_050149.

⁹ Vijay Aswani, *Doctors, Writing, and HIPAA*, 40 FAM. MED. 623, 624 (2008) (discussing how HIPAA places limits on physicians’ non-medical tasks).

¹⁰ Letter from Leon Rodriguez, Dir. of the Office for Civil Rights, to the Nation’s Health Care Providers (Jan. 15, 2013), <http://www.hhs.gov/ocr/office/lettertonationhcop.pdf>.

¹¹ Carolyn Buppert, *Legal Obligations to the Dangerous Patient*, MEDSCAPE (Aug. 18, 2009), <http://www.medscape.com/viewarticle/707580> (discussing the repercussions to health care providers for notifying law enforcement about intoxicated drivers leaving the E.D.); Aswani, *supra* note 9.

¹² See generally Press Release, Centers for Disease Control and Prevention, Alcohol Poisoning Kills Six People in the US Each Day (Jan. 6, 2015), <http://www.cdc.gov/media/releases/2015/p0106-alcohol-poisoning.html>; *Impaired Driving: Get the Facts*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 13, 2015), http://www.cdc.gov/motorvehiclesafety/impaired_driving/impaired-driv_factsheet.html.

clear impact on the intoxicated individual and his potential future victim, many people overlook the impact on emergency departments and health care providers. The following sections of the Background explain how intoxication affects the emergency departments of American hospitals, how the HIPAA Privacy Rule changes the way physicians must handle situations in the E.D., and what the consequences are for physicians who are in violation of HIPAA.

A. Drug and Alcohol Abuse Affecting the E.D.

The alcohol and drug problems plaguing the United States have a correlative effect on the number of intoxicated patients seen by physicians in emergency departments.¹³ The country's drug problem has been on the rise, with E.D. visits for drug related issues increasing by 81% from 2004 to 2009.¹⁴ In 2009, the most recent reporting year for drug-related hospital E.D. visits, approximately 2.1 million people visited the E.D. for visits related to drug abuse.¹⁵ These visits were comprised of situations related to alcohol, illicit drugs, and non-medical use of prescription drugs.¹⁶ Many intoxicated individuals arrive at the E.D. for treatment solely based on their state of inebriation, and not for urgent medical problems.¹⁷ In some circumstances, paramedics transport individuals to the E.D. after giving the individual the choice of going to the hospital to sober up or being taken to jail.¹⁸ The climate of the E.D. has had to change in order to meet the societal needs resulting from the over-population of intoxicated individuals in the E.D.¹⁹

The financial repercussions of intoxicated driving are significant.²⁰ Studies show that the costs are nearly four times greater for emergency providers to treat drunk drivers than they are for the same providers to treat sober drivers.²¹ And while emergency departments resoundingly experience the financial impact, the time and labor associated with intoxicated patients must not be overlooked.²² Because impaired patients are less likely to accurately describe any symptoms or pertinent medical history, physicians feel compelled to perform more in-depth examinations and order more tests

¹³ *DrugFacts: Drug-Related Hospital Emergency Room Visits*, NAT'L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits> (last updated May 2011).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Robert Donovan, *Jail or ER: An Easy Choice for Drunks*, EMS1 (Apr. 8, 2010), <http://www.ems1.com/communications-dispatch/articles/805135-Jail-or-ER-An-easy-choice-for-drunks/>.

¹⁸ *Id.*

¹⁹ Matt Dunning, *Drunk Patient Lawsuit Highlights Hospital Risk Management Issues*, BUS. INS. (Aug. 25, 2013), <http://www.businessinsurance.com/article/20130825/NEWS06/308259976>.

²⁰ Tiffany O'Callaghan, *The ER Costs of Treating Drunk Drivers*, TIME (Oct. 8, 2009), <http://healthland.time.com/2009/10/08/the-er-costs-of-treating-drunk-drivers/>.

²¹ *Id.*

²² *Id.*

than might have been needed had the patient been sober upon arrival.²³

With the large amount of intoxicated patients in the E.D., health care providers must grapple with patient safety issues and the safety of third parties.²⁴ This situation is quite troubling for many health care providers, including a group of physicians who state that there are many patients in their E.D. who are observed and treated for intoxication when this could occur at a specialized facility for the inebriated.²⁵ Due to the amount of intoxicated patients flooding emergency departments across the nation, it is now considered an average day for emergency physicians to have multiple intoxicated patients sobering up under their watch.²⁶

One such average day occurred at St. Francis Hospital in New York—a patient presented to the E.D. with acute intoxication and left the department shortly thereafter while still intoxicated.²⁷ The emergency physician had granted approval for the patient, Kevin Kowalski, to be admitted to the hospital's detoxification center, but before being admitted Kowalski removed his IV and informed the nurse he would be calling a taxi to take him home.²⁸ When the nurse went out of the room to tell the emergency physician about Kowalski's intent to leave, Kowalski left the E.D.²⁹ The physician declined to contact the police but did inform security personnel within the hospital that the patient was intoxicated.³⁰ A short time after leaving the E.D. on his own, a car struck Kowalski as he walked alongside a road.³¹

In his lawsuit against the physician and the hospital, Kowalski argued that the physician should not have allowed him to leave the E.D. but the court disagreed with the patient.³² In affirming a judgment for the physician and hospital, the court held that “the [New York] common law permitted the restraint of people whose mental state might make them a danger to themselves or others *only in extreme circumstances*.”³³ One might ask what classifies as extreme circumstances, which is why the *Kowalski* case illustrates the unsettling situations facing emergency physicians related to intoxication and disclosure.³⁴

Based on the amount of intoxicated patients visiting the E.D., most

²³ *Id.*

²⁴ Cotton et al., *supra* note 5.

²⁵ Ross et al., *supra* note 7, at 183.

²⁶ *Prepared to Care: The 24/7 Standby Role of America's Hospitals*, AM. HOSP. ASS'N 1, 4 (Nov. 2012), www.aha.org/content/12/preparedtocare.pdf (discussing that an average day for an emergency physician can consist of allowing intoxicated patients to sleep in the E.D. until sober).

²⁷ *Kowalski v. St. Francis Hosp. & Health Ctrs.*, 995 N.E.2d 148, 149 (N.Y. 2013).

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.* at 150.

³³ *Id.* (emphasis added).

³⁴ *Id.* at 149.

hospitals have had to create or alter policies to protect themselves, the patient, and third parties.³⁵ These policies often deal with the regulating of blood alcohol content screening, the permissibility of chemical and physical restraints, and how to prevent premature release of still-intoxicated patients.³⁶ At a minimum, the screening policies should include: “how to facilitate an involuntary commitment, when to call law enforcement officials, what reporting laws might apply to the situation (if any), and how to comply with a *Tarasoff* obligation.”³⁷ Without implementing successful policies, especially in the face of confusion felt by many emergency physicians, the E.D. is more likely to face liability after any incident involving an intoxicated patient.³⁸

While a number of intoxicated patients leave the E.D. without making hospital staff aware, others choose to formally discharge themselves against medical advice.³⁹ Proper documentation for leaving against medical advice is likely to protect hospitals and physicians alike, provided they are executed properly and under the appropriate circumstances.⁴⁰ The documentation ends the relationship between physicians and patients, allows providers the defense that the patient assumed the risk of signing out against the advice of his doctor, and shows a record of the patient’s refusal to be treated.⁴¹

Out of practicality for physicians and patients alike, “it is crucial that patient safety and the safety of third parties, as well as any legal requirements, are considered prior to release.”⁴² Patients who decide to sign out of the hospital against medical advice do so to exercise their own right to refuse care, yet physicians must be sure the patient has the requisite capacity to make such a decision.⁴³ If a physician does not believe the patient has adequate mental capacity to sign out against medical advice, holding the patient involuntarily in the E.D. may be the only viable option.⁴⁴ Physicians are

³⁵ Yesha Patel & Gus M. Garmel, *Management of Intoxicated/Violent Patients*, in EMERGENCY MEDICINE: AVOIDING THE PITFALLS AND IMPROVING THE OUTCOMES 99, 99 (Amal Mattu & Deepi Goyal eds., 2007).

³⁶ *Id.* at 101–06.

³⁷ “Difficult” Patients in the Emergency Department: Guidelines to Reduce your Liability Exposure, EMEDICINE ALERT (Medical Insurance Exchange of California, Oakland, C.A.), May 2010, at 2.; see generally Douglas Mossman, *Article Critique of Pure Risk Assessment or, Kant Meets Tarasoff*, 75 U. CIN. L. REV. 523 (2006) (The Tarasoff obligation, stemming from *Tarasoff v. Regents of the University of California*, places a requirement on mental health providers to both recognize and report a serious threat of violence when one is stated by a patient.); see *infra* notes 101–04 and accompanying text.

³⁸ EMEDICINE ALERT, *supra* note 37, at 2.

³⁹ Patel & Garmel, *supra* note 35, at 105.

⁴⁰ Darren P. Mareiniss, *Protecting EDs & Providers When Patients Leave Against Medical Advice*, PHYSICIAN’S WEEKLY (July 2, 2013), <http://www.physiciansweekly.com/emergency-department-proper-discharge/>.

⁴¹ *Id.*

⁴² Patel & Garmel, *supra* note 35, at 105.

⁴³ Frederick Levy et al., *The Importance of a Proper Against-Medical-Advice (AMA) Discharge: How Signing Out AMA May Create Significant Liability Protection for Providers*, 43 J. EMERGENCY MED. 516, 517–18 (2012).

⁴⁴ *Id.*

advised to observe the patient to determine if the level of intoxication interferes with the requisite capacity for a proper discharge against medical advice.⁴⁵ Furthermore, a patient “may compromise [the legal right to leave the E.D.] if he or she intends to get into an automobile, or in some other fashion may become a danger to himself or others.”⁴⁶ Because intoxicated individuals have a large impact on emergency departments, physicians are in an unfortunate position to balance the rights of these intoxicated patients with the safety and liability of others.

B. HIPAA’s Privacy Rule

Since its implementation in December 2000, HIPAA’s Privacy Rule has created consternation for many physicians about the ability to disclose personal information.⁴⁷ The Privacy Rule adds another layer of concern for E.D. physicians. Though physicians are undoubtedly concerned about the repercussions of violation, the Privacy Rule was enacted as a way to champion the protection of patients’ medical records.⁴⁸ The Rule focuses on a patient’s PHI, which is generally interpreted as information found in a patient’s medical record that can identify the patient.⁴⁹ The scope of PHI is quite extensive—any information that could be used to identify a patient, such as his name, date of hospital admission and discharge, or current medical condition is considered PHI.⁵⁰ Additionally, the Privacy Rule is only focused on disclosures made by covered entities, which are defined as health care providers conducting electronic transactions, health care plans, and clearinghouses of health care information.⁵¹

The Privacy Rule permits disclosure of PHI without requiring authorization from the patient if the circumstance fits into one of the provided categories.⁵² Disclosure is permissible when the law requires it, such as for a

⁴⁵ Mareiniss, *supra* note 40.

⁴⁶ Dan Sullivan, *Alcohol Impaired Patient: Risk Management Recommendations*, THE SULLIVAN GROUP, https://www.thesullivangroup.com/risk_resources/alcohol_impaired_patient/alcohol_9_risk_management.asp (last visited Feb. 22, 2016).

⁴⁷ *What Physicians Need to Know About the HIPAA Privacy Rule*, 5 O’CLOCK RECORDS (July 24, 2013), <http://blog.5oclockrecords.com/post/65066347262/what-physicians-need-to-know-about-the-hipaa-privacy>.

⁴⁸ *What Does the HIPAA Privacy Rule Do?*, U.S. DEP’T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocr/privacy/hipaa/faq/privacy_rule_general_topics/187.html (last updated Dec. 11, 2006).

⁴⁹ *Guidance Regarding Methods of De-Identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html#protected> (last visited Feb. 22, 2016).

⁵⁰ Alice G. Gosfield, *The HIPAA Privacy Rule: Answers to Frequently Asked Questions*, 9 FAM. PRAC. MGMT. 35, 36 (2002), www.aafp.org/fpm/2002/1100/p35.html (discussing what information is generally classified as PHI).

⁵¹ *Are You a Covered Entity?*, CTRES. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/AreYouaCoveredEntity.html> (last updated Apr. 2, 2013, 10:13 AM)

⁵² 45 C.F.R. § 164.512 (2013) (stating the permissible uses and disclosures of PHI that a covered entity can make without the patient’s authorization).

judicial or administrative proceeding or for a specialized government function.⁵³ If public health organizations, health oversight agencies, or law enforcement officers request the information, covered entities are permitted to disclose only the PHI that is specifically requested.⁵⁴ When the patient is a victim of neglect, abuse, or domestic violence, the PHI can also be disclosed.⁵⁵ Disclosure is also permissible for authorized research purposes or when required for workers' compensation claims.⁵⁶ If the patient is a decedent and the medical examiner or coroner requests limited amounts of PHI, the covered entity may disclose this information; further, if the decedent's organs are donated, PHI can be disclosed if needed for the donation process.⁵⁷ Lastly, covered entities may disclose PHI *if it is related to a threat to the safety of the public*.⁵⁸

The most relevant and permissible disclosure for physicians dealing with intoxicated patients is the provision about public safety. If a physician is under the impression that a patient has the propensity to cause harm upon leaving the E.D., disclosure is permissible to law enforcement officers who have the capability "to prevent or lessen a serious and imminent threat to the health or safety of a person or the public[. . .]"⁵⁹

C. HIPAA Violations

The Privacy Rule, championed by much of the public, is patient-centric—the Rule provides increased control to patients and more significant consequences for health care providers.⁶⁰ While patients and patient advocates laud the Rule, physicians who must wrestle with its disclosures cannot help but see it as yet another opportunity for liability.⁶¹ Both civil and criminal penalties can occur when a covered entity violates the Privacy Rule.⁶² "[F]ear of liability for violating HIPAA, coupled with [a] misunderstanding of its provisions, can be a recipe for not sharing, even in circumstances where such sharing is expressly permitted and arguably important for patient care and/or public safety."⁶³ In essence, physicians feel

⁵³ *Id.* § 164.512(a)(1).

⁵⁴ *Id.* § 164.512(b), (d), (f).

⁵⁵ *Id.* § 164.512(c)(ii).

⁵⁶ *Id.* § 164.512(i).

⁵⁷ *Id.* § 164.512 (g), (h).

⁵⁸ *Id.* § 164.512 (a)(1), (b)(1), (c), (d) (emphasis added).

⁵⁹ *Id.* § 164.512(j)(i)(A).

⁶⁰ U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 48.

⁶¹ Donna Bowers, *The Health Insurance Portability and Accountability Act: Is it Really All That Bad?*, 14 BAYLOR U. MED. CENTER PROC. 347, 348 (2001), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305898/pdf/bumc0014-0347.pdf> ("Health care providers believe that the privacy rules will impede their ability to treat patients. Health care organizations are worried about their ability to comply since the rules are quite complicated.")

⁶² U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 48.

⁶³ *CDT Testifies, Says HIPAA Sharing Rules Need Clarity*, CTR. FOR DEMOCRACY & TECH. (Apr. 29, 2013), <https://www.cdt.org/blogs/meredith-whipple/2904cdt-testifies-says-hipaa-sharing-rules-need-clarity>.

they are at risk of violating HIPAA when disclosing PHI and also at risk of violating tort law for not disclosing PHI if a third party could be injured. Thus, the nature of the Privacy Rule creates a conflict between tort law and the federal medical privacy law.

Since compliance with the Privacy Rule became effective in 2003, nearly 91,000 complaints have been filed with the Office for Civil Rights.⁶⁴ Of this staggering number, approximately 23,000 of the complaints were investigated and resulted in the strict enforcement of HIPAA.⁶⁵ Causing even more concern for physicians, from 2004 to 2013, the Office for Civil Rights primarily investigated issues of impermissible uses and disclosures of PHI.⁶⁶

Though most physicians are undoubtedly seeking to remain compliant with HIPAA, there is also an inherent desire to protect third parties. When discussing whether to notify police about an intoxicated patient in the E.D. who may have left the scene of an accident where he likely injured others, one physician notes, “[h]e does not enjoy an unbreakable bonding with me as it pertains to his irresponsibility and/or illegal activities. . . . This call serves the greater good.”⁶⁷

III. ANALYSIS

A. *The Privacy Rule Causes Tension for E.D. Physicians*

The Privacy Rule lacks adequate guidance for physicians dealing with intoxicated patients and must be amended. Though the Privacy Rule does not expressly prohibit physicians from disclosing information to law enforcement about intoxicated patients who have left the E.D. and may cause harm, it also lacks sufficient direction about what is permissible to disclose in this type of situation. While it may be easier to defend a breach of PHI than it is to defend a vehicular homicide or personal injury case, more guidance about the scope of the Privacy Rule will be beneficial to physicians. It is clear that the Privacy Rule does not dictate a mandatory duty for physicians to warn of intoxicated patients;⁶⁸ instead, the Privacy Rule merely states that physicians will not be in violation of HIPAA by releasing information falling

⁶⁴ *Health Information Privacy Complaints Received by Calendar Year*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/data/complaintsyear.html> (last visited at Mar. 23, 2015).

⁶⁵ *Enforcement Highlights*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Jan. 31, 2015), <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/highlights/index.html>.

⁶⁶ *Top Five Issues in Investigated Cases Closed with Corrective Action, by Calendar Year*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/data/top5issues.html> (last visited Mar. 23, 2015).

⁶⁷ Cotton et al., *supra* note 5, at 236.

⁶⁸ *When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (JULY 23, 2004), http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_purposes/505.html.

under the itemized circumstance.⁶⁹

Prior to implementation of the Rule, the common law in Ohio offered limited guidance to physicians in situations of extended liability.⁷⁰ In *Biddle v. Warren General Hospital*, the Ohio Supreme Court upheld an independent tort applying to physicians who make unauthorized disclosures of personal medical information.⁷¹ At the same time, the court ruled that physicians have specific common law duties to disclose information that has an effect on third party safety.⁷² In fact, “the breach of [these duties] can result in civil liability.”⁷³ The court held that even in cases without a specific legal obligation, physicians might be privileged to disclose information when it could provide safety for individual third parties.⁷⁴

As far back as 1928, the Ohio Supreme Court has held that a physician’s common law duty is to protect third parties from dangerous patients—this principle stems from a need in the 1920s to disclose the identity of those suffering from small pox.⁷⁵ This same principle also permeates advisory associations, such as the American Medical Association, which has permitted physicians since 1957 to breach medical confidence in situations where it is deemed necessary to protect third party individuals and the community at large.⁷⁶

Upon implementation of the Privacy Rule, physicians face the task of determining what information can be disclosed under their state’s common law and what information can be disclosed under the provisions in HIPAA.⁷⁷ Upon initial analysis of the Privacy Rule, it is clear that physicians were stymied by the ambiguity in the provision. As one law firm writes, “[w]e have counseled numerous clients about the use [of the Privacy Rule exception for preventing harm] in the face of actual fact scenarios over the years.”⁷⁸ Ultimately, the vagueness of the Privacy Rule and how it applies to intoxicated patients causes anxiety for emergency physicians.

First and foremost, physicians feel called to protect people.⁷⁹ The code of ethics for emergency medicine physicians states that these doctors

⁶⁹ 45 C.F.R. § 164.512(j) (2013).

⁷⁰ See, e.g., *Biddle v. Warren Gen. Hosp.*, 715 N.E.2d 518, 524 (Ohio 1999).

⁷¹ *Id.* at 528.

⁷² *Id.* at 524.

⁷³ *Id.* (citation omitted).

⁷⁴ *Id.*

⁷⁵ *Jones v. Stanko*, 160 N.E. 456, 458 (Ohio 1928) (discussing how an Ohio physician has a duty to disclose a patient’s contagious disease to protect third parties).

⁷⁶ *Estates of Morgan v. Fairfield Family Counseling Ctr.*, 673 N.E.2d 1311, 1326 (Ohio 1997).

⁷⁷ *How do Other Privacy Protections Interact with the Privacy Rule?*, NAT’L INSTS. OF HEALTH, http://privacyruleandresearch.nih.gov/pr_05.asp (last visited Feb. 22, 2016).

⁷⁸ Julie A. Knutson, *HIPAA Threat of Harm Exception Gets a Second Look*, BAIRD HOLM LLP (Sept. 2, 2013), <http://www.bairdholm.com/publications-feed/entry/hipaa-threat-of-harm-exception-gets-a-second-look.html>.

⁷⁹ *Code of Ethics for Emergency Physicians (2009)*, ILL. INST. OF TECH. (Oct. 24, 2011, 4:15 PM), <http://ethics.iit.edu/ecodes/node/4892>.

should “[e]mbrace patient welfare as their primary professional responsibility.”⁸⁰ This desire to protect others initially begins with the specific patient, but also flows to nurses, aides, individual third parties such as patients’ families, and the public at large.⁸¹ The vague language of the exception for harm does a disservice to physicians who are not clear about what their rights are under HIPAA. When a frantic E.D. physician realizes an intoxicated patient has left prior to being legally sober, society should not ask this physician to then grapple with nuances of the vague Privacy Rule.⁸² Based on the ethical requirements of the emergency medicine profession, the primary goal is patient care, and to expect any type of legal analysis while in the middle of patient care is both unrealistic and inappropriate.⁸³

Specifically, the physician would likely feel inclined to determine whether the situation with the intoxicated patient reached the requisite level for disclosure, given that intoxication screens may be used for legal purposes.⁸⁴ An intoxication screen “is often done in emergency medical situations[] . . . to evaluate possible accidental or intentional overdose or poisoning. It may help determine the cause of acute drug toxicity[] . . . and to determine the presence of substances in the body for medical or legal purposes.”⁸⁵ The physician, relying on the skills learned in medical school and throughout her medical training, will also feel the pull to use “supplemental information (including . . . performance on psychophysical tests, values obtained in physiological assessments, and unusual behaviors, statements or observations)” in making the decision of the patient’s level of intoxication.⁸⁶ The decision to make a disclosure about an intoxicated patient’s potential harm to others is more difficult to make without actually being able to assess the patient and hospitals encourage patients to resist the urge to leave the E.D. prior to seeing the physician.⁸⁷

Second, the provision’s vagueness enhances the fear most physicians have of incurring a HIPAA violation and the damage it will cause to their personal reputations, their employment statuses, and the reputation of their

⁸⁰ *Id.*

⁸¹ *Id.* (“The emergency physician owes duties not only to his or her patients, but also to the society in which the physician and patients dwell.”).

⁸² Rob Stein, *Patient Privacy Rules Bring Wide Confusion; New Directives Often Misunderstood*, THE WASH. POST (Aug. 18, 2003), <https://www.washingtonpost.com/archive/politics/2003/08/18/patient-privacy-rules-bring-wide-confusion/ba0d516a-7477-41dc-9d7b-6343967bf4c3/> (“But frequent misunderstandings about what the rules allow have been causing frustration, uncertainty and anxiety in doctors’ offices, clinics, hospitals and even pharmacies across the country.”).

⁸³ ILL. INST. OF TECH., *supra* note 79.

⁸⁴ *Toxicology Screen*, N.Y. TIMES (Jan. 27, 2013), <http://www.nytimes.com/health/guides/test/toxicology-screen/overview.html> (describing how the toxicology test may be administered “to determine the presence of substances in the body for medical or legal purposes.”).

⁸⁵ *Id.*

⁸⁶ Sarah Kerrigan, *Drug Toxicology for Prosecutors: Targeting Hardcore Impaired Drivers*, AM. PROSECUTORS RES. INST. 1, 8 (2004), http://www.ndaa.org/pdf/drug_toxicology_for_prosecutors_04.pdf.

⁸⁷ See, e.g., *Emergency Department*, HARDIN MEM’L HEALTH, <http://www.hmh.net/hmhwebsite/Service.aspx?PageID=16> (last visited Feb. 22, 2016).

hospitals.⁸⁸ Though there are specific types of insurance companies working with health care providers who have allegedly violated HIPAA, these are an additional expense for physicians.⁸⁹ Professional liability insurance may also already insure physicians in the event of such a violation.⁹⁰ Certain physicians who are particularly anxious about incurring penalties may desire this double protection, however.

In the current litigious society, medical professionals have a heightened desire to protect themselves from any form of professional or personal penalties.⁹¹ In both recognition of this desire and as an effort to clarify the nature of the Privacy Rule, the Office for Civil Rights at Health and Human Services sent a letter in January of 2013 to explain when it is appropriate to contact authorities when dealing with dangerous patients.⁹² While the letter was undoubtedly written to provide professional clarity to physicians, its focus on mental health leaves much to be desired about proper disclosures for intoxication.⁹³

Third, physicians also fear that not notifying authorities increases the likelihood of future damage or injury, such as extended liability.⁹⁴ Based on medical malpractice standards, most physicians are exceedingly pro-active in preventing any sort of harm that could befall a patient.⁹⁵ Successful medical malpractice lawsuits require a duty of care to patients, a breach of this duty that results in an injury, and proof that the breach of care caused harm.⁹⁶ Though preventing medical malpractice is ingrained in physicians since medical school, avoiding liability can seem out of balance with permitted disclosure under HIPAA's Privacy Rule, at least to an untrained eye.⁹⁷ Even though medical schools do make an effort to teach the basics of legal issues they will face in practice, "the discussion focuses on malpractice as opposed to regulatory and enforcement issues."⁹⁸

⁸⁸ David G. Jensen, *Complaints of HIPAA Violations: Enforcement*, CAL. ASS'N OF MARRIAGE & FAMILY THERAPISTS, <http://www.camft.org/ScriptContent/HIPAA/Complaints.htm> (last updated Aug. 2010).

⁸⁹ David Lenckus, *HIPAA Violations Covered Under Liability Policies*, BUS. INS. (Nov. 14, 2004), <http://www.businessinsurance.com/article/20041114/ISSUE01/100015717>.

⁹⁰ *Id.*

⁹¹ Rob Lamberts, *Dear HIPAA: It's Time to Decide Who You Want to Be*, THE HEALTH CARE BLOG (Mar. 26, 2013), <http://thehealthcareblog.com/blog/2013/03/26/dear-hipaa-its-time/>.

⁹² Rodriguez, *supra* note 10.

⁹³ *See generally id.*

⁹⁴ News Release, Poll of Emergency Physicians Show More Than Half Order Tests as Protection Against Being Sued, American College of Emergency Physicians (May 23, 2011).

⁹⁵ *Id.*

⁹⁶ Carolyn Buppert, *What is My Legal Obligation if I Allow an Intoxicated Patient to Drive Home?*, MEDSCAPE (Aug. 15, 2008), <http://www.medscape.com/viewarticle/578133>.

⁹⁷ Nirav D. Shah, *The Teaching of Law in Medical Education*, 10 AM. MED. ASS'N J. ETHICS 332, 332 (2008), <http://virtualmentor.ama-assn.org/2008/05/oped1-0805.html>.

⁹⁸ *Id.* at 333.

B. Privacy Rule Appears More Attuned to Mentally Ill

Though the HIPAA provision that permits disclosure to prevent an imminent threat technically would apply to intoxicated patients, it is worded to allow physicians to assume it mainly applies to dangerous mentally ill patients. The provision is phrased in a way that nearly quotes the seminal mental health disclosure case, *Tarasoff v. Regents of University of California*, as well as § 41 Restatement (Third) of Torts.⁹⁹ In a society focused on the plight of mental health workers and therapists who oftentimes treat dangerous patients, most physicians would be likely to interpret the provision as applying exclusively to the mentally ill.¹⁰⁰ In fact, “[t]he rule’s approach is consistent with the ‘duty to warn’ third persons at risk, which has been established through case law.”¹⁰¹

Physicians are most likely to equate a duty to warn third parties of dangerous patients with the scenario from the pivotal *Tarasoff* case. Prosenjit Poddar killed Tatiana Tarasoff in 1969 after telling his psychologist of his intent to kill the young woman.¹⁰² Tarasoff’s parents sued the psychologist’s employer, the University of California at Berkeley, alleging that the psychologist, Dr. Lawrence Moore, had urged campus police to detain Poddar after making his threat against Tarasoff but that the police released him shortly thereafter.¹⁰³ The crux of the lawsuit was whether or not Dr. Moore, his superior, or the campus police had a duty to warn Tarasoff or her parents of Poddar’s threat.¹⁰⁴

In holding that mental health practitioners have a duty to warn third parties of threats, Judge Tobin stated, “the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others.”¹⁰⁵ *Tarasoff*, decided in 1976 by the California Supreme Court, has since expanded into a majority of jurisdictions that now also hold that a mental therapist has a duty to use reasonable care in protecting any and all foreseeable victims of a patient who has made a credible threat of harm.¹⁰⁶

Just over twenty years after *Tarasoff* was decided, Ohio implemented its own mandatory duty to warn of explicit threats made by mentally ill

⁹⁹ W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties*, 44 WAKE FOREST L. REV. 877, 877 (2009).

¹⁰⁰ *Id.* at 883.

¹⁰¹ *Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object is Not Required: Uses and Disclosures to Avert a Serious Threat to Health or Safety – § 164.512(j)*, BRICKER & ECKLER, <http://bricker.com/resource-center/hipaa/key-resources/resource/hipaa-privacy-regulations-uses-and-disclosures-for-which-an-authorization-or-opportunity-to-agree-or-object-is-not-required-serious-threats-to-health-or-safety-§-164512j-363> (last visited Feb. 22, 2016).

¹⁰² *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 339 (Cal. 1976).

¹⁰³ *Id.* at 339–40.

¹⁰⁴ *Id.* at 341.

¹⁰⁵ *Id.* at 347.

¹⁰⁶ Cardi, *supra* note 99, at 877.

individuals.¹⁰⁷ This duty to warn covers circumstances where a mental health professional has reason to believe that his patient has the intent to cause harm to a third party as well as the capability to carry out the threat.¹⁰⁸ Following the same line of reasoning as the proposed expansion to the Privacy Rule, it is ideal for duty to warn legislation to apply to intoxicated individuals who have the intent and capability to access a car and drive away from the E.D. While the Ohio law is far from perfect—lacking in the same areas as the Privacy Rule—it succeeds in giving explicit guidance to mental health professionals as to any potential liability after disclosure.¹⁰⁹ Whereas the Privacy Rule skirts around the issue of liability, the Ohio law states that:

The mental health professional or organization is not liable in damages in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority over the professional or organization, for disclosing any confidential information about a mental health client or patient that is disclosed for the purpose of taking any of the actions.¹¹⁰

This provision explicitly dictates to mental health providers that they will suffer no adverse legal and disciplinary action for disclosing relevant threats of harm.¹¹¹ An amendment to the HIPAA Privacy Rule should do the same.

In addition to *Tarasoff* and other states' laws, § 41 Restatement (Third) of Torts also dictates a duty for mental health providers to warn a patient's potential victims.¹¹² While the Restatement is quite clear as to the duty for mental health providers, it is notably silent as to its applicability for health care providers other than those treating the mentally ill.¹¹³ Commentary indicates that the lack of language specifying the same duty to non-mental health-providers could be because a large number of jurisdictions have not yet even addressed this very question—it is a relatively unexplored phenomenon.¹¹⁴ The time to address this phenomenon is now, before an onslaught of scenarios that could occur at any given time.

Though provisions allocating specific care to be taken in relation to dangerous mental health patients is entirely valid and crucial for a safer society, this same impulse to protect should be directly paralleled to the context of intoxicated individuals.¹¹⁵ Though threats made by the mentally ill

¹⁰⁷ OHIO REV. CODE ANN. § 2305.51(B) (LexisNexis 1999).

¹⁰⁸ *Id.* § 2305.51(B).

¹⁰⁹ OHIO REV. CODE ANN. § 2305.51(C)(4) (LexisNexis 1999).

¹¹⁰ *Id.* § 2305.51(C)(4).

¹¹¹ *Id.* § 2305.51(C)(4).

¹¹² RESTATEMENT (THIRD) OF TORTS § 41(b)(4) (2005).

¹¹³ Cardi, *supra* note 99, at 877.

¹¹⁴ *Id.* at 881.

¹¹⁵ Patricia C. Kussmann, *Civil Liability of Psychiatrist Arising out of Patient's Violent Conduct Resulting in Injury to or Death of Patient or Third Party Allegedly Caused in Whole or Part by Mental*

may be of a more direct nature than a more generalized threat of harm, the harm itself is still preventable.¹¹⁶ Further, the nameless people who would be harmed by an intoxicated driver have no less reason to be protected than the named possible victims of a mentally ill patient. Yet despite the parallel to the mentally ill, HIPAA does not require this life-changing disclosure but instead merely permits it.¹¹⁷

C. Amending the Privacy Rule

It is essential to amend the Privacy Rule to create an unequivocal duty to warn authorities when intoxicated patients who have left the E.D. because they have the capability and possibly the intent to cause harm. Emergency physicians work in a tense, fast-paced environment and are not all aware of Privacy Rule's true requirements and allowances.¹¹⁸ It is not timely to contact the legal department in the middle of a shift.¹¹⁹ As such, the amendment should eliminate the guesswork for providers to determine what is permissible and what would constitute a HIPAA violation.

Currently, the relevant portion of the Privacy Rule, 45 C.F.R. 164.512(j)(1)(i), states:

(1) A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat[]¹²⁰

While the provision may be quite clear to legal scholars, the phrases used are more ambiguous to health care professionals who are not as familiar with the nuances of legal analysis. When legislation is written for a specific niche of people—in this scenario, physicians—drafters should remember that laymen

Disorder, 80 A.L.R.6th 469 § 28 (explaining that some courts find that mental health professionals have a duty to protect against foreseeable harm, even if there was not an explicit threat to the third party).

¹¹⁶ *The Highway Safety Desk Book*, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., <http://ntl.bts.gov/DOC/S/deskbk.html> (last visited Feb. 22, 2016) ("Patrolling our streets and highways remains the vital task of protecting public safety, through the proven deterrence of aggressive, intelligent traffic law enforcement.").

¹¹⁷ U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 68.

¹¹⁸ Bonnie Darves, *From Minor Annoyances to Treatment Delays, Physicians Feeling Fallout of HIPAA Privacy Law*, AM. COLL. OF PHYSICIANS (Sept. 2003), <http://www.acpinternist.org/archives/2003/09/privacy.htm>.

¹¹⁹ See, e.g., Tyson, *supra* note 3 (detailing an average shift of an emergency physician); Darves, *supra* note 118 ("[M]ost physicians do not have time to pick up the phone and do some HIPAA education every time they encounter a problem.").

¹²⁰ 45 C.F.R. § 164.512(j)(1)(i) (2013).

are likely to interpret words according to their ordinary meaning, not according to their specialized legal contexts. Specifically, the terms “good faith,” “imminent threat,” “reasonably able,” and “target” in the Privacy Rule are unclear for physicians who must make decisions in the middle of medical emergencies.

“Good faith” is a widely recognized legal term, but is one that causes more confusion for non-legal professionals than it provides answers.¹²¹ The legal community has varying opinions of what “good faith” means, depending on the context and the specialty of law of which it is related.¹²² In adding yet another interpretation of “good faith,” and arguably the only one that matters for the topic at hand, this provision of the Privacy Rule requires either the provider’s actual knowledge or a statement of apparent knowledge by someone other than the provider.¹²³ A physician might be unsure about whether she can notify law enforcement in “good faith” solely based on concerns over the patient’s behavior and mannerisms, or only if the patient’s blood alcohol content is above the legal threshold.¹²⁴

This matter is further complicated by the so-called “left without being seen” occurrence, which is marked by a patient leaving the E.D. prior to any test or treatment.¹²⁵ In fact, “[t]he number of [left without being seen] visits has increased dramatically in the past 15 years,” says Renee Y. Hsia, MD, MSc.¹²⁶ Thus, it can be implied that some intoxicated individuals, or those who are suspected of being intoxicated, leave the E.D. prior to receiving a toxicology screen. Physicians with non-confirmed suspicions about the blood alcohol content of a patient may feel strongly about notifying law enforcement but are unsure if the lack of actual proof meets the “good faith” requirement of the law.¹²⁷ This situation is also compounded by the fact that not all individuals who are over the legal limit portray obvious physical signs; a patient with a blood alcohol level of 0.09, which constitutes illegal intoxication, may exude only minimal signs of impairment.¹²⁸

¹²¹ *Towards an Implied Duty of Good Faith Under English Law*, JONES DAY (May 2013), <http://www.jonesday.com/Towards-an-Implied-Duty-of-Good-Faith-Under-English-Law/>.

¹²² *Duty of Good Faith*, LEGAL INFO. INST., http://www.law.cornell.edu/wex/duty_of_good_faith (last visited Mar. 30, 2015); Mayra C. Artiles Fonseca, *Negotiating in Good Faith: Only a Civil Law Obligation?*, PANGAEA UPR (Oct. 12, 2013), <http://pangeaupr.org/2013/12/10/negotiating-in-good-faith/>.

¹²³ 45 C.F.R. § 164.512(j)(4) (“A covered entity that uses or discloses protected health information . . . is presumed to have acted in good faith . . . if the belief is based upon the covered entity’s actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.”).

¹²⁴ VA. CODE ANN. § 18.2-269(A)(3) (West 2012) (stating that a presumption for alcohol intoxication exists when there is at least 0.08 percent of alcohol in an individual’s blood); IND. CODE ANN. § 7.1-5-10-15.5(b)(1) (discussing how the laws of Indiana consider one form of actual knowledge to be the intoxicated individual’s condition and behavior when leaving the establishment).

¹²⁵ Renee Y. Hsia, *A New Look at Leaving Without Being Seen in EDs*, PHYSICIAN’S WEEKLY (Mar. 27, 2012), <http://www.physiciansweekly.com/a-new-look-at-leaving-without-being-seen-in-eds/>.

¹²⁶ *Id.*

¹²⁷ 45 C.F.R. § 164.512(j)(4) (2013).

¹²⁸ *Alcohol Intoxication, Acute*, MD GUIDELINES, <http://www.mdguidelines.com/alcohol-intoxication-acute> (last visited Feb. 22, 2016).

The use of the word “threat” can also cause hesitation. In the context of HIPAA, “threat” is assumed to be focused on specific threats of violence as opposed to generalized risk of harm from intoxicated driving.¹²⁹ Thus, many physicians might be perplexed in rendering whether an intoxicated patient’s possibility of causing a car accident is the same as when an individual who makes an unequivocal threat to leave the hospital and harm someone.¹³⁰ It is well established that such a specific threat of violence by a patient is certainly applicable to this provision of the HIPAA Privacy Rule.¹³¹ That being said, there are other threats of more generalized harm, such as intoxicated patients behind the wheel of a vehicle, which should not be overlooked.¹³²

Aiding in the oft-limited interpretation of “threat” is the media’s focus on mental health in relation to this provision of the Privacy Rule.¹³³ The application of this provision in the media is mostly seen in connection to mass shootings and other similar tragedies, such as the shootings at Virginia Tech, Newtown, Connecticut, and Aurora, Colorado.¹³⁴ Considering the amount of media coverage on the permissibility of disclosing mentally ill patients who subsequently become shooters, it is not surprising that physicians equate a “threat of imminent harm” with that context only.¹³⁵

Adding yet another layer of perplexity is the phrase “reasonably able.” It is clear that a disclosure about a specific, threatened incident could be made to a law enforcement officer.¹³⁶ In a scenario involving a patient who has threatened to poison a family member, the physician could disclose to law enforcement as much information about the patient and the threat as is needed for the police to be able to protect all relevant parties.¹³⁷ This clear example is far more muddled in relation to an intoxicated patient who is missing from the E.D. A physician may not be aware if the patient drove himself to the

¹²⁹ See, e.g., Peter MacKoul, *Understanding of HIPAA Privacy Rule May Have Avoided Virginia Tech Tragedy*, HIPAA SOLUTIONS (2007), <http://www.hipaasolutions.org/documents/HIPAAatVirginiaTech.pdf>.

¹³⁰ Ericka L. Adler, *HIPAA Does Not Prevent Information Disclosure if Patient Poses Harm*, PHYSICIANS PRACTICE (Jan. 23, 2013), <http://www.physicianspractice.com/blog/hipaa-does-not-prevent-information-disclosure-if-patient-poses-harm> (discussing the difficulty physicians encounter when determining if they can disclose information about a patient who poses a danger to others).

¹³¹ Kussmann, *supra* note 115, at § 28.

¹³² *Drinking and Driving: A Threat to Everyone*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/features/vitalsigns/drinkinganddriving/> (last updated Oct. 15, 2013) (stating that intoxicated drivers are a threat to other individuals on the road).

¹³³ MacKoul, *supra* note 129.

¹³⁴ *Id.*; Rodriguez, *supra* note 10.

¹³⁵ Adler, *supra* note 130 (“With recent incidents like the ones in Newtown, Conn., and Aurora, Colo., providers across the country are questioning what should be done if they believe a patient poses a threat to others.”).

¹³⁶ *Where the HIPAA Privacy Rule Applies, Does it Permit a Health Care Provider to Disclose Protected Health Information (PHI) About a Patient to Law Enforcement, Family Members, or Others if the Provider Believes the Patient Presents a Serious Danger to Self or Others?*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (NOV. 25, 2008), http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa_and_hipaa/520.html.

¹³⁷ *Hospital and Law Enforcement Guide to Disclosure of Protected Health Information*, WASH. STATE HOSP. ASS’N 1, 9 (Aug. 2010), https://depts.washington.edu/comply/docs/HLE_Guide.pdf.

hospital, stumbled into the E.D. on foot, or was a passenger of someone else. Not knowing this critical piece of information could stymie a physician who wonders if the disclosure is even necessary because the patient could be safely strapped into the passenger seat of another's vehicle.¹³⁸

Even if the patient did indeed drive himself, the physician is entirely unlikely to have information from the medical intake forms about the patient's vehicle description or license plate.¹³⁹ Other than the home address of the patient, a standard medical form as used in the E.D. will provide no additional information to any law enforcement officer in order for them to be considered "reasonably able" to lessen the harm.¹⁴⁰ Thus, a physician is perfectly validated in hesitating over this type of disclosure when the PHI is limited. If an intoxicated patient specifically states to the physician his intention to drive on a given road immediately after leaving the E.D., and this patient, for any reason, leaves the E.D. prior to reaching sobriety, the physician has far more indication that an officer could patrol this road to prevent possible harm to other drivers.¹⁴¹ Only in a perfect world, however, is a physician likely to be provided with such clear-cut information from an intoxicated patient.

The last of the potentially unclear terms in the provision is "target." This portion of the provision seems to be more of a linguistic side note, as denoted by the language: "*including* the target of the threat[. . .]"¹⁴² Though this phrase is related to the physician's ability to contact the person named as the potential victim, it is apt to mystify a physician in the midst of the hectic E.D. setting. In situations with intoxicated drivers, the possible target would likely refer to those on the roadways as opposed to a specific person. Determining the target of a patient's threat is no easy task:

There is a distinction between a patient saying, "I am going to kill my wife" (disclosure permitted for her protection) and a general statement, "I'm so angry I could kill someone." Doctors weighing these potential "threats" do so at great peril. In one instance failure to warn may lead to civil liability to the victim; while issuing a warning in too general a threat may lead to legal action by the patient for invading the privilege.¹⁴³

¹³⁸ *Kowalski v. St. Francis Hosp. & Health Ctrs.*, 995 N.E.2d. 148, 151 (N.Y. 2013) (stating that the emergency physician did not have a duty to contact law enforcement when an intoxicated patient left the E.D. because the physician had no specific facts that would help in the search for the patient).

¹³⁹ *Medical Forms*, AM. COLL. OF EMERGENCY PHYSICIANS, <http://www.acep.org/medicalforms/> (last visited Feb. 22, 2016).

¹⁴⁰ *Id.*

¹⁴¹ Rodriguez, *supra* note 10 (discussing that a provider can disclose information to individuals, such as law enforcement officers, who can reasonably lessen the potential harm).

¹⁴² 45 C.F.R. § 164.512(j)(1)(i)(B) (2013) (emphasis added).

¹⁴³ Rich Meehan, *The Limits of Confidentiality*, CONN. MEDIA GRP. BLOG (Aug. 3, 2012), <http://blog.ctnews.com/meehan/2012/08/03/the-limits-of-confidentiality/>.

Given the intricate balance between sharing a general target of harm, such as those on the road between the E.D. and the patient's next destination, and sharing only the name of a specific victim, it is understandable that a physician would wonder if it lines up with the setting she may be dealing with in her E.D.

Taking the aforementioned considerations into account, the Privacy Rule should be amended. The new provision should state:

A covered entity

(1) must, consistent with applicable law and standards of ethical conduct, inform local or state law enforcement officers, and

(2) is permitted to use or disclose protected health information,

when the covered entity reasonably believes a patient is legally intoxicated, and believes the use or disclosure is necessary to prevent the intoxicated patient from

(a) operating a motor vehicle, or

(b) causing any harm to the health or safety of a person or the public.

The use and disclosure may also be made to hospital security to lessen or prevent potential harm while on hospital grounds.

Upon implementing the changes to the Privacy Rule's provision allowing disclosures to be made about intoxicated patients, the likely result will be less confusion for physicians and safer roadways for the public. In addition, the safety of the patient himself must be considered, and this provision will protect not just innocent third parties but will also promote the wellbeing of the patient.

Beyond an amendment to the Privacy Rule, the next best way to provide clear guidance for physicians working in the E.D is for all hospitals to create, publish, and distribute hospital policies relating to intoxicated patients.¹⁴⁴ As one health care attorney explains, having a written policy as to how the hospital or physician practice will handle intoxicated individuals is critical—distributing the policy to staff members and discussing the policy can help eliminate staff members' confusion.¹⁴⁵ The attorney also advises physician to discuss the matter in a non-confrontational way by “approach[ing] the patient about being intoxicated. Express concern about the

¹⁴⁴ Patel & Garmel, *supra* note 35, at 106.

¹⁴⁵ Michael J. Schoppmann, *Intoxicated Patients*, FAMILY PRACTICE MGMT. (July-Aug. 1999), <http://www.aafp.org/fpm/1999/0700/p50.html>.

patient's ability to drive, and offer to help the patient find an alternate ride home. Some practices even pay the patient's cab fare out of a special pettycash fund.¹⁴⁶

In order to protect the hospital and physicians from liability that may result after an intoxicated patient leaves the E.D., appropriate documentation of the patient's visit is critical.¹⁴⁷ When the patient is inebriated, "[a] detailed description of the patient's mental status and overall appearance, including inappropriate actions the patient has taken, should be included in the chart."¹⁴⁸ While an amendment to HIPAA's Privacy Rule is the most effective way to legally protect physicians as well as promote the wellbeing of the public, hospitals should take extra care to make sure physicians are aware of their rights in treating intoxicated patients.¹⁴⁹

IV. CONCLUSION

The influx of intoxicated patients in the emergency departments across America is a problem. When these intoxicated patients leave the E.D. prior to reaching a legal level of sobriety and thus raise the possibility of endangering the public, emergency physicians must venture into the murkiness of the HIPAA Privacy Rule. Instead of providing illustrative guidance to emergency physicians, the Privacy Rule's vague provision about disclosing information to protect the public is confusing at best and misleading at worst. The Privacy Rule must be amended to explicitly permit physicians to make disclosures that could protect the public from harm. Innocent third parties deserve to be protected from all types of danger, but this protection cannot be ensured until physicians are given clear guidance.

¹⁴⁶ *Id.*

¹⁴⁷ Thomas B. Fleeter, *When a Patient Leaves Against Medical Advice*, THE AM. ACAD. OF ORTHOPAEDIC SURGEONS (Nov. 2012), <http://www.aaos.org/news/aaosnow/nov12/managing5.asp>.

¹⁴⁸ *Id.*

¹⁴⁹ Adler, *supra* note 130 (encouraging physicians to contact an attorney who specializes in healthcare law in order to obtain more guidance about Privacy Rule disclosures).