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Geri Amori, PhD, ARM, DFASHRM, CPHRM: Hello everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori.

And today, I am joined by Samantha Chao, MD, HEC-C, Director of Emergency Medicine Ethics and Clinical Assistant Professor in the Department of Emergency Medicine at Michigan Medicine. She is a certified clinical ethicist. She completed medical school, residency training, and both pre- and postdoctoral ethics fellowships at the University of Michigan. She is also a member of both the ACEP and SAEM Ethics Committees.

Saulius D. Poulteritis, Esq., is a principal at Knotts, McKinney, Dwaihy and Beach, specializing in medical malpractice defense. Mr. Poulteritis has worked with various hospital systems and physician groups throughout the state of Michigan, defending medical malpractice claims.

John Dery, DO, has multiple board certifications in emergency medicine. He is an associate professor of emergency medicine at Michigan State University School of Human Medicine in East Lansing, Michigan, and has been in clinical practice for over 14 years. Dr. Dery continues to make changes at both nationally, where he currently serves on the executive board of directors of the American College of Osteopathic Emergency Physicians, and, locally in his community as a sworn law enforcement officer.

Joann Wortham, RN, MSN, JD, CPHQ, CPPS, CPHRM, is a seasoned international thought leader who uses insight from lived experiences, along with her background in education, health care, business, and risk management, to create novel approaches to today's most critical workplace concerns.

So welcome, everyone. Today, we're talking about the inherent conflicting loyalties, ethical duty, and the law. Now, throughout my career as a risk management professional, I've often worked with hospital staff who would ask, well, is it legal for us to? And while these questions frequently did have a legal aspect, they often also involved significant ethical considerations. This would lead us to consult with our ethicist while simultaneously identifying the relevant statutes or regulations.

The most challenging situations were those involving law enforcement officers who appeared in an office, the emergency department, or on an inpatient unit, demanding information or access to records, or to be present during the examination of an incarcerated patient. Now, these visits occurred regularly enough that we developed policies, but not so frequently that all staff could easily navigate that inherent conflict between ethical duties to prevent harm and preserve autonomy, as well as the myriad of legal requirements.

In today's episode of *Perspectives 360*, we are going to discuss the broad concepts of where ethics meets the law and the negotiation of that patient care tightrope. We will touch on how organizations can be prepared and what patients should know. We hope you will also listen to the three next podcasts we will be releasing on this particular topic, where we will delve into greater detail about the impact of this dual responsibility on patient safety and patient rights, on staff, and, ultimately, on strategies for healthcare organizations to prepare for potentially more frequent and more confusing interface with law enforcement officers in healthcare.

So, back to today's topic: The conflicting duties imposed by ethical precepts guiding our care patients and the law. First, I'd like to explore this conundrum and why it exists.

So, Sam, I'd like to start with you. As a physician and a certified clinical ethicist, you have a deep commitment to ensuring healthcare is provided ethically. From reading the literature and listening to the webinar that you and Saulius recently did, it strikes me that healthcare providers focus on respecting patient rights to make decisions about their own bodies and on maintaining their privacy, which aligns with the ethical concept of autonomy, I believe.

On the other hand, it seems that law enforcement is concerned with the well-being of the community, which aligns with the ethical concept of distributed justice. These two ethical perspectives might be at odds, especially when the patient is suspected or proven to have committed a crime.

Why aren't ethics and law aligned, and how can this be reconciled?

Samantha Chao, MD, HEC-C: Geri, I think you pose two very good questions, and I have two answers. The first thing that I always say, especially when I'm giving kind of basic…sharing basic foundations of clinical ethics, is that ethics and law are not the same, and they're not meant to be the same. And I'm sure the two, you know, folks who have legal backgrounds on this podcast, you can speak to it as well.

But, you know, ethics is the study of morality, what is right and wrong, and there are a lot of different ways of approaching those things. But law is really trying to create more rigid boundaries and practical boundaries within those systems. And so there are a lot of times where what we feel is ethical or what we feel is right doesn't necessarily align with what the law says is legal or is not legal, even though in an ideal system you would hope that they would. But they're two separate systems with two very different functions.

And I think to touch on the other point that you make in terms of this kind of tension between our goals as healthcare providers and law enforcement's goals when it comes to ensuring security and safety, like, I think you really hit the nail on the head in the sense that the ends and the, you know, the goals that we are both seeking are very different and come into conflict frequently.

So as a healthcare provider, like, our goal is to focus on the patient and provide patient-centered care and autonomy is something that we think a lot about and sometimes it'd be too much. But, fundamentally, law enforcement and security, at least how it exists in our current…you know, in the U.S. currently, is very not focused on autonomy. It's focused on restricting movement in order to ensure the well-being of the community. And I think in order to reconcile those things, you have to potentially rethink how we view law enforcement and punishment and treating of people who have committed what we view as crimes or come up with a better way of creating a space in which we can work together and collaborate when these patients enter the healthcare space.

Amori: Oh, that's very interesting. Thank you. Ethics is not necessarily the law. That's good.

John, you're a physician and a police officer. Now that is a unique perspective. What is your take on healthcare being able to provide ethical care, respecting the rights of the patients? From your perspective as a law enforcement officer, how do you deal with it? You must see both aspects. Does it ever get confusing?

John Dery, DO, FACOEP-Dist, FACEP, FAWM: Absolutely. Every shift. And it depends which hat you're wearing. And several times I have to remember, remind myself, which master am I serving today? Which coat am I wearing? Am I under a badge, or am I wearing my badge that says physician? Because I have a different sense of duty and responsibility.

As a physician, my job is I'm bound to preserve life. And that's my primary focus. When I'm in a law enforcement perspective, I'm bound to preserve truth and make sure that those processes are both not interfered with. So sometimes it's hard to do both at the same time. And just as Dr. Samantha just mentioned, ethics is not something that we spend a lot of time on in medicine. We learned how to resuscitate bodies. We learned how to deliver medications. We often don't deal with the human aspect of our practice. That's why we do residencies and have to train for so long.

So, situations like this come up very frequently in our emergency medicine practice. And that's why you need to have a good sense of yourself and how you're going to choose to practice. That might change time to time, shift to shift. My mood might change. I might be under a lot of stress some days, and my decisions might not be the same ones I would do the next day, which is not very good because I'm not consistent.

But the end goal is my job as a physician, take care of my patient, protect their autonomy, make sure I do no harm and make sure I'm documenting everything appropriately. When I'm wearing a badge and bringing in a suspect, my job is to make sure I collect my evidence and make sure that I follow proper procedure and I can create a chain of evidence so that that can be admissible in court.

Amori: Wow. That must be confusing sometimes.

Sauli, as a lawyer, your job is to sort out the legal parameters of a given situation. Now we know that there are laws that can disagree with one another because of the different value systems underpinning them. We have laws about patient rights. We have laws that guide what law enforcement can do. How do lawyers address the apparent, or maybe actual, aspects of the law that lead to conflict?

Saulius Polteraitis, Esq.: Well, people assume that as attorneys that we approach these conflicts by who is paying our legal fees, but that is not true. There's a hierarchy and a structure to these various laws. The challenges that we as attorneys face stem from the fact that the public health law is a cumulative body of public health codes, state law, federal law, administrative guidelines, practice guidelines, hospital policies.

Then, we have general ethical considerations and constitutional issues. These interactions kind of govern the relationship between the patient and the provider or the patient and the government or even the provider and the government. As attorneys, we have to analyze what's the legal basis for the law enforcement's actions and, conversely, where does the authority for the right of the patient come from? The Constitution still provides the ultimate authority and the framework for these interactions. I mean, we have the Fourth Amendment protecting privacy. We have the Fifth Amendment protecting a patient from self-incrimination. When in conflict, we have this issue of preemption or where the constitutional rights override or dislodge statutes or regulations and federal law displaces or preempts state law.

In the healthcare context, we have federal laws like EMTALA or HIPAA that would govern a situation. But a lot of time, as an attorney, we are kind of assessing the factual circumstances and seeing if one of the various exceptions applies. For example, HIPAA, that provides the general framework for privacy. But even under that statute, there are carved-out exceptions of when we are allowed to disclose information, you know, private health information to law enforcement. That could be a warrant or a court order or there's some imminent threat or danger. State laws can expand on these exceptions. They govern consent a lot of the times, and they define the scope of practice for these providers.

But even apart from the federal and state law, we have individual and even collective staff ethical considerations, which come into play. You have conscientious objections or religious directives or Hippocratic oaths. So, we approach the interplay by seeing where does the authority lie for law enforcement and where does the authority lie for a patient's rights, and then which one supersedes the other.

Amori: Wow, that must be confusing sometimes. I can only imagine that could be hard.

So let me come to you, Joann. You know, we don't want to leave out the outpatient setting and you have a lot of experience there. We tend to think first about the activity of law enforcement in the emergency department or in other inpatient settings. But I know from

my experience as a risk manager that law enforcement can show up unannounced in the outpatient setting too. What are some of the ways this conflict of protecting patient privacy and the presence and the appearance of law enforcement, how does it show up in the outpatient setting?

Joann Wortham-Moody, RN, MSN, JD, CPHQ, CPPS, CPHRM: Thanks so much for asking. And you're right. A lot of times we don't really think about the clinics and our outpatient services that tend to be sometimes, you know, thinking that they're not a part of the whole. So, it's always important for us to actually reach out in terms of risk management, all of our policies really, to make sure that they are included, especially in something like this. Because when law enforcement comes into a clinic requesting patient information, that's one of those moments where ethics and law kind of collide.

In an outpatient setting, they really don't have, at that particular facility, security, risk management, in-house counsel, or what have you and those particular resources that are readily available, often. So, we get calls from frontline staff, and they're in the fray. They're dealing with it in the moment.

So, legally, under HIPAA, information can only be released to law enforcement if there's valid legal authority just like these other explanations that have been given. Is there a court order? Is there a subpoena or warrant? Or if the patient is given written authorization. So, there are limited exceptions, like when the law requires reporting of gunshot wounds, certain infections, substance abuse, or suspected abuse of a minor, an elder, what have you. There are specific cases.

But staff should never disclose or even confirm that a patient is being seen without proper documentation. And this is some of the things that I talk to the staff about when they call me. So, organizations should have a policy, and that's always what I'm pushing. We need to have a policy and procedure regarding these interactions so that we can assist staff in dealing with these situations. And I just can't say enough about, like, short job aids, checklists or what have you that can be great resources for our clinics that are out there. This includes scripting to tell them what is it that they need to say.

From an ethical standpoint, our duty is to protect the patient's confidentiality and their dignity. Just because someone with a badge is asking doesn't mean we are automatically supposed to comply. We have to balance compassion with compliance. So the right response is a respectful but firm…and I'm going over some of the scripting that we have in some of our policies. Sometimes, we tell them to say this, “I'm happy to help once we verify the appropriate legal authorization.” That protects the patient, that protects the staff, that protects the integrity of the organization.

For patients, it's important to know that their privacy doesn't disappear when law enforcement is involved. They still have rights under HIPAA, including the right to know

who has access to their information. Transparency builds trust, right? So letting our patients know that, you know what, we have your best interest at heart.

The clinics…we do have options in terms of obeying the law in terms of what is legal. Like, there are laws to protect them. And, ultimately, our goal in these situations is to obey the law, but to also protect and act in the patient's best interest, to act with integrity, if you will. And, of course, and this is, you know, all of risk management; You have to document everything and to remember that professionalism lives where ethics and the law meet.

So, this can be quite the balancing act. And we need to provide resources for that outpatient setting so that our staff will know exactly what policy and procedure is and have that guide.

Amori: Okay.

I'm going to skip to a question here to really ask Saulius. Looking strictly at the law, who has more rights? Law enforcement trying to protect the community? Or the patient having the rights to a decision about their own body? What are your thoughts?

Polteraitis: It's not a zero-sum game. And I'm sure…you know, I'm not sure we can approach it as there are rights that are always in conflict. So the real issue is not who has more rights, but how the law balances the rights of the individuals against the powers and duties of the state or law enforcement in this case. I mean, patients and even providers have the right to refuse to speak with police or to withhold consent from searches of their person or property. And these searches apply to medical tests and procedures.

Now, the limitations on law enforcement are a little bit more spelled out, especially when considering that, you know, the processes they have to go to obtain a warrant or the legal requirements to establish probable cause. That even when those criteria are met, the disclosure of the information, while allowable, is typically limited. But, obviously, there are circumstances where the authority of the state does win out over the rights of the individual.

Amori: Joann, have you run into a similar situation when it's not been an emergency, but law enforcement has brought a suspect into the outpatient setting? I mean, it would feel to me that in the outpatient setting, the patient could and should speak for themselves, but can they?

Wortham-Moody: Well, actually, and, you know, these situations come up often. And I would say that oftentimes, when the patients come in, the staff are more concerned about the patient feeling as though they don't have rights and feeling as though they can't say certain things in front of the police officer. And so, therefore, they feel as though they're

not making the proper assessment because they're not getting all the information from the patient.

So, part of what we've worked to do, Geri, is to actually work with law enforcement and to work with our community partners to let them know that if you're bringing a patient in, and there is no safety concern, right, immediate safety concern, and the patient is in custody, you're bringing them in for an appointment at one of our clinics, please let them be in the room with our staff, and let them have some privacy so that they can talk to the doctor about what is going on with them so that we can follow up with them while they're in the room. We can give them their discharge instructions or what have you.

But, of course, again, Geri, it's about safety. So, we want our staff to be safe. We want the patient to be safe. And also, of course, we've been talking about how we also want the community to be safe. So, it really is a partnership that we have with our local law enforcement. And they are very good with telling us, no, this is not that time. This is not that patient versus, yes, this is that time, this is that patient. I can sit outside. So, we have seen how our relationship with them has grown over time, where we trust them, and they trust us.

And I'll be honest, Geri, I think the patients feel that. You know even… they're in custody, but here are police officers…our community police officers walking and saying, hey, Jan, right? And the nurse knows them, and everybody knows each other. Then it really kind of relaxes the whole environment, and we're able to do our jobs. So, I think it's for us, again, like previous speakers have said, a balancing act, if you will, but putting our patients in the forefront and making sure that they get what they need while we obey the law and work with our community partners.

Amori: That's good, Joanne. Sam, you seem to want to say something about that.

Chao: Yeah, I appreciate all of these perspectives so much. And I think, you know, what it's making me think of is like the number one myth that I often have to dispel when I talk about this patient population is that, you know, adult patients with capacity – decision-making capacity – even if they're in custody, even if they're incarcerated, they make their own medical decisions. And we should be treating them the way that we treat any other patient. And I think what happens is, you know, we…these patients come in in custody with law enforcement accompanying them, and we view them as they're, like, in this special box that they're, like, untouchable.

Like we, you know, can't ask them questions privately in the same way or give them the same private exams. Or we somehow feel like we need to share information with officers at bedside. And none of those things are true. Like, we can still treat this patient the way that we treat any of our other patients. We just don't have good guidelines or education around it. So when our staff and providers, you know, are in these situations, they don't

know exactly how to navigate it. And, then, the default is to try to defer to law enforcement at the bedside who also might not know how to navigate a healthcare environment either.

And so, when we talk about like, you know, what rights do these patients have…like, just, treat them like any other patient. I think the biggest thing is their autonomy is restricted in, like, movement, freedom of movement and where they can go. But they still deserve to know all the information they need to know in order to make good medical decisions and to their privacy and dignity, just like Joanne had said, too.

Amori: Yeah, that's good. That's a really, really interesting perspective and a good answer. I kind of want to bring John's perspective into this. John, let's make it more complicated. You're going to have to wear both your hats to answer this one. Let's say law enforcement brings the patient in because they suspect a high blood alcohol, or the patient may have hidden drugs in a body cavity, right? And the patient's in the emergency department, fully conscious, and does not consent to the testing or examination. What then, Mr. Law Officer, Doctor?

Polteraitis: Great question. Am I on shift? Am I working in the department? So this brings up three key concepts. And, again, I mostly practice in a setting with emergency medicine residents and a teaching facility. So, this is a situation where I have a resident perhaps that's initially seen this patient, doesn't know what to do, comes to me. So this is always a great teaching opportunity.

First thing is always going to be patient's autonomy. They have the right to refuse any testing that they want. There's also the idea of non-malfeasance. If I pin this guy down, and I hold his arm against as well, and I get the blood work, there's a chance I could poke an artery. I could cause an infection. I could cause other problems. Now, I'm causing harm to this individual.

And just because…there's a difference between medical consent and a legal consent. A judge signing a warrant for me gives me a judicial authority to grab blood work and obtain that. However, that authority is given to an officer, not to me as a doctor. It is the officer's responsibility who has that ability to obtain that information.

I, as a doctor, can refuse. I'm not under any legal authority to actually go ahead and obtain that forcefully or against the patient's will. One of the things, on other side, when I'm wearing my law enforcement hat, the biggest thing is do I have PC? Do I have probable cause in this entire situation? And that becomes another chain of evidence and forcing non-compliance after that.

So, again, it depends. And it's my job as an officer then to find somebody who would be willing to obtain that specimen for me.

Amori: All right. Well, we have come to the end of our discussion, but I always have this one favorite question I like to ask people. I'm going to ask you to answer it in two to three sentences. And it is the one thing you would like our listeners today to take away from each of your perspectives about the issue of conflicting loyalties, ethical duty in the law, and healthcare. So are you ready to answer this question? You're all laughing. Okay.

Let's start with you, Saulius.

Polteraitis: I think my one big takeaway would be that whatever side you are on, that you have to be aware of what your duty is. So, on the healthcare side, the provider's duty is to the patient. On the law enforcement side, the duty is to the state and the safety of the community. And even when those interests are in conflict, each respective side has to maintain that duty. And it's up to the legal counsel of the hospital or up to the judge to kind of resolve those conflicts. So you just have to maintain, in the heat of the moment, what your duty is and what side you're on.

Amori: Thank you. Okay. Joanne.

Wortham-Moody: Sure. Thanks, Geri. I think, ultimately, for me, it's providing resources for our staff. Oftentimes, you know, having actually all these folks on, we have background, we have years of experience, we have all these types of experiences that we have gone through, and a lot of times our staff have not. And, so, some of them for the first time will be dealing with law enforcement.

We need to have clear policies, clear procedures. It's not enough for us to have just written policies, but also to activate our staff in terms of having some type of training that they can go through that's a little more than just an online video. But, actually, putting them in those scenarios, if you will, some scenario training, so that they can feel those emotions that they'll have during that time, and then also be able to carry out what the policy and procedures say.

So, I think we're going to have to get creative…

Amori: All right.

Wortham-Moody:…and really consider. Yeah.

Amori: All right. Thank you. Dr. Chao, Sam, what are you…what's your closing two to three sentences on this conflict?

Chao: I would say…

Amori: You're the ethicist.

Chao: Yeah. Right. I mean, I would say for this episode, the main takeaway is what I had talked about earlier, which is what is ethical and what is legal are not always the same

thing. And similar to what Saulius was saying, if you ever feel like there is a conflict between the two, I don't think you will ever be wrong doing what you feel like is in the patient's best interest.

You might face legal consequences or ramifications for doing so, but also it can be helpful when you have your institution's support doing the right thing for the patients and supporting you as staff and providers.

Amori: Good. Thank you so much. All of your perspectives are slightly different, but they really work together. And John, you who walk the tightrope every day of this conflict of ethics in the law, would you like to tell us what your two to three sentence, one takeaway you'd like our audience to have?

Dery: One takeaway from a guy who loves to talk. That's hard.

It would be that a warrant authorizes law enforcement, not medicine. As a doctor, my job is to protect the patient's body and preserve their health. As an officer, I'm supposed to protect the integrity of the evidence in the investigation and provide the resources necessary.

The real integrity is in lying…in knowing where those duties kind of divide and where they have to kind of come together. And the forefront will depend on which role you're in at any given time.

Amori: All right. Thank you very much. And I want to thank all of you. This has been an incredibly fascinating discussion. And, I want to thank our panelists for participating and our audience for listening. I hope you found this valuable. I know I certainly did.

And we look forward to seeing you again next time when we discuss another aspect of this issue from a *Perspective 360*.

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