Bringing physicians together
for a healthier Ohio

February 21, 2025

Dr. Dvora Nelson
Lorain County Medical Society
5320 Hoag Drive,
Elyria, OH, 44035

Re: ***In Re: Search of Mercy Health Lorain Hospital, of the Person of Tony Harris For Body Cavity*, Lorain C.P. No. 24MD000713**

Dear Dr. Nelson,

On behalf of the Ohio State Medical Association (OSMA), I am writing concerning the matter currently before the Lorain County Court of Common Pleas styled *In Re: Search of Mercy Health Lorain Hospital, of the Person of Tony Harris For Body Cavity,* Lorain C.P. No. 24MD000713. The Ohio State Medical Association is a nonprofit professional association established in 1835 and is comprised of physicians, medical residents, and medical students in Ohio. The OSMA's membership includes most Ohio physicians engaged in the private practice of medicine. The OSMA's purposes are to improve public health through education, encourage interchange of ideas among members, and maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

OSMA supports those physicians in this case that are potentially subject to contempt of court for using their own professional medical judgement to refuse to perform a body cavity search pursuant to a warrant from law enforcement. The OSMA supports the crucial role physician's independent medical judgement as vital to proper patient care. Determining whether a particular medical task is appropriate for a patient can involve many variables and considerations that require extensive medical education and training. Physicians must be afforded the ability to exercise such medical judgement, which should include refusing to perform a procedure out of concern for the safety of a patient.

The American Medical Association (AMA) also maintains policies that support the independent clinical judgement of physicians. For purposes of brevity of this letter, I have included them as an attachment for your review.

OSMA stands with the Lorain County Medical Society and in its support for the physicians and their exercise of their clinical judgment in this matter. While we hope for a positive outcome in this matter, we also stand by to work with our LCMS partners to provide additional support should the matter continue. Please do not hesitate to reach out with any questions.

Sincerely,

Todd Baker
CEO

Visit
www.OSMA.org
5115 Parkcenter Avenue • Suite 200 • Dublin, OH 43017
ph (614) 527-6762 • (800) 766-6762 • fax (614) 527-6763
info@osma.org

ATTACHMENTS

AMA Code of Medical Ethics Opinion 9.7.2 Court-Initiated Medical Treatment in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

1. Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
2. Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
3. Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
4. Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility

to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

1. When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
2. When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
3. When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

AMA Code of Medical Ethics Opinion 1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties

and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

1. Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
2. Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
3. Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
4. Be mindful of the burden their actions may place on fellow professionals.
5. Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
6. In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
7. Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Code of Medical Ethics Opinion 2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is

critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

1. Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
2. Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

1. the diagnosis (when known);
2. the nature and purpose of recommended interventions;
3. the burdens, risks, and expected benefits of all options, including forgoing treatment.

3. Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

AMA Code of Medical Ethics Opinion 9.7.4 Physician Participation in Interrogation

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations of criminal suspects, prisoners of war, or any other individuals who are being held involuntarily ("detainees") are distinct from questioning used by physicians to assess an individual's physical or mental condition. To be appropriate, interrogations must avoid the use of coercion—that is, threatening or causing harm through physical injury or mental suffering.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to individuals with obligations to

protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest.

Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.

Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.

Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.

Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.

Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.

All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.

The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.

Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

(Res. 523, A-06Appended: Res. 706, A-13Reaffirmed: Res. 250, A-22)

Government Interference in Patient Counseling H-373.995

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

(Res. 201, A-11Reaffirmation: I-12Appended: Res. 717, A-13Reaffirmed in lieu of Res. 5, I-13Appended: Res. 234, A-15Reaffirmation: A-19Modified: Speakers Rep. 01, I-24)

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of our American Medical Association:

1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.

2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

(Sub. Res. 213, A-91Reaffirmed: Sub. Res. 232, I-91Reaffirmed by Rules & Credentials Cmt., A-96Reaffirmed by Sub. \Res. 133 and BOT Rep. 26, A-97Reaffirmed by Sub. Res. 203 and 707, A-98Reaffirmed: Res. 703, A-00Reaffirmed in lieu of Res. 823, I-07Reaffirmation I-09Reaffirmation: I-12Reaffirmed in lieu of Res. 5, I-13Reaffirmed: CEJA Rep. 05, A-23Modified: Speakers Rep. 02, I-24)

The Criminalization of Health Care Decision Making H-160.946

Our American Medical Association opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

(Sub. Res. 202, A-95Reaffirmed: Res. 227, I-98Reaffirmed: BOT Rep. 2, A-07Reaffirmation A-09Reaffirmation: I-12Reaffirmed: BOT Rep. 9, A-22Reaffirmed: Res. 250, A-22Reaffirmed: Res. 252, A-22Reaffirmed: Res. 224, I-22)

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993

Our American Medical Association supports the development of:

Best practices for acute care of patients in the custody of law enforcement or corrections.

Clearly defined and consistently implemented processes between health care professionals and law enforcement that:

can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and

ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and

If conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison.

Our AMA affirms that:

the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.

it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.

Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.

Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.

(Res. 407, A-22Modified: CSAPH Rep. 06, A-23Reaffirmed: CSAPH Rep. 4, I-23)