

COPS IN SCRUBS

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ABSTRACT

An encounter with police often involves more than just the police officer and the individual person. This Article highlights one particular actor integral to police investigations: the medical professional. Medical professionals, whether they be physicians, nurses, nurse practitioners, or other healthcare providers, become part of investigations in many ways. They notify police of crimes. They facilitate police questioning. They provide information gleaned from patient conversations, patient belongings, and their bodies.

—The intertwined relationship between medical professionals and law enforcement is embedded in the legal and regulatory framework. A constellation of laws directs medical professionals to cooperate with law enforcement with very little countervailing authority or guidance on when they should not. These laws force medical professionals—even when they act with good intentions—to move away from medical judgment and be coopted as “cops in scrubs.” Ultimately, the existing legal and regulatory regimes are insufficient in guarding against overbroad police and medical authority. I explore three categories of overlap between medical professionals and law enforcement: crime reporting, questioning of patients, and evidence procured through medical procedures. This exploration reveals a spectrum of how medical professionals act in response to their responsibilities to public safety. Medical professionals may be acting in their role as healthcare providers in the face of difficult ethical, legal, and moral obligations or acting in concert with police. This wide spectrum results in part from courts broadly construing medical professionals’ duties to public safety, the insufficient accounting of the particular potency of medical professionals as aid-to or part of police investigations, and the inadequacies of existing criminal procedure safeguards.

The relationship between medical professionals and law enforcement must be viewed against the backdrop of historical and contemporary racial discrimination and bias by law enforcement and medical institutions. The inadequate regulation of the overlap of medical professionals and law enforcement puts poor and racial minorities groups

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at risk of experiencing an amplified and compounded bias. This Article highlights that potential aggregated effect where people may experience not only worse medical outcomes but also criminal punitiveness because of their race and class. The Article concludes by suggesting doctrinal and statutory changes and other prescriptions as countervailing authority that would allow medical professionals to push back against overbroad police authority.

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INTRODUCTION

More than a year has passed since the murder of George Floyd and the massive protests that followed. The initial fervor of calls to change how our country polices has somewhat abated. Though legislatures have proposed—and some have passed—changes to police reform laws,¹ jurisdictions are struggling to figure out how to address the problems of policing.² The Senate has yet to vote on the George Floyd Justice in Policing Act passed by the House; the proposed law would

1. Walker Orenstein, *The Minnesota Legislature Passed New Deadly Force Standards for Police in 2020. Why Lawmakers Are Already Looking to Change Them.*, MINN. POST Apr. 20, 2021, <https://www.minnpost.com/state-government/2021/04/the-minnesota-legislature-passed-new-deadly-force-standards-for-police-in-2020-why-lawmakers-are-already-looking-to-change-them/> [https://perma.cc/NG6Q-C3T8].

2. Becky Sullivan, *With Slow Progress on Federal Level, Police Reform Remains Patchwork Across U.S.*, NPR (Apr. 27, 2021), <https://www.npr.org/2021/04/27/990580272/with-slow-progress-on-federal-level-police-reform-remains-patchwork-across-u-s> [https://perma.cc/5AW2-C5H6].

make it easier to federally prosecute police cases, creates penalties for racial and religious profiling, and eliminate qualified immunity for law enforcement.³ Some municipalities have shifted city and local budgets away from police to mental health and crisis intervention.⁴ Calls continue for systemic change to policing at the federal, state, and local levels.

Police are the obvious subject of this heightened scrutiny and calls for reform and change. But the work of policing is not carried out by police alone. Encounters with police often involve more than the police officer and the individual citizen. Scholars have highlighted the ways that law enforcement work overlaps with school teachers and officials,⁵ welfare officers,⁶ social workers,⁷ probation officers,⁸ and medical professionals.⁹ Police investigative work is shared by these other institutions and institutional actors who interact with the same groups most vulnerable and susceptible to the harms of policing. These other institutional actors can act as the eyes and ears of police by reporting suspected crimes. They help police with searches and questioning. They provide police with information that later serves as the basis for subpoenas, warrants, and arrests.

Medical professionals stand out among these other actors for their unique expertise, relationship, and proximity to potential crimes and individuals involved in crimes. The racial reckoning that swept across

3. *Justice in Policing Act*, HOUSE COMM. ON THE JUDICIARY, <https://judiciary.house.gov/issues/issue/?IssueID=14924> [<https://perma.cc/SRP2-3R7H>] (last visited May 3, 2021).

4. Rachel Chason, *Prince George's Mental Health Facility Being Built With Funds Shifted From Police Training Building*, WA. POST (Apr. 19, 2021), https://www.washingtonpost.com/local/md-politics/prince-georges-mental-health-police/2021/04/19/a35fc2a8-a121-11eb-85fc-06664ff4489d_story.html [<https://perma.cc/9QQ7-AP4C>].

5. CATHERINE Y. KIM, ET AL., *THE SCHOOL-TO-PRISON PIPELINE: STRUCTURING LEGAL REFORM* 113 (2010); Ron Brown, *Public School District Police Departments*, in *POLICING AMERICA'S EDUCATIONAL SYSTEMS* 54 (John H. Watts, ed. 2019).

6. Kaaryn Gustafson, *The Criminalization of Poverty*, 99 J. CRIM. L. & CRIMINOLOGY 643, 670 (2008-2009).

7. Charles W. Dean, et al., *Social Work and Police Partnership: A Summons To The Village Strategies and Effective Practices*, 1 CRIMINAL JUSTICE FACULTY PUB. (2000); *How Social Workers Improve Relationships Police and Communities*, UNIV. S. CAL. SUZANNE DWORAK-PECK SCH. OF SOC. WORK (Aug. 14, 2018), <https://msw.usc.edu/mswusc-blog/police-community-relations-social-work/> [<https://perma.cc/H747-QBXR>].

8. Patricia Soung, *Is Juvenile Probation Obsolete? Re-Examining Youth Probation Law, Policy and Practice in California*, J. CRIM. L. & CRIM. (forthcoming) (draft on file with author).

9. Osagie K. Obasogie and Anna Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 CAL. L. REV. 101, 104 (Feb. 2021); Sunita Patel, *The Healthcare Policing Web* 5–7 (unpublished manuscript) (draft on file with author); Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646 (2021); DOROTHY ROBERTS, *KILLING THE BLACK BODY* (1997); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CAL. L. REV. 1239 (2012); KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* (2017); MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* (2020); Jamelia Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401 (2021).

the nation last year also touched medical organizations and medical professionals. Doctors, nurses, and other medical providers participated in the widespread protests after the killing of George Floyd. They gave accounts of witnessing police abusing their authority over patients. Last November, the American Medical Association passed a new position statement announcing police brutality as a public health concern and acknowledging the role medicine has played in perpetuating racial bias in medical treatment and other racial inequities in the medical profession.¹⁰

Medical professionals become part of police investigations in more ways than as witnesses to overbroad policing. Medical professionals notify law enforcement of suspected crime and provide information to police obtained from patient conversations.¹¹ They provide information gained from patient conversations to police. They direct police officers to patients for interrogation and may even verify and assure the police officers that the patients are able to answer questions.¹² They conduct the procedures to obtain material, such as blood and other items from patients' bodies that serve as the basis for arrest and/or future criminal prosecution.¹³ When calls for change to policing funding and structures include shifting resources to care settings, the relationship between law enforcement and medical professionals must be fully accounted for and examined.

In this Article, I continue my study of the merging of two realms: policing and medical care.¹⁴ I previously focused on the criminal procedure implications of police presence in one particular healthcare setting, the emergency room. My critiques included the routine recognition by courts of the assistance medical professionals provide to law enforcement as lawful and laudable examples of good citizenship. Constitutional safeguards meant to protect individuals instead shield police and medical professionals from legal scrutiny.¹⁵ This Article hones in on the relationship between these two sets of professionals, and examines the policing implications from the medical professionals' perspective and the health laws, ethics, and professionals norms that apply to them.

This Article argues that the intertwined relationships between medical professionals and law enforcement are created by and deeply

10. *New AMA Policy Recognizes Racism as a Public Health Threat*, AM. MED. ASS'N (Nov. 16, 2020), <https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat> [https://perma.cc/65U6-F8AM].

11. *Infra*, Parts I(B); III(A).

12. *Infra*, Parts I(B); III(B).

13. *Infra*, Parts I(B); III(C).

14. See generally Song, *Policing the Emergency Room*, *supra* n.11. This article argued that the emergency room has become a place where police have wide latitude to conduct investigations, as they do on the street, with the assistance of medical providers and in a place where patients are likely to come from racial minority groups.

15. *Id.* at 32.

embedded in legal and regulatory regimes. A growing number of medical professionals are pushing back against this intertwined relationship between medical providers and police. Healthcare providers in San Francisco started a movement called #DPHMustDivest to remove the Sheriff's department from the city's clinic and public hospital.¹⁶ After yet another police killing at Harbor-UCLA Medical Center, health workers organized and spoke out against police presence in their hospital and have been a major voice in calling for the Los Angeles Board of Supervisors to change the county hospital's policies regarding law enforcement presence.¹⁷ But both efforts face obstacles in existing laws, regulations, and institutional practices.

The current legal and regulatory regimes are askew. By virtue of their professional skills, expertise, and access to patients, medical professionals who participate in police investigations cannot be viewed as simply "good citizens." Their particular expertise and access make them especially potent collaborators in police investigations. Yet these regimes permit or cause medical professionals to act as "cops in scrubs" and allow law enforcement to deploy their authority through medical professionals. The governing framework facilitates, mandates, and encourages medical professionals to act more or less in alignment with law enforcement objectives rather than their medical judgment and standard of care. An array of federal and state laws impose duties and obligations on medical professionals to cooperate with law enforcement. At the same time, very little counterbalances the host of federal and state laws that tell medical professionals how they must or can participate in police investigations. Scant and inadequate legal guardrails mean that it is difficult to distinguish and monitor medical professional conduct that is inevitably intertwined with law enforcement goals from deliberate and coopted actions where medical providers take on public safety policing themselves in contravention to the interests of their patients.

The absence of sufficient countervailing legal authority makes it difficult for medical professionals to push back against overbroad police action. Medical professionals are bound by ethical obligations to care for patients.¹⁸ But these ethical guidelines are an insufficient

16. DPH MUST DIVEST, <https://www.dphmustdivest.com> [<https://perma.cc/Q9FR-MFQK>].

17. Richard Winton, *Patient Shot by Sheriff's Deputy Inside Harbor UCLA Hospital Dies*, L.A. TIMES (Nov. 17, 2020, 5:47 PM), <https://www.latimes.com/california/story/2020-11-17/patient-shotby-sheriffs-deputy-as-he-wield-heavy-medical-device-inside-harbor-ucla-hospital-dies>; Motion by Supervisors Mark Ridley-Thomas and Janice Hahn for Promoting the Health and Safety of Patients, *Visitors and Employees on the County of Los Angeles' Medical Campuses* (Oct. 27, 2020), <http://file.lacounty.gov/SDSInter/bos/supdocs/149686.pdf> [<https://perma.cc/KR3V-GJCT>]; Memorandum from Frontline Wellness Network to the Los Angeles Cty. Bd. of Supervisors (Jan. 29, 2021).

18. *AMA Principles of Medical Ethics*, AM. MED. ASS'N, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> [<https://perma.cc/5Q7S-D5QK>] (last visited May 3, 2021); *Code of Medical Ethics: Privacy, Confidentiality & Medical Records*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering->

counterweight to the existing laws and regulations. Consequently, well-meaning or well-intended medical professionals must rely on more diffuse and less robust ethics and norms as well as their relative lack of legal expertise or the direction of hospital administration. Medical professionals may also want to cooperate with law enforcement because of their alignment with certain public safety goals, political affiliations, and bias. And when the patients are economically or socially vulnerable, and therefore less likely to be able to vindicate their rights, there may be further incentives to give in to police presence or authority or to overlook overbroad police actions that harm patients.

Furthermore, the discretion accorded to both professions exacerbate the problem. Because medical professionals, like law enforcement, also exercise enormous discretion, their actions enable police to circumvent procedures they would otherwise normally need to follow. This combined discretion may lead to compounded abuse of discretion.

This Article highlights the aggregated effect on patients caught at the intersection of policing in healthcare settings who experience an amplified compounded bias by both police and medical providers. Looking at the combined actions of medical professionals and law enforcement allows us to see the full potential amplification of bias and punitiveness experienced by patients. This is especially cause for concern for low-income and racial minority groups already subject to heightened policing and stratified healthcare. Patients in these healthcare settings are subject to the decisions and scrutiny of these two professions—medical professionals and law enforcement—that have contributed to racial disparities and inequities in our society.

The Article contributes to growing literature on the ways the medical profession intersects with policing.¹⁹ It builds upon previous critiques of the ways the medical profession conflicts with certain law

care/ethics/code-medical-ethics-privacy-confidentiality-medical-records [https://perma.cc/RZD8-QHQL] (last visited May 3, 2021); *Code of Ethics for Nurses, with Interpretive Statements*, AM. NURSES ASS'N (2015) <https://www.nursingworld.org/coe-view-only> [https://perma.cc/3VL7-VHQQ]; *Standards of Practice for Nurse Practitioners*, AM. ASS'N OF NURSE PRACTITIONERS, <https://www.aanp.org/advocacy/advocacy-resource/position-statements/standards-of-practice-for-nurse-practitioner> [https://perma.cc/K43M-3AGN], (last visited May 3, 2020); *Guidelines for Ethical Conduct for the Physician Assistant Profession*, AM. ACAD. OF PHYSICIAN ASSISTANTS (2013), <https://westliberty.edu/physician-assistant/files/2017/02/16-EthicalConduct.pdf> [https://perma.cc/MMV3-NEGR].

19. Jamelia Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401 (2021) (discussing the harms of aggressive law enforcement against persons with disabilities in medical facilities); Obasogie and Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 CAL. L. REV. at 104; Patel, *The Healthcare Policing Web* 5–7 (unpublished manuscript) (draft on file with author); Song, *supra* n.11.

enforcement priorities from both the legal²⁰ and medical perspectives.²¹ This Article connects that literature to scholarship on biases in policing practices²² and the biases of medical professionals,²³ as well as the

20. See, e.g., Joanna Wright, *Applying Miranda's Public Safety Exception to Dzhokhar Tsarnaev: Restricting Criminal Procedure Rights by Expanding Judicial Exceptions*, 113 COLUM. L. REV. SIDEBAR 136 (2013); Susan Frietsche, *Policing Drug Use During Pregnancy*, 10 TEMP. POL. & CIV. RTS. L. REV. 411 (2001); Schuyler Frautschi, *Understanding the Public Health Policies Behind Ferguson*, 27 N.Y.U. REV. L. & SOC. CHANGE 587 (2001-02); Elliot B. Oppenheim, *May the Police Practice Medicine*, 8 J. MED. & L. 35 (2003-04); see, e.g., Timothy E. Gammon & John K. Hulston, *The Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749 (1995); Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CINN. L. REV. 657 (2009); Benjamin Pomerance, *Finding the Middle Ground on a Slippery Slope: Balancing Autonomy and Protection in Mandatory Reporting of Elder Abuse*, 16 MARQ. BENEFITS & SOC. WELFARE L. REV. 439 (2015); see, e.g., Caitlin E. Borgmann, *The Constitutionality of Government-Imposed Bodily Intrusions*, 2014 U. ILL. L. REV. 1059 (2014); Jack Brill, Note, *Giving HIPAA Enforcement Room to Grow: Why There Should Not (Yet) Be a Private Cause of Action*, 83 NOTRE DAME L. REV. 2105 (2008); Erin Murphy, *The Politics of Privacy in the Criminal Justice System: Information Disclosure, the Fourth Amendment, and Statutory Law Enforcement Exemptions*, 111 MICH. L. REV. 485 (2013); Rebecah Therkelson Raines, Comment, *Evaluating the Inebriated: An Analysis of the HIPAA Privacy Rule and its Implications for Intoxicated Patients in Hospital Emergency Departments*, 40 U. DAYTON L. REV. 479 (2016); Radhika Rao, *Property, Privacy, and the Human Body*, 80. B.U. L. REV. 359 (2000); Peter H.W. van der Goes, Jr., Comment, *Opportunity Lost: Why and How to Improve the HHS-Proposed Legislation Governing Law Enforcement Access to Medical Records*, 147 U. PA. L. REV. 1009 (1999); Natalie F. Weiss, *To Release or Not to Release: An Analysis of the HIPAA Subpoena Exception*, 15 MICH. ST. U. J. MED. & L. 253 (2011). See, e.g., Timothy E. Gammon & John K. Hulston, *The Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749 (1995); Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CINN. L. REV. 657 (2009).

21. See SW Hargarten & JF Waeckerle, *Docs and Cops: A Collaborating or Colliding Partnership?*, 38 ANN. EMERG. MED. 438 (2001); John C. Moskop et al., *From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part I: Conceptual, Moral, and Legal Foundations*, 45 ANN. EMERG. MED. 53 (2005); *HIPAA Compliance in the ER: Exceptions, Suggestions for Compliance in a Chaotic Clinical Setting*, 5 HEALTH INF. COMPLIANCE INSIDER 1 (2008); William B. Millard, *Body Cameras in the Emergency Department*, 66 ANN. EMERG. MED. 17A (2015); Eileen F. Baker, et al., *Law Enforcement and Emergency Medicine: An Ethical Analysis*, 68 ANN. EMERG. MED. 599 (2016); Adam Ash, *On Resolution 22*, 69 ANN. EMERG. MED. 656 (2017); Sarah F. Jacoby et al., *A Safe Haven for the Injured? Urban Trauma Care at the Intersection of Healthcare, Law Enforcement, and Race*, 199 SOC. SCIENCE & MED. 115 (2018).

22. Tracey Maclin, *"Black and Blue Encounters" – Some Preliminary Thoughts About Fourth Amendment Seizures: Should Race Matter?*, 26 VAL. U. L. REV. 243 (1991); Joshua Correll et al., *The Police Officer's Dilemma: Using Ethnicity to Disambiguate Potentially Threatening Individuals*, 83 J. PERSONALITY & SOC. PSYCHOL. 1314, 1317 (2002); Devon Carbado, *(E)racing Fourth Amendment*, 100 MICH. L. REV. 946, 966 (2002); Jennifer L. Eberhardt, et al., *Seeing Black: Race, Crime, and Visual Processing*, 87 J. PERSONALITY & SOC. PSYCHOL. 876, 877 (2004); Joshua Correll, et al., *Across the Thin Blue Line: Police Officers and Racial Bias in the Decision to Shoot*, 92 J. PERSONALITY & SOC. PSYCHOL. 1006, 1009 (2007); L. Song Richardson, *Implicit Bias and Racial Anxiety: Implications for Stops and Frisks*, 15 OHIO ST. J. CRIM. L. 74, 80 (2017).

23. Barbara A. Noah, *Racist Health Care?*, 48 FLA. L. REV. 357, 375 (1996); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 95 (2001); René Bowser, *Racial Bias in Medical Treatment*, 105 DICK. L. REV. 365 (2001); Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS 52 (2001); Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231, 1235 (2007); Adil H. Haider

work of scholars examining the cumulative negative effect of policing and healthcare, especially as they affect vulnerable groups such as disabled people, veterans, Black mothers, and immigrants.²⁴

Part I begins with a brief recounting of how policing and medical care have contributed to existing racial disparities in the criminal legal system and medical care. It provides a summary of how medical professionals have become part of law enforcement investigations and offers examples of how these combined actions have had harmful effects on marginalized populations most susceptible to the harms of biased policing and medical care. Part II describes the current legal framework, comprised of constitutional rules, federal and state laws and regulations that frame and guide medical professionals' interactions with law enforcement. This examination reveals the extent to which laws direct to medical professionals on how and when to cooperate with law enforcement with very little guidance or countervailing limits on when they should not. Part III delves into specific instances of medical professional and police overlap: crime reporting, questioning of patients, and medical procedures. It examines how courts' broad interpretation of medical professionals' public safety duties, coupled with inadequate criminal procedure safeguards, combined with medical professionals' unique expertise make medical professionals particularly potent and effective helpers in police investigations. Medical professionals' actions interactions with law enforcement may be incidental to their primary responsibilities of providing medical care, or they may be mimicking and taking on characteristics of law enforcement. Their expertise and access to patients propel police investigations, even when their participation may conflict with relevant health law, ethics, and norms, and they may be influenced by other motivations and biases. Part IV sets forth ways in which countervailing legal authority could be constructed to combat the harms of combined policing and medical care and better guide medical professionals on how to work with and push back against overbroad police authority.

et al., *Association of Unconscious Race and Social Class Bias with Vignette-Based Clinical Assessments by Medical Students*, 306 J. AM. MED. ASS'N. 942, 949 (2011); William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e72 (2015); Osagie K. Obasogie, *The Return of the Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments*, 22 S. CAL. INTERDISC. L.J. 1, 5-6 (2012); Osagie K. Obasogie, *Race and Science: Preconciliation as Reconciliation*, RACIAL RECONCILIATION AND THE HEALING OF A NATION: BEYOND LAW AND RIGHTS 49, 50 (Charles Ogletree & Austin Sara eds., 2017).

24. See generally DOROTHY ROBERTS, *KILLING THE BLACK BODY* (1997); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CAL. L. REV. 1239 (2012); KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* (2017); MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* (2020); Patel, *supra*, n.21; Morgan, *supra*, n.21.

I. MEDICAL CARE AND POLICING

Medical professionals' participation in law enforcement investigation and the corresponding law enforcement deployment of authority through medical professionals must be viewed through the historical and current ways these two professions have contributed to our country's problems with racial and class inequities. What follows is a brief overview of the separate problems of policing and medical and a summary of the ways in which the intersection of medical professional and law enforcement practices compound and amplify these problems.

A. *Problems of Bias*

The role of police and medical care cannot be extricated or separated from the issue of race in America and America's problems with racial and class inequities in its criminal and healthcare systems. Scholars and researchers have documented historical and contemporary biased and discriminatory practices of healthcare and law enforcement. This brief discussion only touches upon the complicated issues of race and disparities in policing and healthcare that have been more fully described by scholars elsewhere.

The roots of policing trace back to this country's history of Black slavery and colonization and displacement of indigenous peoples in America.²⁵ Today, racial disparities exist at every point in the criminal process. African Americans represent approximately 13%²⁶ of the adult population but over 37% of those in prison.²⁷ Every stakeholder in the criminal legal system shares responsibility for this.

Policing practices contribute to these racial disparities. Police are more likely to stop and search Black people.²⁸ Black people are much more likely to be the targets of police use of force and violence.²⁹ Implicit and cognitive biases affect the policing of Black people.³⁰ Studies

25. Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CAL. L. REV. 1781, 1819 (2020).

26. *Quickfacts*, UNITED STATES CENSUS, https://www.census.gov/quickfacts/fact/table/US/PST045219_, <https://perma.cc/K7AF-VQ54> (July 1, 2019).

27. *Statistics: Inmate Race*, FED. BUREAU OF PRISONS, https://www.bop.gov/about/statistics/statistics_inmate_race.jsp [<https://perma.cc/ZA56-QYBQ>] (last updated Jan. 16, 2021).

28. See GREG RIDGEWAY, RAND CORP., ANALYSIS OF RACIAL DISPARITIES IN THE NEW YORK POLICE DEPARTMENT'S STOP, QUESTION, AND FRISK PRACTICES (2007); The Stanford Open Policing Project, *Findings* (2021), <https://openpolicing.stanford.edu/findings/> [<https://perma.cc/4FGU-D5SB>].

29. See, e.g., *Young Black Men Are 21 Times as Likely as Their White Peers to be Killed by Police*, EQUAL JUSTICE INITIATIVE (Oct. 20, 2014), <https://ej.org/news/study-shows-young-black-men-21-times-more-likely-to-be-killed-by-police>; *Fatal Force*, WASH. POST. (Jan. 26, 2021), <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/> [<https://perma.cc/G3R7-L33W>].

30. Kristin Henning, *The Reasonable Black Child: Race, Adolescence, and the Fourth Amendment*, 67 AM. UNIV. L. REV. 1513, 1543-46 (2018); L. Song Richardson, *Implicit Bias and Racial Anxiety: Implications for Stops and Frisks*, 15 OHIO ST. J. CRIM. L. 74, 80 (2017).

have shown that police are more likely to perceive Black men as more dangerous and threatening, and associate Black people with crime.³¹ Overt and explicit racism and racist beliefs in law enforcement agencies are also part of the problem. The FBI has documented links between law enforcement and white supremacist and far-right groups.³² News and social media have uncovered similar connections.³³

The history and present-day practices of medicine and the medical profession bear the marks of racism and discrimination. Up until the 1960s, the medical profession actively prevented Black people from joining its ranks. The American Medical Association barred Black doctors from membership until the Civil Rights Act of 1964 made that discrimination unlawful.³⁴ Medical schools barred Black students from enrollment.³⁵ Hospitals and health clinics either did not treat Black patients or provided segregated care.³⁶ Federal policy contributed to healthcare inequities. The federal Hill-Burton Program, created by the Hospital Survey and Construction Act of 1946, led to new hospitals being built throughout the country.³⁷ The bill intended to expand hospital access in poor and rural areas.³⁸ But the new legislation did nothing to remedy segregated hospitals. The law contained an implicit separate-but-equal provision, allowing federal funds to be used to build hospitals that maintained racial segregation.³⁹ Hospitals only desegregated after the enactment of Medicare and other legislative and judicial action in the 1960s.⁴⁰

31. Joshua Correll et al., *Across the Thin Blue Line: Police Officers and Racial Bias in the Decision to Shoot*, 92 J. PERSONALITY & SOC. PSYCH. 1006, 1014 (2007); Joshua Correll et al., *The Police Officer's Dilemma: Using Ethnicity to Disambiguate Potentially Threatening Individuals*, 83 J. PERSONALITY & SOC. PSYCH. 1314, 1317 (2002); Jennifer L. Eberhardt et al., *Seeing Black: Race, Crime, and Visual Processing*, 87 J. PERSONALITY & SOC. PSYCH. 876, 887 (2004).

32. Vida Johnson, *KKK in the PD: White Supremacist Police and What to Do About It*, 23 LEWIS & CLARK L. REV. 205 (2019) (describing an “epidemic of white supremacists in police departments”); Michael German, *Hidden in Plain Sight: Racism, White Supremacy, and Far-Right Militancy in Law Enforcement*, BRENNAN CENTER FOR JUSTICE, (Aug. 27, 2020), <https://www.brennancenter.org/our-work/research-reports/hidden-plain-sight-racism-white-supremacy-and-far-right-militancy-law> [<https://perma.cc/DVV3-JA5T>].

33. GERMAN, *supra* n.5 (listing news articles).

34. James L. Madara, *Reckoning with Medicine's History of Racism*, AM. MED. ASS'N, (February 17, 2021), <https://www.ama-assn.org/about/leadership/reckoning-medicine-s-history-racism> [<https://perma.cc/2ZJR-RL7K>].

35. *A Half-Century of Progress of Black Students in Medical Schools*, 30 J. BLACKS IN HIGHER EDUC. 28, 28 (2000).

36. Ayah Nuriddin, et al., *Perspectives: The Art of Medicine, Reckoning With Histories of Medical Racism and Violence in the USA*, 396 THE LANCET 949, 949 (Oct. 3, 2020) (describing the history of medical racism including segregated medical facilities and exclusion of African Americans from medical education).

37. ANDREA PARK CHUNG, ET AL., *SUBSIDIES AND STRUCTURE: THE LASTING IMPACT OF THE HILL-BURTON PROGRAM ON THE HOSPITAL INDUSTRY 2* (2016).

38. *Id.* at 23.

39. Emily A. Largent, *Public Health, Racism, and the Lasting Impact of Hospital Segregation*, 133 PUBLIC HEALTH RPTS. 715, 715 (2018).

40. *Id.* at 719; describing how Medicare caused hospitals to desegregate). See also George Aumoithe, *The Racist History That Explains Why Some Communities Don't Have*

For centuries, Western science perpetuated the belief of Black inferiority and biological and physical inferiority.⁴¹ During slavery, white physicians “medicalized” racial difference, viewing a slave’s race as a medically significant maker of difference.⁴²

Medical history in the United States includes the experimentation of Black people in the name of scientific progress.⁴³ The infamous Tuskegee decades-long experiment subjected hundreds of Black men to study by giving them noneffective treatments for syphilis.⁴⁴ Six years after the experiment ended, Professor Allen Brandt stated that “[T]he Tuskegee Study revealed more about the pathology of racism than it did about the pathology of syphilis....”⁴⁵ He went on to state that “the notion that science is a value-free discipline must be rejected. The need for greater vigilance and assessing the specific ways in which social values and attitudes affect professional behavior is clearly indicated.”⁴⁶

The Tuskegee experiment is only one historical example. James Marion Sims, known as the “father of modern gynecology,” experimented on Black slaves to form the basis of early “knowledge” and practice in the field.⁴⁷ In 1951, Henrietta Lacks went to a segregated Johns Hopkins because it was one of the few hospitals treating Black patients.⁴⁸ A sample of her cancer cells was given to a cancer and virus researcher. Without the knowledge or consent of Henrietta Lacks and no payment to her or her family, her cell line has become “immortalized” and vital to development in immunology and cancer treatment.⁴⁹ Medical professionals participated in the forced sterilization of Black women and others deemed “undesirable”; this practice continues to this day.⁵⁰

Enough ICU Beds, Wash. Post (Sept. 16, 2020) (describing how it was not until a court decision in 1963 and the 1964 Civil Rights Act “that segregated hospitals were compelled to desegregate”).

41. W. Michael Byrd & Linda A. Clayton, *Race, Medicine, and Health Care in the United States: A Historical Survey*, 93 J. NAT’L MED. ASSOC. 11S, 14S (2001).

42. RANA A. HOGARTH, *MEDICALIZING BLACKNESS: MAKING RACIAL DIFFERENCE IN THE ATLANTIC WORLD, 1780-1840* 2 (2017).

43. Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, 8 HASTINGS CTR RPT. 21, 27 (1978).

44. *Id.* at 25.

45. *Id.* at 27.

46. *Id.*

47. Keith Walloo, *Historical Aspects of Race and Medicine: The Case of J. Marion Sims*, 320 JAMA 1529, 1529 (2018).

48. Johns Hopkins Medicine, *Honoring Henrietta: The Legacy of Henrietta Lacks*, <https://www.hopkinsmedicine.org/henriettalacks/> [https://www.hopkinsmedicine.org/henriettalacks/]; see also REBECCA SKLOOT, *THE IMMORTAL LIFE OF HENRIETTA LACKS* (2010).

49. Johns Hopkins Medicine, *Honoring Henrietta: The Legacy of Henrietta Lacks*, <https://www.hopkinsmedicine.org/henriettalacks/> [https://www.hopkinsmedicine.org/henriettalacks/].

50. Ayah Nuriddin, et al., *supra* n. 37 at 949-50; Alexandra Minna Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those With Disabilities – and Lasted*

Scholars have highlighted how racism endemic in medical research and care, perpetuating stereotypes and false ideas about physiological or biological differences between races.⁵¹ Race shows up in medical research and in the categorization of health conditions.⁵² For instance, when diagnosing chronic kidney disease, a race multiplier is applied to Black people when calculating kidney function based upon historical beliefs of inherent and biological differences between Black and White people, resulting in differential treatment prescriptions.⁵³

Algorithms designed to help hospitals allocate healthcare have been found to discriminate against Black people.⁵⁴ Racial and class biases affect treatment recommendations by medical providers.⁵⁵ Stereotypes about how Black people experience pain (or the lack thereof) have resulted in medical providers dispensing less pain medication.⁵⁶ In emergency room settings, there is evidence of disparate treatment as a result of stereotyping and bias that leads to unequal treatment.⁵⁷ On the receiving end of healthcare, patients on social benefits have reported being treated differently by their medical providers.⁵⁸ This history and the continuing bias in treatment underlie the mistrust of the healthcare system by Black Americans.⁵⁹

Into the 21st Century, THE CONVERSATION (Aug. 26, 2020), <https://theconversation.com/forced-sterilization-policies-in-the-us-targeted-minorities-and-those-with-disabilities-and-lived-into-the-21st-century-143144> [<https://perma.cc/7MHB-G8UH>].

51. Osagie K. Obasogie, *The Return of the Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments*, 22 S. CAL. INTERDISC. L.J. 1, 5-6 (2012); Osagie K. Obasogie, *Race and Science: Preconciliation as Reconciliation*, in RACIAL RECONCILIATION AND THE HEALING OF A NATION: BEYOND LAW AND RIGHTS 49 (Charles Ogletree & Austin Sara eds., 2017).

52. Obasogie, *The Return of the Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments* at 5-6.

53. Salman Ahmed, et al., *Examining the Potential Impact of Race Multiplier Utilization in Estimated Glomerular Filtration Rate Calculation on African-American Care Outcomes*, 36 J. GEN. INTER. MED. 464, 467 (2021).

54. Ziad Obermeyer et al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations*, 366 SCIENCE 447, 477 (2019).

55. Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 GEN. INTERNAL MED. 1231, 1235 (2007) (finding strong associations between physicians' implicit biases and their decisions to perform medical procedures on certain patients).

56. Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J. L. MED. & ETHICS 52 (2001); Janice A. Sabin & Anthony G. Greenwald, *The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Hyperactivity Disorder, and Asthma*, 102 AM. J. PUB. HEALTH 992, 998 (2012).

57. Lynne D. Richardson et al., *Racial and Ethnic Disparities in the Clinical Practice of Emergency Medicine*, 10 ACAD. EMERG. MED. 1184, 1185 (2003).

58. Caitlin Yoshiko Kandil, *Thousands of Medi-Cal Patients Report Poor Treatment by Doctors, Staff*, CAL. HEALTH REPORT (Aug. 16, 2018), <https://www.calhealthreport.org/2018/08/16/thousands-medi-cal-patients-report-poor-treatment-doctors-staff> [<https://perma.cc/SC55-5YT4>].

59. COMMONWEALTH FUND, TRANSFORMING CARE: UNDERSTANDING AND AMELIORATING MEDICAL MISTRUST AMONG BLACK AMERICANS (Jan. 14, 2021),

B. Intersection of Law Enforcement and Medical Care

The work of medical professionals overlaps with law enforcement in many ways. Combined actions of medical and police raise the same concerns of race-based discrimination and bias as when we consider each separately. When medical and police actors act in concert, there is the potential for their actions to amplify bias and discrimination experienced by racial minority patients. This is particularly a concern in healthcare settings more likely to be frequented by poor and racial minority groups and where police are more likely to be present.⁶⁰

A primary and formal way medical professionals' obligations overlap with law enforcement is in their providing information to law enforcement for various types of injuries and suspected crimes. Medical providers must report suspected child abuse,⁶¹ sexual assault,⁶² domestic violence,⁶³ and elder abuse.⁶⁴ They must also provide information about patients with injuries from gunshot wounds, stabbings, and

<https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans#:~:text=Medical%20Mistrust%20and%20Its%20Impacts&text=In%20an%20October%202020%20poll,prevent%20people%20from%20getting%20care> [https://perma.cc/P3XU-9FKG].

60. Song, *Policing the ER*, 134 HARV. L. REV. at 9-18.

61. For a comprehensive list of these statutes, see Leonard G. Brown, III & Kevin Gallagher, *Mandatory Reporting of Abuse: A Historical Perspective on the Evolution of States' Current Mandatory Reporting Laws with a Review of the Laws in the Commonwealth of Pennsylvania*, 59 VILL. L. REV. TOLLE LEGE 37, 57-66 and accompanying footnotes (2014) (citing C. Henry Kempe et al., *The Battered-Child Syndrome*, 181 J. AM. MED. ASS'N. 17 (1962) as that significant article). As Brown and Gallagher note, the model statute proposed by Children's Bureau of the United States Department of Health, Education, and Welfare became the one most adopted by states. *Id.* at 39. This version also "placed the duty to report solely on physicians and other medical staff" though current statutes have a broad range of mandatory reporters. *Id.* at 40, 57-66.

62. See, e.g., ARK. CODE ANN. § 12-12-402 (2021); MASS. GEN. LAWS ANN. ch. 112, § 12A ½ (2021); N.H. REV. STAT. ANN. § 631:6 (2021); N.D. CENT. CODE § 43-17-41(3) (2021). Certain states have provisions that exempt mandatory reporting for injuries related to sexual assault. See OH. REV. CODE ANN. § 2921.22 (West 2021); 18 PA. CON. STAT. § 5106(a)(1) (2021); TENN. CODE ANN. § 38-1-101(e)(1-2) (2021).

63. See, e.g., COLO. REV. STAT. § 12-240-139(1)(a)(I)(a) (2021); KEN. REV. STAT. ANN. § 209A.030 (West 2021); N.D. CENT. CODE § 43-17-41(3) (2021). As in incidents involving sexual assault, certain states have provisions that that exempt mandatory reporting for injuries related to domestic violence. See OH. REV. CODE ANN. § 2921.22 (West 2021); 18 PA. CON. STAT. § 5106(a)(1) (2021); TENN. CODE ANN. § 38-1-101(e)(1-2) (2021).

64. See, e.g., ALA. CODE §§ 38-9-2, 38-9-8, 38-9-9, 38-9-10 (2021); ALASKA STAT. §§ 47.24.010, 47.24.130, 47.24.900, 47.30.915 (2021); ARIZ. REV. STAT. ANN. §§ 46-451, 46-454, § 36-401 (2021); ARK. CODE ANN. §§ 12-12-1701 to -1723 (2021); CAL. WELF. & INST. CODE §§ 15600-15675 (West 2021); COLO. REV. STAT. §§ 18-6.5-102, 18-6.5-108; 26-3.1-101; 26.3.1-102 (2021).

other dangerous weapons.⁶⁵ Certain states have broad language in their statutes to encompass a broad range of potentially criminal conduct.⁶⁶

Medical professionals have long been subject to these reporting requirements, not without complaint. In 1927, the Journal of American Medical Association published an editorial titled “Compulsory Reporting of Gunshot Wounds.”⁶⁷ New York had just passed a law requiring physicians and heads of hospitals to report all gunshot wounds and other injuries resulting from firearms to the police.⁶⁸ Noting the novelty of the New York law but the possibility of its replication in other states, the authors suggested that “Physicians may well consider what policy they should adopt with respect to laws of this character.”⁶⁹ The editorial pointed out all possible people who will have seen the gunshot wound before the person received medical treatment, querying whether and why should doctors and hospitals be the only ones with this statutory obligation.⁷⁰ The authors cited the downsides to this requirement, such as an individual postponing treatment or going elsewhere to seek treatment where their doctor would not have such reporting requirements.⁷¹ These same concerns resonate nearly a century later.

65. See, e.g., ALASKA STAT. § 08.64.369 (2021); ARIZ. REV. STAT. ANN. § 13-3806 (2021); ARK. CODE ANN. § 12-12-602 (2021); COLO. REV. STAT. § 12-36-135 (2021); CONN. GEN. STAT. § 19a-490f (2021); DEL. CODE ANN. tit. 25, § 1762 (2021); FLA. STAT. § 790.24 (2021); IDAHO CODE § 39-1390 (2021); 20 ILL. COMP. STAT. 2630/3.2 (2021); IND. CODE § 35-47-7-1 (2021); IOWA CODE §§ 147.111, 147.113A (2021); KAN. STAT. ANN. § 21-6319 (2021); LA. STAT. ANN. § 14:403.5 (2021); ME. STAT. tit. 17-A § 512 (2021); MD. CODE ANN., HEALTH-GEN § 20-703 (West 2021); MASS. GEN. LAWS ANN. ch. 112 § 12A (2021); MICH. COMP. LAWS § 750.411 (2021); MINN. STAT. §§ 609.2, 626.51 (2021); MISS. CODE ANN. § 56-9-31 (2021); MO. REV. STAT. § 578.351 (2021); MONT. CODE ANN. § 37-2-302 (2021); NEB. REV. STAT. § 28-902 (2021); NEV. REV. STAT. §§ 629.041, 629.045 (2021); N.H. REV. STAT. ANN. § 631 (2021); N.J. STAT. ANN. § 2C:58-8 (2021); N.Y. PENAL LAW §§ 265.25–265.26 (Consol. 2021); N.C. GEN. STAT. § 90-21.20 (2021); N.D. CENT. CODE § 43-17-41 (2021); OH. REV. CODE ANN. § 2921.22 (West 2021); OR. REV. STAT. § 146.750 (2021); 18 PA. CON. STAT. § 5106 (2021); 11 R.I. GEN. LAWS §§ 11-47-48, 23-28.2.24 (2021); S.C. CODE ANN. § 16-3-1072 (2021); S.D. CODIFIED LAWS § 23-13-10 (2021); TENN. CODE ANN. § 38-1-101 (2021); TEX. HEALTH & SAFETY CODE ANN. § 161.041 (West 2021); UTAH CODE ANN. § 26-23a-1 (West 2021); VT. STAT. ANN. tit. 13, § 4012 (2021); VA. CODE ANN. § 54.1-2967 (2021); WASH. REV. CODE § 70.41.440 (2021); W. VA. CODE § 61-2-27 (2021); WIS. STAT. § 255.40 (2021).

66. CAL. PENAL CODE §§ 11160-11163.6 (West 2021) (requiring report of any injury “as the result of assaultive or abusive conduct”); GA. CODE ANN. § 31-7-9 (2021) (requiring report of “any non-accidental injury”); HAW. REV. STAT. § 453-14 (2021) (requiring report of “any non-accidental injury”); UTAH CODE ANN. § 26-23a-1 (West 2021) (requiring report of “any wound or other injury inflicted . . . by violation of any criminal statute”); VA. CODE ANN. § 54.1-2967 (2021) (requiring report of any non-self-inflicted injury resulting from a weapon).

67. Editorial, *Compulsory Reporting of Gunshot Wounds*, J. AM. MED. ASS’N. 404 (Feb. 5, 1927).

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

For other types of reporting obligations, the impetus has come from the medical profession. The medical profession's identification of Battered-Child Syndrome in a medical journal in 1962 prompted states to enact mandatory reporting statutes for child abuse.⁷² Within four years of the publication, all fifty states passed statutes requiring child abuse reporting.⁷³

Some of the most well-documented examples of compounded harms due to the overlap of medical professionals and law enforcement stem from medical professionals providing information about possible criminal activity. A child's injuries are nine times more likely to be reported as resulting from abuse when the child is Black rather than white.⁷⁴ Recent research reviewing data from 2010-2014 found that Black children were overrepresented in suspected reporting of child abuse from a period of racial disparities in the identification of possible child abuse.⁷⁵ With more than 4,000 cases of suspected child abuse, Black victims were disproportionately identified and had longer hospital stays even with less severe injuries.

Medical professionals have also been central to the reporting of and criminalization of Black pregnant women for suspected drug use. The much-criticized drug testing program at the center of the Supreme Court case *Ferguson v. City of Charleston* was started by a nurse.⁷⁶ The nurse got the idea after watching a news program on a similar prosecution program in a neighboring South Carolina city.⁷⁷ As Professor Dorothy Roberts has revealed, in other cities across the country, medical providers played a critical role in reporting Black women for suspected drug use and their prosecution for child abuse if the babies were born with drugs in their system.⁷⁸

72. Leonard G. Brown, III & Kevin Gallagher, *Mandatory Reporting of Abuse: A Historical Perspective on the Evolution of States' Current Mandatory Reporting Laws with a Review of the Laws in the Commonwealth of Pennsylvania*, 59 VILL. L. REV. TOLLE LEGE 37, 37 (2014) (citing C. Henry Kempe et al., *The Battered-Child Syndrome*, 181 J. AM. MED. ASS'N 17 (1962) as that significant article).

73. *Id.*

74. Wendy G. Lane et al., *Racial Differences in the Evaluation of Pediatric Fractures for Physical Abuse*, 288 JAMA 1603, 1607 (2002).

75. Modupeola Diyaolu, et al., *Abstract: Black Children Are Disproportionately Identified as Victims of Child Abuse: A National Trauma Data Bank Study*, PEDIATRICS (Mar. 2021); AAP: *Racial Disparity Observed in Child Abuse Reporting*, PHYSICIAN'S WEEKLY (Oct. 12, 2020), <https://www.physiciansweekly.com/aap-racial-disparity-observed-in-child-abuse-reporting> [<https://perma.cc/8WWD-BD4G>].

76. *Ferguson v. City of Charleston*, 532 U.S. 67 (2001).

77. *Id.* at 70-71.

78. ROBERTS, *supra* note 30 at 173.

The information provided by medical professionals goes beyond just reporting of crime. Medical providers may provide information to police, including but not limited to patient's medical information.⁷⁹ Medical providers may also find contraband on patients and turn it over to hospital security or police directly.⁸⁰ Information from medical providers may be the basis of warrants or subpoenas later issued by law enforcement.⁸¹ Medical providers can also give police officers access to patients for questioning, participate in questioning, or engage in questioning themselves.⁸²

Physicians are often needed to perform procedures for patients in law enforcement custody and to recover illicit substances like drugs at the behest of law enforcement.⁸³ Some hospitals use forensic evidence collection forms that give law enforcement access to patient information, diagnostic information, or material recovered from them.⁸⁴ Medical professionals may be specially trained in forensic procedures, such as nurses trained to assist sexual assault victims.⁸⁵

Medical professionals can also be important witnesses in court cases. For certain types of injuries to infants, medical providers have been critical to prosecutions.⁸⁶ For example, in instances of infant deaths, medical providers have diagnosed Shaken Baby Syndrome and then provided the key expert testimony on how those injuries were caused.⁸⁷

There is scant if any research on how these more informal ways of cooperation perpetuate or continue to reflect or create opportunities for bias. But past and current patterns of bias and discrimination in policing and healthcare raise the very real possibility that these same concerns would apply to other ways in which law enforcement and medical professionals overlap.

79. See *e.g.*, *Lawson v. Halpern-Reiss*, 212 A. 3d 1213, 1215 (Vt. 2019); *Mitchell v. Villien*, et al., 19 So. 3d 557, 560 (La. Ct. App. 2009).

80. See *e.g.*, *United States v. Clay*, 2006 WL 2385353 at *1 (E.D. Ky. Aug. 17, 2006); Interview with hospitalists on May 17, 2021 (notes on file author; identity withheld at request of interviewees).

81. *United States v. Shepherd*, 2014 WL 4594565 at *1 (E.D. Ky. Sept. 15, 2014).

82. *Mincey v. Arizona*, 437 U.S. 385 (1978); See, *e.g.*, *Commonwealth v. Dixon*, No. 148 WDA 2016, 2017 WL 5946524, at *4 (Pa. Super. Ct. Nov. 21, 2017) (detective asked attending physician if defendant was in any condition to be interviewed and was informed that he "could be interviewed").

83. See Part III(C).

84. *Rodriguez v. Pierce*, 176 F. Supp. 3d 445, 453-54 (D. Del. 2016).

85. See generally SANE Program Development and Operational Guide: What Is a SANE?, OFFICE FOR VICTIMS OF CRIMES, <https://www.ovcttac.gov/saneguide/introduction/what-is-a-sane> [<https://perma.cc/S9HY-HQKY>].

86. See generally DEBORAH TUERKHEIMER, *FLAWED CONVICTIONS: "SHAKEN BABY SYNDROME" AND THE INERTIA OF INJUSTICE* (2014).

87. Keith A. Findley, et al., *"Feigned Consensus: Usurping the Law in Shaken Baby Syndrome/Abusive Head Trauma Prosecutions"*, 2019 WIS. L. REV. 1211 (2019).

II. ASYMMETRICAL LEGAL GUIDANCE

Medical professionals are governed by an array of federal and state common law and statutory laws ranging from practice and licensing requirements, responsibilities to their patients, and responsibilities to the state. Medical professionals are also subject to constitutional laws. Many of these laws address the overlap of medical professional and law enforcement responsibilities, including the federal Health Information Portability and Accountability Act (HIPAA); state laws governing mandatory reporting obligations, and doctrinal rules that set the boundaries of tort and constitutional liability.

This array of laws reveal what I call asymmetrical or one-directional legal guidance. First, these laws are directed primarily towards the conduct of medical professionals and not law enforcement, emphasizing what medical professionals *can* and *must* do. Second, law enforcement and public safety priorities, though characterized as discrete exceptions to these protections, result as broad mandates. Broadly worded law enforcement and public safety exceptions are replicated and inserted into medical privacy protections. These laws fail to tell medical professionals what they *cannot* or *should not* do, providing little guidance on how they should exercise their discretion. Third, this lack of guidance is especially concerning when considering the applicable constitutional doctrine. The doctrinal rules are meant primarily to regulate the conduct of law enforcement, and consequently, also emphasize what medical professionals *can do* and not what they *cannot do*.

A. *Health Insurance Portability and Accountability*

In 1996, Congress passed the Health Information Portability and Accountability, or HIPAA for short.⁸⁸ HIPAA provided a unifying federal baseline of privacy protections for patient medical information.⁸⁹ It created a “federal floor of privacy protections for individuals....”⁹⁰ In the twenty-five years since its passage, HIPAA has become almost shorthand for patient privacy in everyday parlance.

88. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

89. *Id.*

90. U.S. DEPT OF HEALTH & HUM. SERV., *Does the HIPAA Privacy Rule Preempt State Laws?*

The legislature enacted HIPAA's Privacy Rule in 2002.⁹¹ The Privacy Rule regulates the disclosure of patient medical records and medical information.⁹² Its core privacy mandates require health care practitioners and institutions to adopt and implement privacy policies and procedures and to notify users of these policies and procedures, including how their protected health information will be used and disclosed.⁹³ Generally, the Privacy Rule prohibits covered entities from disclosing protected health information to third parties.⁹⁴

The Privacy Rule permits—it does not mandate—a number of disclosures related to law enforcement investigative purposes and public safety purposes in discrete circumstances.⁹⁵ These disclosures can be in response to court orders, court-ordered warrants, subpoenas, and administrative requests.⁹⁶ Release of information is permitted in order to identify or locate a suspect, fugitive, material witness, or missing person; to obtain information about a victim of crime when it is suspected that crime caused a death; or when health information can provide evidence of a crime that occurred on medical premises.⁹⁷ Disclosures are also permitted to alert law enforcement about crimes on premises and in emergency situations about the commission and nature of the crime, the location of the crime, and the identity, description, and location of the perpetrator.⁹⁸ In a separate provision, HIPAA allows for the disclosure of information to prevent harm to public safety.⁹⁹ Lastly, perhaps the broadest categories of permitted disclosures under HIPAA are for disclosures otherwise mandated or permitted by law.¹⁰⁰

The Privacy Rule delineates more specific requirements for victims of abuse, neglect, or domestic violence.¹⁰¹ The individual must agree to

91. Subsequent to the enactment of HIPAA, Congress passed the HIPAA Privacy and Security Rules. *See* HIPAA Privacy Rule, 45 C.F.R. § 160 (2013); *see also id.* at § 164(A); *id.* at § 164(E); HIPAA Security Rule, 45 C.F.R. § 160 (2013); *id.* at § 164(A); *id.* at § 164(C). The Privacy Rule lays out more explicitly covered entities' obligations to protect patient privacy. The Security Rule does the same for the security measures necessary to protect patient records.

92. OFFICE OF CIVIL RIGHTS, DEP'T OF HEALTH & HUMAN SERVS., *Summary of the HIPAA Privacy Rule* (2003), <http://www.hhs.gov/sites/default/files/privacysummary.pdf?language=es>. [<https://perma.cc/6FGH-DSDS>].

93. *Id.*

94. *Id.*

95. 45 C.F.R. § 164.512(f) (2002); *see also* OFFICE OF CIVIL RIGHTS, DEP'T OF HEALTH & HUMAN SERVS., SUMMARY OF THE HIPAA PRIVACY RULE (2003); DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE: A GUIDE FOR LAW ENFORCEMENT. (last visited Feb. 6, 2021), http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf [<https://perma.cc/AFY7-NFVM>].

96. *Id.*

97. 45 C.F.R. § 164.512(2)-(5) (2002).

98. *Id.* at § 164.512(f)(5)-(6).

99. 45 C.F.R. § 164.512(j) (2002).

100. 45 C.F.R. § 164.512(f)(1) (2002).

101. 45 C.F.R. § 164.512(c) (2002).

the disclosure.¹⁰² If the individual cannot give consent or some other emergency circumstance prohibits consent, disclosure is only allowed if the information is needed to determine whether a crime is committed by a person other than the victim.¹⁰³ Assurance must be obtained that the information will not be used against the victim when the information is necessary for some immediate law enforcement activity *and* if the providers determine in the exercise of professional judgment that disclosure of the information is in the best interests of the patient.¹⁰⁴

HIPAA broadly defines law enforcement officials. Such an official includes any officer or employee of a state, federal, territorial, or tribal entity empowered to investigate or conduct an inquiry into a potential law violation or prosecute or conduct a criminal, civil or administrative proceeding.¹⁰⁵

HIPAA does not provide for a private right of action, limiting the importance of HIPAA violations in criminal and civil actions.¹⁰⁶ As it stands, HIPAA enforcement is conducted through the Department of Health and Human Services.¹⁰⁷ The data on the types of enforcement actions are not precisely defined to assess how often improper disclosure to law enforcement is subject to challenge.¹⁰⁸ Though the Rule has been subject to a handful of constitutional challenges, none of these challenges have explicitly disputed the law enforcement disclosure exceptions.¹⁰⁹

102. *Id.*

103. 45 C.F.R. § 164.512(c)(1)-(2) (2002).

104. 45 C.F.R. § 164.512(f)(3)(A)-(C) (2002).

105. 45 C.F.R. § 164.103 (2002).

106. *Hudes v. Aetna Life Ins., Co.*, 805 F. Supp. 2d 180, 196 (D.D.C. 2011), *aff'd* 493 F. Appx 107 (D.C. Cir. 2012); *see also Adams v. Eureka Fire Prot. Dist.*, 352 Fed. App'x 137, 138-39 (8th Cir. 2009) (noting that "Courts have repeatedly held" that HIPAA does not create a private right of action).

107. U.S. Dep't of Health & Hum. Serv., *HIPAA Enforcement*, HHS (July 25, 2017), <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html>. Monetary sanctions for violation can range from \$100-\$25,000 per year; criminal penalties include 1 to 10 years of imprisonment and fines from \$5,000 to \$250,000.

108. U.S. DEP'T OF HEALTH & HUM. SERV., HIPAA ENFORCEMENT, <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html> [<https://perma.cc/5DEA-ZSV7>].

109. *See Citizens for Health v. Leavitt*, 428 F.3d 167 (3rd Cir. 2005); *Lemieux v. Tandem Health Care of Florida, Inc.*, 862 So. 2d 745 (Fla. 2nd DCA 2003). The case that came closest to challenging the Rule's enforcement disclosures was brought by plaintiffs including the Association of American Physicians and Surgeons, and then-Congressman Ron Paul. *See Ass'n of Am. Physicians and Surgeons, Inc. v. U.S. Dep't of Health and Human Servs.*, 224 F. Supp. 2d 1115 (S.D. Tex. 2002). The Fifth Circuit affirmed *per curiam*. *See Ass'n of Am. Physicians and Surgeons, Inc. v. U.S. Dep't of Health and Human Servs.*, 67 F. App'x 253 (5th Cir. 2003).

B. State Laws

State laws also provide guidance on the overlap between law enforcement and medical professionals. Though state laws that contradict or provide less protection than HIPAA are preempted, there are exceptions.¹¹⁰ One of the broad categories of permitted disclosures under HIPAA is for disclosures otherwise mandated or permitted by law.¹¹¹ Obviously, state laws that provide stricter privacy measures are not preempted.¹¹² State laws relating to any reporting of disease, injury, child abuse, birth, or death, or for public health surveillance, investigation, and intervention, are also not preempted.¹¹³

State laws governing medical privacy and the actions of medical professionals include state medical privacy acts, medical practice laws, and mandatory reporting and disclosure laws.¹¹⁴ Many of these laws contain exceptions for law enforcement purposes for information disclosure pursuant to mandatory reporting obligations imposed on hospitals and medical professionals. Some state medical practice acts contain provisions that account for mandatory reporting obligations.¹¹⁵ State laws also create exemptions in confidentiality and privilege laws for physicians' reports of crime.¹¹⁶

110. 45 C.F.R. § 160.203 (2002); *see also* U.S. Dep't of Health & Hum. Serv., *Does the HIPAA Privacy Rule Preempt State Laws?*.

111. 45 C.F.R. § 164.512(f)(1) (2002).

112. 45 C.F.R. § 160.203(b) (2002); 42 U.S.C. § 1320d-7(a)(2)(B) (2011).

113. 45 C.F.R. § 160.203(c) (2002).

114. *AMA Principles of Medical Ethics*, AM. MED. ASS'N, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> [<https://perma.cc/V5YY-VX5J>] (last visited May 3, 2021); *Code of Medical Ethics: Privacy, Confidentiality & Medical Records*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-privacy-confidentiality-medical-records> [<https://perma.cc/2A6Q-UDCC>] (last visited May 3, 2021); *Code of Ethics for Nurses, with Interpretive Statements*, AM. NURSES ASS'N (2015) <https://www.nursingworld.org/coe-view-only> [<https://perma.cc/3HDL-DWSC>]; *Standards of Practice for Nurse Practitioners*, AM. ASS'N OF NURSE PRACTITIONERS, <https://www.aanp.org/advocacy/advocacy-resource/position-statements/standards-of-practice-for-nurse-practitioners> [<https://perma.cc/4DD4-MEE5>], (last visited May 3, 2020); *Guidelines for Ethical Conduct for the Physician Assistant Profession*, AM. ACAD. OF PHYSICIAN ASSISTANTS (2013), <https://westliberty.edu/physician-assistant/files/2017/02/16-EthicalConduct.pdf> [<https://perma.cc/A7W5-ZWZ9>].

115. ARIZ. REV. STAT. ANN. § 32-1451 (reference duty to report); DEL. CODE ANN. TIT. 24, § 1701 *et seq.*

116. *People v. Martinez*, 378 P. 3d 761 (Col. Ct. App. 2015) (statement regarding injury admissible under crime reporting exception to physician patient privilege); *People v. J.R.*, 65 Misc. 3d 754, 757 (Cty. Ct. N.Y. 2019) (affirming denial of motion to quash subpoena for medical records and finding Penal Law § 262.25 requiring physician or hospital to report injuries arising from gunshot wound is a statutory exception to physician-patient privilege); *State v. Baptist Mem'l Hosp.-Golden Triangle*, 726 So. 2d 554, 561 (Miss. 1998) (“The investigation into a homicide or other serious felony should not be impeded by an entity or individual attempting to cloak vital information in the physician-patient privilege”).

Mandatory reporting obligations are imposed through state law for certain types of injuries.¹¹⁷ Almost every state imposes mandatory reporting obligations on medical professionals.¹¹⁸ Generally, they require physicians and hospitals to report to law enforcement certain injuries, such as gunshot wounds.¹¹⁹ Some states are very expansive in their requirements, mandating reporting for injuries that *appear* to have been caused through some criminal means.¹²⁰ Many specifically exempt this disclosure from the physician-patient privilege.¹²¹ For example, in Montana, a health care provider can disclose information for certain purposes, such as the general physical condition of a patient if the patient was injured due to a criminal act of another.¹²² Some are a bit more circumspect, like California, which mandates disclosures only with a court order, a warrant, and as required by law for reports of injuries such as child abuse or neglect.¹²³

For disclosures under these state statutes, immunity is generally provided to medical personnel who provide information without the patient's consent.¹²⁴ For example, in some jurisdictions, blood or urine testing conducted at the emergency room may be disclosed to law en-

117. One of the first such laws was passed in New York in 1926. *See* New York Penal Law § 1915 (1926). Canada passed a series of similar laws in the past decade provoking much debate. *See* Merrill A. Pauls & Jocelyn Downie, *Shooting Ourselves in the Foot: Why Mandatory Reporting of Gunshot Wounds is a Bad Idea*, 170 CMAJ 1255 (2004).

118. *Id.*

119. *See Mandatory Reporting of Non-Accident Injuries: A State-by-State Guide*, VICTIM RIGHTS LAW CENTER (updated May 2014) <http://4e5ae7d17e.nxcli.net/wp-content/uploads/2021/01/Mandatory-Reporting-of-Non-Accidental-Injury-Statutes-by-State.pdf> [<https://perma.cc/9Q5H-S7CM>]. (50-state survey of mandatory reporting requirements for health care practitioners). Only Alabama, New Mexico, and Wyoming have no mandatory reporting duty statutes.

120. Hawaii has one of the most far-reaching statute and specific reporting requirements. *See* HAW. REV. STAT. § 453-14. *See, e.g.,* Michigan laws: MICH. COMP. LAWS ANN. § 333.5114 (2019) (HIV reporting requirements); MICH. COMP. LAWS ANN. § 333.5111 (reportable diseases); MICH. COMP. LAWS ANN. § 750.411 (mandatory reporting of injuries by deadly weapons or other means of violence, violation is a misdemeanor, good faith is presumed); MICH. COMP. LAWS ANN. § 722.623(1) (to child abuse hotline); 333.531. Ohio does not permit with grand jury subpoena. *See* OHIO REV. CODE ANN. § 2317.02(B); *see also* VA. CODE ANN. § 32.1-127.1:03(D)(28)-(3).

121. New York also attaches criminal penalties to the failure to report with a potential misdemeanor maximum jail sentence of 1 year. *See* N.Y. PENAL LAW § 265.25. This requirement came to media attention when then New York Giants receiver Plaxico Burres was treated at a hospital, yet the hospital failed to report the gunshot wound to NYPD “at once” as required by law. *See generally* Al Baker, *Hospital Did Not Report Burres’ Wound*, N.Y. TIMES (Dec. 1, 2008).

122. MONT. CODE ANN. § 50-16-805(2)(b) (2017).

123. CAL. CIV. CODE § 56-10 (West 2017); CAL. PENAL CODE §§ 11166 (West 2019).

124. In Maine, the statute provides immunity for medical personnel who provide information to a district attorney, law enforcement, or a court after conducting “a physical examination of the victim...for the purpose of obtaining evidence for the prosecution.” ME. REV. STAT. ANN. TIT. 30-A, § 287 (Maine). *See* *Bonney v. Stephens Mem’l Hosp.*, 17 A.3d 123 (Me. 2011) (holding that immunity statute does not cover information gathered as a result of treatment given to victim and not done so for the purpose of prosecution).

forcement for driving while intoxicated investigations without violating the confidentiality of medical records.¹²⁵ State statutes also explicitly state that physicians must hand over evidence to law enforcement. This often occurs in the drunk driving context, where medical professionals are required to hand over test results.¹²⁶ Twenty-nine states have laws allowing warrantless blood draws from patients suspected of driving while intoxicated.¹²⁷ Medical professionals are shielded from legal liability for any disclosures outlined or required by law.¹²⁸ In Wisconsin, the laws have been recently amended to immunize medical professionals from body cavity searches.¹²⁹

States theoretically provide potential common law remedies. For example, states recognize that “doctor-patient confidentiality” underlies the duty of confidentiality owed to patients by medical providers though courts have treated mandatory reporting obligations as exceptions.¹³⁰ A range of common law tort actions against medical providers includes medical battery, medical malpractice, emotional distress, privacy violations, defamation, and negligence claims.¹³¹

125. 625 ILL. COMP. STAT. 5/11-501.4 (West 2016).

126. IND. CODE ANN. § 9-30-6-6 (West 2019) (samples of, or chemical tests on, blood, urine, or other bodily substance; liability; admissibility).

127. ALA. CODE § 32-5-192(b) (2019); ALASKA STAT. § 28.35.035(b) (2018); ARIZ. REV. STAT. ANN. § 28-1321(C) (2019); ARK. CODE ANN. § 5-65-202(b) (2019); CAL. VEH. CODE § 23612(a)(5) (2019); COLO. REV. STAT. § 42-4-1301.1(8) (2018); FLA. STAT. § 316.1932(1)(c) (2018); GA. CODE ANN. § 40-5-55(b) (2018); 625 ILCS 5/11- 501.1(b) (2019); IOWA CODE § 321J.7 (2018); KY. REV. STAT. ANN. § 189A.103(2) (2019); LA. REV. STAT. ANN. § 32:661(B) (2018); MD. CODE ANN., CTS. & JUD. PROC. § 10-305 (c) (2019); MO. REV. STAT. § 577.033 (LexisNexis, Lexis Advance through 100th General Assembly, HB 14, HB 77, & HB 448); MONT. CODE ANN. § 61-8- 402(3) (2019); NEV. REV. STAT. § 484C.160 (2019); N.H. REV. STAT. ANN. § 265- A:13 (2019); N.M. STAT. ANN. § 66-8-108 (2019); N.C. GEN. STAT. § 20-16.2(b) (2019); OHIO REV. CODE ANN. § 4511.191(4); OKLA. STAT. TIT. 47, §751 (LexisNexis, Lexis Advance through the 57th Legislature act chapter 78, with the exception of chapters 11, 25, 38, 45, 55, & 68); ORE. REV. STAT. § 813.140 (2019); S.C. CODE ANN. § 56-5- 2950(H); TEX. TRANSP. CODE ANN. § 724.014 (2017); UTAH CODE ANN. § 41-6a-522 (2018); 23 VT. STAT. ANN. § 1202(a)(2) (2018); W. VA. CODE, § 17C-5-7(a) (2019); WIS. STAT. § 343.305(3)(b) (2018); WYO. STAT. ANN. § 31-6-102(c) (2019).

128. See e.g., ALA. CODE § 32-5A-194; A.R.S. § 28-8283; AK § 09.65.095; AR § 5-75-10.

129. WIS. STAT. ANN. § 895.535(1) (West 2019).

130. *Lawson v. Halpern-Reiss* at 1214.

131. *Mitchell v. Villien*, 19 So. 3d 557 (La. Ct. App. 2009) (defamation claims against other common law actions against ER doctor for gunshot wound reporting leading to plaintiff's arrest); *Dunkle v. Children's Hosp. Med. Ctr. of Akron*, 5 N.E. 3d 131 (Oh. Ct. App. 2013) (defamation claims filed by parents against physicians for reporting suspected child abuse); *Brown v. Pound*, 585 So. 2d 885 (Ala. 1991) (claims under the Alabama Medical Practice Act and invasion of privacy and for emntal and emotional damages); *David M. v. Beverly Hospital*, 131 Cal. App. 4th 1272 (Cal. Ct. App. 2005) (declaring proper vehicle is negligence but that statute of limitations prohibited case from going forward).

C. Constitutional Laws

While statutory and regulatory laws in place direct medical professionals to cooperate with law enforcement, the applicable constitutional framework is directed mainly towards police conduct.¹³²

Constitutional criminal procedure is the primary regulatory of police conduct; the combined actions of law enforcement and medical professionals are also regulated by the same criminal procedural rules.¹³³ Applicable provisions include the Fourth Amendment for searches and seizures, the Fifth Amendment and Due Process Clause for interrogations, and the Sixth Amendment for issues regarding confrontation of witnesses.¹³⁴

For the most part, when medical professionals become part of police investigatory actions, the constitutionality of those actions are viewed primarily as police action; the actions of medical professionals are viewed as ancillary, incidental, or separate from that of police. At the same time, the constitutional question does not delve with much depth into the health law aspects of the medical professionals' duties to the patients who become the subject of police action.

The threshold question of whether constitutional protections apply to medical professionals when they become part of police investigations depends on whether they are viewed as state actors. Medical professionals who are employees of the state are state actors when providing medical care for those under state care and custody.¹³⁵ Medical

132. Separate and apart from policing-related conduct, the Supreme Court has recognized to varying degrees constitutional protections for matters relating to medical privacy and provider-patient relationships. The Supreme Court stated that medical information "is precisely the sort [of information] intended to be protected by penumbras of privacy." *Doe v. Se. Pa. Transp. Auth.*, 72 F. 3d 1133, 1138 (3d Cir. 1995) (citing *Eisenstadt v. Baird*, 405 U.S. 438, 450 (1972)). *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977), has been interpreted to affirm a constitutional right to confidentiality, but it has been debated whether it created a constitutional right to confidentiality. See Jessica C. Wilson, *Protecting Privacy Absent a Constitutional Right: A Plausible Solution to Safeguarding Medical Records*, 85 WASH. U. L. REV. 653, 657-669 (2007). In *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court acknowledged there is a constitutional right to privacy in the doctor-patient relationship. See also *United States v. Westinghouse Elec. Corp.*, 638 F. 2d 570, 577 (3rd Cir. 1980); *Doe v. Borough of Barrington*, 729 F. Supp. 376, 382 (D.N.J. 1990); *Woods v. White*, 689 F. Supp. 874, 876 (W.D. Wis. 1988); *Carter v. Broadlawns Med. Ctr.*, 667 F. Supp. 1269, 1282 (S.D. Iowa 1987).

133. Rachel A. Harmon, *The Problem of Policing*, 110 MICH. L. REV. 761, 763 (2012) ("The problem of regulating police power through law has been shoehorned into the narrow confines of constitutional criminal procedure."). See also Song, *Policing the ER* at 2664-2703 (discussing the applicability of the Fourth and Fifth Amendment to police investigations in emergency rooms).

134. This article addresses front-end investigations and also does not delve into use of force during the course of an arrest which is also analyzed under the Fourth Amendment search and seizure provision. See also *Graham v. Connor*, 490 U.S. 386 (1989).

135. *Harvey v. Harvey*, 949 F. 2d 1127, 1130 (11th Cir. 1992); *Lowe v. Aldridge*, 958 F. 2d 1565, 1572 (11th Cir. 1992).

professionals have been found to be state actors for the purpose of Fourth Amendment protection when they instigate programs with a sufficient law enforcement purpose such as in *Ferguson*.¹³⁶

However, when medical professionals become part of police investigations in other aspects, the question of state actor becomes much less clear. Searches of patients' belongings and bodies fall under the Fourth Amendment prohibition against unreasonable searches and seizures.¹³⁷ Searches of patients and bodies must be directed by law enforcement in order for there to be constitutional scrutiny, and even then, it is highly unlikely that the medical professional will be the target of that scrutiny. As one federal court commented, "Plainly stated, doctors and nurses are not Fourth Amendment gurus."¹³⁸ Hence, even when medical professionals search patient belongings and hand them over to law enforcement, or hospital security, the courts treat these as private party searches and not action subject to Fourth Amendment protections.¹³⁹

Though searches of patient bodies are subjected to heightened scrutiny, the question of medical professional responsibility is muddled. Courts may view the search as a medically necessary procedure, and not a police-initiated search. And when such searches are considered a police search, medical professional participation is part of the assessment of the constitutionality of these types of searches. The reasonableness—and constitutionality—of such procedures is assessed by examining the individual's interests, public safety, and how they were conducted.¹⁴⁰ The extent to which the medical procedure may threaten the health or safety of the individual is weighed alongside the extent of the intrusion on the person's individual dignitary and privacy interests, and the community's interests in "fairly and accurately determining guilt or innocence."¹⁴¹ Courts must also consider "...the scope of the particular intrusion, the manner in which it is conducted, the justification for initiating it, and the place in which it is conducted."¹⁴² The

136. *Ferguson v. City of Charleston*, 532 U.S. 67, 69 (2001).

137. U.S. CONST. AMEND. IV.

138. *Lockard v. City of Lawrenceburg*, 815 F. Supp. 2d 1034, 1051 (S.D. Ind. 2011).

139. *Song, Policing the ER*, *supra* n.11 at 2679-2680.

140. *See Schmerber v. California*, 384 U.S. 757 (1966); *Winston v. Lee*, 470 U.S. 753 (1985). Before *Schmerber*, the Supreme Court decided body cavity searches fell not under the Fourth Amendment but under the Due Process Clause of the Fourteenth Amendment. *See Rochin v. California*, 342 U.S. 165 (1952). *Schmerber* was the first one of these cases to apply the Fourth Amendment to body cavity searches after the Court's decision in *Mapp v. Ohio*, 367 U.S. 643 (1961) which applied the federal exclusionary rule to state court decisions.

141. *Winston v. Lee*, 470 U.S. 753, 761-62 (1985).

142. *Rodrigues v. Furtado*, 950 F. 2d 80, 811 (1st Cir. 1991) (quoting *Bell v. Wolfish*, 441 U.S. 520, 559 (1984)). The First Circuit did note that the cavity searches involved in *Bell* were of inmates who have lesser liberty interests than non-inmates.

fact that it is conducted by a doctor, in a “private and hygienic setting and in a medically approved manner” is in part what makes the search reasonable.¹⁴³

When it comes to questioning patients, a number of constitutional questions can be triggered based upon the Fifth Amendment’s right to counsel, the privilege against self-incrimination, and due process protection.¹⁴⁴ The primary actor in question, however, is again law enforcement, not the medical professional. Under typical Fifth Amendment analysis, whether someone is in custody is determined by whether they are physically deprived of freedom in a significant manner or placed in a situation where they would reasonably believe that their freedom or action is restricted.¹⁴⁵ The interrogation need not be at a station house in order to count as “in custody.” Courts look to the totality of the circumstances to determine the extent the interrogation is conducted in a “police-dominated atmosphere”¹⁴⁶ and whether a reasonable person would believe he or she were free to leave or to refuse to answer police questioning.¹⁴⁷

The fact that a suspect is in a hospital and cannot leave because of a medical condition does not itself establish custody.¹⁴⁸ Neither is it given that police questioning in a healthcare setting like a hospital warrants Fifth Amendment protection. Courts have characterized the questioning that a police officer must do as investigatory but not necessarily inquisitorial.¹⁴⁹ If there is sufficient indication of police participation,¹⁵⁰ even when a nurse initiates the questioning, that questioning can be a custodial interrogation requiring *Miranda* warnings to be provided.¹⁵¹

A separate constitutional question regarding statements relates to whether they have been coerced.¹⁵² A patient’s physical and mental condition is relevant to whether a statement has been made voluntarily.¹⁵³ Statements of the treating physician or nurse have been taken

143. Rodriques, 950 F. 2d at 811 (citing *Schmerber v. California*, 384 U.S. at 711-12).

144. U.S. CONST. AMEND. V.

145. *Oregon v. Mathiason*, 429 U.S. 492 (1977) (per curiam).

146. *Miranda v. Arizona*, 384 U.S. 436, 445 (1966).

147. *Thompson v. Keohane*, 516 U.S. 99 (1995).

148. *United States v. Robertson*, 19 F. 3d 1318, 1321-22 (10th Cir. 1994); *United States v. Martin*, 781 F. 2d 671, 673 (9th Cir. 1985); *State v. Tucker*, 557 A. 2d 270, 271-73 (1989); *Com. v. Ellis*, 379 Pa. Super. 337, 358 (1988).

149. *Bartram v. State*, 364 A. 2d 1119, 1150 (Md. App. 1976); *Commonwealth v. Ellis*, 549 A. 2d 1323 (Penn. 1988); *Hammond v. State*, 569 A. 2d 81 (Del. 1989).

150. See generally *People v. Jones*, 393 N.E. 2d 443 (NY. 1979).

151. *State v. Ybarra*, 804 P.2d 1053, 1058 (N.M. 1990).

152. *Dickerson v. United States*, 530 U.S. 428 (2000).

153. *Mincey v. Arizona*, 437 U.S. 385, 409 (1978).

into account in determining the voluntariness of statements, whether such medical pronouncements or opinions are made at the time of treatment,¹⁵⁴ or through later testimony in court.¹⁵⁵

The involvement of medical professionals in Sixth Amendment Confrontation Clause questions is viewed with a bit more nuance. The Sixth Amendment provides a right of confrontation so that the accused can face his accuser at trial.¹⁵⁶ In *Crawford v. United States*, the Supreme Court held that testimonial hearsay cannot be admitted at trial without showing the unavailability of the declarant and a prior opportunity for cross-examination by the defendant.¹⁵⁷ The Confrontation Clause applies to witnesses who “bear testimony” against the accused.¹⁵⁸ Considerations of whether statements are testimonial or nontestimonial include if the statements were “made under circumstances which would lead an objective witness reasonably to believe that the statement would be available for use at a later trial.”¹⁵⁹ But if “the primary purpose of the interrogation is to enable police assistance to meet an ongoing emergency” rather than to “establish or prove past events,” then such statements are far more likely to be considered nontestimonial.¹⁶⁰

Statements made to medical professionals during the course of medical treatment are not necessarily testimonial for the purposes of the Sixth Amendment and *Crawford*.¹⁶¹ Even though a police officer may be present during questions posed to the victim by the forensic sexual assault nurse, such statements have been characterized as statements made by victims “to a *medical professional* during an emergency-room examination...”¹⁶² As one court stated, though the sexual assault unit at a hospital “gathers forensic evidence for potential criminal prosecution...its primary purpose is to render medical attention to its patients” and thus not subject the victim to cross-examination at trial.¹⁶³ Others have viewed statements made to sexual assault

154. *People v. Stryker*, 2010 WL 219318, 13 (Cal. Ct. App. Jan. 22, 2010).

155. *People v. Fordyce*, 612 P. 2d 1131 1133 (Colo. 1989); *United States v. Walker*, 272 F.3d 407, 412 (7th Cir. 2001).

156. U.S. CONST. AMEND. VI.

157. *Crawford v. Washington*, 541 U.S. 36, 68 (2004).

158. *Id.* at 69.

159. *Id.* at 51-52.

160. *Davis v. Washington*, 547 U.S. 813, 814 (2006).

161. *State v. Vaught*, 682 N.W. 2d 284 (Neb. 2004); *State v. Krasky*, 696 N.W. 2d 816 (Minn. Ct. App. 2005); *In re T.T.*, 815 N.E. 2d 789 (2004); *People v. Geno*, 683 N.W. 2d 687 (2004); *People v. Vigil*, 127 P. 3d 916 (Col. 2006) (though the police officer had brought the victim to the hospital, the officer was not involved in the medical examination or in the room at the time of the examination).

162. *State v. Stahl*, 855 N.E. 2d 834, 839 (Oh. 2006).

163. *Id.* at 841; *see also* *People v. Spicer*, 884 N.E. 2d 675, 685 (Ill. Ct. App. 2007) (“Almost all emergency room visits by sexual assault victims will have both evidence collection aspects and medical aspects. If we were to hold that an evidence collection purpose made statements

forensic nurses as testimonial even when police are not present during the questioning because of their dual role of “providing medical treatment and gathering evidence” for future criminal prosecution.”¹⁶⁴

The timing of the statements may also determine whether the statement is considered testimonial or not. Statements may be non-testimonial,¹⁶⁵ for instance, when a sexual assault nurse examines a child victim in an ER, and the young person’s well-being and health were the principal focus of the emergency room visit.¹⁶⁶ Another court determined that a statement made to a nurse examiner sometime after the assault was testimonial when the statement was made with the assistance and encouragement of law enforcement.¹⁶⁷

A few states have more expansive constitutional rights to privacy, including the right to privacy in health information.¹⁶⁸ In Florida, one court case reversed and remanded a man’s conviction for driving under the influence of manslaughter.¹⁶⁹ Though the appellate court recognized that compelling governmental interests may be exceptions to the right to privacy in its constitution, the requirements for obtaining medical information in the statute represented the legislature’s efforts to balance patient privacy against the State’s interest.¹⁷⁰

III. MEDICAL JUDGMENT OR POLICE AGENT?

This asymmetrical or one-directional legal and regulatory framework leaves medical professionals with insufficient guidance on when they should not interact with law enforcement. Moreover, the framework artificially divides the roles between law enforcement and medical professionals in what are actually dynamic situations where that division is much more blurred. As a result, a broad range of cooperation and interactions between medical professionals and law enforcement are sanctioned or tacitly allowed at front-end investigations, providing probable cause and other evidentiary information necessary for an arrest.

from a sexual assault evaluation inadmissible, we would in effect obliterate the statute, which applies only in sexual assault cases.”).

164. *Commonwealth v. DeOliveira*, 849 N.E. 2d 219, 224 (Mass. 2006); *Hartsfield v. Com.*, 277 S.W. 3d 239 (Ken. 2009); *see also Medina v. State*, 143 P. 3d 471 (Nev. 2006) (statement given to SANE nurse whose duty it is “to gather evidence for possible criminal prosecution”).

165. *Id.* at 686.

166. *Id.* at 687.

167. *State v. Romero*, 156 P. 3d 694, 698-99 (N. Mex. 2007).

168. ALA. CONST. ART. 1 § 22; ARIZ. CONST. ART. II; § 8; CAL. CONST. ART. I; § 1; FLA. CONST. ART. I, §§ 12, 23; HAW. CONST. ART. I, §§ 6, 7; ILL. CONST. ART. I, § 6; LA. CONST. ART. I, § 5; MONT. CONST. ART. II, § 10; N.H. CONST. ART. 2-B; S.C. CONST. ART. I, § 10; WASH. CONST. ART. I, § 7.

169. *Frank v. State*, 912 So. 2d 329, 330 (Fla. 5th DCA 2005).

170. *Id.*

The upside for police is clear. Police can access the expertise of medical professionals, their professional relationships with patients, and their proximity to vulnerable and potentially compromised patients, in order to gather evidence for an arrest. But the costs or consequences of using medical professionals are high, particularly when viewed through the lens of medical privacy, patient confidences, and trust. Yet the existing legal and regulatory framework *assumes* that there are little to no such costs.

Moreover, the aspects of medical professionals that are advantageous for policing are precisely the reasons to scrutinize whether medical professionals should be easily accessed by law enforcement in the early stage of investigations. Here, we focus on three particular types of investigatory methods: initial reporting of crime, eliciting incriminatory statements from suspects, and retrieval of evidentiarily significant material. I use examples from caselaw to flesh out if medical professionals are only acting in the face of the competing legal and ethical obligations to the patient and to public safety, or when medical professionals may be being coopted by law enforcement priorities, seeing their role as more akin to that of police.

Courts' broad interpretation of the public safety duties of medical professionals, along with the professional expertise and value of medical professionals make a potent combination. Medical professionals are then left to make their own determinations of how to properly allocate their dual loyalties to the patient and the state.

A. *Mandated Reporter or Expert Informant*

Medical professionals are uniquely situated to provide pertinent information to law enforcement. They care for those who may be injured due to criminal activity, and patients may come to healthcare settings incapacitated and sick, and unable to keep their bodies and belongings from being searched. This proximity to patients combined with reporting obligations mean that medical professionals are fertile sources of information on crime or possible criminal behavior. Mandatory reporting obligations may justify certain disclosures. But medical professionals—with court permission—may give information beyond statutory mandates. And medical professionals, by virtue of their unique set of skills as medical diagnosticians, medical professionals' opinions can hold great sway and become the sum of information needed to arrest someone suspected of criminal activity.

Mandatory reporting duties are aimed at curbing certain societal problems, such as drunk driving. Medical professionals are particularly likely to come across injured patients who drove while intoxicated. A nurse, Patricia Halpern-Reiss, made such a report that led to the arrest of Elizabeth Lawson. After lacerating her arm, Ms. Lawson

drove herself to the emergency room.¹⁷¹ After she was treated and cleared for discharge, the nurse reported Ms. Lawson's "blatant intoxication" to a police officer on duty.¹⁷² The nurse had smelled alcohol on Ms. Lawson's breath and knew that a test revealed her blood alcohol level of .214, over two and half times the legal limit.¹⁷³ The nurse told the police officer that she understood from the patient "that she had driven herself to the hospital, and that she was about to drive herself home."¹⁷⁴ The officer then talked to Ms. Lawson and arrested her on suspicion of driving while intoxicated; the charge was later dismissed.¹⁷⁵

Ms. Lawson brought a tort claim against the nurse and the hospital for breaching the duty of confidentiality owed to her.¹⁷⁶ The Vermont Supreme Court affirmed the trial court's judgment, holding that "no reasonable factfinder could determine that the [nurse's] disclosure was for any purpose other than to mitigate the threat of imminent and serious harm to plaintiff and the public."¹⁷⁷ The court recognized her right to a common law private right of action based upon state law concerning patient privacy and confidentiality but also acknowledged state laws immunizing medical providers from disclosures for public safety, and mandatory reporting laws.¹⁷⁸ The court relied upon a HIPAA regulation permitting "disclosures to avert a serious threat to health or safety."¹⁷⁹ The court found that the nurse's statements to the police officer were made in good faith.¹⁸⁰

The opinion reflects the broad permit of law enforcement disclosures without careful examination of the underlying health privacy laws and ethics. Yes, Vermont law requires any health professional who is aware of a high blood alcohol level to report that fact "as soon as reasonably possible" to a law enforcement agency who has jurisdiction over that matter.¹⁸¹ It so happened that in Ms. Lawson's case, "as soon as reasonably possible" became near-immediate because there was an officer "on duty" because of a contract between the hospital and the local police department.¹⁸²

The nurse's disclosures were, in fact, broader than the Vermont requirement since she gave the police officer information—statements

171. *Lawson v. Halpern-Reiss*, 212 A.3d 1213, 1215 (Vt. 2019).

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

176. *Lawson v. Halpern-Reiss* at 1214.

177. *Id.* at 1219, 1220.

178. *Id.*

179. *Id.* at 1222.

180. *Id.* at 1225.

181. Vt. Stat. § 1203b (Duty to report blood test results).

182. *Lawson v. Halpern-Reiss* at 1215.

by Ms. Lawson, test results, and the nurse's other observations— that gave the police officer the necessary information that Ms. Lawson drove while intoxicated beyond the legal limit.

The Vermont Court correctly noted that HIPAA allows broader disclosures of patient health information when there is a “serious and imminent threat.”¹⁸³ But the court made no mention that this provision is permissive and not a mandate. Nor did the court consider agency advisement on that provision or ethical pronouncements on how medical professionals should handle the confidentiality of patients suspected of impairment.

—According to the Department of Health and Human Services advisement, the determination of “serious and imminent threat” is left to the judgment and “good faith belief” of health professionals.¹⁸⁴ The Office of Civil Rights, the enforcement body for HIPAA violations, “would not second guess a health professional’s good faith belief that a patient poses a serious and imminent threat to the health or safety of the patient or others and that the situation requires the disclosure of patient information to prevent or lessen the threat.”¹⁸⁵ The agency advisement does not, however, require disclosure to law enforcement. It permits the disclosure of protected health information without patient consent to various categories of people in order to “prevent or lessen the threatened harm,” including not just law enforcement but also “family, friends, [and] caregivers.”¹⁸⁶

Nurse Halpern-Reiss may well have been motivated by public health considerations about drunk driving and believed that Ms. Lawson’s statement that she was going to drive home might hurt others on the road or at the very least, Ms. Lawson. She made a choice to alert the police officer in lieu of family or friends to prevent Ms. Lawson from driving home. In doing so, she disclosed communications from Ms. Lawson that were made presumably in the course of their treatment relationship, and with the understanding of that confidence. Medical ethics acknowledge the tension between public safety and patient confidentiality when dealing with impaired drivers, but they do not so clearly favor public safety duties over patient confidentiality

183. 45 C.F.R. § 164.512(j) (2002).

184. U.S. Dep’t of Health & Hum. Serv. FAQ, What constitutes a “serious and imminent” threat that would permit a health care provider to disclose PHI to prevent harm to the patient, another person, or the public without the patient’s authorization or permission?, <https://www.hhs.gov/hipaa/for-professionals/faq/3002/what-constitutes-serious-imminent-threat-that-would-permit-health-care-provider-disclose-phi-to-prevent-harm-patient-public-without-patients-authorization-permission/index.html> [<https://perma.cc/66ST-MRRX>].

185. *Id.*

186. *Id.*

when medical professionals suspect impaired driving.¹⁸⁷ The court made little comment about these competing obligations and the disclosure of confidential communications.

Medical professionals may also get it wrong when they report suspect criminal conduct. Unlike blood tests that can determine high alcohol levels with a relatively high degree of certainty, other types of reporting obligations require the subjective interpretation of injuries by medical professionals.¹⁸⁸ This is certainly true of other mandatory reporters, like teachers and social workers. But the subjective interpretation by medical professionals is more problematic because the mandatory reports are portrayed as objective medical diagnoses formed by their professional expertise and a particular set of skills.

Erroneous reporting of a gunshot injury by a physician led to the arrest and incarceration of Christopher Mitchell. Mr. Mitchell brought his companion, Cathy Hall, to the emergency room at New Orleans' Mercy Hospital for a bleeding head wound.¹⁸⁹ The ER physician on duty, Dr. Paul Villien, examined the patient and determined that the wounds on her head suggested that they had been caused by "a gunshot or other bone-piercing object."¹⁹⁰ He instructed his staff to contact the police to report the death. When the homicide detective arrived at the ER, Dr. Villien showed him the injury, placing his finger in the wound.¹⁹¹ The detectives spoke to Mr. Mitchell while he was still at the hospital, took him to his home, and later arrested him.¹⁹² Mr. Mitchell spent several weeks in the parish prison despite the coroner's fairly immediate determination that Ms. Hall died of natural causes and not a gunshot wound.¹⁹³ The investigating detective "emphasized that he would not have arrested Mr. Mitchell except that Dr. Villien had expressed his opinion that Ms. Hall was a gunshot victim."¹⁹⁴

187. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS OPINION 8.2 (IMPAIRED DRIVERS & THEIR PHYSICIANS, <https://www.ama-assn.org/delivering-care/ethics/impaired-drivers-their-physicians> [<https://perma.cc/QH49-QGXY>]; Lee Black, *Physicians' Legal Responsibility to Report Impaired Drivers*, 10 AMA J. ETHICS 393 (2008), <https://journalofethics.ama-assn.org/article/physicians-legal-responsibility-report-impaired-drivers/2008-06> [<https://perma.cc/JB5B-V2MA>]; Carolyn Buppert, *Legal Obligations to the Dangerous Patient*, MASS. NURSES ASS'N. (Aug. 25, 2009), <https://www.mass-nurses.org/news-and-events/p/openItem/2862> [<https://perma.cc/5EVJ-CUZC>].

188. For example, parents have bought suit against doctors for reporting them for child abuse and for the pain and emotional trauma that resulted because of the wrong reports *See generally* *Ferraro v. Chadwick*, 221 Cal. App. 3d 86 (Cal. Ct. App. 1990); *Mohlil v. Glick*, 842 F. Supp. 2d 1072 (N.D. Ill. 2012); *Thomas v. Nationwide Children's Hospital*, 882 F. 3d 608 (6th Cir. 2018).

189. *Mitchell v. Villien, et al.*, 19 So. 3d 557, 560 (La. Ct. App. 2009).

190. *Id.*

191. *Id.*

192. *Mitchell v. Villien, et al.* at 560.

193. *Mitchell v. Villien, et al.* at 560.

194. *Mitchell v. Villien, et al.* at 560.

Mr. Mitchell filed a lawsuit against Dr. Villien, the detective, and the City of New Orleans.¹⁹⁵ The lawsuit failed.¹⁹⁶ The appellate court reversed the trial court's decision denying Dr. Villien's summary judgment motion.¹⁹⁷ The court pointed to the mandatory reporting obligations in Louisiana to report suspected gunshot wounds.¹⁹⁸ Even though the gunshot reporting statute did not have an immunity provision, the appellate court concluded that Dr. Villien enjoyed a "qualified or conditional privilege...when he reported a suspected gunshot wound if in good faith he had a subjective belief in the accuracy of his report at the time."¹⁹⁹ The court noted the public policy reasons behind the mandatory reporting bill: to catch perpetrators of serious crime.²⁰⁰

As the court acknowledged the mistake: "Dr. Villien made a mistake in determining that Ms. Hall had been shot. Mr. Mitchell was deprived of his liberty for over a month. At least as between these two parties, the law has decided that Mr. Mitchell for the good of society must bear the cost of Dr. Villien's mistake."²⁰¹ The appellate court may have thought that Mr. Mitchell would recover against the City, but the court's decision caused the rest of Mr. Mitchell's case to fall apart.²⁰²

Mistaken suspicions by medical providers also led to the arrest of Joseph Myers for the alleged sexual abuse of his daughter. In that case, Joseph Myers's five-year-old daughter complained of various pains.²⁰³ A few hours later, when she stopped breathing, her parents called for an ambulance. Paramedics transported her to the ER by helicopter and she died upon arrival.²⁰⁴ After her death, several of the emergency doctors suspected that the girl had been sexually abused.²⁰⁵ A resident relayed his suspicions to police officers who had arrived at the hospital and spoke to the medical staff. Based upon this information, the police took Mr. Myers and his wife to the police station for questioning, executed search warrants at their home, and interviewed neighbors. After recovering pornographic material from the home, the

195. *Id.* at 560

196. *Id.* at 561.

197. *Id.*

198. *Mitchell v. Villien, et al.* at 565-66.

199. *Id.* at 570.

200. *Id.* at 565. The court cited the legislative history which included the New Orleans district attorney speaking in support of the bill: "The problem is that individuals are being shot and brought to the hospital and leaving the hospital. They are on a wanted list and may be the perpetrator of a serious crime...[T]his is an attempt to have the authorities notify[sic] if a wanted subject is brought into the hospital emergency room as a victim of a shooting or stabbing."

201. *Id.* at 573.

202. Interview with Gary Bizal, attorney for Mr. Mitchell on April 28, 2021 (notes on file with author).

203. *Myers v. Medical Ctr. Of Del., Inc.*, 86 F. Supp. 2d 389 (D. Del. 2000). These facts are taken from the court's ruling on both parties' motions for summary judgment.

204. *Id.* at 394.

205. *Id.*

police learned of the coroner's findings that there was no evidence of physical or sexual abuse.²⁰⁶ The Myers were released the following morning and no charges were ever brought. The Myers brought suit against the physicians and the hospital; the court granted their summary judgment on all counts against them.²⁰⁷

Medical professionals can be an especially potent "white-collar police force," as termed by Professor Sandra Guerra Thompson, when they report criminal behavior to the police.²⁰⁸ Their information can become the totality of the probable cause resulting in the arrest. The kind of professional expertise medical professionals bring to their reports of suspected criminal behavior bear a striking similarity to how medical professionals and forensic medicine have been pivotal in criminal prosecutions of child abuse, child neglect, and crimes related to abortion.²⁰⁹ Professor Deborah Tuerkheimer has described the "prosecution paradigm" used in Shaken Baby Syndrome cases where medical experts, including the initial treating doctor, would provide both the initial medical diagnosis and the bulk of the evidence propelling the criminal prosecutions of these cases.²¹⁰ Tuerkheimer pointed out how the multidisciplinary approach to child abuse formalized alliances between doctors, police, and prosecutors, thereby "subtly reconceive[ing] the function of the physician."²¹¹ As she described, the physicians' diagnosis is necessarily subjective and can be affected by the race and socio-economic of the caregiver and parent.²¹² In these prosecutions, the doctor "is the case."²¹³ They identify the occurrence of the crime, its perpetrator, and their assurances are necessary for a conviction.²¹⁴

206. *Id.* at 395.

207. *Id.*

208. Sandra Guerra Thompson, *The White-Collar Police Force: "Duty to Report" Statutes in Criminal Law Theory*, 11 WM. & MARY BILL RTS. J. 3 (2002).

209. See, e.g., *Young Black Men Are 21 Times as Likely as Their White Peers to be Killed by Police*, EQUAL JUSTICE INITIATIVE (Oct. 20, 2014), <https://eji.org/news/study-shows-young-Black-men-21-times-more-likely-to-be-killed-by-police>; *Fatal Force*, WASH. POST. (Jan. 26, 2021), <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/> [<https://perma.cc/AT55-WK63>]; DEBORAH TUERKHEIMER, *FLAWED CONVICTIONS: "SHAKEN BABY SYNDROME" AND THE INERTIA OF INJUSTICE A MEDICAL 9-13* (2014); Keith A. Findley, et al., *Shaken Baby Syndrome, Abuse Head Trauma, and Actual Innocence: Getting it Right*, 12 HOUS. J. HEALTH L. & POL'Y 209 (2012) (describing diagnosis and the costs on families due to a misdiagnosis of child abuse).

210. DEBORAH TUERKHEIMER, *FLAWED CONVICTIONS: "SHAKEN BABY SYNDROME" AND THE INERTIA OF INJUSTICE A MEDICAL 9-13* (2014).

211. *Id.* at 36.

212. *Id.* at 37.

213. Keith A. Findley, et al., *Feigned Consensus: Usurping the Law in Shaken Baby Syndrome/Abusive Head Trauma Prosecutions*, 2019 WISC. L. REV. 1211 (2019) (arguing that physicians should not be permitted to diagnose shaken baby syndrome in court); see also Keith A. Findley, *Flawed Science and the New Wave of Innocents*, in *WRONGFUL CONVICTIONS AND THE DNA REVOLUTION: TWENTY-FIVE YEARS OF FREEING THE INNOCENT* 190 (Daniel S. Medwed, ed., 2017) ("These cases are deeply worrisome not just because the 'science' can be used to satisfy the legal elements of the offenses, but because it is used to established the most fundamental historical fact in the case: what happened....").

214. *Id.* at 38.

Similarly, Professor Aziza Ahmed has described the significant role of medical and forensic science to prosecute pregnant women and caretakers in a different kind of diagnosis, the hydrostatic lung test (HLT) used to legitimize the prosecution of women who performed self-induced abortions.²¹⁵ She situated HLT in a “long history of cases in which medical and forensic evidence and expertise was mobilized, shaped, and legitimated by courts for the sake of successful prosecution of pregnant women, mothers, and caretakers in the contexts of the “crack baby” epidemic and Shaken Baby Syndrome.”²¹⁶ As in Shaken Baby Syndrome cases, Professor Ahmed highlighted the problematic science behind HLT, the prominent role of physicians in the diagnosis and proof of HLT, and the particular racial and gendered impact of HLT prosecutions on women of color.²¹⁷

At the initial investigatory stage, the medical professional bears much of the same professional credibility to sufficiently persuade law enforcement to arrest and charge. Even though the reporting by medical professionals and their suspicions of crime may not be sufficient to obtain convictions, their actions lead can directly lead to the probable cause for arrest, which can have significant consequences as well.²¹⁸

Despite the particular credibility and objectivity ascribed to their opinion, medical professionals may form conclusions and ascribe criminal conduct to people based upon their own personal motivations and biases. Mr. Mitchell and Ms. Hall were both poor.²¹⁹ The attorney for Mr. Mitchell suspected that the doctor and the police perceived them as “street people.”²²⁰ It is unknown whether how much socio-economic status may have influenced the doctors’ actions in the Myers’ case, though we do know from the facts that the Myers lived in a trailer park.²²¹

Other kinds of bias can enter into a medical professionals’ judgment, such as political affinities. The case of Purvi Patel, discussed by Professor Ahmed, involved a woman who went to a hospital after

215. Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 BOSTON UNIV. L. REV. 1111 (2020).

216. *Id.* at 1115.

217. *Id.*

218. Rachel A. Harmon, *Why Arrest?*, 115 MICH. L. REV. 307 (2016) (arguing that police power of arrest should be curtailed because of the harms to individuals, families, communities, and society as a whole).

219. Interview with Gary Bizal, attorney for Mr. Mitchell on April 28, 2021 (notes on file with author). The facts in the opinion also imply Mr. Mitchell’s socio-economic status. Because he did not have a phone, he walked to the hospital to request an ambulance only to be told by the hospital that he needed to request an ambulance by phone. He walked to a nearby payphone to make that call and then walked back to his home to meet the ambulance. By the time Ms. Hall got to the hospital, she had passed. *Mitchell v. Villien, et al.* at 560.

220. Interview with Gary Bizal, attorney for Mr. Mitchell on April 28, 2021 (notes on file with author).

221. *Myers v. Medical Ct’r. of Del., Inc.*, 86 F. Supp. 2d 389, 393 (D. Del. 2000).

ingesting a drug to induce an abortion. The physician who examined and called the police on her for infanticide belonged to a pro-life physicians group.²²²

Medical professionals may also misunderstand their reporting obligations. Reproductive health advocates have reported incidents of medical provider reports of self-induced abortion in states across the country when these incidents do not fall under any state mandatory reporting schema.²²³ Professional affinities to law enforcement and law enforcement causes may influence how medical professionals interpret their obligations to law enforcement. Medical providers may also be concerned with liability for failing to report or not helping in police investigations.²²⁴ This concern is not unfounded when the laws prescribe mandates, immunize reporting, penalize non-reporting, and have no real counterbalancing or opposite authority that might make medical professionals act with more caution or deliberation.

Medical professionals are not only uniquely able to diagnose certain injuries (correctly or not), they are also often uniquely situated to have access to patients and their belongings at moments of patient vulnerability. Medical professionals may discover contraband or illegal items, such as drugs and firearms in patient belongings. The medical professionals' alerting of the presence of contraband can cause a person—who was previously not under police radar—to come under police suspicion and then arrest. This was the case for Samuel Clay.²²⁵ Mr. Clay was in his car when another driver who was talking on his cell phone ran a red light and hit Mr. Clay.²²⁶ Although he was not at fault, police officers accompanied Mr. Clay to the emergency room.²²⁷ A nurse, Cherrie Hamilton, was attending to Mr. Clay. When Mr. Clay

222. Ahmed, at 1128.

223. Interview with Lauren Palk, *If/When/How: Lawyering for Reproductive Justice* (notes on file with author); see also *If/When/How: Lawyering for Reproductive Justice, Roe's Unfinished Promise: 2019 Update* (2019), <https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/> [<https://perma.cc/C8NP-HBPQ>].

224. W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties*, 44 WAKE FOREST L. REV. 877, 879-80 (2009) (stating that “most courts have endorsed suits by a foreseeably harmed third party against a physician for the failure to warn” patient of risks of spreading disease and other at risk of infection by patient). *Tarasoff v. Regents of University of California*, imposes a duty to warn on mental health professionals. See *Tarasoff v. Regents of University of California*, 17 Cal. 3d 425 (Cal. 1976). In *Shaddox v. Bertani*, the court dismissed a police officer's claim against his dentist for violating the state's medical privacy act and emotional distress because the dentist was complying with his duty to warn against future harm when he reported the police officer's drug use to his employer. See *Shaddox v. Bertani*, 110 Cal. App. 4th 1406 (Cal. Ct. App. 2003). *But see Pipitone v. Williams*, 244 Cal. App. 4th 1406, 1418 (Cal. Ct. App. 2016) (finding that physicians' failure to report did not trigger mandatory reporting duty in a wrongful death suit where the alleged injury was only discovered several days after providing medical service).

225. *United States v. Clay*, 2006 WL 2385353 at *1 (E.D. Ky. Aug. 17, 2006).

226. *United States v. Clay*, 2006 WL 2385353 at *1 (E.D. Ky. Aug. 17, 2006). The facts here come from the District court's Memorandum Opinion and Order denying the defendant's motion to suppress.

227. *Id.* at *1.

instructed her to place his coat in the bag with the rest of his clothes, Nurse Hamilton thought his demeanor was “abnormal.” Nurse Hamilton thought it was hospital procedure for a patient’s personal items to be “inventoried, logged, and safely stored.”²²⁸ She searched Mr. Clay’s coat and discovered cocaine and ammunition.²²⁹ She notified her supervisor and turned over the contraband to the accompanying officer. The officer read Mr. Clay his *Miranda* rights and obtained an admission and consent to search his car. Mr. Clay was subsequently charged with firearm and drug charges in federal court.²³⁰

What else was Nurse Hamilton to do? She came across illegal items. She could not lawfully possess them. What is wrong with her turning over the items to the police? She also might have been worried that destroying them could make her complicit in criminal activity. There are, however, reasonable concerns regarding Nurse Hamilton’s conduct. Nurse Hamilton’s actions prompted the officer’s attention to Mr. Clay and subsequent investigation. She not only turned over the contraband, she connected the items to Mr. Clay. Her actions were not only contrary to her patient’s interests, she also undermined patient trust. It was her relationship to the patient as the patient’s medical provider that gave her access to his belongings.

Nurse Hamilton may have had a difficult choice, faced with the presence of a firearm and drugs. But similar types of concerns have arisen at various hospitals. At one veteran’s hospital, physicians reported to police that a patient undergoing a psychotic episode had brought in a suitcase of various drugs. The patient was arrested. When medical staff contacted the family to see when the patient was going to come in for follow-up care, his mother responded that he was not coming back because of what they did.²³¹ At UCLA Harbor Medical Center in Los Angeles, to address concerns that medical providers would end up being the ones identifying their patients for drug offenses, physicians have proposed setting up contraband bins where patients could dispose of items, no questions asked.²³²

Medical professionals are put in the position of providing information to law enforcement that may have huge consequences for their patients. Their actions may stem from personal understandings of their legal obligations, or their own motivations and ideas of how to allocate their dual loyalty between patient and the state. Regardless, medical professionals wield enormous power in that investigative stage and their actions also yield enormous consequences for patients.

228. *Id.*

229. *Id.*

230. Indictment, *United States v. Clay*, 2006 WL 6463132 (E.D. Ky. July 6, 2006).

231. Interview with hospitalists on May 17, 2021 (notes on file with author) (name withheld by request).

232. Frontline Wellness Network Memorandum to Los Angeles County Board of Supervisors (Jan. 29, 2021) (on file with author).

But the broad interpretation of their public safety duties combined with an insufficient regulation of their particular expertise and proximity and access to patients leave medical professionals in a difficult dilemma.

B. Patient Questioner or Proxy/Aid to Interrogator

Medical professionals also become part of police investigations in healthcare settings through the elicitation of incriminatory statements from patients. The following discussion focuses on two kinds of ways medical professionals become party to statements taken from patient-suspects. The first are those statements obtained through medical professional questioning. The second are statements obtained by law enforcement and where medical professionals play some kind of role.

It would seem that patient questioning and police questioning, or interrogation of patients, would be quite separate from one another. The purpose of patient questioning by medical professionals is to elicit information that can aid in health diagnoses and treatment. Patient questioning is a necessary part of medical examinations. Patient confidentiality is valued to ensure open and honest conversations between provider and patient. Lies or omitted truths could lead to wrong diagnoses or treatment methods. The purpose of police questioning and interrogation is to aid police investigation of crimes. But even though these two categories may appear to be quite separate from one another, they often overlap.

Certain kinds of conversations between patients and medical providers seem to be clearly patient questioning. Their pertinence to criminal cases arise only because they become part of a later court hearing. For example, in one state court case, a doctor testified about the injuries to a victim he treated at the hospital after being brought there by the police.²³³ As was his “usual practice,”²³⁴ the doctor asked him “what happened” in order to find out how the injury might have been caused and “anything that would be relevant to my taking care of him.”²³⁵ In response, the patient replied “he had been held down by his grandmother and cut by his mother.”²³⁶ The doctor did not ask any more questions.²³⁷ The doctor was later called to stand to testify against the patient’s mother in a trial and the California Supreme Court deter-

233. *People v. Cage*, 40 Cal. 4th 965, 971-72 (Cal. 2007).

234. *Id.* at 972.

235. *Id.*

236. *Id.*

237. *People v. Cage* at 972.

mined that the victim's statements to his doctor were admissible because they were made in order to help diagnose the nature of the wound, and to deal with a "contemporaneous medical situation."²³⁸

Now let's change the scenario slightly so that the doctor not only noted the patient's response but then told an officer what the victim had said. Or, let's say a medical professional asks a patient about a crime or matters that go beyond information necessary for medical treatment. At those points, has the medical professional crossed the line?

In one federal case, Clyde Copeland brought suit against Northwestern's hospital, its employees, and city and federal law enforcement.²³⁹ Mr. Copeland went to the ER at Northwestern for psychiatric treatment after experiencing a blackout and then going on a cocaine binge.²⁴⁰

According to Mr. Copeland's *pro se* complaint, a nurse interviewed Mr. Copeland before his admission.²⁴¹ She asked him how much cocaine he had consumed and where he had gotten the money for the cocaine.²⁴² After referring Mr. Copeland for hospital admission, the nurse continued to ask him questions, again asking him where he had gotten the money for the cocaine and if he had committed any crimes, including the most recent crime he had committed.²⁴³ Mr. Copeland replied that he was a convicted felon and told him about a bank robbery that he had memories of committing between his blackout and cocaine binge.²⁴⁴ The nurse then said "that was all she needed and that a doctor should be available soon."²⁴⁵

The facts in the district court's opinion were taken from the *pro se* plaintiff's complaint. They do not have the benefit of being adjudicated facts and the court dismissed the case for failing to state claims.²⁴⁶ But suppose the plaintiff's assertions of the nurse's actions are true. Then they are certainly troubling. The nurse would have acted well beyond her role as nurse in questioning. And with no other witnesses and a mentally compromised patient, it may well mean that these kinds of actions could take place without any repercussions. As it happened,

238. *Id.* at 970.

239. *Copeland v. Northwestern Memorial Hosp.*, 964 F. Supp. 1225 (N.D. Ill. 1997).

240. *Id.* at 1229.

241. *Id.*

242. *Id.* at 1229-30.

243. *Id.* at 1230.

244. *Copeland v. Northwestern Memorial Hosp.* at 1229-30.

245. *Id.* at 1230.

246. The court gave plaintiff leave to amend the complaint against named Defendants. *Id.* at 1242. The court granted the subsequent motion to dismiss brought by the named defendants in response to the amended complaint. *Copeland v. Northwestern Memorial Hosp.*, 984 F. Supp. 1182 (N.D. Ill. 1997).

Mr. Copeland could not name the medical professionals involved and probably would not have been able to get this information even in discovery.

Examples from other cases indicate that this kind of questioning is possible. A reasonable interpretation of the questioning by the nurse in Elizabeth Lawson's case is that she intended to elicit incriminating information about Ms. Lawson's intoxicated driving. In Sterling Joseph Stryker's case, he went to the emergency room because of a gunshot wound to his leg.²⁴⁷ Hospital personnel alerted law enforcement as required by state statute. He told his doctor what had led to the gunshot wound. But the doctor thought his story of being shot seemed "vague and suspicious," and relayed Mr. Stryker's statements to the police.²⁴⁸ Mr. Stryker was later charged with being a felon in possession of a firearm as well as drug charges.²⁴⁹

In these examples, these statements were obtained by medical professionals in the context of a patient interview or examination. Reporting obligations do not provide for disclosing more information than the type of injury. Some statutes may include broadly worded language to include any information helpful to police but there is no specific proviso that that information could also be information obtained through the guise of physician-patient confidentiality. In these instances, it would seem that the statements that they made helped police obtain probable cause.

A possible argument is that the information conveyed is not HIPAA-protected patient health information. Putting aside that any identifying patient information could be construed as patient health information, these statements are still made in the context of the provider-patient relationship. When there is no positive statutory requirement for information obtained from patients about past conduct that does not cause concern for future harm.

These statements to medical professionals are instead often treated as information obtained by a third party and not subject to Fifth Amendment protection. If police were to undertake this kind of questioning, patients might be able to raise constitutional questions. So then, if medical professionals are using their position vis-à-vis the patient to obtain potentially incriminating statements, should not the patient be explicitly warned of that possibility? Professor Michele Goodwin posited that pregnant women should be alerted that their medical providers may be acting as proxies for law enforcement.²⁵⁰ I previously argued that Professor Goodwin's point should extend to all manner of medical professionals cooperating with law enforcement. It

247. *People v. Stryker*, 2010 WL 219318, at *2 (Ct. App. Cal. Jan. 22, 2010).

248. *Id.*

249. *Id.*

250. GOODWIN, *supra* note 30 at 97.

would seem particularly important and in line with the policy considerations underlying *Miranda* and the rationale behind Fifth Amendment protections, that statements should not be used even if obtained by medical professionals without these kinds of warnings.

Of course, there is the real possibility that any medical provider who would give such a *Miranda*-like warning may have a hard time getting accurate or any information from a patient. But that might give pause to medical professionals seeking to aid police investigations in broader ways than their legal requirements mandate, and at the very least, would make clear to patients (and courts) the role medical professionals occupy when they engage in this type of questioning and convey the information to police.

Medical professionals may facilitate police questioning in other ways where they appear to be leaning more into law enforcement roles. The Supreme Court's decision in *Mincey v. Arizona* is a foundational interrogation case.²⁵¹ In *Mincey*, the nurse was with the patient at the time the police questioned him.²⁵² At one point when the patient indicated that he could not say anymore without talking to a lawyer, as the police continued to question him, the nurse also "suggested it would be best if [he] answered."²⁵³ The hospital had provided paper for the patient to write down answers since he was intubated and could not talk.²⁵⁴ The nurse later testified at a pre-trial hearing that the patient was "in moderate pain but was very cooperative."²⁵⁵ She joined the detective's testimony "that neither mental or physical force nor abuse was used . . . Nor were any promises made."²⁵⁶ As Justice Rehnquist stated in his separate opinion dissenting from the majority's decision on the voluntariness of Mincey's statement, these statements provided support for the Arizona Supreme Court's finding that the statement was voluntary.²⁵⁷

—None of the justices took particular umbrage at the nurse's role in the interrogation.

A generous interpretation of the nurse's actions could be that she was helping the patient, but a more likely and reasonable one may be that she saw her role as an aid to the police, even though given the seriousness of Mincey's injuries, she should have perhaps been concerned that his injuries and physical and mental state may have compromised the interrogation.

251. *Mincey v. Arizona*, 437 U.S. 385 (1978).

252. *Id.* at 398.

253. *Id.* at 399.

254. *Id.* at 396.

255. *Id.* at 408 (concurring in part, dissenting in part, J. Rehnquist).

256. *Mincey* at 409 (concurring in part, dissenting in part, J. Rehnquist).

257. *Id.*

This may be because medical professionals see themselves as aligned with law enforcement, or that it is their job to help law enforcement with suspect investigations. This alignment is reflected in professional nursing guidelines and position statements.²⁵⁸ In the position statements of the Emergency Nurses Association, patients who are the subject of law enforcement scrutiny are labeled in a binary of either “suspects” or “victims.”²⁵⁹ The function of nurses as part of the investigative team is made explicit, highlighting the importance of forensic nursing. This includes such issues as sexual abuse victims, trafficking victims, firearm safety, and intimate partner violence.²⁶⁰ This alignment may also be more pronounced among nurses as they tend to be in more regular contact with patients and may feel more in partnership with law enforcement. Regardless, nurse or physician, a professional bias towards law enforcement, could, however, mean that law enforcement is given a hand in interrogations by medical professionals who can alleviate and address physical conditions of patients that might otherwise render them compromised.

There may be other ways in which the medical professional’s behavior or statements can serve to validate the condition of the patient so that the patient’s statements are not viewed as coerced or involuntary. A statement by a physician or nurse saying that treatment is over and that the patient is now available, could be viewed as acquiescence to questioning, either by the police or the patient.

Medical professionals may also witness police questioning patients during their medical treatment, such as in a case a person came to the hospital with a stabbing and the officer continued to question the patient while he was being medically treated.²⁶¹ In those circumstances, medical professionals may end up facilitating police questioning by acquiescing to questioning even when their patients are in pain and distress. Medical professionals, especially trauma surgeons, have talked about how they must make decisions to allow police to question patients while they are undergoing acute trauma treatment.²⁶²

258. Emergency Nurses Ass’n, *Position Statements*, <https://www.ena.org/practice-resources/resource-library/position-statements> [<https://perma.cc/3BDN-AM7B>].

259. “A component of emergency nursing practice includes safeguarding evidentiary material through proper identification, collection, and preservation of forensic evidence.” ENA Position Statement, *Forensic Evidence Collection in the Emergency Care Setting*.

260. *Id.*

261. *People v. Sampson*, 404 P. 3d 273 (Col. 2017) (holding that defendant was not in custody when he was questioned while being treated for stab wounds where officer would cease questioning whenever defendant was being medically treated).

262. Reports from Hospital Professionals (Apr. 7, 2019) (on file with author) (name of hospital withheld for confidentiality) (collecting reports from medical providers of how law enforcement interactions affected patient care); PD in the ED: Policing in a Public Hospital, *Questionable Interviewing Practices by NYPD in the ED* (June 24, 2020), <https://pdinthead.blogspot.com/2020/06/questionable-interviewing-practices-by.html> [<https://perma.cc/4TP8-SMUJ>]. This blog is maintained by physicians in the New York City area.

But courts have been less concerned with the difficult position medical professionals may be when conducting immediate trauma intervention and having to deal with law enforcement at the same time. Indeed, in *Chavez v. Martinez*, the Supreme Court recounted how police questioning continued while Mr. Martinez was undergoing emergency room trauma treatment for injuries that left him permanently blinded and partially paralyzed.²⁶³ The Court determined that the Fifth Amendment did not apply to Mr. Martinez's case because his statements were never used in a criminal proceeding since noncriminal charges were brought.²⁶⁴ The court's analysis of the exigency requiring questioning also indicated that the kind of questioning police make at the time of trauma need is necessary.²⁶⁵ In his concurring opinion, Justice Kennedy, although displaying sympathy to the pain and anguish experienced by Mr. Martinez, stated, "There is no rule against interrogating suspects who are in anguish and pain."²⁶⁶ He went on to list why police may have legitimate reasons to question a person in such physical distress.²⁶⁷

These statements may lead medical professionals to believe that police questioning is always lawful, or that the medical provider cannot stop police or ask the police not to question while performing trauma interventions. It may also be that they rely upon justifications by the police that immediate questioning is required to "solve the crime." But it is questionable whether all situations in hospitals involve these kinds of immediate and emergency situations. Furthermore, there is little evidence to show that the kind of persistent questioning that police may do in hospitals results in solving crime. Broadly applying this justification without adequately considering the medical consequences could severely impact patient care, disturb a medical professional's ability to do their job, and build and maintain patient trust.²⁶⁸

C. *Medical Care or Police-Directed Medical Intervention*

The third category of medical professional overlap in police investigations involves the most intrusive of medical professionals' skills—their ability to conduct medical procedures.

263. *Chavez v. Martinez*, 538 U.S. 760, 776 (2003).

264. *Id.* at 763, 766.

265. The Supreme Court has further suggested that exigency could require immediate questioning without *Miranda* if "the situation [i]s urgent given the perceived risk that [the patient] might die and crucial evidence might be lost." *Id.* at 776.

266. *Id.* at 796 (Kennedy, J. concurring opinion).

267. *Id.*

268. Jane Liebschutz, et al., *A Chasm Between Injury and Care: Experiences of Black Male Victims of Violence*, 69 J. TRAUMA 1372 (2010).

Medical professionals may conduct medical procedures to produce incriminatory evidence pertinent to later criminal prosecutions, including tests to assess alcohol levels, procedures to retrieve secreted drugs, and surgical procedures to remove bullets. Anecdotal evidence from some physicians reveals that many do not conduct these kinds of procedures simply because of a police request or warrant. But the number of cases in caselaw and in the media indicate that this is a continuing issue.

Toxicology screens and blood tests are routine in medical examinations. Drugs that are ingested or hidden in a patient's body could have dire health consequences requiring medical care, with or without police involvement. But when police accompany patients, or are otherwise present in healthcare settings, and can access information and results immediately, there is much more fluidity between medical care solely for medical necessity (or with patient consent) and police-directed medical interventions.

Recall that medical professionals are embedded into the constitutionality of searches of the body. Courts have also deemed certain cavity searches beyond constitutional purview by imposing a binary view of procedures that are either conducted solely for medical purposes or those carried out for law enforcement ones, when these two can be entwined.²⁶⁹

There may be times when the medical procedure is incidental to law enforcement activity. For instance, a police officer holding a patient down while a catheter is inserted, may seem like a police action, or at least one with active police participation.²⁷⁰ But as the Seventh Circuit determined, the officers were only helping a nurse, at her request, restrain an arrestee who needed to be medically cleared before being admitted to the jail for a disorderly conduct arrest.²⁷¹ The problem with a nurse using police power to restrain a patient may be cause for concern, but because the underlying procedure was not intended to elicit evidentiary material, the police action did not trigger Fourth Amendment protections.

In instances where evidence is procured from patient's bodies, either at the request of police or in the presence of police, the role of the medical professional vis-à-vis law enforcement would seem to be more clear. In one case, police brought Billy Jerome Shepherd to the hospital semi-conscious after his arrest based upon information by a confidential informant that he likely had pills in his pelvic area.²⁷² Doctors performed a neurological examination, a urinalysis, a CT scan, and at-

269. *Mitchell v. Wisconsin*, 139 S. Ct. 2525, 2531 (2019) (plurality opinion).

270. *Sullivan v. Bornemann*, 384 F. 3d 372 (7th Cir. 2004).

271. *Id.* at 373-74, 377-78.

272. *United States v. Shepherd*, 2014 WL 4594565 at *1 (E.D. Ky. Sept. 15, 2014).

tempted a digital rectal examination. The examinations revealed multiple capsules in Mr. Shepherd's rectum. The doctor told the police and the police used this information to draw up a warrant.²⁷³ Yet, the Sixth Circuit found that the doctor's examinations were the actions of a private actor and hence, they did not implicate the Fourth Amendment.²⁷⁴

Mr. Shepherd's semi-conscious state may have necessitated immediate medical action. But the medical professionals' actions related to the arrest were precipitated by the police bringing Mr. Shepherd to the hospital. The police investigation had been well underway at the point of medical intervention. Moreover, the presence of the police allowed them to observe and obtain immediate results of the examinations which led to the probable cause necessary for the search warrant.²⁷⁵

The enmeshment of police and hospitals also makes it so that procedures that may be medically necessary, nevertheless end up producing evidence for police in the early stages of an investigation. In Michael Rodriguez's situation, he was taken to an ER after being shot. He underwent surgery to have the bullet removed.²⁷⁶ The hospital had notified the police when he came in. Subsequently, hospital personnel gave police the bullet retrieved from Mr. Rodriguez's body based on the hospital's procedures on collecting and preserving forensic evidence for police use.²⁷⁷ According to the findings made by the court, Mr. Rodriguez had "impliedly" consented to relinquish any possessory rights in the bullet. The court found that the note indicating "Verbal Consent" by a Forensic Nurse Examiner prior to Mr. Rodriguez's surgery sufficed.²⁷⁸ The removal of the bullet may have been for medical reasons only. But the forensic evidence collection procedures in place at the hospital, the participation of a forensic nurse examiner, and the presence of a police officer, facilitated the immediate transfer of this evidence without implicating constitutional requirements.

When it comes to body cavity searches conducted at law enforcement request, the role of the medical professional as an agent of law enforcement is less contested. For example, in the case of Felix Booker, the doctor in question, Dr. Michael LaPaglia, was found to clearly be an agent of the police when he conducted a variety of procedures on Mr. Booker without a warrant.²⁷⁹ These procedures included a digital rectal examination without any medication, the injection of a muscle relaxant, and the intravenous administration of a sedative and paralytic agent, which required Mr. Booker to be intubated for approximately an hour. Mr. Booker was unconscious for 20-30 minutes and paralyzed for 7-8 minutes. The procedures resulted in the removal of

273. *Id.*

274. *Id.* at *5.

275. *Id.* at *1.

276. *Rodriguez v. Pierce*, 176 F. Supp. 3d 445 (D. Del. 2016).

277. *Id.* at 449.

278. *Id.*

279. *United States v. Booker*, 728 F. 3d 535 (6th Cir. 2013).

a rock of crack cocaine.²⁸⁰ Mr. Booker was later charged and convicted for drug possession. The Seventh Circuit, hearing the appeal of the suppression hearing in Mr. Booker's criminal case, found the doctor to be acting as an agent of the police and that his actions were attributable to the police. The court found that no police should have thought that the extent of those procedures without a warrant was constitutional. The court reversed the conviction finding that the search violated Mr. Booker's constitutional rights.²⁸¹ In a separate civil action against the doctor, Mr. Booker settled with Dr. LaPaglia for an undisclosed sum.²⁸²

It may seem that the courts got it right in Mr. Booker's case. Parallel civil and criminal proceedings could have helped the court to view the issue of both police and medical professionals holistically when assessing Dr. LaPaglia's conduct. But the Booker opinions still fall short of providing adequate guidance on what medical professionals should or should not do.

One lesson from the Booker cases may be that a medical professional should not act without a warrant. But warrantless cavity searches are still permitted. In a case recently denied cert by the Supreme Court, a doctor used a speculum to inspect Plaintiff Sharon Lynn Brown's vagina and anal cavity for drugs.²⁸³ Ms. Brown had been arrested and jailed for shoplifting; the next day, two inmates told jail staff that Ms. Brown was hiding drugs in her body.²⁸⁴ The lower courts had determined that public safety reasons, namely jail security, justified this warrantless search.²⁸⁵

280. *Id.* at 539.

281. *Id.* at 544-45. Dr. LaPaglia was also somewhat of a repeat offender; he had conducted three of these types of intrusive cavity searches in the preceding three years at the request of the same law enforcement agency. *Id.* at 538.

282. Jamie Satterfield, *State Restores License for Doctor Sued Over Drug Searches*, KNOX NEWS SENTINEL (Jan. 8, 2015), <http://archive.knoxnews.com/news/local/state-restores-license-for-doctor-sued-over-drug-searches-ep-865916496-353694471.html> [<https://perma.cc/DVR3-M8LP>].

283. *Brown v. Polk County, Wisc.*, 141 S. Ct. 1304 (2021) (Statement of J. Sotomayor for denial of certiorari)

284. *Id.* at 3.

285. *Brown v. Polk County, Wisc.*, 965 F. 3d 534, 541 (7th Cir. 2020). Further complicating matters is that the jail/no-jail distinction made in Ms. Brown's case, is also not so clear. For example, Felix Booker was also on his way to jail and had a strip search by a jail deputy. After the strip search, he was then taken by sheriff's deputies (and not the local police department) for the cavity search. *United States v. Booker*, *supra* note 278 at 537. Perhaps what really made the difference between Ms. Brown and Mr. Booker was the much more intrusive nature of Mr. Booker's procedures. But both the appellate court and Justice Sotomayor noted the "degrading" nature of Ms. Brown's experience. *Brown v. Polk County*, *supra* note 351 at 6; *Brown v. Polk County*, 965 F. 3d at 541 (noting facts of doctor "prying open [Brown's] vagina and anus" and how her body was "laid bare not just for visual inspection but for physical prodding, an intrusion of privacy to the highest degree."). It's hard to imagine, also, that this kind of jail/no-jail distinction would be apparent to medical professionals who may only see a uniformed officer and someone in handcuffs. Police policies are relevant here because they give an idea of how law enforcement agencies may interact with hospitals and medical professionals. While some police departments explicitly state that body cavity searches must be accompanied by a warrant, this prohibition is not across

The existence of a warrant also does not require any medical judgment of the medical professional to enter into the calculus of executing a warrant for cavity searches.

This was the case for Shane Spencer, who was pulled over and arrested for driving with a suspended license, endured multiple tests only for the tests to reveal no hidden drugs.²⁸⁶ Police presented a search warrant for drugs in Mr. Spencer's anal cavity based on a tip from a confidential informant.²⁸⁷ After Mr. Spencer would not consent to a search, the police tried unsuccessfully to conduct a visual search. They then obtained a warrant to search Mr. Spencer's "anal cavity" for cocaine.²⁸⁸ At the hospital, a doctor conducted a digital search which still revealed no drugs.²⁸⁹ The police requested and the physician ordered an x-ray; Mr. Spencer was taken to radiology by two nurses handcuffed to the gurney.²⁹⁰ The x-ray again revealed no signs of cocaine.²⁹¹ Triage notes documented "patient suspected heroin and cocaine inserted rectally here with police with warrant for cavity search."²⁹² Mr. Spencer brought suit against the hospital, the police and the hospital. The federal district court granted summary to defendants on a number of claims, including the Fourth Amendment based upon the cavity search.²⁹³ Mr. Spencer's claim of invasion of privacy also did not survive because the court found that there was nothing to suggest that the nurse knew that the warrant did not justify disclosure of certain diagnostic results.²⁹⁴ The court found that nothing in the record suggested the search was unreasonable—it was performed in a medically appropriate manner by a physician and the search did not go beyond the scope of the warrant.²⁹⁵ Nowhere in the opinion did the court analyze whether these procedures were medically necessary.

the board. Seattle Police Department Manual, Policy 6.030 (Body Cavity Searches), <https://www.seattle.gov/police-manual/title-6---arrests-search-and-seizure/6030---body-cavity-searches> [<https://perma.cc/2CZ5-PPEQ>]; Baltimore Police Department, Policy 1013 (Strip Searches and Body Cavity Searches), <https://www.baltimorepolice.org/1013-strip-searches-and-body-cavity-searches> [<https://perma.cc/B7H4-CDKS>]. For example, the Metropolitan Police Department in Washington, D.C. permits cavity searches conducted at a local hospital with supervisor approval; only if the medical provider refuses, does the policy state that a warrant is needed. Metropolitan Police, District of Columbia, General Order 502-01 (Transportation and Searches of Prisoners) at 9-10, https://go.mpdonline.com/GO/GO_502_01.pdf [<https://perma.cc/YX93-P2RG>].

286. *Spencer v. Roche*, 755 F. Supp. 2d 250, 255 (D. Mass. 2010).

287. *Id.*

288. *Id.* at 256.

289. *Id.* at 257.

290. *Id.*

291. *Spencer v. Roche* at 257.

292. *Id.* at 257.

293. *Id.* at 262.

294. *Id.* at 272. Mr. Spencer's HIPAA and state civil rights claim also failed to survive summary judgment. *Id.* at 264.

295. *Id.*

A warrant can sanitize and provide legal justification for the actions here.²⁹⁶ Cases like Mr. Spencer's may lead medical professionals to believe that their actions are excused because of a warrant. But warrants are products of examinations of probable cause of *criminal* conduct, not whether the procedure is medically necessary. The information underlying the warrant in Mr. Spencer's case, has nothing to do with physical health but rather facts based on confidential tips or officer observations and suspicions to support the existence of hidden drugs.

Court decisions finding unconstitutional warrant-based cavity searches also fall short of fully analyzing when medical professional action may or may not be warranted. Recently, the Minnesota Supreme Court analyzed the body cavity with much more nuance and sympathy towards the medical implications. It ultimately found unconstitutional the cavity search of Guntallwon Brown, which resulted in the drugs that were the basis of the drug possession conviction.²⁹⁷ Police arrested Mr. Brown after witnessing a drug transaction. Based on their observations of suspicious behavior by Mr. Brown, the police officer decided to apply for a search warrant to conduct a cavity search.²⁹⁸ A judge signed a warrant authorizing "a search 'ON THE PERSON OF BROWN.'"²⁹⁹ Mr. Brown was taken to a hospital where the ER doctor, after consulting with a hospital lawyer, did an external body search which revealed nothing and offered Mr. Brown a laxative, which he refused. The police asked the doctor to force Mr. Brown to take the laxative and perform an anoscopy or get another doctor to perform the requested procedures.³⁰⁰ The doctor refused, although he did say that he was "willing to comply with any Court order that specifically designated the appropriate interventions."³⁰¹

Officers got a second warrant, signed by the same judge that authorized hospital staff "to use *any medical/physical means necessary* to have Brown vomit or defecate [sic] the contents of his stomach or physically by any means necessary remove the narcotics from the anal cavity so Officers can retrieve the narcotics."³⁰² The officer had inserted that language because he did not "know any specific medical terms" and added "any means necessary" to leave it up to the doctor's discretion.³⁰³ At the second hospital, the emergency room doctor consulted an on-call deputy county attorney who told the doctor he could execute the warrant. The second doctor, Dr. Paul Nystrom, presented Mr. Brown with four options, two of which would require Mr. Brown's

296. Mr. Spencer had not challenged the validity of the warrant *Id.* at 260-61.

297. *State v. Brown*, 932 N.W. 2d 283 (Minn. 2019).

298. The police officers thought they saw Mr. Brown conceal something in his pants and later at the station observed him acting in a way that made them think he had inserted narcotics into his rectum. *Id.* at 286.

299. *Id.*

300. Anoscopy where a tool is used to look instead a person's rectum. *Id.* at fn.1.

301. *Id.* at 287.

302. *Id.*

303. *Id.*

cooperation. When Mr. Brown did not respond, Dr. Nystrom performed the anoscopy.³⁰⁴ Mr. Brook was strapped down, given a sedative, and used a speculum and forceps to remove a plastic baggie from Mr. Brown's anal cavity.³⁰⁵ The doctor later testified that he understood the warrant language to mean that he could use any means necessary and also testified that the process of "normal elimination" could have been used and no medical emergency necessitated the procedure."³⁰⁶ Mr. Brown was subsequently charged with drug possession. He lost his suppression hearing and was convicted after a jury trial.³⁰⁷

The Minnesota Supreme Court applied a three-factor balancing test and concluded the "coerced anoscopy" was an "extremely serious invasion" of a person's dignity and privacy and that far less intrusive options existed to recover the baggie.³⁰⁸ The Court pointed to the facts, including evidence that the drugs could have passed through the body naturally.³⁰⁹

But the Court's decision still gives pause. Although the Court focused on the coerced aspect of the procedure as well as the lack of medical necessity, dicta suggests that if the court had had evidence about police necessity (lack of staffing to sit with Mr. Brown) or of exigent circumstances, the balance might have gone the other way.³¹⁰

Importantly, the Court did not explicitly criticize the warrants, particularly the second one, which gave *carte blanche* to the medical professional. In fact, no courts seriously question whether a warrant is part of the problem. Instead a warrant is often seen as a sufficient enough check on police authority by requiring a court officer to sign off on these intrusive searches. Body cavity search warrants are essentially viewed no differently than warrants for any other type of search.

Professor Osagie Obasogie and Ann Zaret made a similar argument in the context of the use of ketamine by EMS workers to sedate patients under police arrest with the encouragement or direction of law enforcement.³¹¹ Body-camera footage analysis conducted by a police review agency revealed incidents of police officers participating in the paramedic's decision to administer ketamine. Police officers told paramedics to bring ketamine or were asked by paramedics whether ketamine should be injected and assisted by restraining individuals.³¹² Obasogie and Zaret argued that the Fourth Amendment, in the context

304. *Id.*

305. *State v. Brown* at 288.

306. *Id.*

307. *State v. Brown* at 294.

308. *Id.*

309. *Id.*

310. *Id.*

311. Osagie K. Obasogie and Anna Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 CAL. L. REV. 101 (Feb. 2021).

312. *Id.* at 31-32.

of excessive force claims, should impose limits similar to federal regulations on the use of chemical restraints, giving priority to medical necessity, individual autonomy, and a person's wellbeing.³¹³

Obasogie and Zaret were specifically concerned with medical professionals' participation in patient restraints and use of police force. Here we are dealing with a broader category of medical professionals participating in a particularly intrusive police investigative tool. Given the significant privacy and dignity interests of patients, court scrutiny of body cavity searches and warrants authorizing them should similarly incorporate and reflect legal, ethical, and professional mandates and guidelines that would otherwise apply to physicians and other medical provider conduct. Medical professionals should be mandated to consider the same and not just simply comply with police-directed medical interventions. It is true that having medical providers perform cavity searches are far preferable to having police doing it. But their participation should be with regulations and guidelines in place, regulations and guidelines that already exist in health law and other professional ethics and norms. Such protections must be incorporated as long as our system allows outside, non-law enforcement actors to participate in police investigations.

Compounding the problem of courts' approval of police-directed, and not medically-indicated intrusive interventions, a separate problem can be found in the problems stemming from the overlap of criminal and civil in these types of cases, which can lead less than clear rules to guide the conduct of medical. Part of the problem is due the fact that the rules may stem from different initiating legal questions. For example, in suppression hearings like in *Brown* and *Booker*, the question is whether a police officer, or police officer with the help of a medical professional as an agent, acted unconstitutionally. Suppression hearings are not about deciding medical professionals' liability, and not imposing any liability on the medical profession itself, and primarily speaking to law enforcement. In civil contexts, the alleged unlawful actor may be the police, the local government, or it may be the hospital, or doctor, or a combination of any of these. These cases also involve complicated questions of civil rights, medical tort liability, health law, and criminal procedure; and no. Attorneys may not know to name all potentially liable defendants in civil actions. For example, in Sharon Brown's case, the attorney did not sue the doctor because of a Wisconsin statute immunizing medical providers who perform cavity searches, although the statute does not immunize them from negligence.³¹⁴

313. *Id.* at 51.

314. Interview with Vincent Moccio (notes on file with author); WIS. STAT. ANN. § 895.535(1) (West 2019).

The qualified immunity doctrine as applied to medical professionals contributes to the confusion. For example, in another body cavity litigation case, a court examined whether a “reasonable physician would have believed [the search] was lawful based on the information conveyed by the police officers who held Plaintiff in custody.”³¹⁵ The court did not have sufficient facts on the record to make this determination but indicated in dicta that perhaps if the doctor conducted the search that officers represented were authorized by a warrant, then they could rely on that representation. The court quoted language from a case involving a warrantless coerced blood test: “If police officers, trained in Fourth Amendment law and specifically charged to conduct their activities in conformance with the Constitution, are entitled to rely on legal or factual determinations made by another officer, then [medical professionals] should be able to do the same.”³¹⁶ In an earlier case, where the plaintiff was subjected to a vaginal search, the court held that the warrant supported the search and was facially valid, and that the physician was entitled to qualified immunity whether or not the warrant was supported by probable cause.³¹⁷

Finally, these cases may not necessarily surface to the level of complete court and doctrinal adjudication, or to a court case at all. In one case that got considerable press coverage, the plaintiff David Eckert settled for 1.6 million dollars but the liability of the doctor who performed the various procedures, including a colonoscopy, was not litigated.³¹⁸ Torrence Jackson’s case set off a media furor, but no civil suit has been filed. Mr. Jackson was pulled over by police for failing to use his turn signal and police found a bag of marijuana. Because police thought Mr. Jackson had hidden other drugs in his anus, they took him to the ER at St. Joseph’s Hospital in Syracuse, New York. A judge signed off on a search warrant prepared by the arresting officers, permitting the hospital to use any means to recover drugs, including surgery. The medical staff sedated Jackson and performed a sigmoidoscopy. A few months later, Mr. Jackson received a bill of \$4,595.12 for the procedure.³¹⁹

315. Young v. Gila Medical Center, 2020 WL 3006699, at *7 (Ct. App. N. Mex. June 4, 2020).

316. *Id.* (quoting Marshall v. Columbia Lea Regional Hosp., 345 F.3d 1157, 1180 (10th Cir. 2003)).

317. Rodriques v. Furtado, 950 F.2d 805, 811 (11th Cir. 1991).

318. Eckert v. City of Deming, 2015 WL 1038373 (D. N.M. Oct. 31, 2015); Nicholas Kristof, Opinion, *3 Enemas Later, Still No Drugs*, N.Y. TIMES (Jan. 25, 2014).

319. Douglas Doughty, *Syracuse Man to Sue Over Anal Probe by Police, Hospital: “I Want Accountability*, SYRACUSE.COM (Jan. 18, 2019); *Innocent NY Man Billed \$4,600 for Police Rectal Probe*, BBC NEWS (Dec. 20, 2018); Daniel Moritz-Rabson, *Police Forced Unconscious Man to Receive Rectal Exam in Search for Drugs, Hospital Charged Him Thousands*, NEWSWEEK (Dec. 20, 2018); Ella Torres, *Syracuse Man Subjected to Forced Rectum Probe Later Billed \$4,595 By Hospital*, NY DAILY NEWS (Dec. 20, 2018).

As a result, most medical professionals may not be able to correctly decipher what these rules have to say about prospective medical professional conduct. Nor are hospital administration or risk management necessarily familiar with the overlap of health privacy law and criminal procedure.

Ultimately, medical professionals have little to fall back on to refuse to conduct these procedures. The American College of Emergency Physicians has issued a policy statement stating that “Emergency physicians may conscientiously refuse to carry out or comply with legal orders that violate the rights or jeopardize the welfare of their patients, recognizing that there may be legal repercussions for these decisions.”

But medical professionals who refuse to conduct searches can also be overridden by their institutions. The ER doctors in Torrence Jackson’s case refused to execute the warrant believing any procedures were medically unnecessary. They ended up doing the procedures because the hospital’s general counsel disagreed and overruled the doctors.³²⁰ These professional guidelines are also insufficient protection against criminal sanction, which though may not result, is definitely a possibility. And even if such possibility is remote, medical professionals could end up participating in conduct they think is against their medical ethics because they are afraid of legal consequences, such as arrest or the threat of arrest by police.³²¹

Though the focus of this section has been on body cavity searches, there are other ways police can intervene in medical care that can also implicate many of the same privacy, dignity, autonomy, and comparative public safety interest. For instance, physicians have reported police officers pressuring medical providers to give medical clearance for inmates or, as mentioned in the prior section, to delay treatment so that the police can question patients. The same concerns regarding body cavity searches may certainly apply in these kinds of police interventions in medical care as well.

In all of these instances, patients are at the mercy of two professions who are given a lot of leeway to perform their duties. Police are given much discretion to do their jobs. Medical professionals are also given a wide range to perform their duties. When these two professions intersect, without further guidelines, compounded discretion can lead to compounded abuse.

320. *Id.*

321. Nurse Alex Wubbels was arrested for disallowing a police officer from obtaining a warrantless blood draw from an unconscious patient. See Jessica Miller, *Former Detective Jeff Payne Isn’t Sorry for Arresting Alex Wubbels and He Plans to Sue for \$1.5 Million*, SALT LAKE TRIB. (Nov. 6, 2018). A doctor recounted being threatened with arrest by a police officer for refusing to draw blood when no medical necessity was present. The arrest was only avoided because the patient finally consented. See Zachary Meisel, *Spare the Needle: Doctors Shouldn’t Have to Draw Blood on Behalf of Cops*, SLATE (Sept. 19, 2006).

IV. PROPOSED COUNTERVAILING LEGAL AUTHORITY

This asymmetrical and inadequate framework must be rebalanced and tightened to better aid medical professionals in their interactions with law enforcement and bolster patients' who fall victim to over-broad medical professional and law enforcement authority. Based on the current law, patients may have a range or combination of medical professionals: those who stalwartly defend their privacy rights; others who intend to defend their rights but feel like they cannot; medical professionals who may not be concerned with their obligations vis-à-vis a patient-suspects interactions with law enforcement; or medical professionals who are eager and adverse law enforcement partners.

This Part maps out a number of ways to correct the balance. Though law enforcement bears much if not more responsibility in the overlap of medical professionals and law enforcement, these proposed changes are directed to the medical professional. What follows is the beginning outlines of a solution to this complex intersection implicating numerous legal and regulatory areas.

A. *Doctrinal Changes*

The current criminal procedure doctrine does not adequately account for when medical professionals act as law enforcement state actors. Hence, one potential doctrinal change would take a better measure of the fluidity of interactions between medical professionals and law enforcement and make clearer when criminal procedural rules apply to medical professional-law enforcement actions. Such a change would set better parameters of when medical professionals are state actors when they participate in police investigations. Doctrinal changes would be one way to counter the current imbalance in the law governing searches, seizures, and interrogations, to bring more combined medical professional and law enforcement conduct under constitutional purview.

In *Ferguson*, the question of state action was a relatively easy one because the employees worked for a state hospital.³²² But the Court's discussion provides the contours of a more nuanced state actor test for when medical professionals are involved in criminal investigations. The Court rejected the argument that the drug-testing program fell within a special needs exception.³²³ The Court examined the programmatic purpose and pointed to a number of factors to support its decision: the collaboration between the hospital and police in the development of the program; the threat of criminal prosecution; and that the immediate objective of the program was to generate evidence for the

322. *Ferguson v. City of Charleston* at 76.

323. *Id.* at 81.

police.³²⁴ Although these factors were not analyzed to determine state action, they provide us with a useful way of thinking through medical professional overlap with law enforcement.

By replacing “program” with “action,” a doctrinal test could be constructed from the *Ferguson Court*’s reasoning that may capture a more accurate and wider range of medical professional-law enforcement action within constitutional review. Courts would have to consider a number of factors to assess whether the medical professionals acted in their medical capacity or more like law enforcement: (1) the extent of cooperation between law enforcement and the hospital (informal and formal); (2) the extent of police presence allowed in healthcare settings, either by policy or practice; (3) the extent to which medical professional and law enforcement interacted in performing the instant search or questioning/interrogation; (4) whether criminal prosecution was at issue for the patient; (5) and whether the immediate objective of the alleged search or questioning was to generate evidence.

An additional factor would assess whether mandatory reporting obligations played a part in the medical professionals’ decisionmaking and conduct and the extent to which medical professionals provided information beyond the reporting obligations. Mandatory reporting obligations have been used to justify all sorts of disclosures.³²⁵ Though mandatory reporting obligations do not automatically confer state actor status, and in most instances do not, they should be a factor to consider when assessing whether medical professionals are acting as law enforcement.

Such a multi-factored approach would not only provide remedies for a broader range of would-be unconstitutional conduct but would also give guidance to law enforcement and medical professionals. This approach would also send a message that courts will no longer overlook or gloss over the reality of blurred lines in healthcare settings.

Other doctrinal changes could also remedy the current imbalance. Tests could be formulated for specific types of investigative methods. For example, courts could include requirements for warrants of patient information from their bodies and from private patient care settings. Because of the immense privacy, dignity, and autonomy interests at risk, magistrates should require a heightened showing. For example, the warrant would have to include facts underlying medical necessity when medical interventions are proposed by police.

Changes to doctrine are necessary in addition to any additional statutory protections. Criminal procedure doctrine is still the primary vehicle for regulating law enforcement investigative behavior. In ad-

324. *Id.* at 83.

325. *People v. Martinez*, 378 P.3d 761 (Col. Ct. App. 2015); *In re Grand Jury Subpoena for Med. Recs. Of Payne*, 150 N.H. 436 (N.H. 2004).

dition, dealing with entrenched laws on reporting obligations and corresponding interesting groups may prove to make legislative change difficult. Courts can accomplish what legislatures cannot.

B. *Statutory Protections*

Countervailing legal authority can be constructed by increasing statutory protections and guidance necessary to provide better guardrails for medical professional conduct vis-à-vis law enforcement. Such authority could be created by changing existing statutory authority, including HIPAA, state laws, and enacting affirmative protective provisions state medical privacy statutes.

1. *HIPAA*

Several changes to HIPAA could be enacted to reinforce patient privacy protections. First, HIPAA enforcement should reflect the kinds of dynamic interactions between police and medical professionals described here.³²⁶ The addition of a private right of action in HIPAA could make for more robust claims for privacy violations by patients, including the ability to meaningfully rely upon HIPAA violations when making constitutional claims.

Aspects of the current Privacy Rule can also be expanded. The Rule contains language that could better regulate law enforcement disclosure. It provides further regulations for disclosures related to victims of abuse, neglect or domestic violence,³²⁷ as well as crime victims.³²⁸ These provisions provide more guidance and parameters than those related to certain types of wounds or injuries,³²⁹ reporting crime in emergencies,³³⁰ and reports made to avert a future serious threat to health or safety.³³¹ For victims of crime, (including abuse, neglect, and domestic violence), the Rule specifies a preference for obtaining consent; outlines when disclosure is necessary even without consent; advises that a representation must be obtained that the information is not intended to be used against the individual; and that the individual must be promptly notified that such a report has been made.³³² This

326. A former privacy officer at DHHS stated that the kinds of police access to patient health information as described in this Article are not really what HIPAA enforcement mechanisms and privacy infringements are designed for. (Interview with Former HIPAA Privacy Officer) (notes on file with author) (identity withheld at request of interviewee).

327. 45 C.F.R. § 164.512(c) (2002).

328. 45 C.F.R. § 164.512(f)(3) (2002).

329. 45 C.F.R. § 164.512(f)(1)(A) (2002). Medical professionals in the emergency department have talked about how they often had to either wait for police to finish questioning or interrupt police while performing trauma interventions.

330. 45 C.F.R. § 164.512(f)(6) (2002).

331. 45 C.F.R. § 164.512(j) (2002).

332. 45 C.F.R. § 164.512(c)(1)-(2) (2002); 45 C.F.R. § 164.512(f)(3) (2002).

more protective language about victims could be extended to all patients who come under law enforcement scrutiny and whose patient health information could be requested by law enforcement.

Protective measures could also be taken through agency action. Agency guidance could make more explicit and narrow the kinds of public safety-based provisions not preempted by HIPAA.³³³ More language to guide medical providers may also guard against over- and too much disclosure. A presumption could be applied to HIPAA that law enforcement disclosures should not be made unless a specific showing is made by the requesting authority. HIPAA could also include cautionary language about potentially overbroad law enforcement, including the use of body cameras in health care settings or in asking medical providers for health care information without a formal request.

These kinds of protective changes are necessary, especially in light of recent efforts to broaden medical professional discretion to disclose information to law enforcement under HIPAA. One of the last agency rule changes proposed by the Trump Administration applied to provisions of the Privacy Rule.³³⁴ The proposals include changing the “serious and imminent threat” standard in the permitted public safety disclosure provision with “serious and reasonably foreseeable threat.”³³⁵ This change would *expand* the latitude given to medical professionals to share health information with law enforcement. The proposals also recommend changing “exercise of professional judgment” with “good faith belief.” This change would similarly give more discretion and permission to medical professionals and make their exercises of discretion virtually immune from review.

2. State Law

State laws are equally if not more relevant to day-to-day medical practice than federal laws and regulations.

One possible state law change would be to get rid of mandatory reporting obligations for medical providers. This kind of change may be unlikely given the longevity of mandatory reporting obligations and their broad acceptance, in addition to the political challenges of getting rid of them entirely. But certain other statutory measures could be taken to tighten or narrow these obligations. The reporting duties could be made discretionary, or be limited. A number of states have done just that in domestic violence and sexual assault cases to address

333. U.S. DEP'T. OF HEALTH & HUM. SERV., DOES THE HIPAA PRIVACY RULE PREEMPT STATE LAW TO REPORT CHILD ABUSE?, <https://www.hhs.gov/hipaa/for-professionals/faq/406/does-hipaa-preempt-this-state-law/index.html> [<https://perma.cc/N7MH-NNPB>].

334. Dep't. of Health & Human Serv., *HHS Proposes Modifications to the HIPAA Privacy Rule to Empower Patients, Improve Coordinated Care, and Reduce Regulatory Burdens*, <https://www.hhs.gov/about/news/2020/12/10/hhs-proposes-modifications-hipaa-privacy-rule-empower-patients-improve-coordinated-care-reduce-regulatory-burdens.html> [<https://perma.cc/EK4U-VF9G>].

335. 45 C.F.R. § 164.512(j) (2002).

concerns about the autonomy and safety of victims. Some states exempt domestic violence and sexual assault from mandatory reporting.³³⁶ Others require patient consent or deidentifying patients, as some states have done with sexual assault or domestic violence cases.³³⁷

The reporting obligations could also require a certain degree of certainty. Currently, the immunity granted to medical professionals is broadly worded. They could be amended so that medical professionals are not immunized from overbroad or otherwise unconstitutional conduct. State laws could have a companion to disclosure and immunity requirements, similar to HIPAA, that lists what medical professionals should not do, or at least to legislate the ability of medical professionals to defer to their ultimate decision-making based upon their ethics.

In addition, a counterbalance to mandatory reporting obligations is necessary. One counterbalance would be to impose penalties for the incorrect exercise of mandatory reports or if medical professionals abuse their reporting duties. Penalties could be included in state medical practice acts which govern the practice of medicine. These laws addresses both licensure and continuing practice requirements.³³⁸ Many medical practice acts also have a laundry list of prohibitions that could lead to disciplinary action.³³⁹ Practice acts could specifically include overbroad conduct or participation in law enforcement activities. Or such medical professionals' violations for law enforcement cooperation could be based on existing grounds, such as failing to practice in a manner consistent with public health and welfare.³⁴⁰ For example, in Illinois, disciplinary actions could ensue from failing to report abuse; a corresponding penalty for an abuse of that discretion could be enacted.³⁴¹ At a minimum, the "good faith" presumption existing in many states could also be omitted or replaced with language expressing caution.

In stark contrast to the litany of reporting mandates, there is little obligation on medical professionals to report the overbroad authority of police. Indeed, it seems as though many of the described scenarios, including cavity searches where no drugs are discovered, would be an instance of overbroad police authority. Even though hospitals are the likely destinations of victims of excessive police force, or in some instances, the sites of excessive police force, there is no mechanism like

336. See OH. REV. CODE ANN. § 2921.22 (West 2021); 18 PA. CON. STAT. § 5106(a)(1) (2021); TENN. CODE ANN. § 38-1-101(e)(1-2) (2021).

337. See, e.g., ARK. CODE ANN. § 12-12-402 (2021); MASS. GEN. LAWS ANN. ch. 112, § 12A ½ (2021); N.H. REV. STAT. ANN. § 631:6 (2021); N.D. CENT. CODE § 43-17-41(3) (2021).

338. *Id.*

339. Medical Practice Act of 1987, 225 ILL. COMP. STAT. 60 (2021); TEXAS OCC. CODE ANN. § 164.051 (2019).

340. TEXAS OCC. CODE ANN. § 164.051(6) (2019).

341. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (states can impose reasonable restrictions, requirements, and conditions on the practice of medicine).

mandatory reporting obligations or an appropriate entity to make those reports. Even if other changes could not be made to mandatory reporting schemes, such mechanisms should be created, to facilitate reporting or at the very least the collection of data on use of force incidents observed and witnessed by medical professionals.

Finally, many of these issues arise from the direct access that police have to healthcare settings. Either medical privacy statutes or state constitutions could protect patient spaces from law enforcement presence. I previously argued for a sanctuary-based conception in the courts' protection of the emergency room in Fourth Amendment contexts. This could be extended into a positive statutory right of privacy in healthcare settings, so the fluid exchange of information and evidence could be curtailed.

C. Education

Separate and apart from changes to doctrine and creating statutory legal protections would be a requirement that medical professionals be educated on the law as well as the consequences of their actions. This kind of education must include the criminal procedure implications of actions taken by medical professionals. Just as medical professionals are trained in chain-of-custody requirements for forensic investigations, they should also be trained on how their actions could affect a patient down the road—for example, how might medical professional's actions compromise a patient's constitutional rights? Such education is essential so medical professional do not unintentionally erode their patient's rights vis-à-vis the police.

This kind of education is also necessary because it would combine health privacy and laws that medical professionals may be familiar with what they likely have less familiarity with—criminal procedure and constitutional law. One effort to address the knowledge gap can be found in the Toolkit developed by the Working Group on Policing of Patient Rights begun by me and a handful of other lawyers and healthcare providers. The Toolkit gives medical professionals an overview of the ways policing objectives in the emergency room conflict with patients' rights.³⁴² These types of publications can be one way to disseminate knowledge about the law and legal consequences of police in healthcare settings.

Further education should include how medical professionals should comply with disclosure obligations. Any employees who have access to protected health information must receive HIPAA Awareness training.³⁴³ But even though medical professionals may be trained on the HIPAA Privacy Rule generally, the actual training on law enforcement

342. WORKING GROUP ON POLICING AND PATIENTS' RIGHTS, POLICE IN THE EMERGENCY DEPARTMENT: A MEDICAL PROVIDER TOOLKIT FOR PROTECTING PATIENT PRIVACY (2020) (on file with author).

343. 45 C.F.R. § 164.530(b)(1) (2002).

exceptions may be less than robust. More training could include how HIPAA interacts with mandatory reporting obligations, how medical professionals can exercise their discretion, how implicit biases may affect their reporting duties, and provide practical fundamentals of the criminal process, such as what constitutes a valid warrant.

In addition, medical professionals be educated on the harms of policing, particularly the harms to communities where they provide medical services. Many medical professionals who come into contact with law enforcement will do so because they are working in hospitals used by low-income and racial minority groups. Physicians in Los Angeles have been conducting trainings to educate medical providers on the history of policing in their geographic area; how that policing affects the minority communities serviced by their hospitals, as a preface to highlight how physicians and other medical providers can think of patient privacy in conjunction with policing; and how policing can perpetuate and exacerbate, rather than mitigate the mental and physical harms to their patients.³⁴⁴ This kind of training could be replicated in other jurisdictions to educate physicians not just on their legal and ethical obligations, but to reorient their stance towards the communities they serve.

D. Limitations

These proposed prescriptions, however, will inevitably come up against structural and institutional obstacles. One major obstacle is hospitals that may have different motivations and incentives to work with law enforcement than individual medical providers. One physician who heads up his hospital's emergency department relayed the resistance the physicians faced from hospital administration, legal counsel, and related law enforcement agencies in trying to implement patient-centered privacy approaches.³⁴⁵ Other doctors have expressed frustration at their institutions' failures to address many of the concerns outlined here, or that hospital administration cared far more about relationships with law enforcement. One hospital was so concerned with workplace safety that the hospital now has a wide-ranging set of policies that clearly distinguish the type of care given to anyone in police custody, regardless of their legal status, as long as a police officer is standing next to them.³⁴⁶

Hospital administration and legal counsel must be on board to make institutional and policy changes; they are ultimately the ones in charge. tatutory changes could force hospitals to change their policies.

344. Hannah Janeway, Shamsher Samra, Ji Seon Song, *Managing Law Enforcement Presence (LEP) in Clinical Settings*, (November 23, 2020).

345. Interview with emergency physician on June 28, 2021 (notes on file author; identity withheld at request of interviewees).

346. Interview with emergency physician on June 1, 2021 (notes on file author; identity withheld at request of interviewees).

However, litigation and liability may well be necessary in order for hospitals to see that they have been giving law enforcement too much benefit of the doubt in situations that may well violate the law and, on a broader level, contribute to inequities in healthcare and the criminal legal system.

CONCLUSION

Medical professionals have become part of the fabric of policing, by statute, regulation, institutional practice, and court permission, in ways that are much broader and are in direct conflict with their obligations. Taking into account medical professionals and how they intersect with law enforcement is particularly vital not only because of their critical and unique role in healthcare and the medical profession's own role in racial and socio-economic inequities. As more cities and states look to other social welfare institutions like care settings to take over duties formerly conducted by police, it is also imperative to know and change the ways these institutions and their actors have adopted policing characteristics themselves. There is also more to be done by ethicists, scholars, and advocates, to fully unearth the relationship between two important professions and how their combined authority could exacerbate the harm on vulnerable, highly surveilled, and policed populations.

Finally, medical professionals are but one set of institutional actors who are involved in policing. This Article has set out a framework to think through how other non-law enforcement actors may have become deeply embedded into policing through legal and regulatory mechanisms, yet with little guidance or accountability. Understanding the full scope of legally sanctioned and accepted policing action by other actors in social welfare institutions must precede future efforts to change the way policing functions in our society.