



# Guidelines for an operator medical record

By Kevin B. Gerold, DO, JD and Marita Mike, MD, JD

One function ascribed to a TEMS element is to compile a medical record for each member of a special operations team. If a team member becomes acutely ill or injured, this medical record is available to assist hospital staff by providing information that can affect medical decision-making and care.

While a prepared medical record is usually discussed in the context of SWAT operators, the availability of this medical record is relevant to all police officers and others engaged in high-risk operations. Many officers are healthy and will have little to include in their personal medical record.

This article outlines elements useful for inclusion into an operator medical record so that, in the event of a medical emergency, hospital care providers will have access to up-to-date medical information and important contacts to assist them with providing the officer with the best possible care.

The medical record is protected health information (PHI) and should be secured under the rules established under the Health Insurance Portability and Accountability Act (HIPAA). PHI includes oral or recorded information, including demographic data; information on any past, present and future

physical or mental condition; all health care treatment; and past, present or future payment for health care. PHI includes names, address, date of birth and Social Security number. While police agencies do not fall under HIPAA, agencies should nonetheless protect PHI in a manner that is HIPAA-compliant. Any collection of PHI by a law enforcement agency should be secured through administrative policies and practices that protect an officer's privacy rights and prevents the disclosure of information to persons not directly involved with an officer's care without his or her permission. Any information collected on an

operator's behalf should be stored in a secure location that is accessible only to authorized persons.

A contentious obstacle to creating a medical record for operators is their reluctance to share personal information over concerns that such information will be disclosed to unauthorized persons or for fear that information contained in the record may disqualify them from the team (such as hypertension, high cholesterol, certain medications, etc.). These concerns should not discount the value of having this information on file and stored in a readily accessible location in the event of a serious illness or injury. Early TEMS proponents envisioned the creation of an operator medical record that was maintained by the team medic and stored in a location immediately accessible by the medic or SWAT commander, or kept on the operator.

For operators who are reluctant to submit protected health information over privacy concerns, teams should encourage them to create a medical record on their own. The operator can then provide the medic and SWAT commander with the location of the record

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**Table 1:** Single QR Code (4,269 characters)



and provide the name of someone to contact who can make this valuable information available to hospital care providers. Medics and commanders would then only have to maintain a list of emergency contacts with access to the individual operator's medical record.

It is also possible to store the medical record file in a coded form that is readily accessible to hospital care providers. Medic Alert and Road ID are two examples of online services that allow users to securely store such information to be available to health care providers. Another option is to store basic PHI as a Quick Response Code (QR code). A QR code is a two-dimensional barcode label that is readable using optical scanners present on many cellphones. This graphic code can store up to 4,269 alphanumeric characters (see Tables 1 and 2). When necessary, multiple QR codes can be arranged to capture additional PHI. The medical record file could be stored on a dog tag-style thumb drive maintained by the operator and kept on his or her person.

#### **ELEMENTS OF AN OPERATOR MEDICAL RECORD**

*Element I: Demographic information.* Demographic information is necessary to create an institutional medical record. Information needed to initiate this record includes the operator's full name, current address, date of birth, Social Security number, mother's maiden name, insurance carrier and policy number.

**Table 2:** Grouped QR Codes as a medical cross (21,000 characters)



*Element II: Allergies and medications.* Clinically significant allergies are those that are life-threatening or require specific treatment. Clinically significant allergies are rare and involve responses to medications, food, venoms, vaccines and almost any other foreign substance. Allergies should be distinguished from much more common untoward reactions or medication side effects. For example, a patient who develops hypotension, wheezing and airway swelling and requires resuscitation with epinephrine and intravenous fluids after receiving a medication is likely allergic to that medication. This is different from experiencing nausea or diarrhea while taking an antibiotic, both of which are known side effects and not reasons to discontinue the medication. Anyone with suspected allergies to medications, foods, venoms or other allergens should discuss them with their primary health care provider to distinguish true allergies from less serious anaphylactoid reactions and medication side effects.

Documenting a list of current medications provides health care providers with insight into that person's state of health. This information also helps care providers to avoid drug-drug interactions and provide continuity in the management of ongoing conditions.

The medical record should include a list of medications taken regularly for chronic health conditions (hypertension, diabetes, asthma or hypothyroidism), medications taken occasionally for relief of symptoms (arthritis, seasonal allergies, insomnia), as well as nutrition supplements, vitamins and herbal remedies. When listing medications, include the medication name, the dose and when the medication should be taken.

**Element III: Chronic health conditions and prior surgeries.** The medical record should include a list of all chronic health conditions requiring treatment, past hospitalizations, past surgeries and adverse responses to anesthesia. With the advances in surgical endoscopy, it is no longer possible to identify which patients have undergone major surgery or to suspect the type of procedure performed based on the presence of a scar. The operator should include whether he or she has implanted devices such as orthopedic hardware, prosthetics, surgical clips or retained metallic foreign bodies, especially in the eye.

Also useful for inclusion in a medical record are the dates, reports and location of prior diagnostic studies. Diagnostic studies that are useful to hospital care providers include a prior electrocardiogram (EKG), stress test, echocardiogram, CT scan, MRI scan, plain film x-rays and laboratory studies.

Operators who wear glasses should include a copy of their current eyeglass prescription, including the name and location of their ophthalmologist or optometrist and optician. If the operator's eyeglasses are broken and a second pair is unavailable, it is then a simple matter to obtain a replacement pair.

**Element IV: Emergency contact information.** Important information that should be included in every operator medical record are the names and emergency contact numbers for persons who

will be expected to represent the operator in the event he becomes unable to make medical decisions or manage his own affairs. Health care providers will render care without consent in emergency circumstances when an operator is acutely ill or injured and there is an immediate threat to life, limb or eyesight. Once the need for emergency treatment has passed and under circumstances where the patient lacks the ability to provide consent, health care providers are obligated to identify a legally authorized proxy decision-maker and obtain consent for further care.

The medical record should include emergency contact information for those who are authorized to act on behalf of the injured operator. It should include the name and contact information for a proxy health care decision-maker, and a durable power of attorney who can continue to act financially to pay bills and maintain the household. Police officers, particularly those who are unmarried, who have not appointed a health care agent or a durable power of attorney should consider doing so. The medical record should also include the name and contact information of the patient's primary health care provider and dentist who can provide potentially valuable information about the operator's general state of health and prior treatment to the hospital care team.

In the event that the illness or injury renders the operator unable to provide consent for non-emergency care, hospital providers will need to obtain consent from a proxy; this can be a health care agent, surrogate or a court-appointed guardian. A health care agent is someone appointed in advance by an individual to make his or her health care decisions in the event of incapacity. A health care agent is often a family member, but can be someone else. The agent has the authority to access a patient's medical information, meet with doctors and other health

care professionals and consent or refuse treatment in order to advocate for the patient and insure that the patient receives the care he or she would want under the circumstances.

In the absence of an appointed health care agent, some states convey statutory authority to persons who can serve as a surrogate decision-maker to make decisions on the patient's behalf. For example, Maryland's Health Care Decisions Act lists those able to make medical decisions on behalf of a patient without capacity, including a spouse, adult children, parents, adult sibling or friend, in that order. The statutory authority of a surrogate to act on a patient's behalf is generally more limited than that afforded to a health care agent.

The operator medical record should also contain the name of the operator's immediate supervisor in order to initiate the agency's response to a line-of-duty illness or injury. This is particularly important for operators who work outside a local chain of command such as those serving on task forces or who deploy throughout the United States or abroad.

**Element V: Advance directives, organ donation and wills.** Law enforcement is a hazardous occupation. If one considers the annual death rate, police officer is the third most dangerous occupation (n=133), falling below professional drivers (n=683) and farmers and ranchers (n= 300). Police officers should consider preparing a medical advance directive and a last will and testament, as well as make a conscious decision if they wish to serve as an organ donor.

An advance directive is a legal document that defines an individual's choices for treatment and care and permits the appointment of a health care decision-maker in the event the operator is unable to make medical decisions on his or her own behalf.

It is used to state in advance the type of care that you would like or would refuse under certain conditions. An advance directive can reduce the stress that family members often face with sudden unexpected health care decision-making. This type of planning can make a critical difference in the event of critical illness or injury or when facing end-of-life care situations.

A will is a legal document that directs the disposition of your assets after your death. While not considered part of a medical record, all police officers should consider the preparation and execution of a will. A record of where the will is located and who has access to it is helpful to family members in the event the officer fails to survive.

### SUMMARY

Law enforcement is a dangerous occupation which calls for advance planning for possible serious illness or injury. This planning should include compiling a medical record and a list of emergency contacts, and preparing legal documents such as a health care advance directive, a durable power of attorney, a will and a determination of organ donor status. The medical record and legal documents should be stored in a secure location and accessible to emergency contacts.

While some special operations teams may elect to compile and maintain a medical record file on each operator, those reluctant to do so for privacy concerns should not forego this exercise, but consider the alternative of having each operator create a file, secure it, and provide the team medic and/or commander with a basic file containing, at a minimum, the information in elements I, II and IV. Additional information can be provided by persons listed as emergency contacts when necessary.

Access to a comprehensive medical record file will enable health care

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providers to insure that a critically ill or injured officer receives the best possible care that he or she would want under the circumstances. The value of an operator medical record is relevant to more than operators on special operations teams and should be considered as necessary pre-planning for all police officers. ■

### ABOUT THE AUTHORS

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