To protect and serve: The ethical dilemma of allowing police access to trauma patients

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The physician-patient relationship is as complex as it is critical for surgeons and other medical professionals who provide care to pediatric victims of trauma. As soon as a clinical relationship with the patient has been established, the patient's interests and safety become the physician's primary concern. This responsibility is both an ethical and a legal duty. It applies to all patients, including those who are suspected or convicted of a crime. Physicians are expected to give every patient (or legal guardian of a minor), regardless of background, complete information about his or her care and to obtain informed consent for treatments and procedures, according to institutional policies. This process is particularly important when treating pediatric patients who are exceptionally vulnerable and limited in their ability to speak for themselves due to their age, developmental immaturity, and fear of consequences. Safeguarding the health, autonomy, and dignity of a patient remanded to police custody should be the primary focus of the physician.

At the same time, physicians and law enforcement have an important reciprocal relationship that is often beneficial to both patients and health care providers. Law enforcement personnel frequently accompany patients to the emergency department (ED) or seek access to patients for questioning while they are hospitalized.[1] Physicians in the trauma bay rely on law enforcement to provide crucial initial information regarding patients as they arrive from the field. Law enforcement can be critical in protecting the safety of health care workers and adjacent patients from someone who is violent or physically threatening. The urgent nature of emergency medical and surgical care and criminal investigation, however, may lead to potential conflicts of interest regarding access to patients in the ED.

Police officers have a unique set of responsibilities, primarily concern for public safety, as they focus on investigating and preventing crime. Obtaining accurate interview information is often time-sensitive, which is why, in many cases, these individuals remain at the bedside in anticipation of obtaining information as soon as the patient can provide it.

Despite the frequency with which law enforcement officers accompany patients into the ED, few hospitals or state and local governments have policies that regulate their presence. Indeed, the presence of law enforcement personnel largely falls outside the ethical and institutional guidelines of health care institutions. Nonetheless, law enforcement's presence may distract from and negatively affect the quality of care provided to the patient when police and the medical team have conflicting goals. Such differences can place surgeons in difficult situations as they attempt to manage a patient's care, particularly when the patient is in extremis or needs emergent procedural intervention.

The following article describes a case in which police have requested that they remain at the bedside of a shooting victim. The article specifically discusses potential ways that the attending pediatric surgeon could respond to the request.

The scenario

A pediatric surgeon practicing in a large urban, freestanding children's hospital is called to the trauma bay to evaluate a 17-year-old male with a gunshot wound to the abdomen. The patient is a suspect in an alleged crime and is accompanied by the local police upon arrival. His wrists and ankles are handcuffed to the medical stretcher, and several police officers are surrounding his stretcher.

The initial trauma assessment reveals the patient sustained a severe spinal cord injury resulting in paraplegia, as well as gastric and pancreatic injuries that will require emergent surgical intervention. The multiple officers present insist upon going with the patient directly to the operating room (OR) and to accompanying him afterward to the intensive care unit (ICU) so that they can immediately interview him when he awakens from general anesthesia.

Several members of the nursing staff express concern that the presence of the officers will be detrimental to the patient's care, which requires medical staff to have direct physical access to the patient to reassess his clinical stability and to provide any needed emergent care. In addition, the presence of multiple officers could compromise his private health information because the officers would be able to hear and witness medical provider conversations about the patient. The nurses and other medical staff also are concerned about the effect that the sudden presence of law enforcement officers in the ICU could have on the other pediatric patients and families who are there for critical care.

Discussion of options

With the patient's tenuous hemodynamic status in mind, the pediatric surgeon is presented with a number of ethical concerns and has four potential options:

- Perform the initial operation, and then transfer the patient to the adjacent adult hospital (where additional protocols regarding police interaction are more commonly used) after he is stabilized
- Perform all necessary operations and postoperative care at the children's hospital and allow the officers to remain at the patient's bedside
- Express concern regarding the officers' role and request an ethics consult
- Ask the officers to wait in the designated waiting area away from the OR and away from the patient's bedside until the patient has been declared clinically stable, citing the best interests of the patient, in particular the patient's safety, the need for timely surgical and medical intervention, and the patient's health information privacy

Option 1: Perform the initial operation, and then transfer the patient to the adjacent adult hospital (where additional protocols regarding police interaction are more commonly used) after he is stabilized

This may be an appealing option, especially given the patient's age in this scenario. Gunshot victims are often brought to the adult ED simply because of proximity or because the exact age of the patient is initially unknown. Adult hospitals and EDs may have a more streamlined process for caring for victims of violence, as this problem is more common in the adult population. Adult hospitals and EDs often work closely with local police departments and may also have an in-house security.

However, the prevalence of youth violence argues against the feasibility of this option as a routine solution. Youth violence is an important health care issue across the U.S. Injured victims and perpetrators of violence are frequently seen in pediatric EDs. Homicide is the third leading cause of death for young people ages 15−24 years old.[2] In 2012, 4,787 young people were killed by homicide, which is equivalent to approximately 13 cases per day, and more than 599,000 young people ages 10 to 24 were treated in U.S. EDs for physical assault injuries.[2] Youth homicides and assault-related injuries result in $16 billion in combined medical and work loss costs every year.[2] Violent injuries are often repeated; among youths who suffer a penetrating injury, nearly 45 percent are victims of violence again in the five years following the first injury, and 20 percent will die in the same time frame.[3,4] Given the high rate of violent trauma, especially in urban settings, ideally pediatric EDs and trauma bays should be equipped to care for patients who arrive with police accompaniment.

Initiating a patient's care in one hospital and then transferring the patient to another hospital creates its own set of both practical and ethical complications. Electronic or non-electronic health record communication barriers often exist between hospitals even when they are physically nearby or associated with one another. These communications issues become compounded and even dangerous in situations where the patient requires multiple operations or complex ICU care. Fracturing patient care in this way can be detrimental to the patient, possibly resulting in avoidable medical errors. Transfer from a pediatric facility to an adult facility can also result in poorer outcomes if the adult facility lacks up-to-date pediatric algorithms. For example, pediatric trauma literature supports significantly less invasive surgical management for abdominal trauma with splenic injury than is recommended to treat a similar situation in an adult with abdominal trauma.

Moving the patient to a different surgical team also hinders communication between the surgeon and the patient. When dealing with critically ill patients, continuity of care between the surgical team and family members is imperative to avoid medical error and maintain patient-physician trust. Moving the patient from one team to another at this juncture would dissolve the initial relationship with the family and might create distrust between the medical team and the patient. Bias decisions may then be made with patient or family or any consents obtained during the patient's ongoing medical care. Transfer between facilities, therefore, should only occur when medically necessary and in the best interest of the patient.

Option 2: Perform all necessary operations and postoperative care at the children's hospital, and allow the officers to remain at the patient's bedside

Members of hospital security and law enforcement play key roles in the ED. Numerous important relationships exist between emergency medicine providers, surgeons, and law enforcement. Patients often arrive at the trauma bay

accompanied only by police officers and paramedics. Physicians must work with officers present at the scene to understand exactly what happened to the patient and the circumstances surrounding the event.[5] In this regard, the interests of the police, the patient, and the physician are all initially aligned.

The primary objective for law enforcement, however, is the public's safety. Law enforcement is neither trained nor liable for protecting the health privacy of the patient. Law enforcement is not qualified to know what constitutes the best medical care for the patient. Law enforcement officials are trained to investigate crimes in the most efficient manner possible. Many critical pieces of evidence, such as the testimony of the patient, diminish in accuracy and detail over time, and thus police officers often will physically remain with a detainee in order to initiate an interrogation as soon as possible.[6] They may even request information about the nature of the patient's injuries from surgeons and ICU professionals, which presents a problem for surgeons who are responsible for providing the best possible care to the patient while adhering to the Health Insurance Portability and Accountability Act (HIPAA), which provides strict guidelines regarding patient privacy and confidentiality.[7-9]

If a person is convicted of a crime, U.S. law suspends certain rights, including the right to privacy. These laws are in effect when prisoners are brought to the ED. Depending on local laws, police may be required to remain within visual contact of the patient at all times, which inevitably erodes the patient's privacy. These laws may also apply to individuals for whom arrest is pending. Law enforcement personnel often wait to arrest the suspect until after they have received at least an initial medical assessment, but they may do so immediately if the person is considered highly dangerous or a flight risk. Neither criteria would be met in the scenario described in this article where the patient is not only unconscious, but also paralyzed from the waist down. Even when patients are ultimately arrested, a significant number are never actually charged or convicted.[10]

Despite these laws, the presence of police should have no bearing on the quality of patient care. In situations where the patient is not actually under arrest or incarcerated, very few laws exist regarding police presence at the bedside, and ultimately the decision rests with the attending surgeon.[11]

Option 3: Express concern regarding the officers' role and request an ethics consult

The equal treatment of all patients cannot be taken for granted, and the nursing staff in particular are often acutely aware of inequities given their constant proximity to the patients. Nurses have a similar professional code of ethics that calls for unbiased care regardless of the patient's individual attributes. Particularly in the pediatric setting, nurses passionately protect and advocate for their patients. Ignoring the concerns of nursing staff would be unwise and a potential danger to patient care because it creates disharmony among the provider team.

EDs and ICUs are especially susceptible to aggressive and tense situations due to an environment filled with emotional stress.[12-15] Nurses are at a particularly high risk of exposure to violence.[16,17] In one survey of 27 ED nurses, almost half reported having been physically or verbally assaulted by patients while at work.[18] In addition, law enforcement and hospital security are crucial for the protection of hospital personnel when dealing with violent or aggressive patients. The attending surgeon must take into account the safety of both the patient and the medical staff.

With the conflict between law enforcement and the medical team in this situation, requesting an ethics consult would be appropriate but may be infeasible due to the critical nature of the patient's injuries. Ethics consults can potentially take many days to gather information and to come to a recommendation, which may be an option for stable patients but would likely be impractical for trauma victims arriving to the ED or ICU, unless the ethics consult service has a rapid response process in place.

At times, even the presence of law enforcement can present a conflict for the physician if it affects the quality of care the patient is receiving. When patients are brought in to the trauma bay, they are suffering from both physical and psychological injuries related to their trauma. They are incredibly vulnerable and, when conscious, are often overwhelmed and already feeling unsafe. Studies show that patients have negative views regarding law enforcement institutions in general.[19-21] Patients who are incarcerated or even simply accompanied by police may worry that their physician is working with law enforcement.[22,23] This leads to a breakdown in physician-patient trust, which can lead to the withholding of information that is critical to patient care.

Providing information to outside parties against the patient's wishes would undoubtedly be a violation of the patient's right to privacy. In specific situations, including domestic, child, or elder abuse, physicians are required by law to violate a patient's confidentiality in order to keep the patient or another party safe.[7,8] Most physicians are aware of these exceptions, as they are clearly defined within the law and reinforced by HIPAA and hospital regulations. These laws also designate exactly where and to whom the information should be reported. Conversely, very few laws exist regarding exactly what can be disclosed to police who accompany patients into the ED. In these scenarios, the surgeon must weigh the benefit to the public good against the patient's right to privacy.[7,11] When time allows, ethics consults and hospital legal teams may be beneficial in this decision-making process.

Option 4: Ask the officers to wait in the designated waiting area away from the OR and away from the patient's bedside until the patient has been declared clinically stable, citing the best interests of the patient, in particular the patient's safety, the need for timely surgical and medical intervention, and the patient's health information privacy

This request may be particularly difficult to make. If the patient does not pose an immediate threat to the hospital staff, the need for law enforcement to remain directly at the bedside is significantly diminished. Police may wish to take a statement from the patient, but this is not the priority of the attending surgeon, as the presence of law enforcement may detract from the focus of the health care providers. As discussed earlier in this article, studies have shown that a police presence negatively affects patient perceptions of the quality of their medical care and can limit communication between the physician and the patient.[22,23]

Prioritizing the best interests of the patient makes restricting police access ethically compelling. This path strengthens the physician-patient relationship, allows for open communication with family members, and protects the patient's privacy.[24] Furthermore, the presence of police officers at the bedside represents a violation of the patient's right to privacy and confidentiality. Surgeons should always seek to uphold the integrity of the physician-patient relationship and respect that once a patient enters a clinical care setting, the patient's privacy and confidentiality are of the highest priority. This expectation allows physicians to address deeply personal issues in an effort to better understand a patient's illness or injury. Such an expectation may be heightened when the patient is severely injured or is an alleged victim or perpetrator of violence.

However, it is the surgeon's responsibility to decide when a police presence presents an unnecessary breach of confidentiality or places the patient's health at risk. The surgeon can, and must, prioritize the patient's interests over those of law enforcement. This is a challenging decision to make and rests almost entirely on the shoulders of the individual surgeon, as very few laws or hospital regulations address this concern.

Ethical bottom line

Physicians ask patients and their families to trust that the medical care team will weigh the risks and benefits of all interventions and will do what is in the best interests of the patient, while respecting the patient's goals and values. Pediatric patients who are brought into the trauma bay are particularly vulnerable, especially when they are accompanied by police rather than a parent or guardian. Surgeons enter each case with the understanding that their fiduciary duty requires that the care and protection of the patient be the primary concern. The physician must act as a gatekeeper and guardian for the patient to ensure that privacy and confidentiality are maintained.[25]

The ED and trauma bay are structured, protocol-driven environments. The presence of police officers is often beneficial, and yet is not always clearly defined by either local law or hospital policy. Multiple considerations must be taken into account, including patient privacy, staff and public safety, local laws or institutional guidelines regarding law enforcement, any requirements regarding reporting a patient's status, and the effects on quality of patient care.[24] Ideally, a physician would consult with an ethics review board; however, this may be less feasible in a trauma situation where time is a critical and, ultimately, limiting factor. Hospitals should make an effort to clearly delineate the role of law enforcement in these situations in order to aid the physician and to allow the focus to remain on the patient's medical care.

In the absence of specific laws or hospital policies, a physician must rely on four guiding ethical principles—autonomy, benevolence, beneficence, and justice—to determine when law enforcement should have access to a patient. What these principles mean and questions to ask oneself to ensure they are being applied correctly are as follows:

- The principle of autonomy refers to the patient's right to make decisions regarding his or her own medical care without being influenced or coerced by outside parties. Is the patient actually under arrest or in police custody, or are the police simply accompanying the patient with the intent to question him or her? What are the local laws with regard to these patients?
- Benevolence refers to the physician's responsibility to prevent "deliberate, unnecessary, or avoidable harm to patients."[25] Does the police presence impede the patient's care or violate their trust or privacy?
- The principle of beneficence requires that the physician have a positive impact on the patient's health. Is the presence of law enforcement benefiting the patient in some way?
- The principle of justice delineates that all patients should be treated equally regardless of their personal or financial situation. Is the patient receiving the same care and being treated with the same respect that any other person arriving in the trauma bay would expect to receive?

After these initial concerns are addressed and the basic ethical principles are considered in each unique situation, the surgeon must further ask if staff or public safety concerns are sufficiently compelling to potentially violate the patient's best interests and allow law enforcement to proceed with questioning. Only after assessing each of these variables can the surgeon determine who should have access to the patient and truly provide the most ethical medical care possible.

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