[music]

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'm 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, and she also completed medical school, residency training, and both pre and postdoctoral ethics fellowships at the University of Michigan. She is a member of both the ACEP and SAEM Ethics Committees.

We also have 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 physicians groups throughout the state of Michigan defending medical malpractice claims.

John Dery, DO, FACOEP, and many other things, 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 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, healthcare, business, and risk management to create novel approaches to today's most critical workplace concerns.

Okay with this esteemed group, today we are going to talk about law enforcement in the healthcare setting from the perspective of safety and patient rights. On a previous occasion, we have already discussed the murky boundaries where ethical rights and legal rights of patients meet the legal responsibilities and the rights of law enforcement. Today however, the discussion is going to focus on the implications of law enforcement presence and their actions on the safety of care provided to victims of crime suspects and incarcerated patients brought into the healthcare organization by those law enforcement officers.

Now many of us have experienced the presence of law enforcement officers accompanying a patient in shackles or handcuffed with a body cam running and a very strong legal presence. That energy affects those providing care, clearly. This is not your run-of-the-mill examination. But also the energy has to affect the patient themselves and perhaps even the energy of the law enforcement officer, who may be anticipating pushback or challenge to their authority. So the question for us to discuss today is, how can the healthcare organization recognize and minimize any detrimental effects of just the presence of the law enforcement officer to the safe, legal, and ethical delivery of care to that patient?

So John, I'm going to start with you today. As a law enforcement officer who's also a physician, there must be many times when you'd think I'd love to get a blood alcohol level, a drug screen, a psych eval, or maybe even a blood sugar level on this person. Something's just not right medically. However, you're operating in your capacity as a cop. I want to know how what do you do, especially if the person is in the emergency room and refuses care? What if they're unconscious? How do your medical impulses

interact with what is your job as a law enforcement responsibility? What's your decision-making process?

John Dery, DO, FACOEP-Dist, FACEP, FAWM: That is a great, great moral and ethical dilemma. So when I'm wearing my law enforcement hat, if I have a suspect that is currently in custody, my responsibility, as law enforcement at that point, is that I have custodial responsibility to my suspect at this point, I have to make sure that I am worried about their health and their safety. However, that does not give me any authorization or ability to make medical decisions for them whatsoever. I, as an officer, cannot give consent for that suspect to any type of procedure. That is something I have to defer to my medical colleagues to try and do in that situation. If they're unconscious consciousness just means they can't give or refuse consent, we would have to – putting on a medical hat – stabilize the patient, act in the patient's best interest. And that is up to every provider who is responsible for the medical care at that point. My job, as a police officer, is just custodial care at that point – make sure the suspect is safe, they are stable, that they are cared for in an appropriate manner.

Amori: Okay, that's a tough tightrope you walk. Joann, what is your experience in terms of the impact on the care to that patient themselves, from the presence of law enforcement officers in the outpatient setting? Let's say they're carrying weapons, visible weapons, or they're demanding to be present, or they're wearing body cams, like, how does it affect the patient being examined?

Joann Wortham-Moody, RN, DNP,JD: Well it definitely not only just affects the patient, but it also affects the patients in the waiting room. It affects the staff that are treating the patients, especially if the officer is armed. Again, like you said, wearing a body cam, the patient is shackled. So from a risk management standpoint, the presence of law enforcement changes the whole tone of the visit, if you will. And patients often experience like heightened anxiety. Some of them are embarrassed. Oftentimes, there is a bit of mistrust from the staff, with the staff thinking that, you know, the staff are working, so to speak, hand-in-hand with law enforcement. So, this really can't compromise the accuracy of this assessment, also because of how they're feeling. So, even other patients in the waiting room have said that they feel unsafe. They're reluctant to continue their own care. Some of them just get up and leave. So there is this unintentional, if you will, barrier that may be created.

So, the ethical and clinical goal is to maintain patient dignity and safety while complying with these legal obligations that we have. So best practices is to have, again, clear law enforcement interaction policies. These outline where the officers should stand, when they can be present during the exam, how weapons or recording devices are handled. When possible law enforcement should wait outside the exam rooms unless their presence is absolutely required, right, for safety or custody. Clinics should also train staff to deescalate, maintain neutrality, and also advocate for privacy for the patient.

You want them to be calm, well informed – I'm talking about our team now – and balance both of those obligations in terms of complying with the law, but also doing what we are supposed to do, which is to maintain the patient's privacy and care for the patient. Again, it's a balancing act between the two. But the presence of law enforcement shouldn't strip away a patient's right to safe, private, and compassionate care. And again, it really is more about balancing, working with our community partners to make sure that our patients stay safe but then also, again, keeping staff and the community safe also. But definitely, I would agree it does change the tone of the visit when law enforcement is there.

Amori: That was in the outpatient setting, particularly. But Sam, what about the ED? I would think if I were a person being engaged right now with law enforcement, and there was an armed officer in my examining room when the doctor is asking me intimate questions, that would have a chilling effect on my honesty, not to say my blood pressure. And what if the law enforcement says they can't step out because of some sort of internal protocol or whatever? What if they're pregnant, or they have to go to radiology? What's your experience? What would you do?

Samantha Chao, MD, HEC-C: Geri, I think you picked a really perfect example that kind of encapsulates the biggest dilemma that physicians face at the bedside when they're caring for this patient population. And what I'd say is, you know, early in my residency training, when I didn't really know much about this and my gut intuition was like, you know, I wanted to defer to the officers at bedside, because these are people that I would listen to if I was outside of the hospital. You know, if they pulled me over, stopped me in the street, they're an authority figure that I, you know, think should know all the answers of how to manage and navigate the situation. And so there were many times early in my residency training where I did not question the presence of officers at bedside while I was trying to interview or examine a patient or even do sensitive exams.

And it was really over the course of doing more research and work in this area where I realized like, that is not right, that is not the best, most dignified care that we can give to these patients. And to Joann's point about having policies like, yes, that is the answer. And the problem that happens right now is that there are either no policies that exist at a hospital institution, or it's very variable, or it's very complex, just because of the different levels of jurisdiction that could be involved, whether or not somebody's in state, federal or local custody. Let alone talking about things like, you know, US Immigration and Customs Enforcement. So I would say like, now, having learned more and knowing more, my approach is I try to give these patients the same patient care experience that somebody who is not in custody or incarcerated also experiences. And I try to be very polite but firm with officers at bedside. And I will say, like, I need to interview this patient privately, can you please step out of earshot?

And if they tell me they have an internal protocol, you know, that suggests otherwise, I'll ask them what their protocol is. Oftentimes it's keeping the patient in line of sight. And so I'll say, you know, what is your protocol? I can help work with you to ensure that you are appropriately surveying this patient, but I need to be able to interview them privately. So that way they can tell me exactly as you're saying things that they might not feel comfortable sharing if officers are there and listening at bedside. And for physical exam too, having people step, you know, to a part of the room where they can't see what's going on, draping the patient, having chaperones available, or making sure that the officers at bedside are gender concordant, if that is feasible or appropriate for the situation. Taking care of patients who are pregnant and incarcerated is actually a whole other can of worms that I appreciate you bringing up but probably won't touch on it now. But there's actually a lot of federal best practices specific to that patient population as well in terms of shackling.

Amori: Okay wow, I'm glad to hear that. Saulius, there's a case reported in the literature about a nurse, in Utah, that was arrested because she refused to allow a lab draw on a patient without the patient's consent. You know, what is that story and who was wrong?

Saulius Polteraitis: Sure. So, this happened in about 2017. So the patient was driving a truck and was struck by a vehicle who was fleeing the police. The patient was unconscious and taken to a hospital. He

had extensive burns and other injuries. The charge nurse was caring for the patient when a police detective comes to the burning unit and requests the nurse to perform a blood draw for a serum ethanol, and no warrant is produced, and the nurse refuses. So the hospital had a policy regarding obtaining these blood samples. And the nurse – to her credit – knew the policy and had enough confidence to voice that policy and inform the law enforcement officer and said, look, the hospital has a policy that the patient must give his or her consent. Well, he's unconscious, so he's not able to do that. Or the patient must be under arrest. He was not under arrest. He was actually the victim of this accident. Therefore, a warrant must be issued ordering the taking of a blood sample. Well there was no warrant. So, it did not meet the legal requirements and could not be performed.

So after refusing, the nurse is arrested. Now all of this is recorded, and it's probably one of the reasons why it got such national attention is because this was all recorded on body cams and stuff. So, the nurse was eventually released and not charged, and unfortunately, the patient ends up dying of the burns. The police explained after this all happened that he was not an actual suspect, that he was a victim of the crime, he was not suspected of any wrongdoing, and they were just seeking blood tests to actually protect him. And there was some basis for that, and there are federal regulations for commercial truck drivers that required such bloodwork. But when you ask who was wrong, well, the police chief, even though at first said, you know, none of the officers are going to be disciplined, ends up firing the arresting officer. And then the nurse actually ends up getting a hefty settlement amount. So I guess you can kind of infer who was wrong in that situation and who was right.

Amori: Okay, you know, I want to ask this question of Sam. You know, we're talking here about like the patient – whether it's the victim of a crime or the possible perpetrator or the suspect – their healthcare being affected by the presence of law enforcement. Like maybe their blood pressure does go up, or they don't tell you the truth, or they refuse consent, or that kind of thing. What situations have you seen – or have you seen any – where the presence of law enforcement officers have affected the potential safety of the patient?

Chao: It happens. It happens a lot. I think, you know, that framing makes it seem like having the law enforcement officers there is like always a negative presence, which isn't necessarily true. I think the things that happen are like, you know, I've had definitely many cases where a patient will be brought in emergently from a local prison or a local jail in acute medical distress, and we have to bring them to our resuscitation bay for immediate evaluation and resuscitation. And I've had a handful of instances where they've come in, and they've had a variety of restraints on them.

So they could have like, either shackles around their wrists or even belly restraints or things around their ankles that impede our ability to evaluate, place IVs, draw labs, and do all the things that we would do in an emergent setting in order to evaluate these patients and stabilize them. And so I've grown into my voice, and I think having a long white coat has definitely helped these conversations, too. But I try to be very firm with officers at bedside and say, you know, I need to evaluate this patient and provide appropriate medical care, and I need you to remove or adjust these shackles in order for us to do so. And I would say most of the time, their response has been like reasonable and positive and cooperative and understanding. But I think for sure, the shackles are a big way in which we can impede patient safety, especially if they're acutely ill.

Amori: Okay, good. Thank you. John, you know, speaking of some things that are wrong, you do sit at that apex. I know I've said it again, but let's say a person is brought in from a crime scene, and law enforcement doesn't have them in custody, but they need information. Let's say it's somebody who was maybe raped or they've been assaulted. And if you're the police officer and you come in and that person is already there, do you have any rights to say, we really need a swab? Or do you just have to, like, beg the patient, or what would you do as a law enforcement officer?

Dery: This is where law enforcement and medicine actually come down to the exact same thing – we both deal with people. That's why I'm not a textbook, and I'm not a lab scientist. My job is to interact with individuals. If an individual may or may not have been involved in a rape situation, I can't make them file charges. I can't make them do anything. I can encourage them. I can inform them. My job is to provide them resources. I can say, is there anything else I can do? I can provide them maybe an officer of a different gender that they want to speak to, or a sane advocate, or a sexual certain nurse examiner, some other resources so they feel more comfortable. This is somebody that's been through a traumatic event, perhaps.

Or another example, maybe I don't have…I had somebody that came in that is not in custody, as you said, right now. I have probable cause. I still need to get a search warrant to obtain any type of evidence. Otherwise, any evidence collected is unusable, and then the entire case falls apart for my colleagues down the road. Evidence either has to be given voluntarily, where somebody has informed consent and they say yes, or have to have a valid search warrant, which for police officers, that means we're waiting on paperwork, which could take forever. But for example, like a blood draw, we have preprinted forms. Essentially, we put them on our computers, we can have a search warrant sent off to the judge on call in minutes, and then that usually gets faxed back and in hand within 15, 20 minutes. There's nothing really that terrible that we can't wait for those specimens.

And the other thing is if there's exigent circumstances, an immediate threat to life, not a reported threat to life, any doctor can say, yeah, this person may die. Any one of us may die at a moment, but does that necessarily mean it's a true exigent circumstance that I can take something against someone's will? No. I mean, you mentioned what rights do I have as law enforcement officer. I have the authority to seek out evidence, but it doesn't give me a right to override any type of medical integrity or medical examination or medical decisions. It comes down to my ability to form a relationship with that person and talk to them. And most of the time, police officers, law enforcement officers, you're supposed to be able to relate to that person, discuss with them, get them to understand both sides, deescalate a situation. I probably do more in my law enforcement capacity with my mouth than I ever will with my gun or my handcuffs.

Amori: Okay, that makes sense. Thank you. Good perspective. Joann, you know, sometimes patients have come to you, and they get their care from you – and we know about HIPAA – but maybe you're concerned they aren't going to get proper follow-up care with tests and medications. So how are you ensuring that, especially with people who may be a victim of a crime or may be a suspect, you know, or are you able to do anything?

Wortham-Moody: Well thank you for this question. This is something that I've worked with for quite a while in terms of our social services and our case management folks actually putting together procedural guidelines that allow us to actually do our follow-ups. Sometimes we have people who come in who

actually they're not in custody. They come in after they have…we have different relationships with halfway houses and those type things. They come in, they're afraid for one thing, to actually come in to get care. I think we're going to see a little bit more of that now, particularly in certain circumstances, people are afraid to come in to get care.

Once we get them in there to get care, we really don't have all the information that we need to really do the follow-up. So we have come together as a community. So that we could talk about times in which we have patients who have not been able to come in to get care or who are afraid to come in to get care. Or when they are in there thinking that maybe law enforcement is going to meet them there or be there and, you know, they won't be able to get the care. We form coalitions so that we can actually share information with the folks in the community, so that we can actually get to these folks that we need to get to, in terms of bringing them back in for blood draws.

We've been sending folks out to get blood draws. We've been sending case managers and actually doing home health to send out to folks who need to get that follow-up. This has been especially evident with some of our populations that are dealing with immigration status right now. And so having that extra community touch, if you will, and making those things available to them in different types of ways – actually going to them rather than them coming to us – has actually been really helpful. And I will say this too about local law enforcement – they've actually been helping us in terms of making sure that people feel safe to come to some of our clinics and centers and making sure that they have a safe zone, if you will, for people to come in to receive care and follow-up. So I'm actually very grateful for that question. And I really wanted to say that law enforcement has really been helping in those instances.

Amori: That's good to hear and good to know, because it's easy to see the quagmire, but it's sometimes really nice to hear that, in fact, there can be a dovetailing. Speaking of dovetailing, we happen to know that the laws that govern the actions of law enforcement officers are different state to state, but then there are federal laws, right? So Saulius, how can staff ensure they're working within the proper guidelines for the situation?

Polteraitis: Well, the federal laws set kind of the broad standards for, you know, healthcare access or, you know, civil rights for patients such as HIPAA and EMTALA. And the state laws usually expand on those federal mandates. You know, you look at something like the implied consent laws. Sometimes we see those in the DUI cases on what constitutes implied consent. So those can vary state-to-state. So, what you need to do is, obviously, it just comes down to education, training, and experience. And so, you know, obviously the question is, okay, educate and training them on what? Well you educate the staff on, you know, circumstances that would require the staff to request a warrant or a subpoena or a court order before performing any sort of law enforcement requested test.

A provider is under no obligation to respond to verbal or informal requests by law enforcement. And when in doubt, you have to encourage the staff to involve, you know, a hospital or legal counsel. You know, legal teams can assess, usually, the validity of the law enforcement requests. And finally, you have the staff rely on hospital policies and disclosure protocols. I mean, hospitals often have these forms or procedures for documenting law enforcement interactions. And as long as…we saw in some of the cases, such as the nurse in Utah, it's that familiarity and that knowledge of the hospital policies that ended up driving those ethical considerations for that nurse and for the staff as a whole.

Amori: Okay, thank you so much. So we've come to that portion of our discussion where I'd like to ask you, in two sentences, to each give our listeners one thing to remember about the effects and what to know about the safety of patients when law enforcement officers are in the healthcare setting. So Saulius, I'd like to start with you.

Polteraitis: So the main takeaway is, again, patients retain the right to make their own medical decisions. This applies even to incarcerated patients. And they must be given sufficient information about the condition and the proposed treatments so that they can make choices for themselves.

Amori: Thank you. Joann.

Wortham-Moody: Thanks, Geri. I just wanted to say that for us, especially in this current environment, that patients who fear exposure or retaliation are really less likely to come back for care, and that is really a serious health consequence, and we need to be thinking about that. Compassion and compliance can coexist, but only when we know the rules, and we do what we must protect the patient and the patient's voice in the process, in order that they receive the best care.

Amori: Thank you, Joann, that's a good point. That's a really good point. Sam, would you like to give us a two sentence, one point?

Chao: I think my biggest takeaway is for people who are caring for these patients at bedside, and you're not sure what to do in terms of shackle restraints or like, if you can ask officers to step outside of earshot, like it never hurts to ask. It does not hurt to ask and advocate on behalf of your patient. And I think the biggest thing that I run into is that people are fearful of asking, and then they don't ask those questions because they aren't sure. And I think asking is always the best first step.

Amori: Good. Thank you, ask first. And John, what's your takeaway for us from this?

Dery: My perspective is that the emergency department is where evidence lives and where ethics breathe. So as a badge, I'm seeking the truth. When I'm wearing my stethoscope, I'm guarding a patient's consent. And the justice is what depends on both remembering that the human body is not a crime scene until the law and the patient both say so.

Amori: All right. Thank you very much. You know this has been an incredible discussion, and I want to thank our panelists for participating, and I'd like to thank our listeners for listening to us. I hope you found it valuable and thanks for joining us. We'll see you next time when we explore another aspect of this topic from a *Perspective 360*.

[music]