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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.

We also have joining us Saulius D. Polteraitis, Esq., a principal at Nauts, McKinney, Dwaihy and Beach, specializing in medical malpractice defense. Mr. Polteraitis has worked with various hospital systems and physician groups throughout the state of Michigan defending medical malpractice claims.

And we also have John Dery 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 and has been in clinical practice for over 14 years. Dr. Dery continues to make changes at both the national level, 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.

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

Today we're discussing the interaction among employees, visitors, and law enforcement officers in healthcare facilities. There's a lot of conversation about the presence of law enforcement officers in various settings, like the emergency department or inpatient units and outpatient areas, focusing primarily on patient rights. And these discussions often center on patient privacy, autonomy, and the implications of having an outside party present during examinations or access to records and more. However, there is less discussion about the impact on other people who are seeking care in these settings or on the staff themselves, who may find themselves in difficult and potentially contentious situations.

The presence of law enforcement officers wearing body cams or visible weapons or requiring patients to be shackled or restrained can be unsettling for other patients in the waiting room. On one hand, we understand that law enforcement is involved because the individual is shown or is believed capable of harming others.

My husband, who worked in forensic psychiatry for years, often had an armed law enforcement officer sitting outside his office, ready to act if needed. And I personally was relieved to know someone was there for protection. Yet, many visitors and staff may have traumatic reactions to the authoritative and power-based presence of law enforcement.

Today we're going to talk with our panel of experts about the potential impact on other patients and staff and how healthcare organizations can address these situations to protect staff and visitors from unnecessary trauma.

Joann, I'd like to start with you. You are a thought leader and expert in a number of fields with an expertise in outpatient healthcare. You are keenly aware of how unpredictable situations can have traumatic effects on witnesses. I'm recalling a time when a law enforcement officer entered one of our outpatient offices and threatened the front desk staff because he wanted to know if a certain person had been in for treatment and when that person had left and wanted to talk with the provider and get visit notes. You know, the staff person maintained her cool and got support, but he was big and threatening, and she was definitely scared. So this happened more than once, and I know it happens today.

How do we prevent our frontline staff from feeling bullied by law enforcement officers who show up unannounced making demands?

Joann Wortham-Moody, RN, DNP, JD: Thanks, Geri, for raising that because, unfortunately, that type of situation is not all that rare, and it's incredibly stressful for the people on the frontline. So in our outpatient clinics, I'm talking about our receptionists, our medical assistants, clinical supervisors often they find themselves face-to-face with law enforcement. Law enforcement officers sometimes are frustrated, and they can intimidate the staff.

So from a risk management and a trauma-informed standpoint, the first thing we have to acknowledge is that these encounters can be psychologically injurious and not just to the patient but to the staff who witnessed and experienced them. So an officer's uniform, visible weapons and what have you, and even their body language can trigger past trauma or fear for the staff. So even if the officer believes they're just doing their job, the perceived power imbalance can really create distress for our staff.

So the solution starts with clear policy and proactive training. So staff should never have to deal with this spot-on in terms of responding to law enforcement, not knowing what the policy and procedure is. So every organization should have a law enforcement interaction policy that clearly defines who speaks to the officer. Is that the supervisor, the manager of the clinic? How to verify legal authority. Why are they here? Do they have a subpoena? Do they have a warrant? When staff can safely disengage and call for support, right?

So training should go also beyond just our regular online training or just our HIPAA training. It should really include, again, role playing, de-escalation, and empowerment techniques so staff know that they can just calmly say, I'll need to involve our compliance

officer before proceeding. They need scripting. They need help with knowing how to actually face these very, very difficult situations.

So finally, we need to normalize the psychological safety, too, after these encounters. We need to offer them debriefs, EAP support, peer support, if necessary, and reassurance that protecting privacy is not an obstruction. So it really is professionalism. So when staff feel supported by policy and leadership, they're much less likely to feel bullied and much more likely to gain confidence when they're handling these types of situations, Geri.

Amori**:** That's good to know. And that's really important information. Sam, from an ethical perspective, what is our responsibility to visitors and staff in terms of this?

Samantha Chao, MD, HEC-C: I would say, based on this anecdote that you told, you know, the primary duty and responsibility is protecting patient privacy, which is a way of respecting patient autonomy. And I think the other ethical kind of concept that illustrates the conflict that this person, this front desk person, might have faced when, you know, the law enforcement officer shows up at this outpatient clinic is the idea of dual loyalty too. The dual loyalty is when you feel like you have competing obligations. In this instance, it would be the competing obligation between your obligation to the patient and things that you know that you need to do as a healthcare worker, like protect their patient privacy, but also duty to a third party like the state or representative of the state, as this law enforcement officer is.

And so it can be really challenging in those moments. And as a clinical ethicist, if I got a call about this situation, exactly as Joann said, my response would be, what is the process here? What is the process that this person can follow? Because there should be a process in which it's not a front desk person just handing out private patient information to law enforcement just because they are asking for it in that moment. But there should be an office that is involved assessing whether or not it's appropriate to disclose this information if it meets the exceptions to HIPAA that we're aware of and somebody like, a clear kind of escalation pathway for somebody who’s faced with this type of situation.

Amori: Saulius, now what is our legal responsibility? Can staff turn around and blame us if we don't address their psychological safety? If they are refusing to comply with law enforcement demands for tests, how do we protect them?

Saulius Polteraitis: So hospitals and healthcare facilities they can protect the staff by educating. I mean, educating them on the legal and ethical basis for refusing to engage in certain requests by law enforcement. And, you know, the staff have the right to refuse participation in procedures that breach medical ethics or patient autonomy. And the best way that you can do that is you encourage documentation of these interactions with law enforcement. That will protect them so that you can do whether it's internal reviews, root cause analysis, things like that.

But the other aspect of this is the law enforcement's access to the hospital or facility itself. I mean, a lot of the times these police officers routinely have unrestricted access

because, you know, the staff gets to know them. And it's through habit and routine that they are allowed in certain areas. So what you have to do is educate these staff members at these points of entry to know what circumstances require either getting legal involved, either require documentation, require court orders, subpoenas. Those are the things that you have to educate staff on that will help when you look, you know, retrospectively, at a situation that may have law enforcement making some unethical or unauthorized requests.

Amori: Okay. Good. Thank you.

And John, I was going to ask you about how do people who work in the ED respond to law enforcement, but I'm hearing they really like them. So I'm going to ask you a different question. I want to say that we know that psychiatric patients, whose meds need adjusting or who were having a breakdown, they're thinking differently from other people. They're not bad. They're just thinking differently. So they show up in the ED, and people interpret their behavior in threatening ways or maybe they're suicidal, and maybe law enforcement brought them in. How should law enforcement work with the facility to ensure the least trauma to the other patients who are in the waiting room?

John Dery, DO, FACOEP-Dist, FACEP, FAWM: Great question. So in a law enforcement perspective, I now have custodial responsibility for this patient. And I need to figure out is this a medical problem? Did they overdose on something? Is this a psychiatric problem where they're hallucinating and responding to external stimuli? I'm not a physician in that perspective. My job is to make sure I take care of my suspect because I have that responsibility. My job is, in any way possible, to help prevent them from hurting themselves.

And if I have somebody who is flailing about making threatening statements to other people, maybe trying to harm themselves, trying to run away from the devil who's chasing them or something else, my job is to get them to the facility where they can get the help that they need. That may include getting chemical sedation or restraints in addition to physical restraints that I have on them initially until they can have other types of behavioral compliance. And law enforcement, essentially, is going to work with the emergency department staff.

In general, one of the things we run into a lot, because of the stressful situation, the way in which everybody lives, law enforcement and healthcare workers, firefighters, I mean, they all essentially live, marry, intersperse with each other. So half of my nurses that I work with are married to either police officers or firefighters. In fact, the first thing that I tell any of my new nurses, starting, is avoid the four P's, the physicians, the firefighters, the police, and the paramedics. Inevitably, it kind of intersperses quite a bit. And that can sometimes create these ethical situations where, you know, so-and-so's husband is bringing a suspect in, and, hey, is it okay if we get that blood draw, even though the patient's yelling, and screaming, and refusing?

The biggest thing that I can do, as a law enforcement officer, is use my first tool that I was taught in police academy, and that is command presence. That's not something you just do in law enforcement. It also has to do in medicine when there's a resuscitation going on. First thing we do, we walk in, we get everybody to be quiet. Everybody knows who's in charge. You know, based on how you're carrying yourself, your posture, your movement, your eye contact, your voice, whether it's calm and cool, collective, the proximity that you have from the patients and other family members. You do more with your presence in either of those roles, either the physician or law enforcement, to nullify or bring down the intensity of any situation. And that's really the first tool that any of those specialties should be reaching for.

Amori: Okay, that's good.

So, Joann, I want to ask you a question. I have long been concerned, as a risk-management professional, about outpatient staff who are in difficult family or lover situations. I'm sure you've dealt with them, too. They may have a restraining order on their spouse, or they may be, you know, who knows what, right? And sometimes there's people they are just trying to avoid. What would you advise an organization to do not just to protect that person from harm, because I'm sure you've got policies, but the other staff and visitors in the waiting room from the trauma?

Wortham-Moody: Right,. So actually, and of course, like you just said, we do have policy. But one of the things that I've worked very closely with some of our outpatient clinics with is to actually have drills. A lot of times, a lot of things that happen with them, they have not practiced. They haven't practiced how do you get out of a situation, right? So if someone's spouse does come in, or, you know, they have a restraining order against, you notice this person, what do you do? It's hard for you to try to make decisions in the moment. And oftentimes, we leave outpatient areas outside of the drills that we have, the fire drills we have, the shooter drills we have, and we don't include them.

I'm always telling my facilities to bring them in. Bring in our clinics, in terms of everything that we're doing for the inpatient facility, we should be practicing those drills in the outpatient facilities and protecting those employees with the same robust type of drills that we have and policies that we have for inpatient. So, I've been working with outpatient clinics to actually go out there and talk about the different types of encounters that they have had with patients like you were saying, these different instances when employees may have folks that they're afraid of or what have you.

What has happened is that now that we don't actually have security officers out there, now we have a security champion. And what the security champion does is to look at those situations. We come up with plans for those situations. We drill on those situations. So that those folks that are in those clinics, some of them, Geri, are kind of far out in the country, too, they don't necessarily have a police station around the corner. So we actually are working with them, so they have a plan. Once we do that, Geri, the whole atmosphere changes in terms of how comfortable they feel and how supported they feel.

Amori: Okay, good. That's really great. So, Sam, ethically, what do we owe our staff and the visitors in the waiting room in terms of psychological support after an encounter with a patient who goes off on them or anyone else they feel has bullied them in the workplace?

Chao: I think that's a really big and very interesting question. I think in terms of, like, what we owe patients and visitors, we could do a lot more in terms of offering psychosocial support to people who kind of bear witness to the extreme things that happen in the emergency department. And I think about, you know, patients, not just in the waiting room, but there have definitely been patients who are in, like, hallway spaces who watch us resuscitate a patient who's in cardiac arrest, which can be oftentimes, like, a very violent and graphic thing to bear witness to. And, you know, you walk by those patients, after the fact, and you can see how shocked they are. So I think that's actually, like, pretty unexplored territory.

And in terms of what institutions owe their staff, this is a huge area of active research, advocacy, policy change in terms of, like, workplace violence that nurses, in particular in the ED, as well as physicians face. And I think a lot of institutions are working really hard towards establishing a culture of safety, where we try to draw firmer boundaries around behaviors that we either find acceptable or not acceptable, or that we will, like, pursue consequences for. It's very complicated.

And I would say I also can't have this conversation about, you know, what people who come to the emergency department and are in the waiting room experience without thinking about E-boarding, too. Like I'm about to go walk into a shift as the advanced triage provider. There are 60-plus patients that are sitting in a waiting room that I am going to be the person, you know, taking care of them. And all of these things lead to downstream effects of being in the waiting room long term, being exposed to other patients, wherever they might be coming from, whether in law enforcement custody or not. And I think healthcare organizations need to very seriously be dedicating resources and time to figuring out how we can relieve the issue and the problem of E-boarding, which is multifactorial, which I think can help with the root of a lot of these problems.

Amori: Okay, thank you very much.

All right. I think we're going to jump to our one thing question at this point. So, you know, at the end of each of our discussions, I always like to ask you to give me a two-sentence pitch point that you would like our listeners to take away from our discussion today. Like what is the one thing you would want them to remember about what our responsibility is in terms of the presence of law enforcement, and our visitors, and our staff, and how we take care of them?

So, Saulius, I'd like to start with you

Polteraitis: So, law enforcement agencies they do have specific rights to access medical information without consent when someone threatens violence against healthcare

workers. But as we see in the statute and as it plays out in cases across this country, those exceptions are limited in scope, and they're limited to who receives that information, and the information must be limited to what actually minimizes or eliminates that threat.

Amori: Okay, thank you. That's important information. Joann?

Wortham-Moody: Thanks, Geri. I just want to say that in terms of dealing with law enforcement within the environment, the healthcare environment, when staff feel supported by policy and leadership, they're much less likely to feel bullied and much more likely to handle those moments with confidence and composure. And just knowing that we could be that resource for them and offering psychological safety in those moments is very protective for our staff.

Amori: Okay, thank you. You are a strong advocate of policy and procedure. That comes through loudly and clearly. So I hope our audience is picking up on that.

Sam, what would you say is our takeaway here?

Chao: I would say one of the core things that I always do, as a clinical ethicist, when I'm approaching a specific conflict or question or issue, is one of my goals is to elicit the perspectives of all of the stakeholders that are involved. And so when we think about this idea of feeling safe in, like, the waiting room of the emergency department, there are so many different perspectives to call upon and to think about. Not only the times in which people might feel threatened by law enforcement being there, but also the times where people might feel safer because those people are there. I think there's a lot of different perspectives to listen to and to hear from in order to develop creative solutions to make everybody feel more safe and comfortable in a hospital environment.

Amori: Okay, that's a really, really good point.

And finally, John, from your perspective, what do we need to think about in terms of our visitors and our staff in terms of this issue?

Dery: I would say whether you're wearing a badge and a pistol, a sidearm, or if you're wearing a stethoscope and a white lab coat, the command presence that you have always needs to be calm, confident, projection of control. So that way you're communicating safety and authority without any level of aggression. How I appear is how people are going to interpret things. It can actually steady chaos before a single word is spoken, and that exists whether I'm engaging patients, visitors, staff. It means that you have to lead with composure and empathy, being firm enough to earn respect and steady enough to invite trust.

Amori: So the appearance of that calmness and compassion is really, really important for everyone involved in the situation.

I want to thank all of you. This has been an amazing and interesting discussion. And I appreciate our panelists. I want to thank you for participating. I want to thank our listeners for listening. And I look forward to our next discussion where we can discuss another aspect of this topic from a *360 Perspective*. Thank you.

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