Physician-Victim Approach to Human Trafficking

A *Healthcare* and *Heath Law* Perspective:

The necessary combination of Health, Law, Data protection, and Public Order

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Human Trafficking, Healthcare approach and Health Law:

- What is the U.S. Law saying about HT?
- What is the framework existing at State and Federal level?
- What are the legal issues arising?

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When speaking about **health** and **human trafficking**, we normally talk about:

- Range of **abuses** and traumas victims endure
- The **consequences** of them, in acute and long-term physical and psychological problems (Atkinson et al, JHT, 2016)
- Adverse **physical** outcomes:

Injuries from violence (bruises, concussions, fractures, lacerations, perforations of vagina an rectal walls), infections (sexually transmitted diseases –STDs), pelvic inflammatory disease – PID, and HIV/AIDS; gynecologic issues (repeated unintended pregnancies/abortions, lacerations, hemorrhaging), untreated chronic conditions (diabetes), malnourishment and poor dental care (Kiss et al, 2015)

- Adverse **psychological** outcomes:

Complex trauma related posttraumatic stress disorder (PTSD), anxiety disorder, major depressive disorder, suicidal ideation, psychosomatic illness, trauma-bonding and Stockholm syndrome, drug/alcohol addictions, and eating disorders (Zimerman et. al 2008)

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- We can also understand, **Public Health** and **Human Trafficking**:
- What is the **Public Health approach**?
  - Actions taken to protect people from a **community perspective**;
    - ✓ The individual is seen as **member of the community**: and is protected through **promotion** of good health habits and conditions, **education**, etc.
      - in our topic: about identifying HT, educating to know more about it, to detect it, setting **community early warning alerts**.

- Then, the **Healthcare approach**,
- What is the **Healthcare** approach? The **individual perspective** of the victim of human trafficking when he/she interacts with a physician, or healthcare provider, in a large sense.
  - **Individual health** vs. **collective health** (***of course, they are not disconnected***)

- By connecting **HT** with a **Health Law** perspective, we narrow the circle to fight it, helped by the Law, and addressing questions such as…

A **Bilateral dialog**, built normally on:

- reciprocal **confidence and trust**,
- **patient privacy** and **confidentiality**,
- on **informed consent:** information and voluntarily approach, true information given by patients for diagnosis and treatment by physicians, are basic.
  - But are HT victims really in a confident atmosphere? No, not initially.

    Why? shame, fear of retaliation, unwilling to identify themselves or tell the real origin of their suffering, vulnerability, lack of education, lack of knowledge of until what point the system can be of help, abduction, etc.

Who are these **health personnel** interacting with them?

- *Physicians, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, psychologist, emergency medical technician, dentist, nurse, chiropractor, podiatrist, optometrist, osteopath, allied mental health and human services professional, drug and alcoholism counselor, psychiatrist*.

Physicians are in a **unique position** at the intersection between health and the law (Powell et al. JHT, 2017), "*vital important players*", "*play a critical role*", **they are PRICELESS**, because of the situation in which they are.

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- Able to **detect**
  - after correspondent trainings,
  - or to some healthcare personnel, even without it, with the characteristics ***clinical eye***, medical intuition: "*something is wrong here…*"

- Able to **report** to law enforcement, or public health authorities.

- They can contribute with their action in the **Prosecution.**

- As well as in allowing **the victim's repair: a compensation (is there finally any…?).**

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Down the road, we can find different **legal issues** arising in the **Physician-Victim approach**

- **Data protection issues**.
  - Professional secrecy, privacy, confidentiality,
    - In general, when an information is ***Protected Health Information*** **(PHI)** according to HIPAA (Health Insurance Portability and Accountability Act 1996), **no disclosure is possible**.

- **Lack of consent to disclose**

- **Difficult procedure to report**, complexity of it.

Besides, **psychological issues**: fear of retaliation from victim and physician, individualism, etc.

HIPPA.

- **HIPAA** regulates the people who hold the information: *hospitals, health plans, & health care clearinghouses*:
  - called “covered entities”, and how they have to safeguard medical information.

- HIPAA, created in 90’s: electronic health records were pretty new concepts.

- HIPAA, to facilitate:
  - the exchange of electronic health info
  - and continuity of insurance coverage,

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but **privacy and security rules** are key, because **HT Victims**: have their **right to privacy too**.

- **HIPAA Privacy Rule** specified:
  - how **covered entities may use and disclose** PHI,
  - What are **patient rights** with respect to PHI. **45 CFR section 164.500 et seq**.

What is PHI? Rules define protected health information (PHI) as **health information** paired with **at least one of 18 identifiers**. *Individually identifiable information*; that can be used on a reasonable basis, to **identify individual**.

1. ***Names***
2. All geographical subdivisions smaller than a State, including ***street address***, ***city***, ***county***, ***precinct***, ***zip code***, and their equivalent geocodes, except for the initial three digits of a zip code, 3. All elements of *dates* (except year) for dates directly related to an individual, including *birth date*, *admission date*, *discharge date*, *date of death*
4. ***Phone numbers***
5. ***Fax numbers***
6. ***Electronic mail addresses***
7. ***Social Security numbers***
8. ***Medical record numbers***
9. ***Health plan beneficiary numbers***
10. ***Account numbers***
11. ***Certificate/license numbers***
12. ***Vehicle identifiers and serial numbers***, including ***license plate*** numbers
13. ***Device identifiers*** *and serial numbers*
14. ***Web Universal Resource Locators*** (*URLs*)
15. **Internet Protocol** (IP) address numbers
16. ***Biometric identifiers***, including finger and voice prints
17. ***Full face photographic images*** and any comparable images; and
18. Any other ***unique identifying number, characteristic, or code*** (note this does not mean the unique code assigned by the investigator to code the data)

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- Very hard to **de-identify data** (*encryption*, *codification*, *dissociation*, *pseudonomyzation* processes) and still **have it be useful** for many purposes. Not to mention in HT (it is not impossible though: giving a **code** to the victim?).

- **De-identification**, makes difficult use the information with law enforcement premises (identity, location, habits, etc.)

- Main premise, the HIPAA Rule: **PHI is confidential and cannot be released without patient's written authorization**.

  *Except…*for:

  - Treatment
  - Payment
  - Hospital Operations
  - To friends and family involved in the patient's care
  - For directory purposes (and to the clergy)
  - For research if the IRB waives consent/authorization
  - For preparatory to research purposes
  - Incidental disclosures of PHI
  - **public health, law enforcement, and legal process exceptions, where HT enters**

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Uses and disclosures for **public health** activities:

CFR › Title 45 › Chapter A › Subchapter C › Part 164 › Subpart E › Section 164.512

Code of Federal Regulations (CFR), Title 45

(b) *Standard: Uses and disclosures for public health activities* -

(1) *Permitted uses and disclosures.* A covered entity may use or disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is **authorized by law to collect or receive** such information for the **purpose of preventing or controlling disease, injury, or disability**, including, but not limited to, **the reporting of disease, injury, vital events** such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or **other appropriate government authority** authorized by law to receive reports of **child abuse** or neglect;

- Does HIPAA it says something about HT? **No**, it stays too large. *It would helpful to be mentioned*.

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- U.S. laws about Human Trafficking:
  - *Trafficking Victims Protection Act* 2000 (TVPA) (*perpetrators and victims were punished)*
  - *Trafficking Victims Protection Reauthorization* Act (TVPRA):
    - 2003 (*civil right of action for trafficking victims to sue their traffickers*)
    - 2005 (*pilot program to shelter minors; includes provisions to fight sex tourism*)
    - 2008 (*unaccompanied children screened as potential victims; enhances criminal sanctions against traffickers*)
    - 2013 (*avoids purchasing products made by HT victims; avoids child marriage*)
  - *Justice for Victims Trafficking* (JVTA 2015) (*where victim's perception changed. Victims are not anymore criminalized*).
  - *Trafficking Awareness Training for Health Care* (Act 2015): (*the Agency for Healthcare Research and Quality, gives a grant to the accredited school that could determine* ***best practices for health care professionals to recognize and respond appropriately*** *to victims of severe forms of human trafficking*)

- All **50 states and the District of Columbia**, **have enacted legislation making human trafficking a felony offense** (the first Washington HT criminal statute in 2002).
- Every state has *Child abuse and neglect laws*.
- Though, States have **different definitions of what constitutes human trafficking**…

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- **Dispersed State Laws** dealing with:
  - Sex and/or labor human trafficking.
  - Statutes and laws dealing mainly with **education and training**.
  - Some with **mandatory report**
  - 17 states have enacted legislation **both to sex and labor trafficking** (expect Minnesota that only deals with child sex trafficking), from them:
    - 13 specifically addresses the **education** of health care providers and other professionals about human trafficking
    - 7 states require **mandatory reporting** of trafficking of minors
    - 3 both: **education** and **mandatory reporting** laws (CO, MA, NC)
- **About 7 states with specific mandatory reporting laws regarding HT**:

All seven state report only mandate to minors : why? We need to expand this scope to adults.

- **CA**: only require sex trafficking
- **CO**: only require sex trafficking
- **FL**: addresses both sex and labor trafficking
- **IL**: also mandated residents of state facilities aged 18-22.
- **MD**: only require sex trafficking
- **MA**: addresses both sex and labor trafficking
- **NC**: addresses both sex and labor trafficking

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Reporting:

- The "**See something, say something**" in the healthcare provision world,
  - physicians are in this **unique position**.

- We have a **double direction** flux of information:
  - **Human Trafficking commissions** informing and training **healthcare providers** on how to identify victims when engaged in **examination**, **care**, or **treatment of persons**.

  - For **healthcare providers** to be able to **report** to **public health authorities**, but also to **police and law enforcement**, issues or cases related to persons that could be considered victims of human trafficking.

  - The **consequences** of report: police or law enforcement will inquiry and look closer to the victims situations, fighting HT.

When to report? 5 states: **immediately**, **as soon as possible**.

- MASS extends to **48 hours**, mandating **written report**, the rest **oral** is enough.

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What happen if failure to report?

- Failure to report is **subject to escalated penalties**
  - *fines*,
  - *criminal misdemeanor*,
  - *felony* –when repeated offense-
  - MASS or CA:
    - For not reporting: fine is $1,000;
    - but if willfully failure to report ends, in **dead** or **serious bodily injury**: $ 5,000 and prison up to 2,5 years.
- MASS: has 2 novel provisions:
  - To protect **reporters from workplace retaliation for having reported in good faith**
  - Requires the **Department of Children and Families give written notice to the reporter within 30 days** of the **outcome** of the report and any services provided to the victim.
    - **Instructive feedback** for physicians… shows the **report system** works

HIPPAA allows reporting, even when state laws do not mandate disclosure for suspected trafficking of a minor.

- **2 scenarios** according to HIPAA:

- Patient/victim **discloses**
- Patient/victim **doesn't consent to disclose**:
  - Then physicians, where **mandated reporting exist**, have to do it
  - Also disclosure, **when imminent danger of patient** and Staff (*emergency situation*).

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- But, where State Laws do not mandate, **physicians could legally report trafficking of minors** (it should also allow the report of an adult persons victim of HT)

- The **absence of mention or mandate**, does not prevent physicians to "**say something**".
  - **Regulating the prohibition** of reporting, is what **would prevent physicians** to react, not the opposite. *"Whatever is not prohibited is allow*ed".
    - The analogy to reporting laws apply afterwards…

- Where **mandated**, reports have to be made to.:

- The **competent legal authority** empowered to receive those reports
- The **disclosure of information** should be the **only required, or necessary,** under mandated reporting laws

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What to collect?

There is **no consensus** of **what** gets collected, **how to collect** the data, where to keep it, or **what to do with it**.

It should be (*medical*) **information** that allows to be transformed, to **detect a victim of HT**, to provide **useful information (but: *quality of the date principle…*)**:

- To investigate around the victim: victim identification, location, emails, etc. (all HIPAA identifiers…)
- To protect the victim from the trafficker
- To repair the damage of the victim

Possibility: State Central or Federal Register: **where all the health information** (useful for HT) could be stocked?

If accessible, it enables **Department of Children and Family Services or the competent authority** to immediately have access to information.

CONCLUSIONS

- **Physicians**: increasingly targeted by passing legislation, **specifically addresses physician** and other health care providers roles
  - especially in **trafficking of minors for commercial sexual exploitation**.

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- **Duties**:
  - Imposing reporting obligations
  - Legislation creating **educational** initiatives and **mandating** the **reporting** of trafficking victims by physicians and other health professional.

- **Challenges**:
  - Victims do not want to tell
  - Physicians do not want to participate
  - Avoid the mandatory perspective to report, generate **solidarity** (and **civic conscience** through **education**). Because we seek to fight HT and to make a **positive impact on the lives** of trafficked victims.
    - *Because of the uncertainty that might exist it is always wise to be on the side of protecting patients/victims*

- **Legal challenges**:
  - Disperse laws, confusion, various definitions
  - Relevant legislative efforts, but more needs to be done in terms of clarification and coordination at federal level

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- **National coordination needed** on: What, How, Who, Where to report?

- Create a **National Network Data Organization** for HT where also health information would be processed
  - As an intermediate body (*or use an existing one*) between physicians and law enforcement that could process information.

- **The basic targets (the 4 P's + R): Prevention**, **Protection**, **Prosecution, Partnership**
  - **Plus one more:**
    - **Recovery; compensation; retribution; repair to the victim; to assist and support**
      - a special mention about the reintegration of the victim/patient into society (children, men and women trafficked).

- **Economic challenges.**
  - **Funding resources**,
  - Material and Human resources to **allow a distribution of funds** to all the sectors involved to cope with expenses (training, management costs, etc.)

THANK YOU