Saudi Journal of Medicine and Public Health

https://saudijmph.com/index.php/pub

https://doi.org/10.64483/202412589

The Pathway for "Found Down" or Unidentified Patients: From Field to Identification and Social Reintegration

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Abstract

Background: Patients who are found unconscious or unresponsive, often referred to as "found down" or unidentified individuals, present significant challenges across emergency medicine, forensic science, public health, and social services. Typically, from marginalized groups such as the homeless or those with severe mental illness or substance use disorders, their lack of identity complicates clinical decision-making and undermines person-centered care. This often leads to fragmented treatment, ethical issues, and discharges to unsafe conditions, continuing a cycle of vulnerability. **Aim:** This narrative review synthesizes evidence from 2010-2024 to map and evaluate integrated, ethically grounded protocols for managing unidentified patients from pre-hospital discovery through to identification, clinical stabilization, and safe social reintegration. **Methods:** A comprehensive search of PubMed, Scopus, CINAHL, forensic science, and public health databases was conducted. **Results:** Effective management in healthcare relies on a coordinated multi-agency approach. Key roles include paramedics offering essential scene insights, nursing staff providing trauma-informed care, medical secretaries managing information, laboratories conducting critical analyses, epidemiologists tracking public health trends, and health planners connecting to social services. Successful integration of these roles leads to better patient outcomes, increased identification rates, and lower recidivism by prioritizing identification as a fundamental clinical and ethical task. **Conclusion:** The "found down" pathway is a litmus test for healthcare system equity and resilience. It demands protocols that harmonize acute medical stabilization, forensic investigation, and compassionate social care, ensuring that society's most invisible individuals receive dignified, continuous, and effective support.

Keywords: unidentified patients, forensic nursing, trauma-informed care, patient identification, vulnerable populations

Introduction

Within the ordered chaos of emergency healthcare exists a uniquely complex patient archetype: the individual discovered unconscious in a public space, a private residence, or a remote area, devoid of any identifying documents, known to no bystander, and unable to communicate their own name or history (Verma et al., 2019). Referred to in clinical parlance as "John/Jane Doe," "found down," or unidentified persons, these individuals materialize at the interface of medicine and mystery. They represent a profound challenge to foundational healthcare principles—personalized care, informed consent, continuity—and expose critical gaps in social safety nets (Mugelli, 2022). The population is heterogeneous but disproportionately comprises society's most marginalized: individuals experiencing chronic homelessness, severe and untreated mental illness, substance use disorders, victims of crime or trafficking, and those estranged from family networks (Fernandes et al., 2022). Their presentation is not merely a medical emergency; it is a societal failure made manifest in the emergency department (ED).

The clinical management of an unidentified patient is fraught with immediate obstacles. Without a history, clinicians work in a diagnostic vacuum, unable to access records, allergies, medications, or baseline functional status. This increases the risk of medical errors, redundant testing, and inappropriate treatment (Salloum et al., 2022; Jones et al., 2022). Ethically, providers grapple with performing procedures without formal consent, balancing the

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Receive Date: 22 December 2024, Revise Date: 30 December 2024, Accept Date: 31 December 2024

principles of beneficence and autonomy under legal frameworks of implied or emergency consent (Brenner et al., 2021). Furthermore, the process of identification is often haphazard, relying on chance recognition by staff or the delayed filing of a missing person's report. Upon stabilization, the absence of a viable social identity creates a "discharge to nowhere" scenario, where patients are released back into the same conditions that precipitated their crisis, ensuring a predictable return to the ED in a debilitating cycle of recidivism (Hudson et al., 2015).

This narrative review synthesizes contemporary evidence (2010-2024) to argue that the effective management of unidentified patients demands a radical departure from ad-hoc, siloed responses. It necessitates a formalized, interdisciplinary "Found Down Pathway" that seamlessly integrates clinical stabilization, forensic investigation, and proactive social reintegration. This review analyzes the indispensable roles of six core disciplines: Paramedics, as the first professional responders who interpret the scene; Nurses and Health Assistants, as the providers of trauma-informed, compassionate bedside care under conditions of anonymity; Medical Secretaries, as the crucial coordinators of information and inter-agency liaison; Laboratory Science, as the source of definitive biometric and toxicological data; Epidemiology, as the lens for discerning population-level patterns and risks; and Health Security, as the architect of systems that ensure safe transitions and continuity. The central thesis is that the unidentified patient is not an administrative inconvenience but a canary in the coal mine for systemic failures in mental health, housing, and social care. A compassionate, efficient, and ethical response requires a protocol-driven ecosystem where clinical care and identification efforts are simultaneous, coordinated, and universally understood as two sides of the same life-saving coin.

Scene Response and Field Stabilization – The Paramedic as Forensic Medic

The pathway initiates with the 9-1-1 call and the arrival of Emergency Medical Services (EMS). The paramedic's role in these cases extends far beyond advanced life support; they become forensic medics, whose observations are critical for both immediate care and subsequent investigation.

Scene Assessment and Preservation

Upon arrival, paramedics must conduct a rapid but meticulous scene survey. This includes noting the environment (an alley, a parked car, a secluded wooded area), ambient conditions (extreme heat or cold), the presence of medication bottles, drug paraphernalia, personal effects, or any signs of trauma or struggle (Koenig & Schultz, 2016). This environmental context can provide vital clues to etiology (e.g., hypothermia, overdose, assault) and identity. Paramedics are trained to minimize contamination of potential evidence while providing care, understanding that the scene may later become a crime scene (Kelty et al., 2021).

Clinical Stabilization and "Unknown" Protocol Activation

Medical care proceeds concurrently. Paramedics establish a unique identifier for the patient (e.g., "County EMS Unknown Male #24") and relay this, along with a detailed physical description (approximate age, distinguishing marks, tattoos, clothing) and clinical status, to the receiving hospital. This early notification allows the ED team to prepare (Popescu et al., 2022). Many progressive EMS systems have specific protocols for "unknown" patients, which may include mandated documentation steps and procedures for securing and transporting personal belongings in a standardized manner (Huckvale et al., 2010).

Hospital Admission and Anonymous Care – The Nursing and Health Assistant Imperative

Upon arrival at the ED, the patient enters a critical phase of receiving high-quality clinical care while existing in a state of legal and social anonymity. This is where nursing leadership and compassionate support are paramount.

Trauma-Informed Care Under an Alias

The nursing team, in collaboration with registration (often guided by a medical secretary), establishes a formal hospital alias (e.g., "Trauma Bay 3, John Doe"). From this moment, all care is documented under this alias. The principle of trauma-informed care becomes essential (Wilson et al., 2017). Nurses understand that the patient’s condition and anonymity may be linked to past trauma, violence, or marginalization. Care is delivered with heightened sensitivity, maximizing patient dignity despite the absence of a name (Cannon, 2020). This includes explaining all procedures clearly, using respectful language, and ensuring privacy. Health assistants play a vital supporting role in maintaining this environment, providing basic care and comfort while also being extra observant for any murmured words, reactions to questions, or recognizable behaviors that might offer clues (Nizum et al., 2020).

Clinical Workup in an Information Vacuum

Physicians and nurses must pursue a broad differential diagnosis without the guide of history. The workup is necessarily comprehensive, often including neuroimaging, toxicology screens, and infectious disease panels (Gainotti et al., 2018). Nurses are responsible for meticulous documentation of the patient's physical characteristics—photographs (with institutional policy adherence), detailed descriptions of scars, tattoos, dental condition, and any personal effects—creating a rich phenotypic profile for later identification efforts (Kim et al., 2016).

The Identification Engine – Coordination, Laboratory, and Data Analysis

While clinical care proceeds, a parallel process of identification is activated, requiring

seamless coordination between clinical, administrative, and investigative entities (Table 1).

Medical Secretary: The Nexus of Information Flow

The medical secretary or hospital registrar is the operational linchpin in this phase. They are responsible for creating and maintaining the temporary patient record, ensuring all communications use the correct alias. Crucially, they serve as the primary liaison with external agencies (Kumar et al., 2020). This includes initiating contact with law enforcement to file a missing/unknown person report, providing the physical description and fingerprints (if obtained), and later, coordinating with the police on any potential matches (Gemmati et al., 2019). They may also manage incoming calls from the public or other agencies inquiring about missing persons, requiring both discretion and procedural rigor.

Laboratory Science: The Biochemical and Biometric Arbiter

The laboratory's role is twofold. First, toxicology screening is almost always indicated to identify substance intoxication as a cause of unconsciousness. Comprehensive panels can detect a wide array of drugs, providing critical clinical management information and potential clues to the patient's lifestyle or last known activities (Walsh et al., 2019). Second, the laboratory is central to biometric identification. While fingerprints are often collected by law enforcement or security, hospitals may collect DNA samples (via cheek swab) under specific legal protocols for the purpose of identification. These samples must be handled with strict chain-of-custody procedures if they are to be used for potential forensic matching against missing persons databases (Huang et al., 2022).

Epidemiology and Public Health Intelligence

Epidemiologists, often embedded in public health departments, analyze data from multiple "found down" cases to identify patterns (Kornblith et al., 2013). Are there clusters in specific geographic areas? Temporal patterns linked to extreme weather or drug supply changes? Commonalities in toxicology results suggesting a dangerous new synthetic opioid? This population-level analysis transforms individual tragedies into public health intelligence, guiding targeted street outreach, harm reduction efforts, and resource allocation (Antonini et al., 2022).

Table 1: The Interdisciplinary "Found Down" Pathway: Roles and Responsibilities

Phase of Care	Paramedic (EMS)	Nursing & Health Assistant	Medical Secretary / Registration	Laboratory	Epidemiology & Health Security
1. Discovery & Field Response	Scene safety & assessment; Clinical stabilization; Documentation of environment & belongings; Hospital notification.	–	–	–	–
2. Hospital Admission & Stabilization	Handoff of scene details & patient effects.	Trauma-informed clinical care under alias; Detailed physical assessment & documentation; Custody of personal effects.	Creation of alias medical record number; Initial liaison with security/law enforcement.	Receives orders for urgent toxicology/ metabolic panels.	–
3. Parallel Identification Process	May provide sworn statement to police.	Continue care; Observe for clues to identity; May assist with biometric collection (photos).	**Central Coordinator:** Files official police report; Manages external inquiries; Updates record upon identification.	Processes toxicology; Banks DNA sample per protocol; Performs definitive testing.	Analyzes aggregate case data for patterns; Informs public health response.
4. Pre-Discharge	–	Patient education (if	Coordinates with social work/case	–	**Health Security:** Facilitate

Planning & Reintegration	capacity returns); Assess discharge needs & safety.	management; ensures the correct identity is on final documents.	s warm handoff to community services (shelter, detox, mental health); Develops protocols for safe discharge of vulnerable persons.

Social Reintegration and Safe Discharge – The Health Security Bridge

The culmination of the pathway is not merely identifying the patient, but ensuring their transition out of the hospital does not reconstitute the crisis. This is the domain of health security and social care coordination.

From Patient to Person: The Transition of Identity

Upon identification—whether through fingerprint match, family recognition, or patient recovery—a formal process must update the medical record. The medical secretary ensures all documentation is merged under the legal name. More importantly, the care team can now access past medical history, contact next of kin, and begin to understand the patient's social context (Zelis et al., 2019). Figure 1 illustrates parallel workflows for medical care, identification, and social reintegration of unidentified "found down" patients.

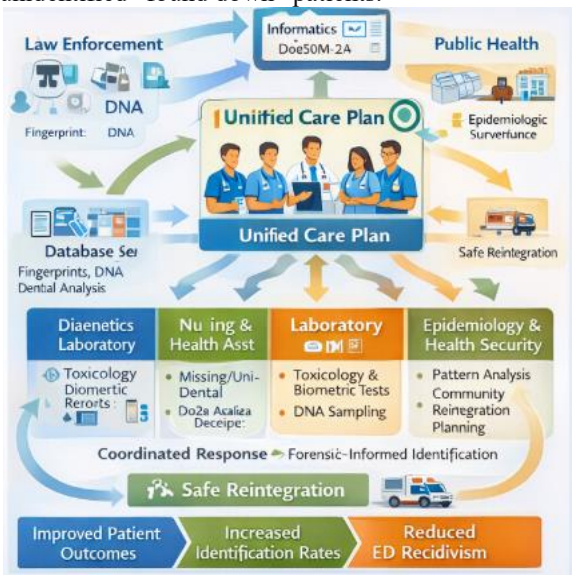

Figure 1. Parallel Identification and Social Reintegration Model for Unidentified Patients

Proactive Discharge Planning for Vulnerability

Identification often reveals profound social needs. Health security, in collaboration with hospital social work and case management, must activate a vulnerable patient discharge protocol (D'Souza & Mirza, 2022). This involves actively bridging the patient to community resources: securing a bed in a shelter or medical respite center, arranging transportation to a detoxification facility, scheduling an appointment with community mental health, or applying for emergency housing or benefits (Hatef et al., 2019). The goal is to move beyond a "medically clear" discharge to a "socially safe" transition, disrupting the cycle of ED recidivism. The health assistant can be instrumental in this phase, helping to gather belongings, providing empathetic support during the transition, and reinforcing follow-up plans (Raven, 2019).

The implementation of structured, interdisciplinary protocols for managing unidentified patients is associated with demonstrably superior outcomes compared to ad hoc approaches. The literature reveals several key operational models that have proven effective (Silva et al., 2022). **Forensic Nurse Examiner (FNE) Programs** represent a critical clinical-forensic bridge. FNEs, whose expertise is traditionally rooted in the care of victims of sexual assault and interpersonal violence, are increasingly being integrated into hospital-based unidentified patient protocols. Their specialized skills in forensic evidence collection, detailed anatomical photography, and trauma-informed, non-judgmental communication are invaluable for gathering high-quality identifying data without re-traumatizing vulnerable individuals (Berishaj et al., 2020). Another foundational model is the **Hospital-Police Memorandum of Understanding (MOU)**, a formal inter-agency agreement that clearly delineates roles, responsibilities, and boundaries. These MOUs standardize procedures for sensitive tasks such as fingerprinting, DNA collection, and information sharing while establishing robust privacy and confidentiality protections, thereby preventing jurisdictional conflicts and ensuring legal compliance (Marcovitz et al., 2021). Technologically advanced systems include **Integrated Electronic Platforms** that create shared, secure databases linking hospitals, medical examiners' offices, and law enforcement missing persons units. These systems allow for the rapid digital comparison of physical characteristics, scars, tattoos, and dental records against existing databases, significantly accelerating the potential for a match (Wang et al., 2022).

The documented outcomes of these integrated, protocol-driven systems are multifaceted and significant. Most directly, they lead to **increased patient identification rates**, thereby reducing the tragic number of individuals who are buried or cremated anonymously. This resolution provides critical closure for families and fulfills a fundamental societal duty (Katsanis et al., 2019). From a healthcare systems perspective, successful identification correlates with a **decreased length of stay** for

unidentified patients. Once identity is established, social solutions such as locating family, activating insurance, or accessing community resources become possible, facilitating appropriate discharge planning and freeing acute care beds (Goldstein et al., 2022). Proactive, multidisciplinary discharge planning for newly identified individuals has also been shown to **reduce 30-day emergency department recidivism**, breaking a cycle of crisis-oriented care. Furthermore, these systems contribute to **enhanced staff moral satisfaction**, as clinicians and security personnel feel equipped and empowered to provide truly holistic, person-centered care rather than experiencing the frustration of delivering care in an informational void (Jabbour et al., 2013).

Underpinning all effective models is a robust ethical framework that guides decision-making. A consistent and paramount principle is the **presumption of personhood**, mandating that unidentified patients be treated with the inherent dignity, respect, and standard of care afforded to any identified individual. This principle counters any tendency toward dehumanization (Tesoriero et al., 2023). The principle of **proportionality** governs investigative methods, requiring that the least intrusive means of identification (e.g., review of missing persons reports, conversation) be exhausted before progressing to more invasive procedures (e.g., forensic fingerprinting, DNA collection) (Tastad et al., 2021). Finally, the principle of **justice** demands that identification efforts be pursued with equal vigor and resource allocation for all individuals, irrespective of their perceived social status, race, socioeconomic background, or the circumstances of their presentation. This ensures the system operates equitably and does not perpetuate societal biases, affirming that every person has an equal right to their identity (Andersen et al., 2022). Figure 2 depicts the end-to-end "Found Down" pathway for unidentified patients, beginning at the scene of discovery and extending through emergency department admission and early inpatient care.

Figure 2. The "Found Down" Pathway: Integrated Clinical, Forensic, and Social Care for Unidentified Patients

Barriers and Future Directions

Despite clear benefits, implementation faces hurdles (see Table 2). Resource constraints limit the availability of dedicated staff for coordination. Privacy laws (HIPAA) and information-sharing barriers between healthcare and law enforcement can create friction. Implicit bias may lead to differential vigor in identification efforts based on a patient's perceived background. Lack of community resources ultimately undermines even the best discharge plans.

Table 2: Barriers and Enablers for an Effective "Found Down" Pathway

Domain	Critical Barriers to Implementation	Essential Enablers & Evidence-Based Solutions
Interagency Collaboration & Workflow	• Deep silos between clinical, law enforcement, and social service agencies. • Absence of formal Memoranda of Understanding (MOUs). • Competing priorities and unclear jurisdictional leadership.	• Establish a **standing Multidisciplinary Unknown Patient Taskforce** with defined authority. • Co-create and adopt **written, cross-agency procedural protocols**. • Designate **specific, named liaison roles** within each organization (hospital, police, social services).
Legal, Regulatory & Privacy	• HIPAA restrictions misinterpreted, blocking crucial information sharing. • Ambiguity surrounding legal consent for biometric collection (DNA, photographs) in unconscious patients. • Liability concerns among staff.	• Develop **HIPAA-compliant authorization forms specific to unidentified patient identification**. • Engage hospital legal counsel to draft **clear institutional policies** governing care of unidentified persons. • Provide staff training on **permissible disclosures for treatment and coordination of care**.

Resource Allocation & Clinical Workflow Integration	• No dedicated funding or Full-Time Equivalents (FTEs) for pathway coordination. • Overwhelmed clinical staff deprioritize identification tasks. • Cumbersome, paper-based processes for documentation and communication.	• Secure **grant funding or internal budget allocation** to pilot and sustain pathway coordination. • **Embed identification tasks into standard nursing/registration workflows** (e.g., mandatory fields in admission assessment). • Implement **technology solutions**: tablet-based photography apps, standardized digital forms, and integrated alert systems.
Community Capacity & Discharge Realism	• Critical shortage of shelter beds, medical respite care, and accessible behavioral health treatment. • "Discharge to nowhere" remains the default, undermining all prior efforts.	• Foster **hospital-community partnerships** through formal agreements or direct investment in respite care. • **Advocate for public policy and funding** to expand housing-first models and low-barrier treatment access. • Develop **hospital-based or affiliated medical respite centers** as a discharge alternative for vulnerable patients.
Ethics, Equity & Implicit Bias	• Unconscious bias leading to less vigorous identification efforts for marginalized individuals. • "Compassion fatigue" and moral distress among frontline staff. • Lack of standardized ethical frameworks for decision-making.	• Implement **mandatory training in trauma-informed care, cultural humility, and implicit bias recognition**. • Integrate **regular ethics consults** into the pathway for complex cases. • **Audit pathway equity** by tracking identification rates and discharge outcomes across patient demographics (race, perceived socioeconomic status).

Future directions must focus on technological integration, such as secure, real-time platforms for sharing de-identified patient descriptors with law enforcement databases. Policy advocacy is needed to fund medical respite care and clarify legal frameworks for unidentified patient management. Ultimately, the pathway must be routinized and funded as a core component of emergency and public health infrastructure.

Conclusion

The journey of the "found down" patient from anonymity to reintegration is a profound narrative about the values of a healthcare system and a society. It tests our commitment to the principle that every individual, regardless of their circumstance or identity at presentation, deserves compassionate, competent, and continuous care. This review demonstrates that meeting this challenge is not the purview of any single profession but the responsibility of a deliberately constructed interdisciplinary ecosystem.

An effective pathway harmonizes the forensic acumen of the paramedic, the compassionate vigilance of the nurse and health assistant, the meticulous coordination of the medical secretary, the definitive science of the laboratory, the population intelligence of epidemiology, and the systemic bridging of health security. By institutionalizing such pathways, we move beyond simply treating the acute crisis of unconsciousness to addressing the chronic crisis of invisibility. We affirm that the ultimate goal of emergency medicine is not just to save a life, but to return a person—known, cared for, and connected—to a community that has a place for them. In doing so, we build a more resilient, just, and humane system for all.

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