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ARTICLES

POLICING THE EMERGENCY ROOM

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POLICING THE EMERGENCY ROOM

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The problems of policing extend beyond the street and into areas of our lives that are often hidden from view. This Article focuses on how policing affects people in one such place where they are particularly vulnerable: the emergency room. It explores how the courts' interpretation of the Fourth and Fifth Amendments has resulted in the criminalization of the emergency room. The ER is where people go when they are vulnerable and injured. ERs play a crucial "safety-net" function for those who do not have access to other types of medical care. Yet courts have interpreted the ER as an extension of the public street, generally permitting the police to engage in highly intrusive searches and questioning there. The doctrine cannot account for the unique characteristics of the ER and the medical vulnerability of patients. Further, police investigations in the ER are enhanced by the participation of medical professionals who have existing professional norms as well as their own history and current evidence of bias and discrimination. Finally, the courts' treatment of the ER as an extension of the street raises the same concerns of racialized street policing because of the convergence of police and marginalized groups in safety-net emergency rooms. The presence of police in the ER has a particularly pernicious effect in emergency rooms that have large percentages of racial minority and poor patients. Especially in these ERs, the doctrine's blind eye to medical vulnerability also renders invisible the race and class dynamics undergirding policing and access to healthcare. I conclude by suggesting that the reasonable expectation of privacy standard should incorporate considerations of medical vulnerability and medical privacy. Further, as we question the harm or necessity of police presence in communities, we should conceptualize ERs as patient sanctuaries to achieve a better balance between the rights of vulnerable patients and public safety.

INTRODUCTION

The past year has exposed in stark relief the age-old fissures of racial inequality in America. Every month of the COVID-19 pandemic has revealed how racial identity affects health and healthcare outcomes. The role of race reverberates in disparate rates of COVID-19 infection,

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treatment, and access to testing and vaccines. During this time of pandemic, the problems of race and policing have also come into intense focus. At the height of the first summer surge of the virus, protests against the killings of Black people at the hands of police, including the murder of George Floyd, swept across cities. A year after the first shelter-in-place orders, the trial and conviction of Derek Chauvin, punctuated by yet more police killings, resurrects the trauma and reminds us that much progress still needs to be made.

The problems of inequality, healthcare, and policing are not new. They are deeply embedded in our history. They are also not siloed. They are, in fact, deeply intertwined.

Commentators widely view the deaths of Black people at the hands of police as the product of overbroad criminal laws and the overwhelming discretion given to police to stop, arrest, and use force on people they encounter in the streets.[1] Many agree that lawmakers criminalize too much routine activity and that the police should not be able to question, arrest, and use force against racial minorities suspected of only minor or vague misconduct.[2]

The conversation is shifting. As deaths of Black people at the hands of law enforcement continue unabated, the talk is no longer just about regulating police. Some are calling for abolition, many for varying degrees of defunding. People are questioning where police are deployed, how and how much they are being funded, and what roles they fulfill. Why should police be the school security guard, substance use and mental health crisis responder, traffic cop, as well as the agent who investigates and uses force?[3]

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[1] Richard Fausset & Shaila Dewan, *Police Decisions Are Scrutinized After Rayshard Brooks's Fatal Encounter*, N.Y. TIMES (Jan. 29, 2021), https://www.nytimes.com/2020/06/18/us/rayshard-brooks-police-tactics.html [https://perma.cc/7EQQ-2RJX]; Conor Friedersdorf, *End Needless Interactions with Police Officers During Traffic Stops*, THE ATLANTIC (July 8, 2016), https://www.theatlantic.com/politics/archive/2016/07/end-needless-interaction-with-cops-during-traffic-stops/490412 [https://perma.cc/4AYY-P5J7]; Sean Illing, *Why the Policing Problem Isn't About "A Few Bad Apples,"* VOX (June 6, 2020, 8:01 AM), https://www.vox.com/identities/2020/6/2/21276799/george-floyd-protest-criminal-justice-paul-butler [https://perma.cc/R8SK-4WP2].

[2] *E.g.*, ISSA KOHLER-HAUSMANN, MISDEMEANORLAND 1–5 (2018); Devon W. Carbado, *From Stopping Black People to Killing Black People: The Fourth Amendment Pathways to Police Violence*, 105 CALIF. L. REV. 125, 127–28 (2017); Alexandra Natapoff, *Misdemeanors*, 85 S. CAL. L. REV. 1313, 1317–18 (2012); Ekow N. Yankah, *Pretext and Justification: Republicanism, Policing, and Race*, 40 CARDOZO L. REV. 1543, 1547–49 (2019).

[3] *Boston Police Commissioner Gross: Officers "Wear Too Many Hats," Duties Should Be Shared*, CBS BOS. (June 12, 2020, 11:49 AM), https://boston.cbslocal.com/2020/06/12/boston-police-commissioner-william-gross-budget-overtime-walsh [https://perma.cc/VA3Z-SKY6]; Natasha Lennard, *Her Former Colleagues Called in a "Wellness Check." Then Police Shot Her to Death.*, THE INTERCEPT (Aug. 22, 2020, 7:00 AM), https://theintercept.com/2020/08/22/police-shooting-wellness-check-sandy-guardiola [https://perma.cc/TQV6-BQ39]; Brett Simpson, *Berkeley Approves Goals to Cut Police Budget by 50%, Reduce Cops' Role in Traffic Enforcement*, S.F.

Problems of policing, however, go beyond the streets and into areas that may be hidden from view. The emergency room replicates problems of policing in a place where people of color and those with lower socioeconomic means are particularly vulnerable. The ER can be viewed as a microcosm demonstrating the consequences of giving police multiple responsibilities that compound and expand their investigative and surveillance capacities. Yet police activity in the ER has largely escaped the scrutiny given to places like welfare offices, schools, and other public institutions.[4]

One reason may be that in contrast to street policing, many — including hospital professionals and staff — may view police presence in the emergency rooms as fully justified, even desirable. Police need to accompany gunshot wound victims and other victims of criminal activity to the hospital.[5] They need to be present to gather evidence from crime victims,[6] to protect medical personnel from the spillover effects of violence from the streets,[7] and to accompany those arrested and convicted of crimes.[8]

This Article argues that even in the ER, where police presence may appear at first blush fully justified, their presence has a dark side. Policing in the ER encompasses more than accompanying injured people to the hospital or gathering evidence from victims. Sociologists have described how police monitor those who come to hospitals and emergency rooms[9] and how nurses in a public emergency room allocate

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CHRON. (July 21, 2020, 8:46 PM), https://www.sfchronicle.com/crime/article/Berkeley-council-bans-police-from-traffic-15410326.php [https://perma.cc/JLC4-NJ4N]; Derek Thompson, *Unbundle the Police*, THE ATLANTIC (June 11, 2020), https://www.theatlantic.com/ideas/archive/2020/06/unbundle-police/612913 [https://perma.cc/WZM5-6PF9].

[4] A note about the terminology is required. "Emergency department" and "emergency room" are used interchangeably, though I mostly use the latter. I use the term "police" generally to refer to law enforcement agencies that have the official power to investigate and make arrests for criminal violations. Defined this way, police include a diverse array of agencies including municipal and state police agencies, sheriff's offices, and some hospital police departments. The terms "police" and "law enforcement" are used interchangeably unless specifically noted.

[5] Sara F. Jacoby et al., *Police-to-Hospital Transport for Violently Injured Individuals: A Way to Save Lives?*, 687 ANNALS AM. ACAD. POL. & SOC. SCI. 186, 187–88 (2020).

[6] *See, e.g.*, *Decide on Core Membership*, OFF. OF JUST. PROGRAMS: SART TOOLKIT, https://www.ncjrs.gov/ovc_archives/sartkit/develop/build-decide.html [https://perma.cc/6Q3E-6579].

[7] Alyssa Rege, *17 Fatal Hospital Shootings Since 2002*, BECKER'S HOSP. REV. (Nov. 21, 2018), https://www.beckershospitalreview.com/care-coordination/17-fatal-hospital-shootings-since-2002.html [https://perma.cc/MQW4-7DYY].

[8] PEW CHARITABLE TRS., STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE 11–12 (2018), https://www.pewtrusts.org/-/media/assets/2018/07/prisons-and-hospital-care_report.pdf [https://perma.cc/BSG6-HQMD].

[9] ALICE GOFFMAN, ON THE RUN: FUGITIVE LIFE IN AN AMERICAN CITY 34 (2014). Professor Alice Goffman's account has drawn criticism. *See* James Forman, Jr., *The Society of Fugitives*, THE ATLANTIC (Oct. 2014), https://www.theatlantic.com/magazine/

medical care based on perceptions of patients' criminality.[10] Hospital professionals have observed officers jotting down patient names and birthdates even when they were not in police custody.[11] Doctors in an urban hospital witnessed security routinely handing over patient cell phones to police, also when they were not in police custody.[12] At yet another hospital, the sheriff's office providing security installed license plate readers at the ER entrance without the hospital's knowledge.[13] Police execute warrants and make arrests in hospitals.[14] Police ask doctors and nurses about injuries and diagnoses. They stand watch during procedures. Meanwhile, doctors, nurses, and other hospital staff become part of police investigations. Beyond helping police by performing pro-

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archive/2014/10/the-society-of-fugitives/379328 [https://perma.cc/P6HP-LZ9A]. Goffman's ethnographic methods and conclusions have been criticized for the claim that police routinely check patients for outstanding warrants. Steven Lubet, *Ethics on the Run*, NEW RAMBLER (2015), https://newramblerreview.com/book-reviews/law/ethics-on-the-run [https://perma.cc/K2LF-HN7Z]. Though there is no empirical data on this point, anecdotal evidence from physicians and health workers in cities other than Philadelphia (the subject of Goffman's study) reveal at least the informal practice of police checking warrants of patients. In interviews with medical staff from different metropolitan areas, the issues of police checking patients' backgrounds and seizing belongings repeatedly came up as routine occurrences. *See* Telephone Interview with Hospital Divest/Defund Organizer (Sept. 17, 2020) (notes on file with author); Telephone Interview by Michael Smith with EW, Hospital Program Manager (Nov. 18, 2020) (transcript on file with author); Telephone Interview by Michael Smith with KH, Working Group Manager (Dec. 18, 2020) (transcript on file with author); Telephone Interview by Michael Smith with MS, Hospital Social Worker (Dec. 22, 2020) (transcript on file with author); Telephone Interview by Michael Smith with MT, Working Group Manager (Dec. 22, 2020) (transcript on file with author); Telephone Interview by Carly Loughran with MO, Working Group Manager (Dec. 22, 2020) (transcript on file with author); Telephone Interview by Michael Smith with MM, Working Group Manager (Dec. 22, 2020) (transcript on file with author). These interviews are part of a larger survey by the Working Group on Policing and Patient Rights, co-led by me. Michael Smith and Carly Loughran assisted with these interviews. The names of the interviewees and hospitals have been withheld for confidentiality. *See also* Reports from Hospital Professionals (Apr. 7, 2019) [hereinafter Hospital Reports] (on file with author) (name of hospital withheld for confidentiality) (collecting reports from medical providers of how law enforcement interactions affected patient care).

[10] *See* ARMANDO LARA-MILLÁN, REDISTRIBUTING THE POOR: JAILS, HOSPITALS, AND THE CRISIS OF LAW AND FISCAL AUSTERITY 112 (2021); Armando Lara-Millán, *Public Emergency Overcrowding in the Era of Mass Imprisonment*, 79 AM. SOCIO. REV. 866, 874–77 (2014).

[11] This information was compiled by medical professionals in response to concerns of law enforcement effects on patient care. *See* Hospital Reports, *supra* note 9. The hospital is a safety-net Level 1 Trauma facility in an urban metropolitan area.

[12] Telephone Interview with Trauma Surgeon and Hospital Social Worker (Sept. 2, 2020) (notes on file with author) (names withheld at request of interviewees).

[13] Darwin BondGraham, *Highland Hospital Surveillance Stirs Concerns*, E. BAY EXPRESS (Nov. 22, 2017), https://eastbayexpress.com/highland-hospital-surveillance-stirs-concerns-2-1 [https://perma.cc/399U-5LFZ].

[14] *See* Mark Berman, *Jacob Blake Is No Longer Handcuffed in Wisconsin Hospital, Attorney Says*, WASH. POST (Aug. 29, 2020, 6:10 PM), https://www.washingtonpost.com/nation/2020/08/29/jacob-blake-is-no-longer-handcuffed-wisconsin-hospital-attorney-says [https://perma.cc/Q4RA-JHR6].

cedures and testing, they pass on information about patients. They direct police officers to patients and attest to their capabilities for questioning.[15]

When police go into emergency rooms, they are also entering places where society's vulnerable and marginalized groups seek medical care. Emergency rooms reflect many of this country's deepest and most entrenched problems. ERs catch people with mental and/or chronic illnesses and others who fall through the gaps. The people who use the emergency room as a safety net come into contact with police in the same way scholars have described in other important public institutions like welfare offices,[16] schools,[17] public housing,[18] and other medical settings.[19] In poor communities, disproportionately composed of racial minorities, police presence in the ER can have a net-widening effect as in these other contexts. Because of the significant discretion given to police to conduct searches and interrogations in the ER, police have the ability to surveil and monitor poor people and racial minorities with the help of the very medical professionals who are also tasked with treating them.

Although police are present in other healthcare settings, police in the emergency room merit particular attention for a number of reasons. First, the ER by definition receives urgent cases, the nature of which may overlap with law enforcement concerns. These cases include assaults, stabbings, gunshot wounds, and arrests relating to drug and alcohol use. The ER becomes a portal for police to these types of cases by virtue of their security, emergency response, and investigative roles. Second, ERs now occupy an outsized role in healthcare itself, acting as a gatekeeper for hospital admissions and playing a particularly important part in providing primary healthcare to people of lower socioeconomic means. Lastly, the ER presents us with a specific, unique, and defined doctrinal area to explore the criminal procedure doctrine's ability — or inability — to cabin police overreach.

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[15] *See infra* Part I, pp. 2654–64.

[16] KAARYN S. GUSTAFSON, CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY 2, 6–7 (2011).

[17] KIMBERLÉ CRENSHAW ET AL., BLACK GIRLS MATTER: PUSHED OUT, OVERPOLICED AND UNDERPROTECTED 5 (2015); Alexis Karteron, *Arrested Development: Rethinking Fourth Amendment Standards for Seizures and Uses of Force in Schools*, 18 NEV. L.J. 863, 872–73 (2018); Catherine Y. Kim, *Policing School Discipline*, 77 BROOK. L. REV. 861, 862–63 (2012).

[18] Alexis Karteron, *When Stop and Frisk Comes Home: Policing Public and Patrolled Housing*, 69 CASE W. RSRV. L. REV. 669, 681–86 (2019).

[19] *See* KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS 120–21, 127 (2017) (Medicaid); MICHELE GOODWIN, POLICING THE WOMB 80–81 (2020) (prenatal care); DOROTHY ROBERTS, KILLING THE BLACK BODY 58 (1997) (access to birth control); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239, 1252–53 (2012) (reproductive healthcare for incarcerated women).

The Article centers itself on this last point. It engages in a doctrinal critique of Fourth and Fifth Amendment jurisprudence from the perspective of the criminalization of poverty. Courts treat the emergency room as an extension of the street despite the vulnerability of the marginalized populations that rely on the ER for their medical care. Their decisions legitimize and, as a result, incentivize police investigatory activities in the ER. Judges are not merely interpreters of preexisting police practices that occasionally appear for ratification within their courtrooms; their decisions play a role in the overbroad actions of police in the ER by conceiving many of its facets as lawful activity, often comfortably within the doctrinal boundary lines of constitutional criminal procedure.

In this examination of the intersection of policing and the emergency room,[20] the Article connects literature on race and policing,[21]

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[20] Policing in healthcare encompasses a broad range of actors and settings. A growing number of scholars have begun to explore policing at this intersection. Emergency (EMT/EMS) medical workers are important parts of police investigations. Professor Osagie Obasogie has written about the relationship between police and paramedic partnerships in the context of police use of force, the Fourth Amendment, and use of sedatives by paramedics in prehospital settings. *See* Osagie K. Obasogie & Anna Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 CALIF. L. REV. 1 (2021). Professor Sunita Patel examines the role of the Veterans Affairs Police Force in VA Medical Centers and how policing in veterans medical care settings constitutes a broad surveillance web beyond policing those with mental illness. *See* SUNITA PATEL ET AL., NATIONAL ASSOCIATION OF MINORITY VETERANS (NAMVETS) AND UCLA VETERANS LEGAL CLINIC ADVISORY: THE U.S. DEPARTMENT OF VETERANS AFFAIRS POLICE FORCE 4 (2020); Sunita Patel, The Healthcare Policing Web 5–7 (Feb. 12, 2021) (unpublished manuscript) (on file with the Harvard Law School Library).

[21] *E.g.*, I. Bennett Capers, *Policing, Race, and Place*, 44 HARV. C.R.-C.L. L. REV. 43, 44 (2009) [hereinafter Capers, *Policing, Race, and Place*] (situating the importance of racialized spaces in examining policing and race); I. Bennett Capers, *Rethinking the Fourth Amendment: Race, Citizenship, and the Equality Principle*, 46 HARV. C.R.-C.L. L. REV. 1, 30 (2011) (arguing that the Supreme Court's criminal procedure jurisprudence between the 1920s and 1960s reveals a goal of "equal citizenship"); Devon W. Carbado, *(E)racing the Fourth Amendment*, 100 MICH. L. REV. 946, 967–68 (2002) [hereinafter Carbado, *(E)racing the Fourth Amendment*] (arguing that the Supreme Court's Fourth Amendment case law is a "jurisprudential site" where the Court "constructs" and "reifies" race, legitimizing and reproducing racial inequality in policing, *id.* at 967); Devon W. Carbado, *From Stop and Frisk to Shoot and Kill:* Terry v. Ohio*'s Pathway to Police Violence*, 64 UCLA L. REV. 1508, 1513 (2017) (arguing that Fourth Amendment stop-and-frisk jurisprudence not only contributes to but also facilitates police violence against African Americans); Tracey Maclin, *Race and the Fourth Amendment*, 51 VAND. L. REV. 333, 340 (1998) [hereinafter Maclin, *Race and the Fourth Amendment*] (criticizing the Court's decision in *Whren v. United States*, 517 U.S. 806 (1996), and arguing that race matters when assessing the legitimacy of police-citizen encounters); Tracey Maclin, Terry v. Ohio*'s Fourth Amendment Legacy: Black Men and Police Discretion*, 72 ST. JOHN'S L. REV. 1271, 1283 (1998) (arguing that *Terry v. Ohio*, 392 U.S. 1 (1968), represents a capitulation by the Warren Court by authorizing police practice used to subvert rights of Black people); Alice Ristroph, *The Constitution of Police Violence*, 64 UCLA L. REV. 1182, 1189–90 (2017) (arguing that viewing Fourth Amendment seizure authority through the lens of resistance and compliance reveals how law redistributes risks of violence and offers new ways of redistributing those risks).

policing and healthcare,[22] and the criminalization of Black motherhood and poverty.[23] I draw largely upon case law as well as a variety of other materials, including sociological studies, medical literature, and my own interviews with medical professionals. Through an analytical sampling of cases, I examine how the doctrine speaks to the complex socio-legal dynamics at play in the emergency room. The arguments presented here apply to emergency rooms as a whole. But police presence has a particularly pernicious effect in those emergency rooms that serve high numbers of racial minorities and the poor. In these emergency rooms especially, I argue that the courts can interpret the emergency room as an extension of the street only by rendering invisible the race and class dynamics undergirding policing and access to healthcare.

Part I begins by describing the stratified state of emergency medicine in the United States. I describe how certain hospitals, known as "safety-net hospitals," bear responsibility for serving low-income and minority populations, largely through their ERs. I then provide an overview of the ways police investigate in the emergency room.

Part II describes the Fourth and Fifth Amendment doctrines regarding searches, seizures, and interrogations in the ER and presents three critiques of the current doctrinal approach. First, the doctrine cannot account for the unique medical context of the ER and allows police to take advantage of the medical vulnerability of patients. Second, the courts enable police officers to exploit the assistance of medical professionals, even when their assistance conflicts with medical professional norms and responsibilities. Third, the relaxed privacy protections in the ER also raise concerns about the potential for race-based policing practices, such as heightened surveillance of people of color and pretextual investigations. I argue that the criminal procedure protections are inadequate because they fail to account for the vulnerability of patients

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[22] *E.g.*, Caitlin E. Borgmann, *The Constitutionality of Government-Imposed Bodily Intrusions*, 2014 U. ILL. L. REV. 1059, 1075; 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, 504–05 (2013); Elliot B. Oppenheim, *May the Police Practice Medicine?*, 8 J. MED. & L. 35, 41 (2003–04). *See generally* Radhika Rao, *Property, Privacy, and the Human Body*, 80 B.U. L. REV. 359 (2000) (accounting for when the human body is treated as having property or privacy interests in the law and how that different categorization might change legal rules).

[23] *See* Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1195–96 (2017); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1476 (2012); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420–21 (1991) [hereinafter Roberts, *Punishing Drug Addicts*]; sources cited *supra* note 19. For discussions on the criminalization of poverty, see generally GUSTAFSON, *supra* note 16 (delving into the welfare system's policies and actors to demonstrate how the welfare system replicates and employs punitive measures in the criminal legal system); LOÏC WACQUANT, PUNISHING THE POOR: THE NEOLIBERAL GOVERNMENT OF SOCIAL INSECURITY (2009) (connecting rise in punitive policy in the United States to social insecurity and describing a new government regime of insecurity integrating welfare and criminal justice policies).

who are experiencing medical crises, while emphasizing the participation of patients' medical providers to help police. These inadequate protections instead create the potential for race-based policing when racial minorities and police converge in safety-net ERs.

Lastly, in Part III, I argue that police presence in the ER must be reexamined. Even if some police presence may be justified, police should not operate in a way that can heighten the surveillance and policing of marginalized groups and disproportionately funnel them into the criminal justice system. I suggest a potential reimagining of the doctrinal approach to privacy grounded in medical definitions and notions of patient privacy. I conclude by offering an approach conceptualizing the emergency room as a place of sanctuary to achieve a better balance of patient privacy and dignity on the one hand and legitimate public safety and security concerns on the other.

I. EMERGENCY ROOMS AND POLICING

Emergency rooms reflect the deep disparities in American healthcare. Emergency rooms are used differently by people depending on their economic means and geography. At the same time, police routinely perform a variety of functions in emergency rooms, including providing security, accompanying victims and people with mental illnesses, working with medical professionals, and investigating crime. This discussion sets the stage for my later examination and critique of the courts' views of ER-based police investigations.

A. Poor People in the ER

The emergency room provides a much-needed service and has come to play an important role in our healthcare system. ERs provide nearly half of all hospital-associated medical care.[24] But people use the ER differently based upon their socioeconomic status.

People with more money and better healthcare still experience emergencies, but likely as rare occurrences. Even in the face of an emergency, financially comfortable people are able to choose their care. Options like electronic communications and telemedicine now mean that prescriptions can be filled and questions answered, all without entering a doctor's office or hospital.[25] The poor, disproportionately made up of

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[24] David Marcozzi et al., *Trends in the Contribution of Emergency Departments to the Provision of Hospital-Associated Health Care in the USA*, 48 INT'L J. HEALTH SERVS. 267, 281–83 (2018) (finding that, on average, between 1996 and 2010, 47.7% of medical care contacts in hospital outpatient departments, emergency departments, and ambulatory surgery locations were emergency room visits).

[25] In some instances, those with access to online service and online financial payment options can pay a fee to select a time online for the emergency room and wait in the comfort of their own homes until their appointments. *See Emergency/Urgent Care*, INQUICKER, https://

Black and brown people, use ERs very differently. Their myriad vulnerabilities make continuous emergencies a greater likelihood. These vulnerabilities, combined with lack of access to steady healthcare, mean that many use ERs as their primary healthcare site, and not just for urgent and emergency care.[26]

Poor people have long relied upon the important social welfare function fulfilled by emergency rooms.[27] As people flocked to cities during the postwar period, emergency rooms attracted people with inadequate insurance and who lacked the wherewithal to navigate the intricacies of a modernizing healthcare system.[28] The annual number of people using the emergency room reached the millions, resulting in severe overcrowding and problems with quality of care.[29] In 1986, in response to highly publicized incidents "patient dumping,"[30] where hospitals discharged, transferred, or failed to screen patients unable to pay,[31] Congress passed the Emergency Medical Treatment and Labor Act[32] (EMTALA). The

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inquicker.com/solutions/emergency-urgent-care [https://perma.cc/AUU3-Z6NF]; Patricia Yollin, *Online Service Allows UCSF Patients to Reserve Emergency Department Visit*, UCSF (July 25, 2011), https://www.ucsf.edu/news/2011/07/10333/new-online-service-allows-ucsf-patients-reserve-emergency-department-visit [https://perma.cc/6A2D-7XV3].

[26] *See* Shreya Kangovi et al., *Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals over Ambulatory Care*, 32 HEALTH AFFS. 1196, 1201 (2013); Daniel Weisz et al., *Emergency Department Use: A Reflection of Poor Primary Care Access?*, 21 AM. J. MANAGED CARE e152, e154 (2015).

[27] *See* James A. Gordon, *The Hospital Emergency Department as a Social Welfare Institution*, 33 ANNALS EMERGENCY MED. 321, 322 (1999). Modern emergency medicine and the emergency department are relatively recent creations. *See* Brian J. Zink, *Social Justice, Egalitarianism and the History of Emergency Medicine*, 12 VIRTUAL MENTOR 492, 492 (2010); *see also* BRIAN J. ZINK, ANYONE, ANYTHING, ANYTIME: A HISTORY OF EMERGENCY MEDICINE 23–25 (2006). Modern-day hospitals only became standard at the turn of the twentieth century. *See History of Hospitals*, PENN NURSING, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals [https://perma.cc/A5QJ-PKWN]. The funding available through passage of the Hospital Survey & Construction (Hill-Burton) Act, Pub. L. No. 79–725, 60 Stat. 1040 (1946), in 1946 led to new hospitals being built throughout the country even in poor and rural areas. *History of Hospitals*, *supra*.

[28] *See* ZINK, *supra* note 27, at 23.

[29] *Id.* at 13. ERs have had this high rate of use for decades. Between 1965 and 1970, the number of ER visits jumped from twenty-nine million to forty-three million per year. *Id.* at 56. Today, that number is over 130 million. *Emergency Department Visits*, NAT'L CTR. FOR HEALTH STAT. (Mar. 1, 2021), https://www.cdc.gov/nchs/fastats/emergency-department.htm [https://perma.cc/FD86-M4WQ].

[30] Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians*, 14 BAYLOR U. MED. CTR. PROC. 339, 339 (2001). The practice of patient dumping has not been eradicated by EMTALA. A recent study revealed that uninsured and Medicaid recipients were still more likely to be transferred despite hospitals' ability to provide the needed care. *See* Arjun K. Venkatesh et al., *Association Between Insurance Status and Access to Hospital Care in Emergency Department Disposition*, 179 JAMA INTERNAL MED. 686, 687 (2019).

[31] *See* Zibulewsky, *supra* note 30.

[32] Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd).

federal law mandates medical screening of all patients regardless of ability to pay at any hospital accepting Medicare funding.[33]

Due in part to these changes in law, ERs reimbursed by federal funding act as "the safety net of the safety net,"[34] and "the only place[s] in the U.S. healthcare system where the poor cannot be turned away."[35] This is particularly true at "safety-net hospitals," which serve high numbers of low-income and uninsured patients.[36] As "providers of last resort,"[37] safety-net hospitals have assumed a major role in the provision of comprehensive services to medically and socially vulnerable populations.[38] Safety-net hospitals encompass a wide range of organizations, including public hospitals, academic medical centers, nonprofit entities, and private hospitals.[39] Many are located in large, metropolitan areas.[40]

People with Medicaid account for the second-largest percentage of those visiting the ER,[41] and they are much more likely to visit the ER with nonurgent conditions than those with commercial healthcare

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[33] *See EMTALA Fact Sheet*, AM. COLL. OF EMERGENCY PHYSICIANS, https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet [https://perma.cc/8YUB-TLF3].

[34] KRISTY GONZALEZ MORGANTI ET AL., RAND CORP., THE EVOLVING ROLE OF EMERGENCY DEPARTMENTS IN THE UNITED STATES 3 (2013); *see also* Catherine W. Burt & Irma E. Arispe, *Characteristics of Emergency Departments Serving High Volumes of Safety-Net Patients: United States, 2000*, 13 VITAL HEALTH STAT., no. 155, May 2004, at 1. The healthcare safety net more broadly includes hospitals, community health centers, and clinics that provide the bulk of care for Medicaid patients and those who lack insurance. Robert M. Politzer et al., *Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care*, 58 MED. CARE RSCH. & REV. 234, 236 (2001). There is also a separate category of hospitals that are reimbursed for serving a significantly disproportionate number of low-income and Medicaid patients; these hospitals are also known as "Disproportionate Share Hospitals." *See Disproportionate Share Hospitals*, HEALTH RES. & SERVS. ADMIN. (May 2018), https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals/index.html [https://perma.cc/CG8E-898B].

[35] GONZALEZ MORGANTI ET AL., *supra* note 34, at 2; *see also* Mary W. Herman, *The Poor: Their Medical Needs and the Health Services Available to Them*, 399 ANNALS AM. ACAD. POL. & SOC. SCI. 12, 14 (1972).

[36] *See* Ioana Popescu et al., *Comparison of 3 Safety-Net Hospital Definitions and Association with Hospital Characteristics*, 2 JAMA NETWORK OPEN e198577 (2019).

[37] INST. OF MED., AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 54 (Marion Ein Lewin & Stuart Altman eds., 2000).

[38] *Id.*; PETER CUNNINGHAM & LAURIE FELLAND, ENVIRONMENTAL SCAN TO IDENTIFY THE MAJOR RESEARCH QUESTIONS AND METRICS FOR MONITORING THE EFFECTS OF THE AFFORDABLE CARE ACT ON SAFETY NET HOSPITALS 3–4 (2013); Shaun Ossei-Owusu, *Code Red: The Essential yet Neglected Role of Emergency Care in Health Law Reform*, 43 AM. J.L. & MED. 344, 362 (2017).

[39] *See* JANET PAGON SUTTON ET AL., STATISTICAL BRIEF #213: CHARACTERISTICS OF SAFETY-NET HOSPITALS, 2014, at 1 (2016), https://www.ncbi.nlm.nih.gov/books/NBK401306/pdf/Bookshelf_NBK401306.pdf [https://perma.cc/88S2-WK8K]; Popescu et al., *supra* note 36.

[40] PAGON SUTTON ET AL., *supra* note 39.

[41] Marcozzi et al., *supra* note 24, at 273.

plans.[42] Unhoused people also frequent ERs at high rates due to a wide range of medical needs and the higher likelihood of mental illness, all of which are compounded by other barriers to access of non-ER care, like lack of transportation and insurance.[43] The decreased availability of public mental health services has meant that emergency rooms or jails become the default placements for many people suffering from mental health crises.[44] Visits to the emergency department (ED) due to mental health crises rose by 44.1% from 2006 to 2014[45] and account for one in eight ED visits.[46]

Existing research reveals that poor and racial minority groups rely upon emergency rooms as their primary healthcare, especially in poor, urban areas.[47] One nationwide study of ED usage between 1996 and 2010 reported an increase of emergency care visits by almost 44%.[48] Compared to white and Asian patients in the study, Black patients were most likely to use EDs over other healthcare resources.[49] In 2010, over half of all the documented medical visits by Black patients were to emergency rooms.[50] These patients included those in metropolitan areas and those on Medicaid.[51] Meanwhile, in California, researchers concluded

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[42] Hyunjee Kim et al., *Comparing Emergency Department Use Among Medicaid and Commercial Patients Using All-Payer All-Claims Data*, 20 POPULATION HEALTH MGMT. 271, 273–74 (2017).

[43] RUIRUI SUN ET AL., STATISTICAL BRIEF #229: CHARACTERISTICS OF HOMELESS INDIVIDUALS USING EMERGENCY DEPARTMENT SERVICES IN 2014, at 1 (2017), https://www.ncbi.nlm.nih.gov/books/NBK481367/pdf/Bookshelf_NBK481367.pdf [https://perma.cc/9Q3G-9Z5P].

[44] *See* HEATHER BARR, PRISONS AND JAILS: HOSPITALS OF LAST RESORT 2 (2003); EILEEN SALINSKY & CHRISTOPHER H. LOFTIS, SHRINKING INPATIENT PSYCHIATRIC CAPACITY: CAUSE FOR CELEBRATION OR CONCERN? 2 (2007); Egon Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 SOC. PROBS. 278, 278 (1967); Neal L. Cohen & Luis R. Marcos, *Law, Policy, and Involuntary Emergency Visits*, 61 PSYCH. Q. 197, 202 (1990). For a theoretically informed explanation of this inequality in treatment, see Neil Gong, *Between Tolerated Containment and Concerted Constraint: Managing Madness for the City and the Privileged Family*, 84 AM. SOCIO. REV. 664 (2019).

[45] BRIAN J. MOORE ET AL., STATISTICAL BRIEF #227: TRENDS IN EMERGENCY DEPARTMENT VISITS, 2006–2014, at 1 (2017), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf [https://perma.cc/97PU-32QE].

[46] AUDREY J. WEISS ET AL., STATISTICAL BRIEF #216: TRENDS IN EMERGENCY DEPARTMENT VISITS INVOLVING MENTAL AND SUBSTANCE USE DISORDERS, 2006–2013, at 1 (2016), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf [https://perma.cc/4Z3A-2RU5].

[47] The data does not completely capture the number of poor and racial minority patients in safety-net hospitals.

[48] Marcozzi et al., *supra* note 24, at 272.

[49] *Id.* at 274; *see also* Lindsay E. Brown et al., *Factors Influencing Emergency Department Preference for Access to Health Care*, 13 W.J. EMERGENCY MED. 410, 413 (2012).

[50] Marcozzi et al., *supra* note 24, at 274.

[51] *Id.* The data revealed an increase of 2% of Black patients in metropolitan areas and an increase of more than 10% of Black patients with Medicaid. *Id.* Black patients on Medicare, on

that Black patients with private health maintenance organization insurance frequented EDs more than other kinds of care, suggesting that factors other than geography and income may be at play.[52] Another national study of Medicare enrollees' use of ambulances revealed that Black and Hispanic patients were more likely to be transported to safety-net ERs than white patients from the same zip codes.[53]

Hospital closures have also contributed to the increased usage of public ERs by Black people living in urban and poor communities.[54] More broadly, research has demonstrated that hospital closures have taxed the healthcare safety net enormously.[55] Between 1990 and 2010, approximately 200 hospitals closed across America's largest cities, including 148 nonprofit hospitals.[56] Of those that have stayed, many have chosen to close their emergency departments.[57] The resulting chronic overcrowding has placed increasing pressure on ERs that predominantly serve poor communities.[58] Meanwhile, people with private

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the other hand, used EDs and outpatient facilities at similar rates, and white and Asian patients showed relatively stable rates of ED use. *Id.*

[52] DYLAN H. ROBY ET AL., UCLA CTR. FOR HEALTH POL'Y RSCH., AFRICAN AMERICANS IN COMMERCIAL HMOS MORE LIKELY TO DELAY PRESCRIPTION DRUGS AND USE THE EMERGENCY ROOM 2, 11 (2009).

[53] Amresh D. Hanchate et al., *Association of Race/Ethnicity with Emergency Department Destination of Emergency Medical Services Transport*, 2 JAMA NETWORK OPEN e1910816, at 1 (2019). The study did not examine the impact on patient outcomes or whether patient choice or prior care may have been a determining factor. The study noted that further research was needed to determine whether access barriers accounted for the designation and whether the destination had any effect on patient outcomes. *Id.* at 9.

[54] *See, e.g.*, Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1034 (2005); Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1303–04 (2012).

[55] *See* Shaun Ossei-Owusu, *The State Giveth and Taketh Away: Race, Class, and Urban Hospital Closings*, 92 CHI.-KENT L. REV. 1037, 1059 (2017); Alan Sager, *Urban Hospital Closings in the Face of Racial Change*, 5 HEALTH L. PROJECT LIBR. BULL. 169, 169 (1980) (adapted from testimony before the House Ways and Means Committee).

[56] Lillian Thomas, *Hospitals, Doctors Moving out of Poor City Neighborhoods to More Affluent Areas*, MILWAUKEE J. SENTINEL & PITT. POST-GAZETTE (June 14, 2014, 3:15 PM), https://archive.jsonline.com/news/health/hospitals-doctors-moving-out-of-poor-city-neighborhoods-to-more-affluent-areas-b99284882z1-262899701.html [https://perma.cc/H4CY-H26V].

[57] Renee Y. Hsia et al., *Factors Associated with Closures of Emergency Departments in the United States*, 305 JAMA 1978, 1978 (2011).

[58] *Id.* at 1984. Rural areas have been hit particularly hard by hospital closures, while the rate of usage of ERs by rural patients with either Medicaid or no insurance has sharply increased. From 2005 to 2016, rural ED visits increased from 16.7 million to 28.4 million while urban ED visits increased from 98.6 million to 117.2 million. Margaret B. Greenwood-Ericksen & Keith Kocher, *Trends in Emergency Department Use by Rural and Urban Populations in the United States*, 2 JAMA NETWORK OPEN e19191, at 1 (2019). In 2005, 769 of 2,009 rural hospitals were considered safety-net emergency departments; by 2016, that number had increased to 1,187 out of 1,855 hospitals. *Id.* at 5; *see also id.* at 4 (noting that medical visits in rural areas jumped from 56.2 to 112.6 per 100 persons, and that visits by uninsured patients rose from 44 to 66.6 per 100 persons).

health insurance and better economic means now have a growing array of choices for emergency and urgent care. As hospitals have left poor communities, many have simply relocated or opened new locations in more affluent areas,[59] where they offer state-of-the-art care and have access to a well-insured pool of patients. Emergency care options have also diversified so that ERs are not the sole recourse for those with money. Concierge medical practices have come on the scene in recent years, allowing those with means to bypass hospitals altogether if they choose and have thousands of dollars a year to spend on the service.[60] Concierge services offer 24/7 phone and email access to private doctors, as well as same-day appointments and home delivery of medications.[61] In New York City, where wait times at the ER may be several hours,[62] an annual fee of $5,000 can get you access to an on-call private clinic staffed 24/7 with doctors trained in emergency medicine.[63] Stand-alone ERs or freestanding emergency departments (FSEDs) offer an additional option of care in affluent areas.[64] Originally conceived of in the

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At the same time, hospital resources have become scarcer across the country. CDC statistics show that from 1975 to 2015, the number of hospitals in the United States decreased from 7,156 to 5,564, with a corresponding decrease of more than a half million hospital beds. *Hospitals, Beds, and Occupancy Rates, by Type of Ownership and Size of Hospital: United States, Selected Years 1975–2015*, CTRS. FOR DISEASE CONTROL & PREVENTION (2017), https://www.cdc.gov/nchs/data/hus/2017/089.pdf [https://perma.cc/HQ8U-ZKBQ]. The more recent passage of the Affordable Care Act has exacerbated the financial pressures on hospitals due to the decreasing amount of federally reimbursed care. *See* Tamara Hayford & Lyle Nelson, *CBO's Analysis of Financial Pressures Facing Hospitals Identifies Need for Additional Research on Hospitals' Productivity and Responses*, CONG. BUDGET OFF. (Sept. 8, 2016), https://www.cbo.gov/publication/51920 [https://perma.cc/Q227-M55A].

59 Thomas, *supra* note 56.

60 Paul Sullivan, *An E.R. That Treats You Like a V.I.P.*, N.Y. TIMES (Apr. 20, 2018), https://www.nytimes.com/2018/04/20/your-money/concierge-emergency-room.html [https://perma.cc/RXM9-7YN3]. Concierge practices charge retainer agreements of about $1,200 to $1,500 a year, but this fee does not include the additional insurance for drugs, treatment costs, and hospitalization costs, which can be a few hundred dollars more a month. *See* Joel Keehn, *Is "Concierge Medicine" Worth the Extra Cost?*, CONSUMER REPS. (Sept. 27, 2015), https://www.consumerreports.org/cro/health/concierge-medicine [https://perma.cc/6CEG-7XNK].

61 Hallie Levine, *What to Know About Concierge Medicine*, AARP (Apr. 25, 2019), https://www.aarp.org/health/conditions-treatments/info-2019/what-to-know-about-concierge-medicine.html [https://perma.cc/NR2N-TG4Q]; *What Is Concierge Medicine?*, CONCIERGE MED. TODAY (Jan. 30, 2021), https://conciergemedicinetoday.org/2021/01/30/education-what-is-concierge-medicine-what-is-direct-primary-care [https://perma.cc/6FGT-GA65].

62 Reuven Blau, *Kings County Hospital in Brooklyn Has the Longest Emergency Room Wait of City Hospitals*, N.Y. DAILY NEWS (Dec. 2, 2018, 12:55 PM), https://www.nydailynews.com/new-york/ny-metro-emergency-room-20181129-story.html [https://perma.cc/A3Z3-CRUR].

63 Hilary Brueck, *I Visited a "Private ER" Where People Pay up to $5,000 a Year to Skip the Hospital — Take a Look*, BUS. INSIDER (Dec. 19, 2019, 2:30 PM), https://www.businessinsider.com/concierge-medicine-what-is-a-private-emergency-room-photos-2019-12 [https://perma.cc/YC8N-99SQ]; *Membership*, SOLLIS HEALTH, https://sollishealth.com/membership [https://perma.cc/Z5XB-7E5Z].

64 Cedric Dark et al., *Freestanding Emergency Departments Preferentially Locate in Areas with Higher Household Income*, 36 HEALTH AFFS. 1712, 1715 (2017); Jeremiah D. Schuur et al., *Where*

1970s as a way to solve the problem of access to emergency care in rural areas,[65] most FSEDs offer shorter wait times and minimal security in exchange for a service fee.[66] Urgent care centers have also increased in cities throughout the country.[67] EMTALA does not necessarily apply to these entities, thus exempting some from having to accept nonpaying or low-income patients.[68]

B. Police in the ER

Police perform a wide range of tasks in the emergency room. They provide security, they accompany injured people, they bring inmates and prisoners into the hospital for medical treatment, and they come into the emergency department to investigate crimes.

One extreme example of hospital and police collaboration to detect drug use among pregnant (and mainly Black) women was the center of the dispute in *Ferguson v. City of Charleston*.[69] In that case, screening practices by public hospitals serving poor, minority communities were one of the main sources of information on Black women's prenatal drug use for law enforcement agencies in South Carolina.[70] The program in Charleston was one of many in hospitals throughout the country that particularly criminalized pregnant women of color.[71]

Do Freestanding Emergency Departments Choose to Locate? A National Inventory and Geographic Analysis in Three States, 69 ANNALS EMERGENCY MED. 383, 386 (2017); David Olinger, *Free-Standing ERs Abound in Affluent Colorado Neighborhoods*, DENV. POST (Apr. 21, 2016, 9:04 PM), https://www.denverpost.com/2015/09/24/free-standing-ers-abound-in-affluent-colorado-neighborhoods [https://perma.cc/TB7V-Y5AZ].

[65] Catherine Gutierrez et al., *State Regulation of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, and Services Provided*, 35 HEALTH AFFS. 1857, 1857 (2016).

[66] Vivian Ho et al., *Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers*, 70 ANNALS EMERGENCY MED. 846, 846 (2017); N.Y. STATE DEP'T OF HEALTH, FREE STANDING EMERGENCY DEPARTMENTS 3 (2013). From 1978 to 2008, the number of FSEDs grew from 55 to 222. MIKE WILLIAMS & MICHAEL PFEFFER, CAL. HEALTH FOUND., FREESTANDING EMERGENCY DEPARTMENTS: DO THEY HAVE A ROLE IN CALIFORNIA? 2 (2009). By the end of 2015, 400 freestanding EDs had opened in 45 states. *See* N.Y. STATE DEP'T OF HEALTH, *supra*, at 5.

[67] Joanne Finnegan, *Now More than 9,000 Urgent Care Centers in the U.S., Industry Report Says*, FIERCE HEALTHCARE (Feb. 26, 2020, 9:45 AM), https://www.fiercehealthcare.com/practices/now-more-than-9-000-urgent-care-centers-u-s-industry-report-says [https://perma.cc/7PNY-FRWF].

[68] *But see* Friedrich v. South Cnty. Hosp. Healthcare Sys., 221 F. Supp. 3d 240, 242–44 (D.R.I. 2016) (finding that hospital-owned urgent care clinic fell under the definition of entities covered under EMTALA because it appeared to be an "appropriate place to go for emergency care," *id.* at 244).

[69] 532 U.S. 67 (2001); *see also* ROBERTS, *supra* note 19, at 166.

[70] *See* ROBERTS, *supra* note 19, at 164–65.

[71] *See id.* at 166. Professor Dorothy Roberts's early work described hospital programs in the 1980s where medical professionals collaborated with law enforcement to penalize Black women for their use of drugs during pregnancy. *See, e.g.*, Roberts, *Punishing Drug Addicts*, *supra* note 23, at 1421.

But *Ferguson* is not the only kind of police surveillance and investigation that occurs in emergency rooms. ERs are places where poor people are subject to police view and investigation. Patients' belongings and bodies can be searched for tangible evidence by police and medical professionals. Patients seeking medical treatment can be questioned by police. Criminal cases are made and convictions are obtained by investigations conducted in the emergency room.

Police enter into the emergency room in many ways — as security, emergency responders, and investigators. As part of their security function, police conduct arrests, run surveillance, patrol and winnow down the waiting room by pressuring patients to leave, and check visitors and patients for outstanding warrants.[72] Police who accompany injured patients as part of emergency response may stay. They may be asked to provide information about patients if the patient is not able to.[73] They document the extent of injuries by taking photographs or through body camera footage.[74] Police will ask medical professionals for the condition and treatment course of patients and ask for results of diagnostic testing.[75] If crime is suspected, police collect evidence from patient belongings[76] and obtain statements from patients.[77] They can access treatment and diagnostic areas, and may even follow the patient to the operation room.[78]

Police often remain with the injured patient if they are under arrest.[79] Cities and local governments have tasked police with responding to mental health crises.[80] In some jurisdictions, psychiatric patients are held in emergency rooms and watched over by police officers.[81]

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[72] *See, e.g.*, Davis v. Purcell, 2-cv-02112, 2014 WL 988596, at *5 (N.D. Ala. Mar. 13, 2014).

[73] Katherine C. Ott et al., *To Protect and Serve: The Ethical Dilemma of Allowing Police Access to Trauma Patients*, 102 BULL. AM. COLL. SURGEONS 42, 43 (2017).

[74] Eileen F. Baker et al., *Law Enforcement and Emergency Medicine: An Ethical Analysis*, 68 ANNALS EMERGENCY MED. 599, 599 (2016). Body camera footage taken without the consent of all involved parties is discouraged by the American College of Emergency Physicians. *See* AM. COLL. OF EMERGENCY PHYSICIANS, LAW ENFORCEMENT INFORMATION GATHERING IN THE EMERGENCY DEPARTMENT (2017), https://www.acep.org/patient-care/policy-statements/law-enforcement-information-gathering-in-the-emergency-department [https://perma.cc/42K5-A3BN].

[75] Baker et al., *supra* note 74, at 604.

[76] *E.g.*, DENVER POLICE DEP'T, OPERATIONS MANUAL § 106.02(1)(d)(3) (2019).

[77] *See, e.g.*, Chavez v. Martinez, 538 U.S. 760, 764 (2003); State v. Foster, No. 1 CA-CR 16-0338, 2017 WL 2189495, at *1 (Ariz. Ct. App. May 18, 2017); People v. Cage, 155 P.3d 205, 208 (Cal. 2007); *see also* Sara F. Jacoby et al., *A Safe Haven for the Injured? Urban Trauma Care at the Intersection of Healthcare, Law Enforcement, and Race*, 199 SOC. SCI. & MED. 115, 116 (2018); Jane Liebschutz et al., *A Chasm Between Injury and Care: Experiences of Black Male Victims of Violence*, 69 J. TRAUMA INJ. INFECTION & CRITICAL CARE 1372, 1375 (2010).

[78] *See* Jacoby et al., *supra* note 77, at 119–20.

[79] *See, e.g.*, DENVER POLICE DEP'T, *supra* note 76, § 113.01(6)(b).

[80] *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.41 (McKinney 2021).

[81] Amy Kolb Noyes & Peter Hirschfeld, *Vermont Wants to Stop Paying Sheriffs to Watch Mental Health Patients in ERs*, VPR NEWS (Feb. 6, 2019), https://www.vpr.org/post/vermont-wants-stop-

Mentally ill people who refuse to leave the premises may also be escorted off the premises by police.[82]

Police also enter the hospital specifically to investigate suspects of crimes. The ER is a window into this country's most pressing public safety challenges. Millions end up in ERs after car crashes,[83] with drunk driving a major contributing cause.[84] Victims of gun violence end up in the ER.[85] In 2009, out of 4.6 million drug-related visits to EDs in the United States, 21% involved illicit drugs.[86]

Police may be called in to investigate by hospitals themselves[87] for certain types of injuries[88] or in response to police request.[89] Or they may be alerted because of 9-1-1 dispatch, crisis response lines, or through other informal channels, such as hospital security.[90] Police investigations in the emergency department can range from seizing evidence,[91] conducting identification procedures to identify a culprit,[92] and interrogating suspects, to retrieving evidentiary matter from suspect bodies. Where police suspect intoxication, they may transport suspects to hospitals to undergo further testing, such as catheterizations[93] or

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paying-sheriffs-watch-mental-health-patients-ers [https://perma.cc/VHA2-PAU2]; *cf.* Dominic Fracassa, *S.F. Cops Spending Thousands of Hours on Hospital Watch Instead of out on Streets*, S.F. CHRON. (Jan. 27, 2020 3:44 PM), https://www.sfchronicle.com/bayarea/article/S-F-cops-spending-thousands-of-hours-on-hospital-14996722.php [https://perma.cc/8F8C-K7DN].

82 DISABILITY RTS. OR., THE "UNWANTEDS": LOOKING FOR HELP, LANDING IN JAIL 12 (2019).

83 *Motor Vehicle Crash Injuries: Costly but Preventable*, CTRS. FOR DISEASE CONTROL & PREVENTION: VITAL SIGNS (Oct. 2014), https://www.cdc.gov/vitalsigns/crash-injuries/index.html [https://perma.cc/39FY-8BU5].

84 Aaron M. White et al., *Trends in Alcohol-Related Emergency Department Visits in the United States: Results from the Nationwide Emergency Department Sample, 2006 to 2014*, 42 ALCOHOLISM CLINICAL & EXPERIMENTAL RSCH. 352, 355 (2018).

85 Valerie Beaman et al., *Lethality of Firearm-Related Injuries in the United States Population*, 35 ANNALS EMERGENCY MED. 258, 258 (2000). A recent study found that an average of about 8,300 children and teenagers are treated for gunshot wounds in emergency departments each year. *See* Faiz Gani & Joseph K. Canner, Letter, *Trends in the Incidence of and Charges Associated with Firearm-Related Injuries Among Pediatric Patients, 2006–2014*, 172 JAMA PEDIATRICS 1195, 1195 (2018).

86 NAT'L INST. ON DRUG ABUSE ET AL., DRUG-RELATED HOSPITAL EMERGENCY ROOM VISITS (2011), https://www.drugabuse.gov/sites/default/files/hospitalvisits.pdf [https://perma.cc/4W5Q-6SE5].

87 *See* VICTIM RTS. L. CTR., MANDATORY REPORTING OF NON-ACCIDENTAL INJURIES: A STATE-BY-STATE GUIDE, at Index (2014). Only Alabama, New Mexico, and Wyoming have no mandatory reporting duty statutes. *Id.*

88 United States v. Davis, 657 F. Supp. 2d 630, 634 (D. Md. 2009) (gunshot wound); Myers v. Med. Ctr. of Del., Inc., 86 F. Supp. 2d 389, 412 (D. Del. 2000) (child abuse); Holt v. United States, 675 A.2d 474, 477 (D.C. 1996) (gunshot wound).

89 United States v. Nanos, No. 06-52-P-H, 2006 WL 3469633, at *1 (D. Me. Nov. 3, 2006).

90 *E.g.*, State v. Miller, 141 N.E.3d 604, 608 (Ohio Ct. App. 2019).

91 People v. Sanders, 47 N.E.3d 770, 770–71 (N.Y. 2016).

92 CITY OF BUFFALO POLICE DEP'T, MANUAL OF PROCEDURES, ch. 3, § 5.3 (2018).

93 Lockard v. City of Lawrenceburg, 815 F. Supp. 2d 1034, 1038 (S.D. Ind. 2011); Elliott v. Sheriff of Rush County, 686 F. Supp. 2d 840, 851 (S.D. Ind. 2010); Sparks v. Stutler, 71 F.3d 259,

blood draws.[94] Patients can be subjected to even more intrusive police-initiated cavity searches for drugs, with the help of medical professional assistance, with or without a court order.[95] Law enforcement agencies in charge of jails and prisons also bring inmates to emergency rooms and hospitals for their medical care.[96]

Victims of crime may also encounter police when they come in for treatment. Throughout the country, hospitals and law enforcement partner in sexual assault cases. Specialized police protocols have been adopted in many jurisdictions, including the creation of forensic evidence collection protocols.[97] These Sexual Assault Response Team[98] (SART) or Sexual Assault Nurse Examiner[99] (SANE) programs are often located in emergency departments.[100] Police are an important

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260 (7th Cir. 1995); *see also* Ken Armstrong, *When the Cops Take Your Urine by Force*, MARSHALL PROJECT (Oct. 3, 2016, 10:00 PM), https://www.themarshallproject.org/2016/10/03/when-the-cops-take-your-urine-by-force [https://perma.cc/JL8C-FL9V].

94 *See, e.g.*, Schmerber v. California, 384 U.S. 757, 758 (1966).

95 Rodriquez v. Furtado, 771 F. Supp. 1245, 1249 (D. Mass.), *aff'd sub nom.* Rodriques v. Furtado, 950 F.2d 805 (1st Cir. 1991); *see* United States v. Shepherd, No. 13-25, 2014 WL 4594565, at *1 (E.D. Ky. Sept. 15, 2014), *aff'd*, 646 F. App'x 385 (6th Cir. 2016); Young v. Gila Reg'l Med. Ctr., No. A-1-CA36474, 2020 WL 3006699, at *2 (N.M. Ct. App. June 4, 2020); *see also* United States v. Chukwubike, 956 F.2d 209, 211 (9th Cir. 1992) (per curiam); Eckert v. City of Deming, No. CIV 13-0727, 2015 WL 10383783, at *1 (D.N.M. Oct. 31, 2015); Nicholas Kristof, Opinion, *3 Enemas Later, Still No Drugs*, N.Y. TIMES (Jan. 25, 2014), https://www.nytimes.com/2014/01/26/opinion/sunday/kristof-3-enemas-later-still-no-drugs.html [https://perma.cc/7FNS-AZUZ].

These types of searches have been controversial when patients do not consent. For instance, a nurse in Salt Lake City refused law enforcement's request for a blood draw because the patient was not under arrest, the officer did not have a warrant, and the patient could not give consent because he was unconscious. *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, 6:32 PM), https://www.sltrib.com/news/2018/11/06/former-detective-jeff [https://perma.cc/K9FJ-FZ3Y]. Stories of doctors and nurses being arrested are not common. But anecdotal evidence suggests that they nevertheless occur or are potential occurrences. In one article, a doctor recounted being threatened with arrest by a police officer for refusing to draw blood when no medical necessity seemed 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, 3:16 PM), https://slate.com/technology/2006/09/doctors-shouldn-t-draw-blood-on-behalf-of-cops.html [https://perma.cc/7L4N-UR7F].

96 *See, e.g.*, *Stutler*, 71 F.3d at 260.

97 There have been calls for even further protocols and policies to be put in place in emergency departments to help collect forensic evidence. *See* Jayne J. Batts & Robert M. Sanger, *Collecting Forensic Evidence in the Emergency Department: A Guide for Lawyers, Investigators, and Experts*, 42 AM. J. TRIAL ADVOC. 331, 332 (2019).

98 *See generally SART Toolkit Section 2.1: Learn About SARTs*, NAT'L SEXUAL VIOLENCE RES. CTR., https://www.nsvrc.org/sarts/toolkit/2-1 [https://perma.cc/Z8WT-HTEN].

99 *See generally SANE Program Development and Operational Guide: What Is a SANE?*, OFF. FOR VICTIMS OF CRIMES, https://www.ovcttac.gov/saneguide/introduction/what-is-a-sane [https://perma.cc/ZNW9-TGR7].

100 *See, e.g.*, *Emergency Medicine,* NYC HEALTH & HOSPS.: N. CENT. BRONX, https://www.nychealthandhospitals.org/northcentralbronx/our-services/emergency-medicine [https://perma.cc/2JUT-W53L]; *Emergency Medicine*, SANTA CLARA VALLEY MED. CTR., https://www.scvmc.org/health-care-services/Emergency-Medicine/Pages/Resources.aspx [https://

component of SARTs and SANE teams, working alongside counselors and nurses within the ER who are trained in forensic evidence collection.[101]

II. PROBLEMS OF POLICING IN THE ER

Police investigative methods and conduct in and out of the ER are regulated primarily by constitutional criminal procedure.[102] An analysis of the doctrine reveals an impoverished view of privacy in the ER, and a heavy emphasis on public safety and the ability of police to investigate. The resulting Fourth and Fifth Amendment jurisprudence weighs, in balance, against the individual patient and sanctions a broad range of police searches, seizures, and interrogations in the ER.

As an initial matter, courts do not recognize the emergency room as a place with a reasonable expectation of privacy, rendering policing in the ER no different from street policing. Police are able to engage in intrusive searches, seizures, and interrogations, the consequences of which fall most heavily on the populations that rely on emergency rooms for their medical care.

This Part presents three critiques of the courts' evaluation of police behavior in the emergency room and encouragement of police misuse of ERs. First, the doctrine takes advantage of the medical vulnerability of emergency room patients. Second, the courts enable police officers to exploit the assistance of nurses and physicians for adversarial purposes without fully acknowledging their professional obligations and ethical mandates. Third, the treatment of the ER as an extension of the street raises concerns that police will engage in race-based policing methods such as heightened surveillance and pretextual investigations.

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perma.cc/VH2L-HNYF]; *see also* MARY B. MALEFYT ET AL., PROMISING PRACTICES: IMPROVING THE CRIMINAL JUSTICE SYSTEM'S RESPONSE TO VIOLENCE AGAINST WOMEN 79 (Joan A. Kuriansky ed., 1998).

101 MEGAN R. GREESON, SEXUAL ASSAULT RESPONSE TEAM (SART) FUNCTIONING AND EFFECTIVENESS 6 (2015), https://www.nsvrc.org/sites/default/files/2015-05/publication_researchbrief_sexual-assault-response-team-functioning-effectiveness.pdf [https://perma.cc/NC97-BFN7].

102 *See* 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."). This Part focuses solely on Fourth and Fifth Amendment questions about searches, seizures, and interrogations. Police investigations in the ER prompt other constitutional issues such as Sixth Amendment Confrontation Clause claims, use of force claims under the Fourth Amendment, and adequacy of medical care of prisoners under the Eighth Amendment. Investigations of non–U.S. citizen patients raise issues under the Due Process Clause of the Fifth Amendment. Those issues are not discussed in this Article. With the exception of notes 197 and 201, this Part also does not discuss special needs doctrine in hospitals.

A. Discounting Medical Vulnerability

Few things make a person feel more vulnerable than physical or mental ailment and injury. That sense of vulnerability only increases when, as patients, we experience poking and prodding by strangers into our most intimate areas. The concept of "medical vulnerability" more broadly includes the physical, emotional, and cognitive vulnerability patients often experience.[103]

The patients in the emergency room are in various states of medical vulnerability. Yet, elements of criminal procedure doctrine allow police to take advantage of medically vulnerable patients. First, the acontextualized approach of the "reasonable expectation of privacy" standard pays scant attention to the medical context of the emergency room and considerations of medical vulnerability. Second, the broad access given to police and the doctrine's emphasis on police's ability to conduct general investigations contribute to patients' diminished Fifth Amendment protections against police questioning.

1. An Acontextualized Approach to Privacy. — The reasonable expectation of privacy test acts as a gatekeeping function for the Fourth Amendment.[104] This doctrinal test precedes the court's assessment of the constitutionality of a contested search or seizure. The test, derived from Justice Harlan's concurrence in *Katz v. United States*,[105] has two requirements.[106] An individual must exhibit an actual or subjective expectation of privacy in the place where the search or seizure occurred, and the expectation of privacy must also be one that society recognizes as reasonable.[107] Only when both conditions are satisfied will courts

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[103] There are specific concepts of vulnerability within the medical field. *See, e.g.*, Joachim Boldt, *The Concept of Vulnerability in Medical Ethics and Philosophy*, 14 PHIL. ETHICS HUMANS. MED., Apr. 2019, at 1, 1; Beth Clark & Nina Preto, *Exploring the Concept of Vulnerability in Health Care*, 190 CMAJ E308, E308 (2018). Here, however, I use the term medical vulnerability in the colloquial, commonly understood manner. *Merriam-Webster's Dictionary* defines "vulnerable" as "capable of being physically or emotionally wounded," or being "open to attack or damage." *Vulnerable*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/vulnerable [https://perma.cc/9R6R-CFFB].

[104] Robert S. Litt, *The Fourth Amendment in the Information Age*, 126 YALE L.J.F. 8, 9, 13 (2016).

[105] 389 U.S. 347 (1967).

[106] *Id.* at 361 (Harlan, J., concurring).

[107] *Id.* The objective prong of the test is typically the determinative factor; when a defendant is found to have a reasonable expectation of privacy that society recognizes, the court will likely find that the defendant had a subjective expectation of privacy as well. A study of 540 Fourth Amendment cases decided in 2012 found that only 12% applied the subjective prong; the subjective prong did not control the outcome of any of those cases. *See* Orin S. Kerr, Katz *Has Only One Step: The Irrelevance of Subjective Expectations*, 82 U. CHI. L. REV. 113, 114 (2015).

examine whether a warrantless search or seizure is justified by a specified exception, and regardless of warrant, whether the intrusion is reasonable.[108]

Courts generally view the ER as a place with no expectation of privacy, shielding certain searches and seizures from further scrutiny. Courts treat emergency rooms as other "business and commercial premises" where a variety of police investigative procedures can be deployed without constituting a Fourth Amendment search.[109] The doctrine also does not make significant distinctions between the spaces within the ER. Courts have failed to address potential Fourth Amendment violations in cases involving searches in ER entrances and waiting areas,[110] and in ER treatment areas, including hallways,[111] curtained-off areas,[112] more private rooms,[113] and diagnostic and treatment areas.[114]

Courts have justified the lack of reasonable expectation of privacy in two primary ways. First, courts rely upon the porous nature of the emergency room and the "public" view of patients to medical personnel and other people within the ER.[115] Second, they point to the patient's

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[108] *See, e.g.*, Kentucky v. King, 563 U.S. 452, 459 (2011); California v. Acevedo, 500 U.S. 565, 580 (1991); New Jersey v. T.L.O., 469 U.S. 325, 341 (1985) ("Determining the reasonableness of any search involves a twofold inquiry: first, one must consider 'whether the . . . action was justified at its inception . . .'; second, one must determine whether the search as actually conducted 'was reasonably related in scope to the circumstances which justified the interference in the first place[.]'" (omission in original) (citations omitted) (quoting Terry v. Ohio, 392 U.S. 1, 20 (1968))); Chimel v. California, 395 U.S. 752, 768 (1969).

[109] 1 WAYNE R. LAFAVE, SEARCH AND SEIZURE: A TREATISE ON THE FOURTH AMENDMENT § 2.4(b) (6th ed. 2020), Westlaw SEARCHSZR (discussing business and commercial premises); *see id.* at 856–57 n.68; People v. Torres, 494 N.E.2d. 752, 755 (Ill. Ct. App. 1986).

[110] Davis v. Purcell, No. 12-cv-02112, 2014 WL 988596, at *4 (N.D. Ala. Mar. 13, 2014). Though the legality of the search was not raised by the litigants, the facts of the case show that the search took place in the waiting area of the emergency room. The court's opinion passes over these facts without any opprobrium, seemingly having no problem with the search. Mr. Davis went to the ER to visit a friend who had gotten into an accident. *Id.* His pocket knife set off the metal detector, and as he was walking back he "experienced a grand mal seizure." *Id.* Officers alleged that Mr. Davis was acting in a "threatening manner." *Id.* They took him to the ground and arrested him for disorderly conduct. *Id.* at *4–5. The charge was later dropped. *Id.* at *5. For procedural reasons, the court was conducting a de novo review of the record relating to particular objections Mr. Davis had made, and the court assumed some facts favorable to Mr. Davis, namely "that Mr. Davis did suffer from a seizure; he did not attempt to run through the metal detector without being screened; he did not refuse a request to go through the metal detector; and he did not raise his hand in a threatening manner toward any officer." *Id.* at *2.

[111] State v. Porter, No. 0010010287, 2001 Del. Super. LEXIS 214, at *3 (June 20, 2001); State v. Bailey, No. A-2311-14T1, 2016 WL 3369474, at *3 (N.J. Super. Ct. Law Div. June 20, 2016).

[112] State v. Cromb, 185 P.3d 1120, 1126 (Or. Ct. App. 2008).

[113] Matthews v. Commonwealth, 517 S.E.2d 263, 264 (Va. Ct. App. 1999); State v. Rheaume, 889 A.2d 711, 714 (Vt. 2005). *But see* People v. Gill, 103 N.E.3d 459, 480 (Ill. App. Ct. 2018) (finding a privacy expectation in a private ER room, but not in the emergency room in general).

[114] Green v. State, 274 N.E.2d 267, 272 (Ind. 1971); State v. Thompson, 585 N.W.2d 905, 911 (Wis. Ct. App. 1998).

[115] *See, e.g.*, *Rheaume*, 889 A.2d at 714.

lack of autonomy and ability to exercise control over their space while emphasizing the hospital staff's authority to control access.[116] Each of these doctrinal rationales demonstrates the incongruity of applying the reasonable expectation of privacy standard to a medically vulnerable patient in the ER.

Beyond the waiting room, courts describe how the emergency room is freely accessed by medical personnel, hospital staff, patients, families, and emergency workers.[117] Courts have particularly highlighted the ability of police officers to move in and out of the emergency room freely. Their roles as emergency personnel and investigators accord them broad access to emergency rooms.[118] Medical professionals' permission (explicit and implicit) grants police access to emergency rooms as well.[119] Furthermore, police access to the ER is often deemed necessary by the courts so they can find out the medical status of a person, investigate patients for possible criminal activity, search for identification, and determine whether a patient is a victim of a crime.[120] Several other courts have pointed to mandatory reporting statutes of injuries resulting from crime and that "[o]ne obvious consequence of requiring such reports is that police officers will begin their investigations at the medical facility."[121]

The courts' view of ERs as public and open has significant implications for the legality of searching the belongings of patients who are not in police custody.[122] Because conversations and belongings are "subject

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[116] *Id.*; United States v. Franklin, 64 F. Supp. 2d 435, 439 (E.D. Pa. 1999); State v. Lomax, 852 N.W.2d 502, 506 (Iowa Ct. App. 2014).

[117] *Rheaume*, 889 A.2d at 714 (noting that the ER is "by its very nature . . . a freely accessible area over which a patient has no control and where his privacy is diminished" (quoting State v. Stott, 794 A.2d 120, 127 (N.J. 2002))).

[118] *Id.*; *see also* United States v. Howard, No. 10-CR-121, 2011 WL 1459375, at *9 (N.D. Ga. Apr. 15, 2011); Dombrovski v. State, Nos. A-7238, A-4253, 2000 WL 1058953, at *3 (Alaska Ct. App. Aug. 2, 2000); Buchanan v. State, 432 So. 2d 147, 148 (Fla. Dist. Ct. App. 1983); Wagner v. Hedrick, 383 S.E.2d 286, 292 (W. Va. 1989).

[119] *Rheaume*, 889 A.2d at 712 (citing hospital policy listing police as "authorized personnel"). Other courts have pointed to acquiescence or the failure to deny entry as permission by the hospital to enter. *See Lomax*, 852 N.W.2d at 506; State v. Cromb, 185 P.3d 1120, 1126 (Or. Ct. App. 2008); *see also* People v. Torres, 494 N.E.2d 752, 755 (Ill. App. Ct. 1986).

[120] *Wagner*, 383 S.E.2d at 292; State v. Bailey, No. A-2311-14T1, 2016 WL 3369474, at *3 (N.J. Super. Ct. App. Div. June 20, 2016); United States v. Pugh, No. CR417-051, 2017 WL 6270151, at *2 (S.D. Ga. Oct. 19, 2017) (finding it undisputed that officer was lawfully present in ER responding to defendant, "a potential suspect or victim, with a gunshot wound to the chest"), *report and recommendation adopted*, No. CR417-051, 2017 WL 6210510 (S.D. Ga. Dec. 8, 2017). *But see* People v. Tyler, 569 N.E.2d 240, 244 (Ill. App. Ct. 1991) (finding that officer's justification for looking into wallet for identification an hour into treatment did not justify search).

[121] *Torres*, 494 N.E.2d at 755; *see* Blakney v. Winters, No. 04-CV-07912, 2008 WL 4874852, at *7 (N.D. Ill. Aug. 15, 2008) (citing *Torres*, 494 N.E.2d 752); State v. Turner, 416 P.2d 409, 411 (Ariz. 1966).

[122] *Cromb*, 185 P.3d at 1122; *see also Dombrovski*, 2000 WL 1058953, at *3 (describing the "public nature of the emergency room"); State v. Peltz, 391 P.3d 1215, 1221, 1223 (Ariz. Ct. App. 2017)

to the eyes and ears of passersby,"[123] the Fourth Amendment protection against unreasonable searches does not apply to objects that are in the plain view of lawfully present police.[124] The "plain view" doctrine commonly arises in the emergency room with clothing discarded by hospital personnel during treatment or illicit substances that fall out of clothing or from patients while they are being treated.[125] If an item is within "plain view," its incriminatory character is "immediately apparent," and the officer has a "lawful right of access to the object," then the police have every right to take that item for later use as evidence without implicating the Fourth Amendment.[126] Courts have not required patient consent, interpreting the clothing as being abandoned and as evidence of possible criminal conduct.[127] Some courts have viewed clothing that patients wore when entering the ER as in an officer's "plain view."[128]

(describing officer overhearing conversation when standing by a nurse's station in a "public" passing area while awaiting blood sample and completing paperwork, *id.* at 1221, and noting defendant was in an "open hospital room" and officer was in a "public area," *id.* at 1223).

123 *Rheaume*, 889 A.2d at 714 (quoting State v. Brooks, 601 A.2d 963, 964 (Vt. 1991)).

124 As the Supreme Court has stated, it is "long . . . settled that objects falling in the plain view of an officer who has a right to be in the position to have that view are subject to seizure and may be introduced in evidence." Harris v. United States, 390 U.S. 234, 236 (1968) (per curiam) (citing Ker v. California, 374 U.S. 23, 42–43 (1963); United States v. Lee, 274 U.S. 559 (1927); Hester v. United States, 265 U.S. 57 (1924)).

125 United States v. McCloud, No. 06-CR-6233L, 2007 WL 3354189, at *2 (W.D.N.Y. Aug. 16, 2007) (officer observed crack cocaine on floor of hospital); United States v. Franklin, 64 F. Supp. 2d 435, 439 (E.D. Pa. 1999) (officer retrieved patient's bloody clothing that would have otherwise been discarded by medical staff); People v. Tracy, 749 N.Y.S.2d 610, 611 (App. Div. 2002) (officer retrieved drugs that had fallen from patient's body); *Bailey*, 2016 WL 3369474, at *1 (officer retrieved drugs that fell from pants when they were being cut away from patient). *But see Tyler*, 569 N.E.2d at 244 (rejecting argument that clothing in basket was in plain view of officer and holding no showing had been made that it was common practice for police to conduct inventory search of clothing removed pursuant to hospital policy).

126 Horton v. California, 496 U.S. 128, 136–37 (1990); *McCloud*, 2007 WL 3354189, at *11; *see also Harris*, 390 U.S. at 236 (citing *Ker*, 374 U.S. at 42–43; *Lee*, 274 U.S. 559; *Hester*, 265 U.S. 57); LAFAVE, *supra* note 109, § 2.4(b). Other commercial premises similarly situated include a "bus terminal, auto repair shop, salvage yard, demolition site, used car lot, parking lot, dock, real estate office, construction company office, courier company office, motel, hospital, pool hall, bar, restaurant, furniture store, bookstore, or variety store." *Id.* at 856–57 (footnotes omitted).

127 United States v. Mattox, No. 18-cr-263, 2019 WL 2343697, at *1, *7 (D. Minn. Apr. 3, 2019) (citing the incriminating nature of bloody clothing even if not incriminating the defendant himself), *report and recommendation adopted*, No. 18-263, 2019 WL 2341578 (D. Minn. June 3, 2019); United States v. Pugh, No. CR417-051, 2017 WL 6270151, at *2 (S.D. Ga. Oct. 19, 2017), *report and recommendation adopted*, 2017 WL 6210510 (S.D. Ga. Dec. 8, 2017); United States v. Howard, No. 10-CR-121, 2011 WL 1459375, at *9 (N.D. Ga. Apr. 15, 2011); *Franklin*, 64 F. Supp. 2d at 438–39; Purifoy v. State, 225 So. 3d 867, 871–72 (Fla. Dist. Ct. App. 2017); State v. Smith, 559 P.2d 970, 976 (Wash. 1977); State v. Thompson, 585 N.W.2d 905, 907 (Wis. Ct. App. 1998).

128 Holt v. United States, 675 A.2d 474, 480–81 (D.C. 1996). This rationale has been dismissed by one federal circuit court, noting that the clothing must be in plain view at the time of seizure. United States v. Neely, 345 F.3d 366, 371 (5th Cir. 2003).

In rare instances, courts have also invoked the inventory search exception to the warrant clause to justify the seizure of patient clothing and belongings by police who accompany patients to the ER.[129]

Medical personnel's free access to patients in the emergency room is doctrinally viewed as tantamount to access by a much broader audience, and in particular police.[130] This is not surprising as the courts have often interpreted "public" quite literally. To the courts, "public" essentially means any area that can be viewed by other people. Seclusion or retreat from public view matters.[131] Even when property is marked as private, if that property can theoretically be viewed by a person in an airplane, it is a place with no expectation of privacy.[132] The courts take the same literal view of "public" in the ER.

It is true that patients in the waiting room or trauma bay are visible to people; they might not be secluded in private rooms. But what courts fail to acknowledge or recognize is that there is, in fact, a closed universe of people who view patients. ERs are not actually borderless and wide-open spaces. They are much more monitored and restricted. Many emergency rooms have lobbies and waiting rooms — secured by guards, monitored entryways, and sometimes metal detectors — that are separate from ER treatment areas.[133] In addition, strong medical privacy norms continue to exist in ERs to protect patients.[134]

The determination that police personnel have public and open access to the ER also disregards that police present a qualitatively different factor in the ER than do other medical personnel and lay visitors. Just

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[129] *See* State v. Lovaina-Burmudez, 303 P.3d 988, 994 (Or. Ct. App. 2013) (holding that inventory exception allowed police to secure defendant's clothing, shoes, and cash, but that subsequent processing of items as evidence constituted unlawful search and seizure); *cf.* United States v. Hawkins, No. 00-CR-53-BS, 2001 WL 103542, at *2, *10–12 (D. Me. Feb. 6, 2001) (affirming validity of inventory search of clothing given to police by paramedics pursuant to unwritten police policy).

[130] *Franklin*, 64 F. Supp. 2d at 439 ("We seriously doubt that the defendant had any reasonable expectation of privacy in the hospital emergency room which he shared with all the medical personnel.").

[131] Katz v. United States, 389 U.S. 347, 361 (1967) (Harlan, J., concurring) ("[A] man's home is, for most purposes, a place where he expects privacy . . . .").

[132] California v. Ciraolo, 476 U.S. 207, 215 (1986).

[133] *See* Debajyoti Pati et al., *Security Implications of Physical Design Attributes in the Emergency Department*, 9 HEALTH ENV'TS RSCH. & DESIGN J. 50, 54–58 (2016); Amy Eagle, *Hospital Designs to Bolster Security*, HEALTH FACILITIES MGMT. (Apr. 5, 2017), https://www.hfmmagazine.com/articles/2795-hospital-designs-to-bolster-security [https://perma.cc/JFW8-UGQX].

[134] Jon C. Olsen & Brad R. Sabin, *Emergency Department Patient Perceptions of Privacy and Confidentiality*, 25 J. EMERGENCY MED. 329, 329 (2003); *see* U. MICH. HEALTH SYS., FINAL REPORT FOR THE EMERGENCY DEPARTMENT FRONT END STUDY TO IMPROVE PATIENT PRIVACY AND PATIENT AND VISITOR FLOW 12–13 (2005) (recommending improvement to patient perception of privacy in emergency department); Joel Martin Geiderman et al., *Privacy and Confidentiality in Emergency Medicine: Obligations and Challenges*, 24 EMERGENCY MED. CLINICS N. AM. 633, 634 (2006); *infra* section III.C, pp. 2711–17.

because a patient may reasonably expect that certain medical information may be shared with a medical team does not mean that the same patient expects information to be shared more broadly.[135] It is also reasonable for a patient to think that in the emergency room, medical personnel will be in and out of his or her treatment area for a wide variety of reasons. But that expectation may not extend to people outside medical treatment teams, let alone law enforcement. Sharing physical space with another sick patient or their family members differs from sharing space with police. Justice Powell pointed out the qualitative difference between laypeople and police in his dissent in *California v. Ciraolo*.[136] In *Ciraolo*, the Court determined that an expectation of privacy could not exist in property marked as private because the property could be observed from a passenger plane.[137] Justice Powell criticized the majority's failure to consider the difference between police surveillance and the remote possibility of an airline passenger observing outdoor marijuana cultivation.[138] Other people in the ER are not as remote as airline passengers at 33,000 feet, but it is probably safe to say that, aside from medical staff, other patients and accompanying family or friends will likely not scrutinize fellow patients in the same way a police officer would.

Though an individual's subjective actions are given far less weight by courts when assessing an expectation of privacy,[139] the courts' adjudication of this prong of the test also reveals a heavy discounting of patients' vulnerability. One court held that a patient's failure to ask an officer to leave or limit contact reflected his lack of a subjective expectation of privacy.[140] Still another reasoned that clothing in a patient's room was in "plain view" because the unconscious patient had not taken action to make his belongings private.[141] Implicit in many of the decisions finding that patients abandoned their clothing is a determination that the patient did not sufficiently express their desire to keep belongings private.

A patient in the ER cannot exhibit precautionary behavior as did the defendant in *Katz*.[142] Patients face certain limitations when they are in

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[135] *Cf. The HIPAA Privacy Rule*, HHS, https://www.hhs.gov/hipaa/for-professionals/privacy/index.html [https://perma.cc/L5W9-U6UB] (mandating strict rules for disclosure of medical information).

[136] 476 U.S. 207.

[137] *Id.* at 211–12, 215.

[138] *Id.* at 224–25 (Powell, J., dissenting).

[139] *See supra* note 107.

[140] State v. Rheaume, 889 A.2d 711, 714 (Vt. 2005).

[141] State v. Thompson, 585 N.W.2d 905, 907–09 (Wis. Ct. App. 1998).

[142] *See* Aya Gruber, *Garbage Pails and Puppy Dog Tails: Is that What* Katz *Is Made Of?*, 41 U.C. DAVIS L. REV. 781, 792 (2008) ("Katz was 'entitled' to Fourth Amendment protection because, among other things, he 'shut[] the door behind him.'" (alteration in original) (quoting Katz v. United States, 389 U.S. 347, 352 (1967))).

the ER. They cannot exercise autonomy and control in the ER as they would in other circumstances. Patients cannot exert the same amount of control over their space, and they may not be aware of who can view them or who physically enters their space. Patients must relinquish control over when medical professionals see them and where they are placed. Staff choose where patients await treatment. Placements may be a curtained-off area, a gurney in a hallway, or a private room. Overcrowding, triage, and hospital policies dictate these decisions by hospital personnel. The patient in the hallway or on a gurney may be moved later to a more private area or room. ER patients may be waiting for formal admission to the hospital because of the hospital's practice of "boarding" patients in the ER.[143]

But patients' inability to control the space and access does not strip them of privacy and the ability to have a say in who visits them. Nor does the inability to control the space give hospital staff complete authorization to grant or deny access to the patient. Yet the courts interpret medical professionals as if they are like homeowners who can grant and deny access to a space without any consideration of their guests.[144]

2. Deference to General Police Investigation. — The courts' determination of the ER as an open and public space is also premised on the need for police to conduct general fact-finding investigations. This means that police can engage in preliminary investigations without triggering constitutional requirements. Mere questioning does not convert an encounter into a seizure.[145] Consensual encounters are also not seizures when the police officer has not made a show of force and the person is free to leave.[146] In street investigations, an officer can briefly detain a person to investigate for possible criminal activity as long as there is reasonable articulable suspicion.[147] In the emergency room, these issues tend to be elided because officers rarely have to display a show of force against a patient to conduct questioning. Courts tend to overlook this issue because the inability to leave a police encounter due to a medical condition is not interpreted to be the same as the inability to leave because of law enforcement force or authority.

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143 Ian Higginson, Review, *Emergency Department Crowding*, 29 EMERGENCY MED. J. 437, 441 (2012); Clayton Dalton & Daniel Tonellato, Opinion, *Emergency Rooms Shouldn't Be Parking Lots for Patients*, NPR (Nov. 30, 2019, 7:00 AM), https://www.npr.org/sections/health-shots/2019/11/30/783278033/opinion-emergency-rooms-shouldnt-be-parking-lots-for-patients [https://perma.cc/GCQ7-7G32].

144 *See* Dombrovski v. State, Nos. A-7238, A-4253, 2000 WL 1058953, at *3 (Alaska Ct. App. Aug. 2, 2000) (noting that, among other things, the patient did not "reserve[]" the treatment room and hence did not have the requisite control to be able to grant or deny access); *see also* State v. Cromb, 185 P.3d 1120, 1125 (Or. Ct. App. 2008) (noting that patients are in ERs for only "a few hours at the most" (quoting Buchanan v. State, 432 So. 2d 147, 148 (Fla. Dist. Ct. App. 1983))).

145 Florida v. Bostick, 501 U.S. 429, 434 (1991).

146 United States v. Mendenhall, 446 U.S. 544, 553–54 (1980) (opinion of Stewart, J.).

147 Terry v. Ohio, 392 U.S. 1, 30–31 (1968).

In one case, police questioned the defendant while she lay on a full spine board, immobilized.[148] Though the court recognized that she was not free to leave, it stated that "[her] confinement was unrelated to police conduct."[149] The court compared the defendant's situation to that of the defendant in *Florida v. Bostick*,[150] in which the Supreme Court decided that a passenger on a bus, stopped by law enforcement for a drug sweep in rural Florida, had not necessarily been subjected to a "coercive" seizure.[151] This decision has been heavily criticized, particularly because a Black man like Mr. Bostick would undoubtedly not have felt at liberty to ignore the officers' questions or leave the bus.[152] A patient who is in the ER for a medical emergency has far less ability to resist, defy, or express displeasure at police presence, and could very well draw a negative and perhaps even deadly response from police.[153]

The police's ability to conduct investigations in the ER includes the questioning of patients. Here again, the doctrine takes insufficient account of the unique circumstances of patients. The *Miranda* rule applies only to custodial interrogations.[154] Courts generally do not consider hospitals to be a custodial setting. The simple fact that a patient cannot leave a hospital bed or room because of a medical condition does not itself establish custody.[155] Courts have pointed to a variety of conditions that demonstrate lack of custody, including the lack of restraints or handcuffs, or an officer's testimony that he did not view the patient as

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148 State v. Pritchard, No. 69862-1-I, 2013 WL 1809921, at *1 (Wash. Ct. App. Apr. 29, 2013).

149 *Id.* at *5.

150 501 U.S. 429 (1991); *see Pritchard*, 2013 WL 1809921, at *4–5.

151 *Bostick*, 501 U.S. at 431–32, 436.

152 *See* DAVID COLE, NO EQUAL JUSTICE: RACE AND CLASS IN THE AMERICAN CRIMINAL JUSTICE SYSTEM 20 (1999); Carbado, *(E)racing the Fourth Amendment*, *supra* note 21, at 975–90 ("At no time does Justice O'Connor consider how Bostick, or a man in his racial position, might have experienced two white police officers crowded around him on a bus." *Id.* at 985.); Cynthia Lee, *(E)Racing Trayvon Martin*, 12 OHIO ST. J. CRIM. L. 91, 97–100 (2014).

153 *See* Cindy Chang, *L.A. to Pay $3.9 Million to the Parents of a Man Fatally Shot by Police at Harbor-UCLA Medical Center*, L.A. TIMES (Apr. 11, 2018, 6:45 PM), https://www.latimes.com/local/lanow/la-me-lapd-shooting-settlement-20180411-story.html [https://perma.cc/MAJ6-BYNT]; Jennifer Tsai, Opinion, *Get Armed Police Out of Emergency Rooms*, SCI. AM. (July 14, 2020), https://www.scientificamerican.com/article/get-armed-police-out-of-emergency-rooms [https://perma.cc/DZ6W-CUTK].

154 Miranda v. Arizona, 384 U.S. 436, 444 (1966). In typical Fifth Amendment analysis, a person is in custody if they are physically deprived of freedom in a significant manner or placed in a situation where they would reasonably believe that their freedom is restricted. Oregon v. Mathiason, 429 U.S. 492, 494–95 (1977) (per curiam).

155 United States v. Robertson, 19 F.3d 1318, 1320–21 (10th Cir. 1994); United States v. Martin, 781 F.2d 671, 673 (9th Cir. 1985); State v. Tucker, 557 A.2d 270, 272–73 (N.H. 1989); Commonwealth v. Ellis, 549 A.2d 1323, 1333 (Pa. Super. Ct. 1988); State v. Pritchard, No. 69862-1-I, 2013 WL 1809921, at *5 (Wash. Ct. App. Apr. 29, 2013).

a suspect.[156] On the other hand, a patient's formal arrest clearly satisfies the custody requirement.[157] Other indicia of law enforcement custody short of formal arrest include when patients are in handcuffs[158] or detained by hospital security guards,[159] or when there is overwhelming police presence.[160]

Courts often find that patients are not in "custody" for Fifth Amendment purposes because patients come to the ER voluntarily to seek treatment and their presence in the ER is due to their medical condition and not as a result of police action.[161] Although the question of whether a person feels at liberty to terminate an interrogation requires more than a reasonable belief that they have been temporarily restrained, in some of the decisions courts intersperse the Fourth Amendment seizure analysis.[162] These courts have relied upon Fourth Amendment verbiage of whether a person felt free to leave in determining that a patient is not in custody for the purposes of police questioning.[163]

Indeed, the courts' determinations that the custody prong cannot be met in the emergency room mimic much of the courts' rationales in the Fourth Amendment reasonable expectation of privacy analysis. In both circumstances, the courts stress the openness and public nature of the ER. In the Fifth Amendment context, beyond emphasizing the voluntary nature of the patient's stay, courts note the public nature of the ER and that hospitals — not patients — controlled access.[164] One court

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156 People v. Stryker, No. A118638, 2010 WL 219318, at *9 (Cal. Ct. App. Jan. 22, 2010); State v. LaCouture, 213 P.3d 799, 803–04 (N.M. Ct. App. 2009); State v. Maestas, 272 P.3d 769, 779 (Utah Ct. App. 2012).

157 United States v. Cunningham, 546 F. App'x 203, 208 (4th Cir. 2013) (per curiam); Scales v. State, 219 N.W.2d 286, 291 (Wis. 1974).

158 State v. Ybarra, 804 P.2d 1053, 1054–55 (N.M. 1990).

159 State v. Pebria, 938 P.2d 1190, 1192–93 (Haw. Ct. App. 1997).

160 State v. Philbrick, 436 A.2d 844, 851 (Me. 1981); Cummings v. State, 341 A.2d 294, 298, 301 (Md. Ct. Spec. App. 1975); State v. O'Loughlin, 637 A.2d 553, 560 (N.J. Super. Ct. App. Div. 1994). The court in *State v. Philbrick*, 436 A.2d 844, identified several factors that collectively pointed to a coercive situation that created a custody-like setting. These included the officers' focus on the patient; the presence of the police in the small confines of the ambulance and then emergency room; the physical condition of the patient himself, which included his deficient sight due to the loss of his glasses as well as his serious injuries; and the absence of family as moral support. *Id.* at 851.

161 Hammond v. State, 569 A.2d 81, 94 (Del. 1989); State v. Melton, 476 N.W.2d 842, 844–45 (Neb. 1991) (per curiam); Commonwealth v. Perry, 710 A.2d 1183, 1186 (Pa. Super. Ct. 1998); State v. Nichols, No. 2008AP940-CR, 2009 WL 818983, at *6 (Wis. Ct. App. Mar. 31, 2009) (noting that defendant "had sought treatment on his own initiative" and "[p]olice merely questioned him while he was there").

162 *See, e.g.*, Florida v. Bostick, 501 U.S. 429, 436 (1991).

163 *Id.*; *see also* United States v. Jamison, 509 F.3d 623, 628 (4th Cir. 2007).

164 *In re* I.F., 229 Cal. Rptr. 3d 462, 485 (Ct. App. 2018); State v. Clappes, 344 N.W.2d 141, 146 (Wis. 1984); *see also* State v. Kyseth, 240 N.W.2d 671, 672 (Iowa 1976) (police officer asked physician for permission to interview defendant); *Perry*, 710 A.2d at 1186 (presence of family member and medical staff indicated lack of custodial interrogation).

described the hospital environment as a "public atmosphere, in which passersby could view the interaction, [and which is] 'substantially less police dominated.'"[165] The Court in *Miranda* made clear that "[g]eneral on-the-scene questioning as to facts surrounding a crime or other general questioning of citizens in the fact-finding process is not affected by our holding."[166] Hence, general investigatory or "fact-finding"[167] inquiries in the ER — rather than inquisitorial inquiries — do not require *Miranda* warnings.[168]

The courts largely dismiss or overlook the possibility that police questioning of patients (not under formal arrest) may constitute custody because, in their view, the patient is in the ER for voluntary medical treatment and not because of any police action. Courts have stated that a reasonable person should understand that by being a victim of a crime and seeking medical attention, further investigation should be expected.[169] Though the cases rarely discuss patient consent to police investigation, the issue still lurks in the background. What may be deemed as consensual encounters on the street are in fact often coercive.[170] These issues of consent are likely to be exacerbated for a patient in the ER. Coercion has long been intricately tied to the issue of consent in Fourth Amendment doctrine.[171] But neither is addressed with any significance in the emergency room cases because patients' presence in the ER is viewed by courts as voluntary and as a result of their medical condition.

This interpretation is striking when we compare these encounters to street encounters. Part of the justification for applying an objective analysis to police detention on the street is that we do not expect police officers to know if the person they approach is the "eggshell plaintiff."

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165 People v. Stryker, No. A118638, 2010 WL 219318, at *9 (Cal. Ct. App. Jan. 22, 2010) (internal quotation marks omitted) (quoting Berkemer v. McCarty, 468 U.S. 420, 438–39 (1984)); *see also Clappes*, 344 N.W.2d at 146 ("The circumstances were public with witnesses present and no apparent police trickery or deception was used.").

166 Miranda v. Arizona, 384 U.S. 436, 477 (1966).

167 People v. Milhollin, 751 P.2d 43, 51 (Colo. 1988) (en banc); *see, e.g.*, Hammond v. State, 569 A.2d 81, 94 (Del. 1989); *Kyseth*, 240 N.W.2d at 673; Commonwealth v. Fento, 526 A.2d 784, 787–88 (Pa. Super. Ct. 1987) (finding that routine questioning of driver treated at hospital was not tantamount to custodial interrogation requiring *Miranda* warnings); Guerrero v. State, 605 S.W.2d 262, 265 (Tex. Crim. App. 1980).

168 *Hammond*, 569 A.2d at 94; State v. Sandoval, 452 P.2d 350, 354–55 (Idaho 1969); Bartram v. State, 364 A.2d 1119, 1135 (Md. Ct. Spec. App. 1976), *aff'd*, 374 A.2d 1144 (Md. 1977); Commonwealth v. Ellis, 549 A.2d 1323, 1333 (Pa. Super. Ct. 1988).

169 United States v. Jamison, 509 F.3d 623, 632 (4th Cir. 2007).

170 *See* Paul Butler, *Stop and Frisk and Torture-Lite: Police Terror of Minority Communities*, 12 OHIO ST. J. CRIM. L. 57, 63 (2014); Carbado, *(E)racing the Fourth Amendment*, *supra* note 21, at 1023; Tracey Maclin, *"Black and Blue Encounters" — Some Preliminary Thoughts About Fourth Amendment Seizures: Should Race Matter?*, 26 VAL. U. L. REV. 243, 272 (1991).

171 *See* Amos v. United States, 255 U.S. 313, 317 (1921); Zap v. United States, 328 U.S. 624, 630 (1946); Schneckloth v. Bustamonte, 412 U.S. 218, 221 (1973).

The objective lens avoids the scenario where police would have to make individual and specific assessments of the vulnerability of the person they are approaching, stopping, or questioning. But in the emergency room, the patient they approach is by definition medically vulnerable. Yet the courts overlook how this might affect the patient-police interaction.

Medical vulnerability does play an explicit role in the determination of whether statements made to police are voluntary under the Due Process Clauses of the Fifth and Fourteenth Amendments.[172] Courts must examine how a patient's medical condition might influence their ability to answer questions or make them susceptible to police questioning.[173] The Supreme Court's decision in *Mincey v. Arizona*[174] has come to stand as the benchmark for the kind of pain and suffering that would cause a suspect's will to be overborne. In *Mincey*, the defendant was taken to the emergency room after a gunshot wound that damaged his sciatic nerve and caused partial paralysis of his leg.[175] The Court pointed to the length of the interrogation of nearly four hours, the officer's continuing interrogation despite the seriousness of the defendant's condition, the difficulty defendant had in responding to questioning, and the defendant's intermittent expressions not to be interrogated as evidence of involuntariness.[176] Lower courts have applied *Mincey* when determining the voluntariness of a waiver or statement.[177]

But, even in the voluntariness analysis, courts have shifted responsibility to the medical treatment itself as the cause for the patient's isolation and lack of ability to consent when coercive police tactics are absent; here, again, courts emphasize the open access to the patient granted by hospitals.[178] Medical vulnerability also becomes a reason for why *Miranda* protections might not apply, such as when police ask patient-

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[172] U.S. CONST. amends. V, XIV; *cf.* Colorado v. Connelly, 479 U.S. 157, 164 (1986). Courts look to the totality of the circumstances to determine whether police used coercive methods to obtain a statement and if the statement is the product of the patient's will being overborne. *Schneckloth*, 412 U.S. at 225–26. Any statement that is a product of coercive police action is not voluntary. *Connelly*, 479 U.S. at 167; *Schneckloth*, 412 U.S. at 225 ("The ultimate test remains . . . [:] the test of voluntariness. Is the confession the product of an essentially free and unconstrained choice by its maker?").

[173] *See* State v. Rodriguez, 669 P.2d 601, 603 (Ariz. Ct. App. 1983).

[174] 437 U.S. 385 (1978).

[175] *Id.* at 396.

[176] *Id.* at 398–402.

[177] *See, e.g.*, State v. Maestas, 272 P.3d 769, 781–82 (Utah Ct. App. 2012). Courts appear to view *Mincey* as the measure of the threshold level of pain and suffering required to deem a statement constitutionally involuntary. *See, e.g.*, State v. Roseboro, No. CR5-81771, 1990 WL 277237, at *14 (Conn. Super. Ct. Oct. 4, 1990); State v. Ison, No. 905, 1980 WL 353212, at *4 (Ohio Ct. App. Oct. 8, 1980); *Maestas*, 272 P.3d at 782.

[178] *Maestas*, 272 P.3d at 779.

suspects if they have swallowed illicit drugs.[179] 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."[180] In these circumstances, medical vulnerability is used to justify and not limit police investigation.

The courts' failure to sufficiently account for patients' medical vulnerability amounts to *caveat emptor*, "buyer beware"; by coming into a hospital, patients assume the risk that they will be subject to police surveillance, search, and questioning. The cost of obtaining medical care is police access. This itself can have disastrous chilling effects for people voluntarily seeking medical care. But the courts' assumption-of-risk analysis has little to do with whether "public 'exposure' is voluntary, morally wrong, or inefficient."[181] Take, for example, a patient who is the victim of police brutality. The patient's own actions are not what put him in the emergency room. His presence in the ER is not voluntary aside from arguments that his actions may have provoked the officers' use of force. Yet police can accompany him, speak to the treatment team about the injuries, be present during his treatment, block access to visitors, and gather information that can result in criminal charges against the patient.[182]

The initial determination that the ER is a public space opens the door for police to take patient belongings, and observe and question

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[179] State v. Londo, 158 P.3d 201, 202–03 (Ariz. Ct. App. 2006); People v. Stevenson, 59 Cal. Rptr. 2d 878, 881 (Ct. App. 1996); State v. Betances, 828 A.2d 1248, 1255 (Conn. 2003); Benson v. State, 698 So. 2d 333, 337 (Fla. Dist. Ct. App. 1997).

[180] Chavez v. Martinez, 538 U.S. 760, 776 (2003). In *Chavez v. Martinez*, 538 U.S. 760, the Court determined that the Fifth Amendment could not apply to Mr. Martinez's case because his statements were not being used in a criminal proceeding. *Id.* at 766. Mr. Martinez was never criminally charged; he brought a civil suit against the police officers for violations of the Fourth and Fifth Amendments. *Id.* at 764–65. Mr. Martinez had been shot by police and interrogated in the ambulance and then in the emergency room over a forty-five-minute period. His injuries subsequently left him permanently blinded and paralyzed from the waist down. *Id.* at 764. The Court was highly fractured with six separate opinions and Justice Thomas writing the opinion of the Court. *Id.* at 762. In a separate opinion, Justice Kennedy also recognized that exigency could apply even when a person is injured, stating: "There is no rule against interrogating suspects who are in anguish and pain. The police may have legitimate reasons, borne of exigency, to question a person who is suffering or in distress." *Id.* at 796 (Kennedy, J., concurring in part and dissenting in part). He clarified that such instances could include questioning to locate a kidnapping victim, to find a "dangerous assailant or accomplice," or to determine "whether there is a rogue police officer at large." *Id.*

[181] Gruber, *supra* note 142, at 794.

[182] *See* Kristine Guerra, *Policies Banning Hospital Visits of Crime Suspects Outrage Families*, INDY STAR (July 15, 2014, 11:05 AM), https://www.indystar.com/story/news/crime/2014/07/14/policies-banning-hospital-visits-crime-suspects-outrage-families/12657203 [https://perma.cc/5GKU-YZAN]. For discussion of police violence and use-of-force policies from a public health perspective, see Osagie K. Obasogie & Zachary Newman, *Police Violence, Use of Force Policies, and Public Health*, 43 AM. J.L. & MED. 279, 281–84 (2017).

patients, all without implicating criminal procedural protections. The courts' impoverished view of the privacy rights of patients in the ER is yet another example of William Stuntz's statement that "[p]rivacy, in Fourth Amendment terms, is something that exists only in certain types of spaces; not surprisingly, the law protects it only where it exists."[183] In blunter terms, the "Fourth Amendment law makes wealthier suspects better off than they otherwise would be, and may make poorer suspects worse off."[184] The wealthy enjoy the privacy afforded by "freestanding home[s], fences, lawns, heavy curtains, and vision- and sound-proof doors and walls,"[185] private cars instead of public transportation,[186] and enclosed spaces rather than "assembly lines or shop floors or hotel kitchens."[187] As a result, the lives of the wealthy are more private and shielded from police view.

Unsurprisingly, privacy protections of the ER are experienced differently depending on socioeconomic status and race. Overcrowding and boarding are much more likely in hospitals suffering from heavy use and financial pressures. The pervasive police presence found in the emergency room of an area's safety-net hospital does not occur in a primary care doctor's office or in a suburban urgent care clinic. Poor people and racial minorities also have less choice about accessing emergency room care. The healthcare realities mean that the factors the courts look to in deciding a space does not merit privacy protections, while formally class- and race-neutral, are more likely to be found in the ER for the poor than the ER for the rich.

No small part of the problem lies in what constitutes privacy in the Fourth Amendment sense.[188] The courts' superficial treatment of privacy in the emergency room is somewhat understandable as it is a difficult concept to pin down.[189] Privacy in the ER includes but is not

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[183] William J. Stuntz, *The Distribution of Fourth Amendment Privacy*, 67 GEO. WASH. L. REV. 1265, 1266 (1999).

[184] *Id.*

[185] Christopher Slobogin, *The Poverty Exception to the Fourth Amendment*, 55 FLA. L. REV. 391, 401 (2003).

[186] Stuntz, *supra* note 183, at 1271.

[187] *Id.*

[188] *See* David Alan Sklansky, *Too Much Information: How Not to Think About Privacy and the Fourth Amendment*, 102 CALIF. L. REV. 1069, 1076–85 (2014) [hereinafter Sklansky, *Too Much Information*]; David A. Sklansky, *Two More Ways Not to Think About Privacy and the Fourth Amendment*, 82 U. CHI. L. REV. 223, 233–41 (2015); Daniel J. Solove, *Conceptualizing Privacy*, 90 CALIF. L. REV. 1087 (2002); William J. Stuntz, *Privacy's Problem and the Law of Criminal Procedure*, 93 MICH. L. REV. 1016, 1020–25 (1995) [hereinafter Stuntz, *Privacy's Problem*]; William J. Stuntz, *The Substantive Origins of Criminal Procedure*, 105 YALE L.J. 393 (1995).

[189] This difficulty can also be seen when applying Professor Orin Kerr's four models of Fourth Amendment protection to the emergency room. *See* Orin S. Kerr, *Four Models of Fourth Amendment Protection*, 60 STAN. L. REV. 503, 508–22 (2007).

limited to informational privacy and the importance of protecting personal data.[190] The vulnerability of patients in the ER may make it more like a "zone of personal refuge,"[191] but the ER is also not "a sphere of individual sovereignty partially shielded from public scrutiny and regulation."[192]

What the courts have opted for instead is yet another example of the kind of "painfully constrained"[193] Fourth Amendment privacy jurisprudence that ends up having a disproportionate and more harmful effect on people who are not just medically vulnerable but also economically and socially vulnerable. Professor Khiara Bridges observes that poor people's "zones of privacy" shrink in comparison to those of people with more material means.[194] Poor mothers' lives become public because they have to turn to government welfare programs, use public transportation, live in public housing, and go to public hospitals.[195] The emergency room allows the police to have broad and immediate access to the poor, and at moments of acute medical vulnerability.

B. Enlisting Medical Professional Assistance

In the ER, police have access to specialized assistants in the form of medical professionals. Police searches and questioning of patients are aided by medical professionals.[196] The added benefit of medical professionals figures prominently in the doctrine. Courts not only recognize medical professional participation but also endorse and uphold the participation as an example of good citizenship.

1. Medical Professional Participation. — Medical professionals' participation in the emergency room can be categorized as either state action subject to constitutional limitations or private third-party action that does not carry the same obligations. Status as a government professional does not automatically convert procedures conducted by a medical professional to government searches or interrogations. Non–law enforcement actors employed by the government have been consid-

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190 *Cf.* Julie E. Cohen, *Examined Lives: Informational Privacy and the Subject as Object*, 52 STAN. L. REV. 1373, 1423–28 (2000) (explaining the importance of data privacy in protecting informational autonomy); Daniel J. Solove, *Introduction: Privacy Self-Management and the Consent Dilemma*, 126 HARV. L. REV. 1880, 1892–93 (2013) (examining the social functions of individual privacy).

191 Sklansky, *Too Much Information*, *supra* note 188, at 1101.

192 *Id.* at 1119; *see also* Stuntz, *Privacy's Problem*, *supra* note 188, at 1016.

193 BRIDGES, *supra* note 19, at 89.

194 *Id.*

195 *Id.* at 86.

196 *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").

ered state actors, such as teachers who carry out disciplinary functions.[197] A government-employed physician can be a state actor liable under the Fourth Amendment. If there is sufficient evidence that the police and the medical professional were acting in concert, the search comes within Fourth Amendment protection.[198] For example, in *Ferguson v. City of Charleston*,[199] the Supreme Court ruled unconstitutional a drug-testing program for expectant mothers at the Medical University of South Carolina, a state hospital in Charleston.[200] The Supreme Court rejected the argument that the program could be justified under the special needs exception to the Fourth Amendment's probable cause requirement.[201] Instead, the Court held that the program violated the Fourth Amendment, citing the collaboration between the hospital and police in the development of the program, the threat of criminal prosecution as a sanction, and the fact that the "immediate objective" of the program was "to generate evidence for law enforcement purposes."[202]

Other actions of medical professionals and hospital staff are viewed by courts as third-party actions that do not fall under constitutional regulation. In such cases, permutations of the third-party doctrine govern, resulting in determinations that an individual does not retain privacy interests in information turned over to a third party.[203] For instance, medical professionals' searches of patient belongings are often viewed as outside constitutional purview. Fourth Amendment protections do not generally apply if medical professionals search the patient belongings pursuant to hospital policy.[204] If hospital staff find contraband and

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197 New Jersey v. T.L.O., 469 U.S. 325, 335–37 (1985). The "special needs" exception, where a search can be justified with a showing of reasonableness rather than probable cause, has applied in other administrative contexts in hospital settings. *See* O'Connor v. Ortega, 480 U.S. 709, 725 (1987) (upholding searches of hospital employees based upon special needs rationale). For more discussion on administrative searches in hospitals, see Lily Alves, *At Their Mercy: Why the Protection of Our Most Personal Privacy Interests Should Not Be Placed Solely in the Hands of Health Care Facilities*, 5 HOUS. J. HEALTH L. & POL'Y 75, 84 (2005).

198 *See* United States v. Booker, 728 F.3d 535, 540–41 (6th Cir. 2013); United States v. Attson, 900 F.2d 1427, 1433 (9th Cir. 1990).

199 532 U.S. 67 (2001).

200 *Id.* at 84–86.

201 *Id.* at 84 (emphasis omitted).

202 *Id.* at 83; *see id.* at 82–84.

203 Smith v. Maryland, 442 U.S. 735, 743–44 (1979); United States v. Miller, 425 U.S. 435, 442–44 (1976). The Supreme Court's recent decision in *Carpenter v. United States*, 138 S. Ct. 2206, 2217 (2018), breathed new life into the third-party doctrine and conceptions of the reasonable expectation of privacy in digital information. *See* Susan Freiwald & Stephen Wm. Smith, *The Supreme Court, 2017 Term — Comment: The* Carpenter *Chronicle: A Near-Perfect Surveillance*, 132 HARV. L. REV. 205, 206 (2018); Orin S. Kerr, *Implementing* Carpenter 1 (USC L. Legal Stud., Paper No. 18-29, 2018); Paul Ohm, *The Many Revolutions of* Carpenter, 32 HARV. J.L. & TECH. 357, 358 (2019).

204 United States v. Clay, No. 06-CR-83-S, 2006 WL 2385353, at *2 (E.D. Ky. Aug. 17, 2006); People v. Rodgers, 661 N.Y.S.2d 452, 453, 457 (Cnty. Ct. 1997), *aff'd as modified*, 670 N.Y.S.2d 600

turn it over to the police, the courts have treated such events as third-party searches that do not implicate patients' constitutional rights.[205] Courts have been more inclined to protect patients' possessory rights in their belongings if the hospital has a policy or practice in place to safeguard those belongings.[206] Some courts have characterized the hospital as the bailee who has a duty to safeguard clothing, prohibiting them from handing over belongings without a patient's consent or a warrant.[207]

Body cavity searches initiated by medical professionals are also viewed as distinct from searches initiated by police. Though sometimes these searches are categorized as falling under a medical emergency exception to the warrant requirement, they are often viewed as medical treatment by the medical professional, separate from the investigative purposes of law enforcement.[208] Such situations commonly arise when arrestees are brought to the emergency room for medical clearance before they can be admitted to the local jail.

(App. Div. 1998); Wilson v. State, 99 S.W.3d 767, 771 (Tex. App. 2003) (finding that hospital inventory search of patient bags that revealed contraband later turned over to police was reasonable). *But see* State v. Klase, 131 N.E.3d 1054, 1057, 1067 (Ohio Ct. App. 2019) (affirming lower court finding that hospital inventory search was not a standardized police department policy for inventory search exception to warrant requirement where patient was not under arrest but placed under seventy-two-hour mental health hold). In *People v. Rodgers*, 661 N.Y.S.2d 452, upon arriving at the emergency room where the defendant was being treated, a trooper assisted medical professionals in getting the man's clothes off. *Id.* at 453. While taking his clothes off for treatment, according to hospital procedure, a syringe and a spoon fell out. *Id.* The court held that these events constituted a private search and the involvement of the police was "purely incidental," hence the spoon and syringe could not be suppressed. *Id.* at 457.

[205] *See Clay*, 2006 WL 2385353, at *2.

[206] United States v. Neely, 345 F.3d 366, 370 (5th Cir. 2003); Jones v. State, 648 So. 2d 669, 672, 675 (Fla. 1994); People v. Jordan, 468 N.W.2d 294, 300–01 (Mich. Ct. App. 1991); People v. Yaniak, 738 N.Y.S.2d 492, 495–96 (Cnty. Ct. 2001). The court's question is whether a "'seizure' of property [has] occur[red]," which takes place "when there is some meaningful interference with an individual's possessory interests in that property." United States v. Jacobsen, 466 U.S. 109, 113 (1984); *see also* Texas v. Brown, 460 U.S. 730, 747 (1983) (Stevens, J., concurring); People v. Hayes, 584 N.Y.S.2d 1001, 1002–04 (Sup. Ct. 1992).

[207] *Jordan*, 468 N.W.2d at 301; *see also Neely*, 345 F.3d at 370–71; People v. Watt, 462 N.Y.S.2d 389, 391 (Sup. Ct. 1983); Commonwealth v. Silo, 389 A.2d 62, 66 (Pa. 1978); Morris v. Commonwealth, 157 S.E.2d 191, 194 (Va. 1967); State v. Lopez, 476 S.E.2d 227, 233 (W. Va. 1996).

[208] *See, e.g.*, United States v. Attson, 900 F.2d 1427, 1433 (9th Cir. 1990) (holding that government-employed physician acted for "purely medical reasons" in drawing blood, and suppression of resulting evidence was therefore not required); United States v. Shepherd, No. 13-25-ART-EBA-(3), 2014 WL 4594565, at *5 (E.D. Ky. Sept. 15, 2014); People v. Loggins, 981 P.2d 630, 634–35 (Colo. App. 1999) (alternatively finding that the search was not a search for the purpose of the Fourth Amendment, and even if a search had occurred, medical emergency exception applied); *see also* United States v. Chukwubike, 956 F.2d 209, 212 (9th Cir. 1992); Favela v. City of Las Cruces *ex rel.* Las Cruces Police Dep't, 398 F. Supp. 3d 858, 932, 937 (D.N.M. 2019) (finding that medical necessity led to catheterization due to plaintiff's medical state and was not implemented for or necessitated by criminal investigation).

The constitutional question of the reasonableness of the search is separate from whether medical professionals' actions are subject to constitutional limitations. Medical professionals are key components of the reasonableness test of law enforcement–initiated searches that go beneath the skin. Such searches include blood draws,[209] catheterizations,[210] as well as body cavity searches for illegal contraband such as drugs and bullets.[211] The Supreme Court analyzed early blood sample and body cavity search cases under the Due Process Clause.[212] The Court first applied the Fourth Amendment to these types of searches in *Schmerber v. California*.[213] Warrantless searches of people's bodies are permitted, but the police must be justified in requiring the individual to submit to the procedure, and the means and procedures employed must be reasonable.[214] Consent can also make a warrantless blood sample or body cavity search lawful.[215] Further, exigent circumstances justify warrantless body cavity searches.[216] Though the Court has held that dissipation of alcohol in the blood does not count as an exigent circumstance that would excuse the lack of warrant,[217] in the recent case of *Mitchell v. Wisconsin*,[218] the Court held that the state of unconsciousness at the emergency room could be an exigent circumstance.[219]

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[209] *See, e.g.*, Mitchell v. Wisconsin, 139 S. Ct. 2525, 2534 (2019) (plurality opinion); Missouri v. McNeely, 569 U.S. 141, 165 (2013); Schmerber v. California, 384 U.S. 757, 758 (1966).

[210] *See, e.g.*, Lockard v. City of Lawrenceburg, 815 F. Supp. 2d 1034, 1038 (S.D. Ind. 2011).

[211] *See, e.g.*, Rodriquez v. Furtado, 771 F. Supp. 1245, 1246 (D. Mass.), *aff'd sub nom.* Rodriques v. Furtado, 950 F.2d 805 (1st Cir. 1991); Eckert v. City of Deming, No. CIV 13-0727, 2015 WL 10383783, at *1 (D.N.M. Oct. 31, 2015).

[212] *See, e.g.*, Breithaupt v. Abram, 352 U.S. 432, 433–34 (1957); Rochin v. California, 342 U.S. 165, 166, 168 (1952).

[213] 384 U.S. 757; *see id.* at 768. *Schmerber* was the first one of these cases to be decided after the Court's decision in *Mapp v. Ohio*, 367 U.S. 643 (1961), which applied the exclusionary rule to state court decisions. *Id.* at 655.

[214] *Schmerber*, 384 U.S. at 768.

[215] Schneckloth v. Bustamonte, 412 U.S. 218, 219 (1973); Farmer v. Commonwealth, 169 S.W.3d 50, 52 (Ky. Ct. App. 2005). In cases involving driving while intoxicated, most states have implied consent laws that also figure into the analysis of consent. *See, e.g.*, Mitchell v. Wisconsin, 139 S. Ct. 2525, 2531–33 (2019) (plurality opinion); Commonwealth v. Seibert, 799 A.2d 54, 63–64 (Pa. Super. Ct. 2002); State v. Reynolds, 504 S.W.3d 283, 299 (Tenn. 2016).

[216] State v. Strong, 493 N.W.2d 834, 836–37 (Iowa 1992) (exigency justified stomach pumping when arrestee had ingested cocaine).

[217] Missouri v. McNeely, 569 U.S. 141, 165 (2013).

[218] 139 S. Ct. 2525.

[219] *Id.* at 2531 (plurality opinion). In *Mitchell*, a police officer received a report of a drunk man, Gerald Mitchell, taking off in a van. *Id.* at 2532. The officer soon encountered Mr. Mitchell near a lake. *Id.* According to the petitioner's briefing, a neighbor had called the police fearing that Mr. Mitchell was planning to take his own life. Brief for the Petitioner at 3, *Mitchell*, 139 S. Ct. 2525 (No. 18-6210). Mr. Mitchell was arrested and driven to the station, but because he could not take a breath test, the officer took him to a nearby hospital. *Mitchell*, 139 S. Ct. at 2532. There the officer read a "slumped," *id.*, and "incapacitated" Mr. Mitchell his statutory right to withdraw consent, *id.* at 2542 (Sotomayor, J., dissenting). At the officer's direction, hospital staff drew a sample of Mr. Mitchell's blood. *Id.* at 2532 (plurality opinion). He did not wake up for the procedure. *Id.*

Even with a court order, the Supreme Court has required that the body cavity search be reasonable.[220] In *Winston v. Lee*,[221] the Court affirmed the lower court's injunction against a surgery for a bullet lodged in the defendant's chest without the consent of the defendant[222] after weighing the defendant's "interests in privacy and security" against "society's interests in conducting the procedure."[223] Courts consider factors such as (1) the extent the medical procedure may threaten an individual's health or safety, (2) the extent of the intrusion on the person's individual dignitary and privacy interests, and (3) the community's interests in "fairly and accurately determining guilt or innocence."[224] Courts 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."[225]

The reasonableness of a body cavity search depends in large part on whether the search has been conducted by a doctor, in a "private and hygienic setting and in a medically approved manner."[226] The Supreme Court has long recognized and respected medical professionals' cooperation with police in these types of investigations.[227] In *Rochin v. California*,[228] Justice Frankfurter made this point explicit, delineating a "brutal" stomach pumping[229] from "cases which have arisen in the State

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The Court remanded the ultimate question of the constitutionality of the forced blood draw. *Id.* at 2539. The Court held that warrantless blood tests are usually constitutional, except in the "unusual case" where a "defendant would be able to show that his blood would not have been drawn if police had not been seeking BAC information" and where "police could not have reasonably judged that a warrant application would interfere with other pressing needs or duties." *Id.*

220 *See* Winston v. Lee, 470 U.S. 753, 759–60 (1985).

221 470 U.S. 753.

222 *See id.* at 757, 767.

223 *Id.* at 760. This case involved a court order to surgically remove a bullet from Rudolph Lee's body. *Id.* at 756. The Court ruled the order unreasonable, finding that even though there was probable cause to issue the warrant, the surgical intrusion far outweighed the state's need for the bullet. *Id.* at 763–67. See ALAN HYDE, BODIES OF LAW 161–64 (1997), for a critical examination of how the Court's jurisprudence on body cavity searches reflects "[t]he construction and deployment of a privacy interest . . . to make appear objective what might just as well symbolize the radically subjective, unstable, problematized, that is, the boundaries of the body." *Id.* at 161.

224 *Winston*, 470 U.S. at 761–62.

225 Rodriques v. Furtado, 950 F.2d 805, 811 (1st Cir. 1991) (quoting Bell v. Wolfish, 441 U.S. 520, 559 (1979)). The First Circuit noted that the cavity searches involved in *Bell v. Wolfish*, 441 U.S. 520, were of inmates, who have lesser liberty interests than do noninmates. *Rodriques*, 950 F.2d at 811 n.5.

226 *Rodriques*, 950 F.2d at 811 (citing Schmerber v. California, 384 U.S. 757, 771–72 (1966)).

227 *See, e.g.*, Mitchell v. Wisconsin, 139 S. Ct. 2525, 2537–39 (2019) (plurality opinion); Missouri v. McNeely, 569 U.S. 141, 159 (2013) (plurality opinion); *Schmerber*, 384 U.S. at 771–72; Breithaupt v. Abram, 352 U.S. 432, 439 (1957); Rochin v. California, 342 U.S. 165, 174 (1952). Other Supreme Court cases have looked at investigations where medical professionals played a part though the role of the medical professional was not at issue for the Court. *See, e.g.*, *Winston*, 470 U.S. at 755; United States v. Montoya de Hernandez, 473 U.S. 531, 534 (1985).

228 342 U.S. 165.

229 *Id.* at 173.

courts through use of modern [medical] methods and devices for discovering wrongdoers and bringing them to book."[230] Such cases included hospital-assisted blood draws and forcible stomach pumping.[231] In *Breithaupt v. Abram*,[232] the Court continued to emphasize the role of medicine in police investigation.[233] The Court characterized the doctor in the case as a "skilled technician"[234] and noted "there is nothing 'brutal' or 'offensive' in the taking of a sample of blood when done, as in this case, under the protective eye of a physician."[235]

Beyond participation in searches, information from medical professionals can have a significant effect on constitutional questions. By law, medical professionals are required to inform law enforcement of a wide range of nonaccidental injuries. Almost every state imposes these types of duties.[236] Courts have interpreted these statutes — which are about providing *information* — to also include *access* to patients.[237] Courts regularly rely upon medical professional reporting obligations as a reason for why police should be allowed access to the emergency room and to certain types of patients, such as patients suffering from drug overdoses or gunshot wounds.[238]

Information from reporting requirements — like a hospital policy requiring drug overdose patients to be reported to the police — has been held to be insufficient to establish reasonable articulable suspicion.[239] But when an officer is provided more information, such as information

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[230] *Id.* at 174.

[231] *See, e.g.*, People v. Tucker, 198 P.2d 941, 943 (Cal. Dist. Ct. App. 1948) (doctor took blood sample from individual suspected of causing an accident with injuries while intoxicated); People v. One 1941 Mercury Sedan, 168 P.2d 443, 444 (Cal. Dist. Ct. App. 1946) (police brought individual thought to be transporting marijuana to an emergency room where individual was placed on operating table and doctor forcibly pumped the individual's stomach; items removed from the person's stomach subsequently placed in jars by narcotics enforcement inspector).

[232] 352 U.S. 432.

[233] *Id.* at 439.

[234] *Id.* at 437.

[235] *Id.* at 435. There is a strong corollary here to the participation of medical professionals in the torture context, which has also been the subject of scholarly discussion. *See generally* Deborah D. Ascheim & Andrea Gittleman, *Divided Loyalties of Health Professionals: Professional Standards and Military Duty*, 43 CASE W. RSRV. J. INT'L L. 625 (2011); Michael P. Scharf, *Tainted Provenance: When, If Ever, Should Torture Evidence Be Admissible?*, 65 WASH. & LEE L. REV. 129, 162–68 (2008); Michael K. Gottlieb, Note, *Executions and Torture: The Consequences of Overriding Professional Ethics*, 6 YALE J. HEALTH POL'Y L. & ETHICS 351 (2006).

[236] *See* VICTIM RTS. L. CTR., *supra* note 87 (fifty-state survey of mandatory reporting requirements for healthcare practitioners). Only Alabama, New Mexico, and Wyoming have no mandatory reporting duty statutes. *Id.* at 1, 24, 40.

[237] Recent bills highlight the importance of providing timely information to law enforcement about the victims of crimes. For example, a Washington statute specifically states that "[t]he obligation to provide information . . . is secondary to patient care needs." *See* WASH. REV. CODE § 18.73.270(3) (2021).

[238] *See* cases cited *supra* note 121 and accompanying text.

[239] *See* State v. Weisgarber, 88 N.E.3d 1037, 1043 (Ohio Ct. App. 2017).

from hospital personnel about a drug overdose as well as X-rays revealing the possible presence of drugs, that information has been determined to be sufficient for probable cause to arrest.[240]

Information provided about a patient by a treating physician or nurse, either at the time of treatment or in later testimony, can also significantly affect the constitutionality of patients' statements to law enforcement.[241] The Due Process Clauses of the Fifth and Fourteenth Amendments provide separate grounds for suppression of coerced statements.[242] Patients' medical conditions are key components of the voluntariness analysis, such as whether their conditions made them more susceptible to police questioning or unable to understand the *Miranda* admonishment.[243] In an early case, one court relied upon the testimony of the medical team to show that the patient was not in a physical state to make a voluntary statement given his brain injury and being sleepy and groggy, alongside defendant's testimony that he had not fully regained consciousness.[244] To determine a patient's ability to speak voluntarily, another court pointed to testimony by a medical professional stating that certain drugs did not influence a patient's "ability to understand questions and function appropriately"[245] and that the patient was "lucid, aware, and able to make decisions."[246] Even in the Supreme Court's decision in *Mincey*, though the Court ultimately found Mr. Mincey's statement involuntary, a different reading of the facts reveals how the nurse played an integral role in the police officer's interrogation of a severely compromised Mr. Mincey: she suggested to Mr. Mincey that it would help if he cooperated with the interrogation and was otherwise present to facilitate the interview, where Mr. Mincey wrote down answers on hospital-provided paper because he could not speak.[247]

2. Medical Professionals as Good Citizens. — In all these ways, courts encourage police use of medical professionals for adversarial purposes. Collaborations between other social actors and law enforcement

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[240] *See* United States v. George, 987 F.2d 1428, 1430, 1432 (9th Cir. 1993).

[241] *See, e.g.*, United States v. Walker, 272 F.3d 407, 412–13 (7th Cir. 2001) (relying on physician's testimony to affirm district court's conclusion that defendant's confession was voluntary); People v. Stryker, No. A118638, 2010 WL 219318, at *13 (Cal. Ct. App. Jan. 22, 2010) (holding that defendant's statements were voluntary in large part because physician testified that defendant retained his free will).

[242] U.S. CONST. amend. V; *id.* amend. XIV, § 1; Colorado v. Connelly, 479 U.S. 157, 167 (1986).

[243] *See, e.g.*, State v. Rodriguez, 669 P.2d 601, 603 (Ariz. Ct. App. 1983); State v. Pitman, No. 12-1743, 2014 WL 251899, at *3 (Iowa Ct. App. Jan. 23, 2014).

[244] *See* Vandegriff v. State, 409 S.W.2d 370, 372–73 (Tenn. 1966).

[245] *Pitman*, 2014 WL 251899, at *3.

[246] *Id.* at *10.

[247] *See* Mincey v. Arizona, 437 U.S. 385, 396, 399 (1978).

is nothing new.[248] Scholars have laid responsibility for the criminalization of Black pregnant women on hospital reports of infant toxicologies and other evidence of drug use, almost exclusively provided by public hospitals serving poor minority communities, as in *Ferguson*.[249] In the emergency room, the participation of medical professionals comes in a wide range of cases and at the expense of a broader patient base.

Practices in the ER reflect how deeply embedded such collaboration and surveillance is in healthcare for the poor. Beyond reporting to police, attesting to patient conditions, and performing procedures for police, medical professionals have acted in other ways to diminish the privacy of their patients. Even the simple acts of directing police to patients' locations within the ER, performing their own "searches" of patients and belongings, and handing over that information to the police make medical professionals investigative participants even as they shield such searches from constitutional scrutiny. Seemingly inconsequential actions, like waving a police officer into the ER, or answering yes when an officer asks if a patient is "okay to talk," can have significant consequences. This participation may be inadvertent or unintended. As courts have repeated, medical professionals are not constitutional experts.[250] But the negative effects on patients' rights are the same.

The Supreme Court has reinforced the idea of medical professionals as valuable partners in law enforcement investigations. Even though the Court ultimately invalidated the hospital's program of drug-testing pregnant women in *Ferguson*,[251] it took pains to emphasize the citizenship duties of medical officers.[252] Justice Stevens, writing for the majority, likened the hospital employees to "other citizens, [who] may have a duty to provide the police with evidence of criminal conduct that they inadvertently acquire in the course of routine treatment."[253]

What courts expect from medical professionals as part of their "citizenship" duties, however, can conflict with their professional duties. By

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[248] *See, e.g.*, GUSTAFSON, *supra* note 16, at 2.

[249] ROBERTS, *supra* note 19, at 173.

[250] *See, e.g.*, Marshall v. Columbia Lea Reg'l Hosp., 345 F.3d 1157, 1180 (10th Cir. 2003) ("Nurses and other medical personnel have neither the training nor the information that would be necessary to second-guess police determinations regarding probable cause, exigent circumstances, and the like."); United States v. Velasquez, 469 F.2d 264, 266 (9th Cir. 1972) ("Since a physician is required to have no knowledge of the law of search and seizure to practice his profession, any such enumeration of the facts . . . to the doctor would be a meaningless ritual . . . comparable to requiring the police to recite to a locksmith the basis for their probable cause before he could legally open a lock for them."); Lockard v. City of Lawrenceburg, 815 F. Supp. 2d 1034, 1051 (S.D. Ind. 2011) ("Plainly stated, doctors and nurses are not Fourth Amendment gurus.").

[251] Ferguson v. City of Charleston, 532 U.S. 67, 85–86 (2001).

[252] *Id.* at 84–85.

[253] *Id.*

ignoring medical professional ethics and norms,[254] the courts implicitly prioritize the public safety obligations of medical professionals over the duties they owe their patients. The courts' view of medical professionals as good citizens is reflected in the inclusion of their role in the legal standard for the highest level of physical intrusions — body cavity searches and blood draws.[255] Even when the courts have deemed cavity searches unconstitutional, they rarely question the physician's participation.[256]

In one case, *Rodriques v. Furtado*,[257] the court granted qualified immunity to a doctor for a search conducted pursuant to a search warrant, noting that the doctor's status as a physician imposed an even greater

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[254] *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/3NVY-UUEL] (compiling ethics guidance for physicians relating to patient privacy, confidentiality, and medical records); *The Hippocratic Oath*, NAT'L INSTS. OF HEALTH: GREEK MED. (Feb. 7, 2012), https://www.nlm.nih.gov/hmd/greek/greek_oath.html [https://perma.cc/D7UE-67RZ]; *Patient Rights: Code of Medical Ethics Opinion 1.1.3*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/patient-rights [https://perma.cc/KRL8-8B57] (outlining the rights of patients).

[255] *See* Schmerber v. California, 384 U.S. 757, 771-72 (1966); *supra* p. 2681.

[256] Only in the rare case has a doctor been taken to task by the courts for assisting police officers by performing procedures. In one such case it was only because the doctor had participated in a number of forced rectal examinations. United States v. Booker, 728 F.3d 535, 538 (6th Cir. 2013). In this case, the doctor performed a variety of procedures at the request of police: a digital rectal examination without any medication, the injection of a muscle relaxant, and the intravenous administration of a sedative and paralytic agent, requiring the defendant, Felix Booker, to be intubated for approximately an hour. *Id.* at 539. He was unconscious for twenty to thirty minutes and paralyzed for seven to eight minutes. *Id.* The doctor removed a rock of crack cocaine and gave it to the police officer. *Id.* at 539–40. The Sixth Circuit reversed the defendant's drug conviction. *Id.* at 537. It criticized the doctor's actions and the officers for standing by and watching the doctor intubate and paralyze the defendant without his consent. *Id.* at 544–45. The court also recounted the number of times (three in three years) that the doctor had assisted the same Sheriff's Office with digital rectal examinations. *Id.* at 538. The doctor's conduct was not at issue before the court, but the court upheld the suppression of evidence, saying that the police officers should have known that the doctor was engaging in conduct that "constitute[d] medical battery." *Id.* at 542.

As a sensational coda to the story, the doctor himself was later convicted of drug charges. *See* Rebecca Haw Allensworth, *Licensed to Pill*, N.Y. REV. (July 21, 2020), https://www.nybooks.com/daily/2020/07/21/licensed-to-pill [https://perma.cc/4SGF-LZ2D]. After responding to a domestic disturbance, police uncovered a large supply of drugs and guns at Dr. Michael LaPaglia's house, including "45 quart-sized jars with marijuana," "127 glass marijuana pipes," and several bottles and vials containing other prescription drugs. *Doctor Being Sued in Fed Court Charged with Weapons, Drug Charges*, OAKRIDGER (Sept. 6, 2013, 3:49 PM), https://www.oakridger.com/article/20130906/NEWS/130909932 [https://perma.cc/D5UG-PQGH]. The officers also recovered three loaded guns and ammunition. *See id.* Dr. LaPaglia entered a conditional plea to state charges. *See* John North, *ET Doc Who Once Conducted Illegal Search of Suspect's Rectum Faces Federal Drug Charges*, WBIR (Nov. 30, 2018, 4:26 PM), https://www.wbir.com/article/news/crime/et-doc-who-once-conducted-illegal-search-of-suspects-rectum-faces-federal-drug-charges/51-619111708 [https://perma.cc/YQ4K-TYUF]. Subsequently, LaPaglia signed a plea agreement in federal court to plead guilty to charges of conspiring with another doctor to illegally distribute narcotics and illegally writing prescriptions. *See id.*

[257] 950 F.2d 805 (1st Cir. 1991).

obligation than a private citizen.[258] "[T]he physician," the court stated, "is 'invested with [and has accepted] the responsibilities of a public official in the public interest.'"[259] A search warrant had been issued for the search of Shirley Rodriques's vagina for drugs based upon a tip from an informant.[260] Police knocked her door down in the middle of the night and found Ms. Rodriques sleeping in her room.[261] They took her to an emergency room where a doctor examined and searched her.[262] No drugs were found.[263] The court justified its grant of qualified immunity because to do otherwise could deter doctors from assisting with valid warrants.[264] Such "reluctance on the part of physicians to perform body cavity searches could well signal a loss to society of a valuable crime detection procedure or result in these procedures having to be carried out by nonprofessionals, a situation which would be even more intrusive of the subject's privacy."[265]

This latter concern expressed by the court is a valid problem. Police-conducted body cavity searches have garnered much controversy as an example of their abuse of authority.[266] But the fix to highly intrusive and unconstitutional police cavity searches cannot be just to have these searches be conducted under medical supervision.

The courts' current approach to body cavity searches should be questioned. First, it is not so clear that the societal value of finding drugs in a person's body is so great that it justifies the intrusion of a person's right to privacy, dignity, and bodily integrity. Second, in many of these situations, patient consent is not given — or required — for body cavity

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[258] *Id.* at 815.

[259] *Id.* (second alteration in original) (quoting Duncan v. Peck, 844 F.2d 1261, 1264 (6th Cir. 1988)).

[260] *See id.* at 807, 812 n.9.

[261] *See* Rodriquez v. Furtado, 771 F. Supp. 1245, 1248 (D. Mass. 1991), *aff'd sub nom. Rodriques*, 950 F.2d 805.

[262] *See Rodriques*, 950 F.2d at 808. Though the facts do not specify the procedure, the way it is described will most likely be recognized by many readers as a Pap smear. *See id.* at 808 n.2.

[263] *See id.* at 808.

[264] *See id.* at 815.

[265] *Id.*

[266] *See* Steven Hsieh, *City to Pay $1.6 Million to Victim of Illegal Cavity Search by Phoenix Police*, PHX. NEW TIMES (Dec. 17, 2019, 1:44 PM), https://www.phoenixnewtimes.com/news/cavity-search-phoenix-police-illegal-erica-reynolds-claim-settle-11408536 [https://perma.cc/53DV-WYY7]; Emma Ockerman, *The Tennessee Cop Accused of Probing a Black Man's Anus Also Allegedly Groped Teen Girls and Stalked a Woman for a Year*, VICE NEWS (Dec. 17, 2019, 1:21 PM), https://www.vice.com/en/article/4agyw3/the-tennessee-cop-accused-of-probing-a-black-mans-anus-also-allegedly-groped-teen-girls-and-stalked-a-woman-for-a-year [https://perma.cc/MLF4-EN4F]; Mark Joseph Stern, *The Ruling Against a Cop Accused of a Horrific Body Cavity Search Is a Rare Victory for Police Accountability*, SLATE (June 5, 2019, 5:35 PM), https://slate.com/news-and-politics/2019/06/michigan-lawsuit-officer-daniel-mack-illegal-body-cavity-search.html [https://perma.cc/LL3L-MV7V].

searches conducted at the behest of law enforcement. But if law enforcement actions are out of the equation, invasive medical procedures require patient consent.[267] If such consent cannot be procured because the patient is not conscious or is otherwise unable to give consent, then when threat to life and limb is not at issue, a substitute decisionmaker with authority to give such consent must be found, such as a spouse or parent.[268]

Accounts by medical professionals working in EDs reveal great discomfort with this kind of participation with police. Doctors have recounted instances where they have refused to conduct a search without an independent medical basis. One emergency professional recounted that once, when confronted with a suspect and a warrant, he simply handed the police the equipment to pump the patient's stomach.[269] Another doctor refused to comply with the warrant, only for the police to take the patient to another hospital where a doctor agreed to execute the warrant and failed to find any drugs.[270] Doctors do have an independent basis for refusing court orders in these circumstances, and though statutes authorize them to comply with search warrants, several states do not compel them to do so.[271] Yet the doctrine treats this as more of a choice by medical professionals rather than a decision grounded in their ethical and moral obligations.

The courts' approval of the liberal use of medical professionals mirrors what Professor Bennett Capers describes as the espousal of good citizenship in Supreme Court criminal procedure decisions.[272] A good citizen not only "willingly cedes their constitutional protections to aid the state,"[273] but also informs the police of the criminal behavior of

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[267] *See* Paul S. Applebaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1834 (2007).

[268] *See id.* at 1834, 1838; Yen-Ko Lin et al., *How to Effectively Obtain Informed Consent in Trauma Patients: A Systematic Review*, 20 BMC MED. ETHICS, no. 8, 2019, at 1.

[269] Charles A. Pilcher & Erika Schroeder, *Must an Emergency Physician Comply with a Body Cavity Search Warrant?*, ACEP NOW (Oct. 9, 2016), https://www.acepnow.com/article/must-emergency-physician-comply-body-cavity-search-warrant [https://perma.cc/Q46H-ZU8F]; *see also* MICHELE HARPER, THE BEAUTY IN BREAKING 100–02 (2020).

[270] Eckert v. City of Deming, No. CIV 13-0727, 2015 WL 10383783, at *2 (D.N.M. Oct. 31, 2015); Adam Ash, *On Resolution 22*, 69 ANNALS EMERGENCY MED. 656, 656 (2017); Kristof, *supra* note 95.

[271] Pilcher & Schroeder, *supra* note 269 (citing WASH. REV. CODE § 10.79.080 (2021); ME. REV. STAT. ANN. tit. 5, § 200-G (2020); TENN. CODE ANN. § 40-7-121 (2021)). Wisconsin, on the other hand, recently passed contrary legislation. *See* 2015 Wisconsin Act 238, § 1, 2015 Wis. Sess. Laws 1230, 1230 (codified at WIS. STAT. § 895.535 (2021)).

[272] I. Bennett Capers, Essay, *Criminal Procedure and the Good Citizen*, 118 COLUM. L. REV. 653, 654 (2018).

[273] *Id.* at 657.

others.[274] A good citizen provides evidence to police and acts as a surveillance agent.[275] Capers argues that "there is something deeply problematic about citizenship talk that encourages citizens to surrender constitutional protections and to serve as willing posse comitatus to a criminal justice system known for overcriminalization, overincarceration, and unequal policing."[276]

The problem is even greater when that *posse comitatus* is made up of medical professionals. Good citizenship by medical professionals in terms of criminal procedure assistance can come into conflict with professional norms of medical professionals that are distinct from those of law enforcement. The medical professional has unique skills and knowledge. Medical professionals have their own ethical, legal, and moral obligations to their patients, starting with the fundamental medical principle of "do no harm."[277] Even exceptions carved out in law for law enforcement are textually limited. For example, the law enforcement exceptions contained in the Health Insurance Portability and Accountability Act of 1996[278] (HIPAA) are permissive, not mandatory, and maintain HIPAA's requirements to give minimal information.[279] The disclosures that hospitals and medical professionals can make are carefully delineated and specified and contain even stricter requirements for patients who are victims of crimes.[280]

Ultimately, however, patients who are criminal suspects are subjected to different treatment by their medical professionals. Capers describes Supreme Court criminal procedure jurisprudence as a means of disciplining citizens into becoming "obedient subjects, or good citizens."[281] The same applies to the jurisprudence on policing in the emergency room. Police communicate their views of good citizenship to the courts; the courts reflect them back in their decisions; and medical professionals are shaped by this view of good citizenship.[282] In a case

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[274] *Id.* at 677 (citing McCray v. Illinois, 386 U.S. 300, 308 (1967)).

[275] *See id.*

[276] *Id.* at 670 (footnote omitted).

[277] This phrase is commonly attributed to the original Hippocratic Oath, but scholars have pointed out that the phrase came about much later, though it is very much a core principle of medical care. *The Hippocratic Oath*, *supra* note 254.

[278] Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of the U.S. Code).

[279] OFF. FOR C.R., U.S. DEP'T OF HEALTH & HUM. SERVS., HIPAA ADMINISTRATIVE SIMPLIFICATION 92–93 (2013) [hereinafter HIPAA PRIVACY]; *When Does the Privacy Rule Allow Covered Entities to Disclose Protected Health Information to Law Enforcement Officials?*, HHS (July 26, 2013), https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html [https://perma.cc/A2YR-RZQZ].

[280] HIPAA PRIVACY, *supra* note 279.

[281] Capers, *supra* note 272, at 671.

[282] *See id.* at 673.

brought against a doctor for conducting medical procedures pursuant to a warrant, the doctor stated in his deposition testimony that he complied with the warrant because "I think as citizens, that's what we're supposed to do, right?"[283] Indeed, in Wisconsin, the state legislature recently extended immunity provisions for medical professionals conducting nonconsensual blood draws to include nonconsensual body cavity searches.[284]

Patients may also be completely unaware of the degree to which their medical providers cooperate with law enforcement. "HIPAA rights" have become everyday shorthand for privacy and patients generally expect their doctors to hold their confidences. Professor Michele Goodwin argues that at least a medical type of *Miranda* warning would serve the purpose of alerting patients and avoid the use of medical providers as law enforcement proxies.[285] She raised this proposed reform in the context of pregnant women who may have had no idea that their doctor's visit could lead to a criminal investigation.[286] In the ER, patients also cannot always see how their medical team's roles are conflated with those of police.[287] For example, patients may never see the nurse who looks into their belongings while they are being treated, or hospital staff pointing them out to police, or the officer standing in the CT room with the doctors. Even though hospitals may have privacy forms with HIPAA and other caveats about law enforcement purposes, these hardly stand in for the kind of warning to which patients should be entitled.[288]

Moreover, the issue of bias in the medical profession is compounded when patients are perceived to be criminals. Separately, each of the two institutions here — law enforcement and medicine — have long histories of discrimination and bias. The treatment of Black people by the police and the medical profession bears the marks of the lasting impact of slavery and segregation.[289] The problems with policing and racism are well-

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[283] Timothy Young's Motion for Summary Judgment on the Claim of Unlawful Search, Exhibit 3, at 47 ll. 21–22, Young v. Gila Reg'l Med. Ctr., No. A-1-CA-36474, 2020 WL 3006699 (N.M. Ct. App. June 4, 2020) (on file with the Harvard Law School Library). The warrant authorized the doctor to perform procedures in order to retrieve drugs. No drugs were found. *Id.*, Exhibit 2, at 2–3.

[284] WIS. STAT. § 895.535 (2021).

[285] GOODWIN, *supra* note 19, at 97.

[286] *Id.*

[287] *See id.*

[288] *See* Sanchez v. Pereira-Castillo, 590 F.3d 31, 46 (1st Cir. 2009). Certain hospitals have forms that contain blanket provisions regarding forensic use of diagnostic results. Rodriguez v. Pierce, 176 F. Supp. 3d 445, 453–54 (D. Del. 2016).

[289] Linda Villarosa, *Myths About Physical Racial Differences Were Used to Justify Slavery — And Are Still Believed by Doctors Today.*, N.Y. TIMES MAG. (Aug. 14, 2019), https://nyti.ms/38RE95Y [https://perma.cc/G3ND-5DTY]; Jill Lepore, *The Invention of the Police*, NEW YORKER (July 13, 2020), https://www.newyorker.com/magazine/2020/07/20/the-invention-of-the-police [https://perma.cc/785G-A2JH]. *See generally* Marvin J.H. Lee et al., *Overcoming the*

known. Black people are more likely to be stopped and searched by police, and are more likely to receive harsher punishments.[290] Mass incarceration in America affects Black men disproportionately more than other groups.[291] Similarly well-documented is medicine's historical and continuing biases and treatment of Black people. Black people have been the subjected to medical tests on the false belief that they could not feel pain.[292] Myths about Black physiology have been perpetrated by the medical profession.[293] Purported biological differences grounded in racial categories preserve racial hierarchy and continue racial insubordination.[294] Race continues to play a role in physician diagnoses, patient care, and health outcomes.[295] Structural and institutional biases have had lasting effects on the access to and quality of medical care.[296] The problem of bias bleeds into how patients may be perceived by their treatment team. Dr. John Rich, an African American physician, described his observations of physician bias when working as a primary care physician at Boston City Hospital.[297] He saw the way his colleagues approached Black males who would come in with gunshot wounds. In one instance, he described how one Black patient who had suffered a gunshot wound was left without pain medication for hours until he personally intervened.[298] Nurses and doctors talked about these

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Legacy of Mistrust: African Americans' Mistrust of Medical Profession, 4 J. HEALTH ETHICS & ADMIN. 16 (2018).

290 *Findings*, STAN. OPEN POLICING PROJECT, https://openpolicing.stanford.edu/findings [https://perma.cc/XJ34-G9AG]; U.S. SENT'G COMM'N, DEMOGRAPHIC DIFFERENCES IN SENTENCING 2 (2017).

291 *See* ASHLEY NELLIS, THE SENT'G PROJECT, THE COLOR OF JUSTICE: RACIAL AND ETHNIC DISPARITY IN STATE PRISONS 3 (2016); *see also* ELIZABETH HINTON ET AL., VERA INST. FOR JUST., AN UNJUST BURDEN: THE DISPARATE TREATMENT OF BLACK AMERICANS IN THE CRIMINAL JUSTICE SYSTEM (2018); *Statistics: Inmate Race*, FED. BUREAU OF PRISONS (Jan. 30, 2021), https://www.bop.gov/about/statistics/statistics_inmate_race.jsp [https://perma.cc/V8XZ-3TKA].

292 *See* Villarosa, *supra* note 289.

293 *See id.*; Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4296, 4299 (2016).

294 Osagie K. Obasogie, *Race and Science: Preconcilitation as Reconciliation*, *in* RACIAL RECONCILIATION AND THE HEALING OF A NATION: BEYOND LAW AND RIGHTS 49, 49 (Charles Ogletree & Austin Sarat eds., 2017).

295 *See, e.g.*, 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, e60 (2015); Natalia N. Khosla et al., *A Comparison of Clinicians' Racial Biases in the United States and France*, 206 SOC. SCI. & MED. 31, 31–32 (2018).

296 *See, e.g.*, René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 120 (2001); *cf.* Janice A. Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 907 (2009).

297 JOHN A. RICH, WRONG PLACE, WRONG TIME: TRAUMA AND VIOLENCE IN THE LIVES OF YOUNG BLACK MEN 1, 4 (2009).

298 *Id.* at 18–19.

patients as though they were expendable: because they were perceived to be "gangbangers" or otherwise criminal, gun violence was just a normal part of life for them.[299]

Those who are most vulnerable to bias and discrimination by institutional actors, including police and medical practitioners, are acutely vulnerable to and subject to the *combined* actions of medical professionals and police.[300] Yet medically vulnerable patients, who are also vulnerable to bias, are at the mercy of the combined power of medical professionals and law enforcement, and with the express imprimatur of the courts.

C. Possible Race-Based Policing

Though the arguments raised here apply to all emergency rooms, emergency rooms with a high number of racial minority patients raise an additional issue. Because ERs are not viewed much differently than public streets, the same concerns of race-based street policing arise in them. These concerns are particularly salient given the interactions between police and racial minorities who frequent safety-net hospitals. This section highlights two potential ways racialized policing could occur in the emergency room. First, police presence increases the ability of police to conduct surveillance of the people who enter these safety-net emergency rooms. Second, the permission given to police to conduct preliminary and general investigations without triggering Fourth or Fifth Amendment requirements could lead to pretextual investigations.

1. Convergence in Safety-Net ERs. — A number of reasons factor into police presence in safety-net hospitals. Law enforcement agencies are an integral part of emergency personnel who respond to trauma-based 9-1-1 calls. Most 9-1-1 dispatch centers are centralized in law enforcement agencies,[301] enabling police to be dispatched quickly to the scene of the emergency. In some places, police have formalized and expanded their emergency personnel role with certain ERs. In Philadelphia, the City implemented a policy known as "scoop and run," which allows police to transport gunshot victims directly to the ER to shorten the time between the incident and trauma intervention.[302] In

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[299] *Id.* at 17.

[300] *See* Ji Seon Song, *Cops in Scrubs*, 48 FLA. ST. L. REV. (forthcoming Aug. 2021).

[301] *See 911 Master PSAP Registry*, FED. COMMC'NS COMM'N (Mar. 12, 2021), https://www.fcc.gov/general/9-1-1-master-psap-registry [https://perma.cc/B5SK-4VCN] (file available for download).

[302] PHILA. POLICE DEP'T, DIRECTIVE 3.14: HOSPITAL CASES § 2.A.1 (2018), https://www.phillypolice.com/assets/directives/D3.14-HospitalCases.pdf [https://perma.cc/N5DS-KTNN]; Elizabeth Van Brocklin, *Philly Police Are Saving Lives by Taking Shooting Victims to the Hospital Without Waiting for Paramedics*, SLATE: JURISPRUDENCE (Nov. 14, 2018, 8:30 AM), https://slate.com/news-and-politics/2018/11/philadelphia-police-scoop-and-run-ambulance.html [https://perma.cc/S3MD-63FG].

2015, police transported more than fifty percent of individuals with penetrating wounds to Philadelphia ERs.[303] Other cities, such as Chicago, Detroit, and Stockton, California, also permit their officers to transport shooting victims, though none with the regularity of Philadelphia.[304]

Law enforcement–accompanied suspects, arrestees, and inmates often end up in safety-net hospitals. Safety-net hospitals are more likely to house trauma centers capable of handling a wide range of medical issues. They tend to be located in urban, metropolitan areas with higher crime rates and higher concentrations of low-income people and racial minorities. Financial concerns may also be a contributing factor. For nonfederal prisoners, local taxpayers may be responsible for inmate healthcare pending trial because of a policy excluding certain inmates from benefits including Medicaid.[305] Some police manuals actually identify the local safety-net hospital as the default place to transport sick or injured persons.[306] In certain larger jurisdictions, the safety-net hospitals partner with local law enforcement directly. Bellevue Hospital in New York City, Los Angeles County + USC Medical Center, and the University of Texas at Galveston Medical Center have each worked with their local department of corrections to establish jail wards in their hospitals or, in the case of Los Angeles, formed a hospital unit in the jail itself.[307]

Police may also already be in safety-net hospitals. Some ERs have a documented risk of violence. Violence in the ER can stem from factors associated with poverty, including overcrowded ERs, an increasing

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[303] Elinore J. Kaufman et al., *Patient Characteristics and Temporal Trends in Police Transport of Blunt Trauma Patients: A Multicenter Retrospective Cohort Study*, 21 PREHOSPITAL EMERGENCY CARE 715, 717 (2017); *see also* Jacoby et al., *supra* note 5, at 188.

[304] Van Brocklin, *supra* note 302.

[305] NAT'L ASS'N OF CNTYS., FEDERAL POLICY IMPACTS ON COUNTY JAIL INMATE HEALTHCARE & RECIDIVISM 3 (2019). Medicaid now covers inpatient care for a federal inmate if the person would have been Medicaid eligible if the person were not incarcerated. OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF JUST., THE FEDERAL BUREAU OF PRISONS' REIMBURSEMENT RATES FOR OUTSIDE MEDICAL CARE 15 (2016); *see also* PEW CHARITABLE TRS., *supra* note 8, at 2.

[306] *E.g.,* DENVER POLICE DEP'T, *supra* note 76, § 113.01(6); JORGE R. COLINA, MIAMI POLICE DEP'T, DEPARTMENTAL ORDERS pt. 10 § 9.4.2.2 (2020) ("As a general rule, injured persons shall be taken to Jackson Memorial Hospital."). The Buffalo Police Department manual directs their psychiatric and inmate patients to the local public hospital, Erie County Medical Center. CITY OF BUFFALO POLICE DEP'T, *supra* note 92, ch. 3, § 14.3.A. Seattle's public hospital, Harborview Medical Center, regularly treats inmates from the local jail, King County Correctional Facility. Patrick J. Maher et al., *Emergency Department Utilization by a Jail Population*, 36 AM. J. EMERGENCY MED. 1631, 1631–32 (2018).

[307] *Bellevue Hospital Prison Ward*, CORR. OFFICERS' BENEVOLENT ASS'N, INC., https://www.cobanyc.org/bellevue-hospital-prison-ward [https://perma.cc/WH8T-263W]; Douglas Morino, *County to Honor USC Correctional Health Program*, HSC NEWS (Oct. 7, 2015), https://hscnews.usc.edu/county-to-honor-usc-correctional-health-program [https://perma.cc/67Y9-78ED]; *Correctional Managed Care*, UTMB HEALTH, https://www.utmb.edu/cmc/home [https://perma.cc/E82S-MAHB].

number of mental health and substance-dependent patients, prolonged stays, crowded treatment facilities, understaffing, and the lack of preexisting relationships between the treatment provider and the patient that would facilitate trust.[308] Twenty-nine states and the District of Columbia have enacted legislation allowing hospitals to form their own police departments.[309] Typically these police departments are wholly separate from the local police force.[310] Public safety-net hospitals have increased their use of police in the last two decades.[311] Hospitals that do not have their own police departments contract with private security firms[312] or employ off-duty police officers because of their training and powers of arrest.[313] Those hospitals that have only hospital security staff may collaborate with the local police department.[314]

Police arrive in safety-net hospitals through these various pathways, raising the question of how their presence affects the patients who come

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[308] Creagh Boulger et al., *Management of the Violent Patient in the Emergency Department*, EMERGENCY MED. REPS. (May 1, 2017), https://www.reliasmedia.com/articles/140623-management-of-the-violent-patient-in-the-emergency-department [https://perma.cc/5WQH-XK3M]; *see also* Sandra K. Richardson et al., *Management of the Aggressive Emergency Department Patient: Non-pharmacological Perspectives and Evidence Base*, 11 OPEN ACCESS EMERGENCY MED. 271, 279 tbl.2 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6861170 [https://perma.cc/7LNL-KB48].

[309] John Diedrich et al., *New Police Force in America: More Hospitals Are Creating Private Departments, Raising Concerns About Secrecy and Abuse*, MILWAUKEE J. SENTINEL (Jan. 13, 2021, 5:25 PM), https://www.jsonline.com/in-depth/news/investigations/2020/12/15/hospital-police-have-power-officers-but-little-oversight/6362900002 [https://perma.cc/H6CS-GH7E]; *Some Hospitals Forming In-house Police Departments*, HEALTHCARE DIVE (Jan. 14, 2015), https://www.healthcaredive.com/news/some-hospitals-forming-in-house-police-departments/352252 [https://perma.cc/RVY4-38MF]; *see, e.g.*, Act of May 7, 2013, Pub. L. No. 199-2013, § 1, 2013 Ind. Acts 2052, 2052–53; H.B. 4540, 2020 Leg., Reg. Sess. (W. Va. 2020), https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB4540%20INTR.htm&yr=2020&sesstype=RS&i=4540 [https://perma.cc/Y7ZG-CS8W].

[310] For example, the New York City Department of Health and Hospitals Police is separate from the NYPD. It is a law enforcement division for the New York City Health and Hospital Corporation. Press Release, NYC Health + Hospitals, NYC Health + Hospitals Celebrates Newest Graduating Class of Special Officers at the NYC Hospital Police Academy (Feb. 6, 2020), https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-celebrates-newest-graduating-class-at-nyc-hospital-police-academy [https://perma.cc/S8FJ-74CB].

[311] From 2000 to 2008, the number of police forces in public hospitals increased from forty-two to sixty-four. Lara-Millán, *supra* note 10, at 877; *see also* BRIAN A. REAVES, BUREAU OF JUST. STAT., CENSUS OF STATE AND LOCAL LAW ENFORCEMENT AGENCIES, 2008, at 8 tbl.7 (2011). As Professor Armando Lara-Millán points out, this number is more significant than facially apparent as "the number of general acute care public hospitals in the 100 largest U.S. cities fell to just 70." Lara-Millán, *supra* note 10, at 877.

[312] *See, e.g.*, *Healthcare Security*, HSS, https://hss-us.com/security-services/healthcare-security [https://perma.cc/VQX6-HQWJ].

[313] *See* Elisabeth Rosenthal, *When the Hospital Fires the Bullet*, N.Y. TIMES (Feb. 12, 2016), https://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html [https://perma.cc/98TG-75RP]; *see also* Seth W. Stoughton, *Moonlighting: The Private Employment of Off-Duty Officers*, 2017 U. ILL. L. REV. 1847, 1855–56.

[314] *See, e.g.*, CAROLINAS COLL. OF HEALTH SCIS., CAROLINAS HEALTHCARE SYSTEM CORPORATE SECURITY, 2016 CAMPUS SAFETY AND SECURITY REPORT 2 (2016).

to the ERs for care. Scholars have described the discriminatory policing practices affecting Blacks and other racial minorities.[315] Legal academics have also argued that the Fourth Amendment jurisprudence has exacerbated or paved the way for race-based policing.[316] These same issues arise in the ER.

2. Heightened Surveillance. — The lack of special privacy protections in the ER enables informal or formal collaborations between law enforcement and hospitals that heighten the police surveillance of patients. Several scholars have written about the systematic stigmatization and criminalization of Black mothers in medical settings.[317] The Charleston hospital's program of drug testing pregnant women, at the heart of the Supreme Court's decision in *Ferguson v. City of Charleston*, has garnered the most attention. But well before the Supreme Court's decision in *Ferguson*, the majority of states criminalized maternal drug use through laws ranging from assault and child abuse to manslaughter.[318]

Sociological accounts reflect informal practices of surveillance in ERs. In his study of a large public ER, Professor Armando Lara-Millán described police checking IDs of people in the ER waiting room when it became particularly crowded and taking names to run background checks.[319]

Anecdotal information from hospitals show how surveillance can occur in the treatment area itself. In another hospital located in a primarily Black and immigrant neighborhood, medical professionals noted instances where police seemed to be jotting down names of patients and their date of births, even when the patient had not come in with police

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315 Capers, *Policing, Race, and Place*, *supra* note 21, at 46; Carbado, *(E)racing the Fourth Amendment*, *supra* note 21, at 985; David A. Harris, *Factors for Reasonable Suspicion: When Black and Poor Means Stopped and Frisked*, 69 IND. L.J. 659, 660 (1994); Lenese C. Herbert, Bête Noire*: How Race-Based Policing Threatens National Security*, 9 MICH. J. RACE & L. 149, 155–56 (2003); Maclin, *Race and the Fourth Amendment*, *supra* note 21, at 336; *see also* Frank Rudy Cooper, *"Who's the Man?": Masculinities Studies,* Terry *Stops, and Police Training*, 18 COLUM. J. GENDER & L. 671, 676, 683 (2009).

316 *See* Carbado, *supra* note 2, at 129 ("Over the past four decades, the Supreme Court has interpreted the Fourth Amendment to enable and sometimes expressly legalize racial profiling."); Paul Butler, *The White Fourth Amendment*, 43 TEX. TECH L. REV. 245, 252 (2010); Cynthia Lee, *Reasonableness with Teeth: The Future of Fourth Amendment Reasonableness Analysis*, 81 MISS. L.J. 1133, 1136 (2012).

317 *See* sources cited *supra* note 19.

318 ROBERTS, *supra* note 19, at 153.

319 Lara-Millán, *supra* note 10, at 877. Professor Lara-Millán does not reveal the name of the hospital but states that it is "consistent with the flagship public ERs of Chicago, Los Angeles, and New York City." *Id.* at 870. The hospital is located in a metropolitan with a population of more than 1.5 million. *Id.* The area served by the hospital reports a poverty rate of at least twenty percent. *Id.* His observations echo what Professor Goffman described in her work as young Black men avoiding hospitals for fear of rearrest. *See* GOFFMAN, *supra* note 9, at 34–35.

escort.[320] In a hospital in Oakland, the sheriff's department, contracted to act as hospital security, installed a license plate reader at the entrance of the emergency department without the knowledge of hospital administration.[321] For three years, hundreds of thousands of patients had their license plates sent to federal law enforcement agencies.[322] Medical professionals in another large safety-net hospital serving a majority Black population described an informal but routine practice of hospital security taking patients' IDs and cell phones and handing them over to police, even when patients were not in police custody.[323] In Baltimore, a group of patients recently filed a civil rights lawsuit against the Baltimore Police Department alleging unconstitutional seizures of their belongings, including money and cell phones, while they were being treated in local hospitals.[324]

In her critique of the welfare system, Professor Kaaryn Gustafson describes how the welfare system became an extension of the criminal justice system. In particular, Gustafson describes "Operation Talon," a federal law enforcement program that transformed food stamp offices into "sites of sting operations for arresting individuals with outstanding warrants"[325] and traps for "hungry lawbreakers."[326] Similarly, the practices of background and warrant checks in the ER converts the ER into a trap for "sick or injured lawbreakers." Though the surveillance observed in emergency rooms comes nowhere near the formality of Operation Talon, the two settings are similar in one important sense. Just as welfare recipients face the choice of either accepting needed social benefits or having no shelter or food, people who rely on the ER for their medical care face a similar lack of meaningful choice: either go to the ER for medical treatment and risk enforcement or fail to receive needed medical care.[327]

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[320] This information was compiled by medical professionals in response to concerns about the effects of law enforcement on patient care. *See* Hospital Reports, *supra* note 9. The hospital is a safety-net Level 1 trauma facility in an urban metropolitan area.

[321] BondGraham, *supra* note 13.

[322] *Id.*; Darwin BondGraham, *Alameda Health Systems Removes License Plate Reader Surveillance Camera from Highland Hospital in Oakland*, E. BAY EXPRESS (Nov. 30, 2017), https://eastbayexpress.com/alameda-health-systems-removes-license-plate-reader-surveillance-camera-from-highland-hospital-in-oakland-2-1 [https://perma.cc/YR4G-PVUT].

[323] *See* Telephone Interview by Michael Smith with EW, *supra* note 9, at 5, 15–19.

[324] *See* Class Action Complaint and Jury Demand, Cottman v. Balt. Police Dep't, No. 21-cv-00837 (D. Md. Apr. 1, 2021).

[325] Kaaryn Gustafson, *The Criminalization of Poverty*, 99 J. CRIM. L. & CRIMINOLOGY 643, 669–70 (2009).

[326] *Id.* at 670.

[327] Erin M. Kerrison & Alyasah A. Sewell, *Negative Illness Feedbacks: High-Frisk Policing Reduces Civilian Reliance on ED Services*, 55 HEALTH SERVS. RSCH. 787, 787, 790 (2020) (analyzing responses of 2,920 individuals to measure correlation between race, emergency room usage, and stop-and-frisk tactics in Philadelphia and finding that though poorer health leads to higher ED usage, individuals in areas with higher frisk concentrations are less likely to use the ED).

3. Pretextual Investigations. — The broad authority given to police to conduct general fact-finding in the emergency room without triggering constitutional protections also raises the possibility of race-based policing. Courts emphasize the importance of the police's ability to question patients in the emergency room for possible criminal activity.[328] One of the doctrinal justifications for police presence in the ER is the need for police to check in on injured patients as victims of possible crimes.[329] This need for general investigation also justifies preliminary questioning by police.[330] If the questioning of a patient makes clear that the patient is the object of police suspicion, police involvement in the questioning, even if indirect, constitutes an interrogation requiring Fifth Amendment protection.[331] In one such case, a nurse began asking questions of the patient about the alleged crime under the "direct scrutiny of a police officer."[332] The court did not require evidence of overt collusion between the nurse and the officer; the officer's silent acquiescence by listening and then participating in the questioning himself was sufficient evidence of a custodial interrogation.[333]

But the ways in which the courts have interpreted whether a patient is viewed as a suspect or a mere subject of general police inquiry can open the door for pretextual investigations. The kinds of pretextual investigations I discuss here are similar to pretextual traffic stops but with key differences. The Supreme Court discussed the issue of pretextual traffic stops in *Whren v. United States*,[334] holding that the subjective intent of a police stop did not matter as long as the police had probable cause that a law had been violated, even if that law were one of a multitude of often byzantine traffic violations or regulatory offense

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[328] *See supra* note 122 and accompanying text.

[329] State v. Cromb, 185 P.3d 1120, 1122 (Or. Ct. App. 2008) (officer had a "'working relationship with the emergency room technicians' who gave him access for investigative purposes to anyone who was receiving treatment in the emergency room"); State v. Thompson, 585 N.W.2d 905, 911 (Wis. Ct. App. 1998) (privacy not offended "when a police officer, in responding to an emergency call and with the acquiescence of hospital staff, enters the treatment area of an emergency room"); *see also* United States v. Mattox, No. 18-cr-263, 2019 WL 2343697, at *1 (D. Minn. Apr. 3, 2019), *report and recommendation adopted*, No. 18-264, 2019 WL 2341578 (D. Minn. June 3, 2019); United States v. Clancy, No. 18-CR-20058, 2019 WL 245921, at *3 (W.D. Tenn. Jan. 17, 2019); United States v. Pugh, No. CR417-051, 2017 WL 6270151, at *2 (S.D. Ga. Oct. 19, 2017), *report and recommendation adopted,* No. CR417-051, 2017 WL 6210510 (S.D. Ga. Dec. 8, 2017).

[330] *See supra* notes 166–168 and accompanying text.

[331] State v. Ybarra, 804 P.2d 1053, 1056 (N.M. 1990); People v. Jones, 393 N.E.2d 443, 445 (N.Y. 1979) (citing Miranda v. Arizona, 384 U.S. 436, 444 (1966)); Commonwealth v. Whitehead, 629 A.2d 142, 145 (Pa. Super. Ct. 1993).

[332] *Ybarra*, 804 P.2d at 1056.

[333] *Id.*

[334] 517 U.S. 806 (1996).

codes.[335] *Whren* has been heavily criticized as allowing, or facilitating, racial profiling by police.[336]

The concern of pretextual investigations in the emergency room comes not from the targeting of suspects who are racial minorities based upon any law violation, but from police characterizing their interactions with Black or other racial minority patients as generally investigatory and not designating the patient as a suspect when all other factors indicate otherwise. This shift in orientation from victim to suspect naturally occurs in police investigations and may happen without any nefarious intent by the police officer.[337] But the following two examples show how these kinds of investigations could occur, particularly for Black men who come into the emergency room. They also demonstrate how the label of victim can be used to investigate a suspect and how a police officer's characterization of a person as a victim affects the outcome of a constitutional question.

After being shot, Marcus Mattox was taken to the local hospital in Saint Paul, Minnesota.[338] A police officer reported to the hospital after being told that a gunshot victim had arrived and an officer "needed to watch over the victim."[339] The officer later testified that he headed to the hospital to collect evidence and try to get a statement.[340] He testified that he considered Mr. Mattox to be a victim, but that he also checked if the patient had any warrants "because he had information that there were multiple different types of caliber bullets at the scene of the shooting."[341] The officer asked the nurse for Mr. Mattox's clothing while he was out of the room for a CT scan, and the nurse also provided Mr.

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[335] *Id.* at 813.

[336] *See, e.g.*, Paul Butler, *The System Is Working the Way It Is Supposed To: The Limits of Criminal Justice Reform*, 104 GEO. L.J. 1419, 1453 (2016); Gabriel J. Chin & Charles J. Vernon, *Reasonable but Unconstitutional: Racial Profiling and the Radical Objectivity of* Whren v. United States, 83 GEO. WASH. L. REV. 882, 884 (2015); Kevin R. Johnson, *How Racial Profiling in America Became the Law of the Land:* United States v. Brignoni-Ponce *and* Whren v. United States *and the Need for Truly Rebellious Lawyering*, 98 GEO. L.J. 1005, 1066 (2010).

[337] Cat Smith, *"Victim" Becomes Suspect*, MOHAVE VALLEY DAILY NEWS (Nov. 4, 2013, 7:00 PM), https://mohavedailynews.com/news/65172/victim-becomes-suspect [https://perma.cc/8LDS-A4MQ]; *Victim of Shooting in Richmond Wednesday Becomes Suspect at Hospital*, RICHMOND STANDARD (Apr. 16, 2015), https://richmondstandard.com/beyond-richmond/2015/04/16/richmond-police-investigating-drive-by-shooting-that-injured-25-year-old-man [https://perma.cc/JDR6-4ET4]; News Release, L.A. Police Dep't, Suspect Becomes a Victim (June 1, 2008), https://www.lapdonline.org/van_nuys_news/news_view/38372 [https://perma.cc/SDN5-EW6F].

[338] United States v. Mattox, No. 18-263, 2019 WL 2343697, at *1 (D. Minn. Apr. 3, 2019). Regions Hospital is the safety-net hospital for the east metro area in Saint Paul. *See Regions Hospital Foundation*, REGIONS HOSP., https://www.healthpartners.com/hospitals/regions/about/foundation [https://perma.cc/SCN2-V4E6].

[339] *Mattox*, 2019 WL 2343697, at *1.

[340] *Id.*

[341] *Id.*

Mattox's ID from his clothing.[342] He then ran a warrant check, "which came back clear."[343] When Mr. Mattox returned to his room, the officer attempted to interview him; the officer testified he was interviewing Mr. Mattox "as a gunshot victim and not a suspect."[344] Mr. Mattox's face was swollen from the gunshot wound to his face and "he had difficulty mouthing words."[345] The officer did not arrest Mr. Mattox at that time.[346]

At the same time, another officer learned that several items had been collected as evidence from the shooting scene, including two handguns.[347] He also gathered information about Mr. Mattox, including his prior felony conviction, which prohibited him from possessing a firearm.[348] He included this in a search warrant application for Mr. Mattox's DNA.[349] The officer interviewed Mr. Mattox the following day, a day after Mr. Mattox's surgery.[350] He did not administer *Miranda* warnings because "[Mattox] was not a suspect and he was not detained."[351] In a suppression hearing, Mr. Mattox challenged his statements and the clothing recovered.[352] The court determined that the statements were taken in a noncustodial environment and that his clothing was in "plain view" of police, who were there for the lawful purpose of investigating him as the victim of a shooting.[353] A jury later convicted Mr. Mattox of being a felon in possession of a firearm.[354]

Following a shooting in Maryland, Eric Jamison arrived at the hospital in a car driven by his friends.[355] The court's decision recounted the defendant arriving at the ER and telling an officer at the entrance "I've been shot[!]"[356] The court would later rely upon this initial contact as evidence that the defendant "invited" a later interview during which he confessed that he shot himself.[357] His admission formed the basis for a subsequent charge of being a felon in possession of a firearm.[358] The defendant's brief tells the facts differently. When he arrived at the ER,

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342 *Id.* at *2.
343 *Id.*
344 *Id.*
345 *Id.*
346 *Id.*
347 *Id.*
348 *Id.* at *3.
349 *Id.*
350 *Id.* at *2–3.
351 *Id.* at *3.
352 *Id.* at *4.
353 *Id.* at *8.
354 United States v. Mattox, No. 18-263, 2020 WL 2404826, at *1 (D. Minn. May 12, 2020).
355 United States v. Jamison, 509 F.3d 623, 625 (4th Cir. 2007).
356 *Id.* (alteration in original).
357 *Id.*
358 *Id.*

a police officer came out to the car and then followed Mr. Jamison into a hospital room and began taping paper bags to his hands without Mr. Jamison's permission.[359] The officer explained this was standard procedure for gunshot victims so that gunshot residue tests could be conducted "to rule them out as the shooters."[360] The government's brief does not give specifics about this encounter but concedes that, at some point during the initial encounter, bags were placed on Mr. Jamison's hands.[361] The Fourth Circuit found that bagging Mr. Jamison's hands did not render the questioning custodial in nature, reversing the lower court's determination that the questioning of Mr. Jamison violated the Fifth Amendment.[362]

Mr. Mattox and Mr. Jamison are Black men.[363] The police investigated both men and treated them in ways that seem incongruous with notions of how victims should be treated. In Mr. Mattox's case, all the actions that the police took, including getting a search warrant, seem consistent with how police might approach a suspect. But the court took at face value the officer's statement that Mr. Mattox remained a victim and not a suspect. Similarly, the act of placing paper bags over Mr. Jamison's hands to preserve gunshot residue could only be interpreted as the police officer's suspecting him of being a shooter himself. Moreover, if a Fourth Amendment objection had been raised, such conduct arguably rises to a seizure without appropriate justification by the police.

The fact that courts often accept a police officer's characterization of a patient as a victim is striking. Just because a police officer says a person is a victim or a suspect does not make it so. A court does not accept at face value a police officer's claim that a handcuffed person is not under arrest.[364] It examines the reasonableness of that statement.

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[359] Brief of the Appellee at 2–3, *Jamison*, 509 F.3d 623 (No. 07-4101).

[360] *Id.*

[361] Brief of the United States, Appellant at 3, *Jamison*, 509 F.3d 623 (No. 07-4101). In yet another case involving unlawful possession of firearm, an officer testified that he began questioning the defendant, a Spanish speaker, "[b]elieving [he] was the victim of an assault." People v. Ochoa, No. A155735, 2019 WL 4640044, at *1 (Cal. Ct. App. Sept. 24, 2019).

[362] *Jamison*, 509 F.3d at 625. Carl Overington experienced similar police suspicion as soon as he arrived at the emergency room with a gunshot wound; an officer met him at the door to the ER and patted him down before he was allowed inside for treatment. United States v. Overington, No. 07-147, 2007 WL 3119843, at *1 (E.D. Pa. Oct. 24, 2007). The officer then searched the car Mr. Overington had arrived in and found a gun. *Id.* Another officer went in to question him. *Id.* at *2. Only after he was questioned by two officers did the officers administer *Miranda* warnings. *Id.* The court found that he was not in custody as he had come to the hospital voluntarily and any restraint of his movement was due to medical and not investigative reasons. *Id.* at *4; *see also* United States v. Davis, 657 F. Supp. 2d 630, 634 (D. Md. 2009).

[363] *See* Telephone Interview with F. Clayton Tyler, Att'y for Mr. Mattox (Aug. 18, 2020) (notes on file with author); Email from Paresh Patel, Fed. Def., to author (Aug. 18, 2020, 12:50 PM) (on file with author).

[364] *Cf. supra* pp. 2672–73.

An officer's characterization of a patient as victim is not subject to scrutiny in the same way.

Racial stereotypes held by police could also be masked by police characterizing the patients as victims and not suspects. Bias and preconceived perceptions of criminality shape the way that police react to Black patients so that even with gunshot victims, police could investigate in ways that are consistent with how they would investigate suspects.[365] Studies of Black male victims of violence reflect these individuals' experiences with police as ones where some felt they were being treated as suspects and not victims.[366] Police interviewing of Black patients in ambulances and emergency rooms caused patients an increased sense of vulnerability and the sense that "they were being treated as the perpetrator."[367] What the patients in this study recounted calls to mind Professor Devon Carbado's term "racial insecurity" to describe "a racial sense of exposure, anxiety, and vulnerability that some people experience in the context of police encounters."[368] The racial insecurity of the Black patients in this study compounded their sense of physical insecurity and vulnerability.

Courts' treatment of police encounters with patients as voluntary or consensual also raises heightened concerns when it comes to Black patients. "Consensual encounters" are not necessarily consensual.[369] The courts' characterizations of police behavior as benevolent ignores that "police" means very different things to different people.[370] Especially for people of color, police interactions might not be viewed in a benevolent light.

That more formal indicia of suspect-narrowing, custody, or formal arrest are required to trigger constitutional protections also ignores that there may be very good reasons why a police officer may not take that additional step of formal arrest. From a police officer's perspective,

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[365] *See* 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); Phillip Atiba Goff et al., *The Essence of Innocence: Consequences of Dehumanizing Black Children*, 106 J. PERSONALITY & SOC. PSYCH. 526, 535 (2014).

[366] Liebschutz et al., *supra* note 77, at 1375.

[367] *Id.*

[368] Carbado, *supra* note 2, at 142; *see also* L. Song Richardson, *Implicit Racial Bias and Racial Anxiety: Implications for Stops and Frisks*, 15 OHIO ST. J. CRIM. L. 73, 80 (2017) ("For Black individuals, racial anxiety is experienced as the fear of being victimized by police racism.").

[369] *See* Carbado, *(E)racing the Fourth Amendment*, *supra* note 21, at 1023; Maclin, *supra* note 170, at 272.

[370] *See* Carbado, *(E)racing the Fourth Amendment*, *supra* note 21, at 952; Kristin N. Henning, *The Reasonable Black Child: Race, Adolescence, and the Fourth Amendment*, 67 AM. U. L. REV. 1513, 1522–23 (2018).

there may be many advantages to maintaining the victim status or nonarrest status. It may be that they need more time to build a case and know that they can question a person in the hospital without fear that it will amount to a custodial interrogation. It may be because they know that the patient is going to be staying put at the hospital due to their injuries and that the hospital will notify them when the patient is released. It may be based on more mundane and administrative reasons such as not wanting the government to shoulder any financial responsibility for the patient.[371] These reasons, however, do not demonstrate that a police officer actually views the patient as a victim, but rather that the hospital setting provides incentives to not have to deal with the formalities and the regulations of arrest.

There is also no reason to believe that police would engage in these kinds of pretextual investigations only in gun violence cases. For example, one of the main actions of police in the ER that Lara-Millán studied involved interrogating patients.[372] He provides one example of two officers talking to a young man strapped and handcuffed to a gurney about his life as a drug dealer.[373] The officer explained to Lara-Millán that the man was there not because of any criminal charges but because he was high and drunk.[374] In his words: "A lot of these guys are high when we take them in, you know like we can pretty much find stuff people are doing illegal just by talking to them . . . and we're trying to crackdown on that area."[375] The nurse then escorted the police officers to a bed where they "[sat] with the man for the next few hours."[376]

III. ERS AS PATIENT SANCTUARIES

The current criminal procedure doctrine does not provide patients with adequate protection from harmful police practices. Instead, the doctrine approves of broad police action in the emergency room as a valued societal benefit. As conversations about defunding and abolishing police have gained hold, police presence in the emergency room confirms the need to reexamine the doctrine and consider policy proposals

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[371] Local government entities may bear financial costs of any medical care provided to pretrial arrestees. *See* Sharp Healthcare v. County of San Diego, 68 Cal. Rptr. 3d 152, 153 (Ct. App. 2007) ("[T]he County is not liable for the medical care expenses of a person arrested and treated at a hospital before the arrestee is committed to the county jail."). In one particularly egregious example, sheriffs in Alabama would bail sick inmates out of jail to avoid medical costs. *See* Connor Sheets, *Unchecked Power: These Sheriffs Release Sick Inmates to Avoid Paying Their Hospital Bills*, PROPUBLICA (Sept. 30, 2019, 6:00 AM), https://www.propublica.org/article/these-sheriffs-release-sick-inmates-to-avoid-paying-their-hospital-bills [https://perma.cc/2ALM-B6DA].

[372] Lara-Millán, *supra* note 10, at 879.

[373] *Id.* at 879–80.

[374] *Id.* at 879.

[375] *Id.* at 880 (omission in original).

[376] *Id.*

that go beyond the courtroom. The terms "defund police" and "abolish police" mean different things to different people.[377] At a minimum, there is agreement that the footprint of police in our society must shrink in order to address the state-sanctioned violence police inflict on Black communities and other communities of color.

The presence of police in the ER reflects what some have described as police being a "one-size-fits-all" solution to a whole host of social problems.[378] Substance abuse, homelessness, mental illness, and traffic-related injuries all appear in emergency rooms, with police playing integral roles. The ER also displays the problems with giving police all these responsibilities. Police presence results in a net-widening effect and even physical harm, including death. As Professor Christy Lopez has argued, the first step in addressing the problem of policing must be to recognize our overreliance on police to solve a wide range of problems.[379] Because of the many roles police take on in the ER, the ER is an ideal place to recognize and correct this overreliance. At the same time, valid concerns of security and violence in the ER complicate the analysis.

This Part only begins to touch upon the issues of defunding and abolishing police in the ER by suggesting ways in which the role of police in the ER can be reimagined. I put forward two proposals for decreasing, shifting, and restricting police's immediate access to patients. The first outlines a doctrinal framework for better privacy protections. The second sketches out institutional measures specifically targeted at hospital practices. These two proposals are interrelated in the sense that changes in institutional practices could ultimately contribute to heightened privacy protections in the emergency room.

A. Sanctuary in the ER Context

My suggestions are rooted in a conceptualization of the emergency room as sanctuary borrowed from immigration advocates in movements past and current. This conception of sanctuary combines the idea of

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[377] Sean Illing, *The "Abolish the Police" Movement, Explained by 7 Scholars and Activists*, VOX (June 12, 2020, 11:00 AM), https://www.vox.com/policy-and-politics/2020/6/12/21283813/george-floyd-blm-abolish-the-police-8cantwait-minneapolis [https://perma.cc/5BD9-R5XA]; *see also* Aaron Ross Coleman, *Police Reform, Defunding, and Abolition, Explained*, VOX (July 16, 2020, 8:00 AM), https://www.vox.com/21312191/police-reform-defunding-abolition-black-lives-matter-protests [https://perma.cc/YSA8-TSFG]; Mariame Kaba, Opinion, *Yes, We Mean Literally Abolish the Police*, N.Y. TIMES (June 12, 2020), https://www.nytimes.com/2020/06/12/opinion/sunday/floyd-abolish-defund-police.html [https://perma.cc/2SFT-FJQF].

[378] All Things Considered, *What Police Are For: A Look into Role of the Police in Modern Society*, NPR (June 10, 2020, 3:57 PM), https://www.npr.org/2020/06/10/874340093/what-police-are-for-a-look-into-role-of-the-police-in-modern-society [https://perma.cc/N965-X8J8].

[379] Christy E. Lopez, Opinion, *Defund the Police? Here's What that Really Means.*, WASH. POST (June 7, 2020), https://www.washingtonpost.com/opinions/2020/06/07/defund-police-heres-what-that-really-means [https://perma.cc/WL2F-PHN6].

refuge from government authorities in places like churches with current conceptions of jurisdictional sanctuaries where cities and other government localities restrict police participation in federal immigration enforcement activity.[380]

This concept of sanctuary has been applied to immigration enforcement in healthcare settings.[381] In response to the rise of immigration enforcement in hospitals, Physicians for Human Rights has released a report advocating for patient privacy rules and norms grounded in conceptions of sanctuary.[382] The report uses the term "sanctuary hospital" to describe "the concept of a safe space where patients' rights are uniformly protected by providers and respected by government authorities."[383] A sanctuary hospital would have policies that feature various measures designed to protect patients, including "direct[ing] staff on how to interact with immigration agents; explain[ing] how to approach immigration issues with patients; not[ing] the best way to record relevant patient information; and clarify[ing] obligations under [HIPAA] as pertaining to immigrant patients."[384]

At the same time, medical professional organizations and institutions have developed materials addressing immigration enforcement and patients' rights.[385] California has dealt with the situation legislatively and adopted the California Values Act[386] in response to the ramp-up of immigration enforcement. The new law requires hospitals as well as other public institutions to adopt policies that restrict ICE activity and other

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[380] *See generally* SUSAN BIBLER COUTIN, THE CULTURE OF PROTEST: RELIGIOUS ACTIVISM AND THE U.S. SANCTUARY MOVEMENT (1993); Barbara E. Armacost, *"Sanctuary" Laws: The New Immigration Federalism*, 2016 MICH. ST. L. REV. 1197; Bill Ong Hing, *Immigration Sanctuary Policies: Constitutional and Representative of Good Policing and Good Public Policy*, 2 U.C. IRVINE L. REV. 247 (2012).

[381] Medha D. Makhlouf, *Healthcare Sanctuaries*, 20 YALE J. HEALTH POL'Y L. & ETHICS (forthcoming June 2021) (manuscript at 6–10) (on file with the Harvard Law School Library) (examining the laws, policy, and practice of immigration surveillance in healthcare and proposing implementing sanctuary policies to protect immigrants seeking care).

[382] PHYSICIANS FOR HUM. RTS., NOT IN MY EXAM ROOM: HOW U.S. IMMIGRATION ENFORCEMENT IS OBSTRUCTING MEDICAL CARE 3 (2019); *see also* Makhlouf, *supra* note 381 (manuscript at 5–6) (explaining how current laws and policies are insufficient to create "healthcare sanctuaries" and arguing that more robust legal protection is necessary). As the Physicians for Human Rights report notes: "Historically, the [U.S.] government's policy . . . recognized medical facilities as 'sensitive locations,' where enforcement operations should not occur absent 'exigent circumstances' or prior supervisory approval." PHYSICIANS FOR HUM. RTS., *supra*, at 5 (citing *FAQs: Sensitive Locations and Courthouse Arrests*, U.S. IMMIGR. & CUSTOMS ENF'T (Jan. 31, 2018), https://www.ice.gov/faqs-sensitive-locations-and-courthouse-arrests [https://perma.cc/3JQ7-7CRT]). However, as the report details, recent years have seen violations of this "sensitive locations" policy. *Id.* at 5–6.

[383] PHYSICIANS FOR HUM. RTS., *supra* note 382, at 4.

[384] *Id.* at 5.

[385] *See, e.g.*, *Provider Resources, Helpful Links & Documents*, ILL. ALL. FOR WELCOMING HEALTH CARE, https://www.ilalliancehealth.org/resources [https://perma.cc/M6KZ-L6FM].

[386] CAL. GOV'T CODE §§ 7284–7284.12 (West 2021).

immigration enforcement on their premises.[387] The California Attorney General's Office has issued model policies to assist hospitals in responding to border enforcement issues.[388]

It is true that the issues with immigration enforcement are different from those with law enforcement more generally. Immigration enforcement in local institutions raises the issue of states' rights and resources being used for federal enforcement purposes, especially when those two jurisdictions conflict. Immigration enforcement is also presumably about one discrete issue — whether someone is in the country lawfully — which is different from the various crime-related reasons why police may be involved in the emergency room. But the harms to patients detailed in the report apply more broadly than just to immigration enforcement. The California Attorney General's report describes how immigration enforcement forces clinicians to compromise ethical obligations and potentially violate laws and policies intended to ensure nondiscrimination, patient privacy, and confidentiality.[389] These concerns mirror the issues of police in the ER.

This conception of a medical facility as sanctuary more generally has also been raised as a solution to police presence on Veterans Affairs (VA) medical campuses. A recent policy advisory issued by the National Association of Minority Veterans and UCLA Veterans Legal Clinic proposes that VA campuses be transformed "into sanctuaries where veterans can seek refuge from the challenges they face after serving our country."[390] The policy advisory examines the harmful practices by the VA Police Force on VA campuses, including police violence against veterans and medical staff.[391] The report argues that VA medical facilities should become sanctuaries from police practices, instead of places where police use of excessive force and surveillance technology pose a "potentially significant barrier to veterans seeking healthcare and refuge on VA campuses."[392]

Other medical professionals have supported the healthcare-as-sanctuary approach more broadly. In a recent podcast on structural racism, police violence, and health, several panelists talked about the police presence in healthcare settings like emergency rooms.[393] Dr. Rhea

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387 *Id.*

388 XAVIER BECERRA, CAL. ATT'Y GEN., PROMOTING SAFE AND SECURE HEALTHCARE ACCESS FOR ALL: GUIDANCE AND MODEL POLICIES TO ASSIST CALIFORNIA'S HEALTHCARE FACILITIES IN RESPONDING TO IMMIGRATION ISSUES (2018).

389 *Id.* at 23.

390 PATEL ET AL., *supra* note 20, at 2.

391 *Id.* at 1.

392 *Id.*

393 *Antiracism in Medicine Series Episode 1 — Racism, Police Violence, and Health (Full Transcript)*, CLINICAL PROBLEM SOLVERS (Aug. 25, 2020), https://clinicalproblemsolving.com/wp-

Boyd, a pediatrician and public health advocate and scholar, employed the language of abolition and sanctuary, saying that those in healthcare need to "be building that sanctuary for folks as [their] human right but also as a health intervention for people."[394] Building healthcare settings as sanctuaries can lessen the harmful effects of police presence in places like ERs, including mistrust of providers through information sharing with police and implicit bias of providers, increases in use-of-force incidents against patients, the perpetuation of racial discrimination and bias by both police and healthcare providers, and privacy violations.[395]

B. Doctrinal Privacy Rooted in Sanctuary

The idea of the ER as a place for sanctuary could also inform doctrinal changes. This conception begins with the reasonable expectation of privacy standard. Instead of ignoring medical vulnerability and medical privacy norms and rules, courts could assess privacy in the ER by accounting for these same conditions.

A plausible counterargument to proposals to restrict police behavior in the ER is that bringing the police's conduct under constitutional scrutiny hinders their ability to investigate crime.[396] But the way in which gunshot victims like Mr. Mattox and Mr. Jamison are treated stands in stark contrast to the treatment of a different kind of victim — the sexual assault victim. In response to perceived mismanagement of sexual assault cases in the criminal justice system, including biases and beliefs held by law enforcement, specialized protocols now govern the collection of evidence in and investigation of sexual assault cases.[397] These protocols delineate roles of law enforcement and medical professionals. They also prescribe how victims should be approached. For example, a victim's vulnerability should be assessed prior to police questioning. The

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content/uploads/2020/08/FULL-TRANSCRIPT-Racism-Police-Violence-and-Health.pdf [https://perma.cc/UBK7-SCNL].

394 *Id.*

395 *See* Kate Gallen et al., Health Effects of Policing in Hospitals: A Review (unpublished manuscript) (on file with the Harvard Law School Library).

396 One might argue that police should be given this amount of discretion especially in the cases of Mr. Mattox or Mr. Jamison, who are gunshot victims. The argument may be that it is desirable to give police more discretion to investigate, especially if a Mr. Mattox or Mr. Jamison contributes to violence in a neighborhood. Charging them with a gun possession offense, then, is a public safety benefit, perhaps more so than finding the actual shooter. But this argument raises other issues about problems in the criminal justice system, including the reality that any number of crimes, whether felonies or misdemeanors, can disqualify someone from having a gun, and Black men are disproportionately convicted of offenses with these types of collateral prohibitions. Skirting or cutting close on constitutional rules based upon how police label a person seems less than desirable.

397 *See SART Toolkit: Resources for Sexual Assault Response Teams, How Did SARTs Evolve?*, OFF. OF JUST. PROGRAMS, https://www.ncjrs.gov/ovc_archives/sartkit/about/about-evolve.html [https://perma.cc/H5CK-GZKU]; *see also* MALEFYT ET AL., *supra* note 100, at 115.

victim also retains autonomy to acquiesce and cooperate as they wish.[398] This is not to ignore that there may still be problematic practices in sexual assault investigations.[399] But the comparison is useful here to show the deference and relative respect given to the sexual assault victim where presumably similar public safety and law enforcement goals exist. The point here is not that gunshot victims can never be perpetrators, but that courts should reasonably account for that by treating those patients as suspects entitled to constitutional protections, rather than simply as victims.

The root of the doctrinal view of the ER as an extension of the street lies in the Fourth Amendment reasonable expectation of privacy standard. Searches, seizures, and interrogations fall outside constitutional review because police are considered lawfully present when they investigate patients. This doctrinal rule impacts all subsequent policing measures in the emergency room by lowering the threshold requirement of what police conduct triggers constitutional protections. The emergency room provides an example of why the reasonable expectation of privacy standard should be normative and not descriptive. As Professor Aya Gruber puts it, the courts should protect "what we ought to be able to regard as private" rather than what we "actually believe[] is private."[400] The Supreme Court has more often than not approached the inquiry as an empirical fact of privacy incursions, evidenced by such decisions as those permitting police aerial surveillance of residential backyards,[401] or looking through people's trash.[402] The courts do the same when it comes to analyzing the reasonable expectation of privacy in the emergency room.

The doctrinal choice made by courts to treat emergency rooms as public thoroughfares exemplifies how empirical conclusions about reasonable expectations of privacy deepen the divide of privacy depending on race and class. Courts literally interpret patients' visibility to others as the rationale for diminished privacy. In doing so, they neglect the many aspects of patients' stays in the emergency room that point to the

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398 *SART Toolkit: Resources for Sexual Assault Response Teams, Develop a SART: Know Your Team*, OFF. OF JUST. PROGRAMS, https://www.ncjrs.gov/ovc_archives/sartkit/develop/team-print.html#law [https://perma.cc/8AKX-MCQH] (stating that law enforcement officials should give choice to victims and give them time, as well as demonstrate sensitivity in questioning).

399 *See* Rose Corrigan, *The New Trial by Ordeal: Rape Kits, Police Practices, and the Unintended Effects of Policy Innovation*, 38 L. & SOC. INQUIRY 920, 923–24 (2013); Shana L. Maier, *"I Have Heard Horrible Stories . . .": Rape Victim Advocates' Perceptions of the Revictimization of Rape Victims by the Police and Medical System*, 14 VIOLENCE AGAINST WOMEN 786, 787 (2008).

400 Gruber, *supra* note 142, at 795 (describing it as an "is-ought" problem); *see also* Anthony G. Amsterdam, *Perspectives on the Fourth Amendment*, 58 MINN. L. REV. 349, 404, 407 (1974); Melvin Gutterman, *A Formulation of the Value and Means Models of the Fourth Amendment in the Age of Technologically Enhanced Surveillance*, 39 SYRACUSE L. REV. 647, 649 (1988).

401 California v. Ciraolo, 476 U.S. 207, 209, 215 (1986).

402 California v. Greenwood, 486 U.S. 35, 37 (1988).

need for greater protections. Patients in the ER are often in some state of undress and more likely lying on a bed, even if that bed is a gurney. They are in physical or emotional pain. The intimate displays in the ER are because certain kinds of urgent medical professional care can be obtained only outside the home.

In thinking about what ought to be the expectation of privacy in the ER, I look to patient privacy as viewed by the medical field as a starting point. HIPAA is the federal statutory authority governing health information disclosures. Enacted in 1996, it created a uniform standard for protecting patient health information from what was a hodgepodge of state privacy protections. The detailed and complicated preconditions required prior to law enforcement disclosures reflect a commitment to protecting patient health information.[403]

Privacy in the medical context is also more expansive than just the privacy of patients' medical information.[404] According to an Opinion in the American Medical Association Code of Medical Ethics, patient privacy encompasses multiple facets. In addition to informational privacy, "patient privacy encompasses . . . personal space (physical privacy), . . . personal choices . . . (decisional privacy), and personal relationships with family members and other intimates (associational privacy)."[405] The Opinion further provides that "[p]hysicians must seek to protect patient privacy in all settings to the greatest extent possible."[406] In addition, physicians must seek to minimize intrusions on patients' privacy and inform them when there has been a significant intrusion on their privacy of which they might not have been aware.[407] Medical vulnerability does not mean lack of autonomy,[408] nor should it be a complete relinquishment of patient modesty and intimacy.[409]

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[403] 45 C.F.R. § 164.512(c), (f) (2019). I previously have argued for greater HIPAA and state statutory protections to create countervailing legal authority for medical professionals. *See* Song, *supra* note 300.

[404] *See, e.g.*, United States v. Mattox, No. 18-263, 2019 WL 2341578, at *1–2 (D. Minn. June 3, 2019); State v. Onumonu, No. 0010002000, 2001 WL 695539, at *2 (Del. Super. Ct. June 18, 2001).

[405] *Code of Medical Ethics Opinion 3.1.1*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/privacy-health-care [https://perma.cc/6AWW-89EX].

[406] *Id.*

[407] *Id.*

[408] *See* Geiderman et al., *supra* note 134, at 634; John C. Moskop et al., *Emergency Department Crowding, Part 1 — Concept, Causes, and Moral Consequences*, 53 ANNALS EMERGENCY MED. 605, 608 (2009) (stating that the principle of autonomy grounds patients' rights to privacy and confidentiality).

[409] *See* Geiderman et al., *supra* note 134, at 653; *see also* Anita Allen, *Privacy and Medicine*, *in* STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., Winter 2016 ed.), https://plato.stanford.edu/archives/win2016/entries/privacy-medicine [https://perma.cc/3E75-DJN2].

Patient privacy is still a goal of emergency departments, even with the practical difficulties posed by overcrowding.[410] The American College of Emergency Physicians has released a position statement on law enforcement information gathering in the emergency department. The statement affirms physicians' fundamental responsibility to patients and specifies only three circumstances where doctors may give law enforcement patient information.[411] The first is when a patient consents; the second is when there is an "applicable law[] or regulation[] mandat[ing] the reporting of the requested personal health information"; the third is in response to a subpoena or court order.[412] Even when presented with a warrant or court order, the statement emphasizes that the physician must make "considered judgments" between physician-patient and public safety obligations.[413] It concludes that "[e]mergency physicians may . . . refuse to . . . comply with legal orders that violate the rights or jeopardize the welfare of their patients," though doing so could have legal repercussions.[414]

An article by emergency physicians lays out further specifics about how patient privacy could be protected even with the presence of law enforcement. For example, they recommend that "ED patients should be asked for and give their permission to be visited by law enforcement officers and to have patient information released to law enforcement."[415] Recognizing that those in law enforcement custody — suspects and inmates — may have limited rights and that law enforcement can access patient information through ex parte warrants, the authors emphasize that "law enforcement activities should not otherwise interfere with patient care."[416]

The authors advise that, as with other visitors, "law enforcement officers should also not be allowed to wander and view patient care activities not related to their reason for being in the ED."[417] Further,

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[410] *See* Olsen & Sabin, *supra* note 134, at 333 (concluding, based on study of ED patients regarding their privacy and confidentiality, that healthcare providers "need to be aware of breaches [of] confidentiality and privacy" during patients' ED stays).

[411] *Policy Statement: Law Enforcement Information Gathering in the Emergency Department*, AM. COLL. OF EMERGENCY PHYSICIANS (June 2017), https://www.acep.org/patient-care/policy-statements/law-enforcement-information-gathering-in-the-emergency-department [https://perma.cc/P5VR-L48H].

[412] *Id.*

[413] *Id.*

[414] *Id.*

[415] John C. Moskop et al., *From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine — Part II: Challenges in the Emergency Department*, 45 ANNALS EMERGENCY MED. 60, 61 (2005) (citing *Policy Statement: Law Enforcement Information Gathering in the Emergency Department*, *supra* note 411).

[416] *Id.*

[417] *Id.*

emergency physicians should protect patient privacy by allowing visitors only when approved of by the patient in case they add stress or are unwelcome, and surrogates should be assigned if patients are unable to consent.[418] "Visitors should be identified and registered with security" and not be allowed to enter unauthorized areas of the ED where they can hear other patients or overhear confidential information.[419]

An aspirational reasonable expectation of privacy should incorporate these medical conceptions and goals of privacy. Then courts would not be able to rely upon a rationale that the ER is open to all. Nor would they be able to justify police presence by stating that any manner of entry gives police carte blanche to enter all spaces of the ER. Further, patients' explicit consent instead of a default that police can enter into treatment spaces to question and search patients should be required to further heighten the privacy protections accorded patients. Moreover, an aspirational standard would recognize that medical professionals should be more circumscribed about providing police access to patients, rather than using medical personnel consent as justification.

An aspirational standard that accounts for the full measure of medical privacy could also bring further meaning to Fourth Amendment privacy, moving it closer to Professor David Sklansky's articulation of privacy as a "zone of refuge."[420] Such a standard makes room for greater consideration of individual autonomy and dignity in Fourth Amendment analyses.

The idea of sanctuary could impact other doctrinal areas as well. For example, nothing is as invasive to the idea of sanctuary as forced procedures that invade the body. The current procedural check of a warrant seems hardly effective when news headlines routinely report warrant-based searches where the person undergoes multiple medical procedures to find no evidence of illicit drugs or substances.[421] Perhaps the highly intrusive nature of body cavity searches should require hearings, similar to what occurred in *Winston v. Lee*, where, because the request to surgically remove a bullet came during the course of the criminal case, the trial court reviewed the constitutionality of the matter before police could submit the request to doctors.[422]

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418 *Id.*

419 *Id.*

420 Sklansky, *Too Much Information*, *supra* note 188, at 1115.

421 *See supra* notes 95–96 and accompanying text.

422 Winston v. Lee, 470 U.S. 753, 757 (1985).

C. Beyond Doctrine

But the problem of policing in the ER raises the question of whether another kind of prescription is necessary or more desirable than a doctrinal proposal.[423] Calls for reducing police presence in the streets have gone from being marginalized reform proposals to possible, increasingly mainstream one.[424] Shouldn't hospitals also consider whether and to what degree police presence serves the interests of the communities who are most vulnerable in the ER? Perhaps the most expedient and desirable solution is to build up other institutions so that they can monitor and circumscribe overbroad police authority themselves. Furthermore, institutional change could have the dual effect of providing immediate change for patients and to police practices and of ultimately affecting how courts view the "empirical facts" of privacy in the ER.

Public health principles of harm reduction provide a framework for ascribing appropriate boundaries for police in the ER.[425] Harm reduction "offers a pragmatic yet compassionate set of principles and procedures designed to reduce the harmful consequences" of the problem causing harm to the individual and the broader society.[426] The aim of harm reduction is to "reduce the harms associated with certain behaviours."[427] Harm reduction strategies have been employed for public health issues such as drug and alcohol abuse, teen pregnancies, and sexually transmitted diseases.[428]

An application of harm reduction principles to police presence in the emergency room would identify police presence as a potential harm to patient care. The idea that police presence is a harm to be addressed in medical settings has come to the fore in recent months.

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[423] A possible prescription not discussed here but elsewhere in my work is a legislative response that would enact a statutory right to privacy for patients in healthcare settings like the emergency room. *See* Song, *supra* note 300 (manuscript at 31–32).

[424] Some local jurisdictions have worked to decrease police funding. *See* Jemima McEvoy, *At Least 13 Cities Are Defunding Their Police Departments*, FORBES (Aug. 13, 2020, 3:04 PM), https://www.forbes.com/sites/jemimamcevoy/2020/08/13/at-least-13-cities-are-defunding-their-police-departments [https://perma.cc/SF3V-B5PF]. Others are looking to examples where emergency response is diverted from police to other agencies, as in mental health calls. *See, e.g.*, GREG STEWART ET AL., PORTLAND POLICE BUREAU, REPORT ON POLICE INTERACTIONS WITH PERSONS IN MENTAL HEALTH CRISIS 34–35 (2012), https://www.portlandoregon.gov/police/article/440249 [https://perma.cc/A52D-3JKU].

[425] G. Alan Marlatt, *Harm Reduction: Come as You Are*, 21 ADDICTIVE BEHAVS. 779, 779 (1996) (describing harm reduction in drug abuse as a "middle-road alternative to the two established traditional approaches": "the moral model" and "the disease model"). I borrow the term "harm reduction" in order to highlight the fact that unregulated police presence itself as a harm, rather than to highlight drug-related harm as this term has traditionally been utilized in harm reduction literature.

[426] *Id.*

[427] Karen Mary Leslie, Position Statement, *Harm Reduction: An Approach to Reducing Risky Health Behaviors in Adolescents*, 13 PAEDIATRICS & CHILD HEALTH 53, 53 (2008).

[428] *Id.*

Last June, a medical resident at the University of California, San Francisco (UCSF) tweeted "Hospitals are places of healing, sanctuary spaces. Why such a high police presence? No reason for armed police officers. Time to rethink those contracts . . . . First #DoNoHarm."[429] UCSF is the teaching institution affiliated with San Francisco General Hospital, the main safety-net hospital in the city.[430] Medical staff at UCSF have argued against the presence of armed police officers on the medical campus. A Black midwife on faculty has been on strike since July 8, 2020, in protest of the use of force by deputies.[431] She described deputies placing Black people in headlocks, arresting them, and running into the birthing unit with their hands on their holsters in response to a reported threat.[432] Use of force incidents totaled over 200 in the 2019–2020 fiscal year, with incidents arising in the emergency room more than any other location.[433] As a result of the protests, San Francisco Department of Health has begun to examine the security relationship between San Francisco General Hospital and the Sheriff's Department.[434] The CEO of the hospital wrote a letter affirming the traumatizing impact of deputies on the medical campus.[435] A coalition group called "DPH Must Divest" has demanded that the Department of Public Health divest from the Sheriff's Department and reinvest those funds into the community.[436] Members of "DPH Must Divest" argue that the hospital should increase the number of their Behavioral Emergency Response Teams (BERTs) consisting of psychiatric nurses.[437] Right now, the hospital has one, in comparison to its twenty-three on-site sheriff's deputies.[438]

This may soon change. In late April 2021, the Director of Security for the Department of Public Health submitted a proposal to the San Francisco Health Commission that emphasized that "[a] consistent and critically important issue the department must address is the inequitable

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[429] @Adali_Mtz, TWITTER (June 9, 2020, 4:30 AM), https://twitter.com/Adali_Mtz/status/1270272162830532608 [https://perma.cc/WBU5-ZCZA].

[430] *See About Us*, ZUCKERBERG S.F. GEN. HOSP. & TRAUMA CTR., https://zuckerbergsanfranciscogeneral.org/about-us [https://perma.cc/6Q6G-656H].

[431] *Petition to Stand in Solidarity with Asmara Gebre, CNM: Remove the Sheriffs from SFGH*, https://docs.google.com/forms/d/e/1FAIpQLSdJuy5f3LtMM_Oj5Uzvguz-VLhLLAgzFOnfZskqVMSGcWw2H7w/viewform [https://perma.cc/VRL4-5ZA8]; Mallory Moench, *Defund the Police? Debate Rages at SF General Hospital over Use of Sheriff's Deputies*, S.F. CHRON. (Aug. 8, 2020, 2:16 PM), https://www.sfchronicle.com/health/article/Defund-the-police-Debate-rages-at-SF-General-15465734.php [https://perma.cc/W4R9-ZTYZ].

[432] Moench, *supra* note 431.

[433] *Id.*

[434] *Id.*

[435] *Id.*

[436] DPH MUST DIVEST, https://www.dphmustdivest.com [https://perma.cc/KC7W-WG8C].

[437] *Re-envisioning Safety*, DPH MUST DIVEST, https://www.dphmustdivest.com/alternatives [https://perma.cc/NJ24-XZ85].

[438] *See* Telephone Interview with Hospital Divest/Defund Organizer, *supra* note 9.

use of force with respect to patient population."[439] The Director further recognized that "the presence of uniformed law enforcement officers is often at odds with the department's goal of creating a safe, healing, and welcoming health care environment."[440] The Department has proposed a staffing plan that would replace at least seventeen of the twenty-three current deputy sheriff positions with forty-four clinical and healthcare security staff.[441] The proposal also includes the establishment of a "Security Equity Group" and further training of department staff to respond to "challenging patient issues" and to determine when healthcare staff should respond as opposed to law enforcement.[442]

Other hospitals have taken steps to address the harms associated with police presence in incremental ways. The University of Utah Hospital has changed its policies to circumscribe and monitor police access. The change came about after the much-publicized 2017 arrest of Nurse Alex Wubbels for refusing an officer's request that she draw blood from an unconscious patient.[443] The hospital's new procedure requires all law enforcement officers entering the ED to communicate with the hospital-based police officer and the charge nurse of the ED.[444] The police department also changed its policies to mirror those of the hospital, emphasizing that police must treat hospital personnel with respect and check in with administrators as soon as they arrive.[445]

Though Bellevue Hospital does not directly employ harm reduction language, its internal guidelines demonstrate how a hospital can approach police presence from a harm reduction standpoint. Bellevue sees a wide array of law enforcement, including its own hospital security personnel, NYPD, and federal agents, who regularly enter the ER with

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439 Memorandum from Basil A. Price, Dir. of Sec., San Francisco Dep't of Pub. Health, to President Dan Bernal and Members of the San Francisco Health Comm'n 1 (Apr. 30, 2021), https://sf.gov/sites/default/files/2021-04/Health%20Commission%20Security%20Staffing%20Memo_%20Final%204-30-21.cleaned.pdf [https://perma.cc/95EL-GR4B].

440 *Id.*

441 *Id.* at 2.

442 *Id.* at 5; *see also* Mallory Moench, *S.F. Looks to Replace Some Law Enforcement Guarding City Hospitals with Mental Health Teams*, S.F. CHRON. (May 5, 2021, 4:56 PM), https://www.sfchronicle.com/local/article/S-F-to-replace-some-sheriff-s-deputies-at-health-16152227.php [https://perma.cc/6MJU-46ZC].

443 *See* Miller, *supra* note 95.

444 Paige Minemyer, *University of Utah Hospital Bars Police Officers from Interacting with Frontline Staff Following Nurse Arrest*, FIERCE HEALTHCARE (Sept. 5, 2017, 12:59 PM), https://www.fiercehealthcare.com/healthcare/university-utah-hospital-bars-officers-from-interacting-frontline-staff-following-nurse [https://perma.cc/2PW5-LNNA].

445 *University of Utah Hospital and Salt Lake City Police Department Policies*, UNIV. OF UTAH HEALTH (Oct. 11, 2017, 10:18 AM), https://healthcare.utah.edu/publicaffairs/news/2017/10/police-policy.php [https://perma.cc/7XN5-CFGD].

suspects.[446] The Department of Corrections also routinely brings in inmates from correctional facilities.[447] The hospital developed recommendations for its emergency room staff on how to balance law enforcement involvement in patient cases.[448] The guidelines reflect a concern for patient privacy and the health and economic concerns particular to the demographics of their patients. Staff are advised to assess the legal custody status (that is, arrestee versus inmate) and to be cognizant of the legal process when releasing patients.[449] To protect privacy, patient information is placed in a sealed envelope if patients are being transported by law enforcement.[450] Hospital staff are required to ask officers to step out of earshot when talking with the patient.[451] If an officer refuses to remove restraints for medical need, they must provide reasons for the denial.[452] Police requests for medical examinations and procedures are considered alongside medical necessity; a general warrant does not alter this requirement.[453] Any suspicion of use of force must be reported to Risk Management and a social worker, and the practitioner may also give the patient information about filing a complaint with the Civilian Complaint Review Board.[454] Medical professionals prepare discharge plans that consider whether the patient is going to an in-custody facility and provide patients with local legal aid information at discharge.[455]

In these examples of measures adopted by hospitals, we see different ways hospitals have addressed police presence in the emergency room, which account for the current law and the need for police presence in hospitals for other reasons such as security and safety. Because hospitals and medical professionals are integral to the constitutionality of police investigations in the ER, their adoption of ER-as-sanctuary, harm-reductionist, and patient-centered approaches could very well accomplish change more immediately than any doctrinal change could.

Conceiving of the emergency room as a sanctuary does not turn emergency rooms into safe havens for criminals. Police have to perform certain functions in hospitals. But thinking of the emergency room as a sanctuary is a first step in decreasing the frequency and pervasiveness

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446 Interview with Bellevue Emergency Medicine and Risk Management in N.Y.C., N.Y. (June 18, 2018) (notes on file with author) (names withheld for confidentiality).

447 Bellevue Hospital, Bellevue Emergency Department Guideline for Medical Management of Patients in Custody of Law Enforcement § 1.04 (on file with author).

448 *See* Interview with Bellevue Emergency Medicine and Risk Management, *supra* note 446. The issues of medical care and conditions at New York City's pretrial detention facilities (including Rikers Island) were of particular concern when developing the guidelines.

449 Bellevue Hospital, *supra* note 447, §§ 1.03, 1.04, 2.01.

450 *Id.* § 2.01(e)(6).

451 *Id.* § 3.01(b).

452 *Id.* § 3.01(c).

453 *Id.* § 3.01(h).

454 *Id.* § 3.01(f).

455 *Id.* § 2.01(e)(6).

of police presence. Police searches and questioning could be regulated without stripping officers' abilities to do their job. Aside from instances where immediate questioning is needed to locate an active and dangerous suspect, searches and questioning do not necessarily have to be at the acute point of patients' entries into the emergency room. Indeed, hospitals could designate public and private places, identify a point person or task force to handle law enforcement requests, and require the documentation of officer information and confirmation of why an officer is present.[456] Certain patient-level interventions that have been recommended in the immigration enforcement context also apply, such as educating patients of their rights vis-à-vis law enforcement and pursuing medical-legal partnerships to expand the capability of hospitals to consider and address the legal issues arising from law enforcement interactions.[457]

Finally, in addition to changing policies regarding police access to patients in the emergency room, steps can be taken to restrict the many pathways police now have into the emergency room. These solutions, separate and apart from hospital-based approaches, would shift responsibilities away from police to non–law enforcement entities. For example, police officers have been widely criticized for being ill-equipped to handle mental health crises.[458] Departments have been called upon to step up their training to avoid horrific results, such as death; some departments have begun to respond.[459] Police departments are increasing

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[456] *See* ALTAF SAADI, DRS. FOR IMMIGRANTS, WELCOMING AND PROTECTING IMMIGRANTS IN HEALTHCARE SETTINGS 9–12, 14 (2020) (making such proposals in the immigration enforcement context).

[457] *See id.* at 17–19.

[458] *See, e.g.*, *Detroit Police Officer Convicted in Naked Woman's Beating at Hospital*, DET. FREE PRESS (Mar. 19, 2019, 4:09 PM), https://www.freep.com/story/news/local/michigan/detroit/2019/03/19/detroit-police-officer-convicted-naked-womans-beating-hospital/3215369002 [https://perma.cc/NH7J-V23S]; Lennard, *supra* note 3; Frank Stoltze, *Family Blames Police for Mentally Ill Man's Death in L.A. County*, KQED (Aug. 30, 2017), https://www.kqed.org/news/11614816/family-blames-police-for-mentally-ill-mans-death-in-l-a-county [https://perma.cc/8NM2-YEL5].

[459] *See, e.g.*, Kassadee Paulo, *City of Fulton Implements Police Reform, Reinvention Plan*, OSWEGO CNTY. TODAY (Apr. 11, 2021), https://oswegocountytoday.com/news/fulton/city-of-fulton-implements-police-reform-reinvention-plan [https://perma.cc/KR8N-NLC4]; William J. Redman, Opinion, *Viewpoint: Taking a Proactive Approach to the Mental Health Crisis in Our Community*, S. BEND TRIB. (Apr. 10, 2021), https://www.southbendtribune.com/news/opinion/viewpoint/viewpoint-taking-a-proactive-approach-to-the-mental-health-crisis-in-our-community/article_e17aa2bc-9337-11eb-8bea-6b6cb23f88d7.html [https://perma.cc/AZ28-L43H]; Elliot C. Williams, *Montgomery County Is Reimagining How Police Officers Respond to Mental Health Crises*, DCIST (Mar. 23, 2021, 3:08 PM), https://dcist.com/story/21/03/23/montgomery-county-reimagines-police-involvement-in-first-response [https://perma.cc/966W-DVWD].

their crisis intervention training.[460] Some localities are funding treatment facilities so that police are able to take people directly there instead of to the emergency room.[461] Others have begun exploring solutions such as starting psychiatric "emergency rooms" (which are still housed within hospitals)[462] or setting up specialized response teams for mental health calls.[463]

Other localities are looking to take police out of mental health response completely. Some jurisdictions had already begun to do so well before this year. For example, in Eugene, Oregon, a specialized mental health crisis intervention team called CAHOOTS (Crisis Assistance Helping Out on the Streets) answers calls for suicide interventions, substance abuse, and other mental health issues.[464] The response team consists of a medic (a nurse or EMT) and a crisis worker.[465] They arrive often without police support.[466] CAHOOTS was started in 1989 and

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[460] *See, e.g.*, Matt Delaney, *Use of Force Committee's Report Spurs F.C. Police Changes*, FALLS CHURCH NEWS-PRESS (Mar. 5, 2021, 11:00 AM), https://fcnp.com/2021/03/05/use-of-force-committee-report-spurs-f-c-police-changes [https://perma.cc/4J7M-CCJK].

[461] *See, e.g.*, Kate Payne, *State Officials Herald New Mental Health Access Center in Iowa City*, IOWA PUB. RADIO (Feb. 11, 2021, 9:02 PM), https://www.iowapublicradio.org/ipr-news/2021-02-11/state-officials-herald-new-mental-health-access-center-in-iowa-city [https://perma.cc/95JE-TFBN]; Sady Swanson, *How a Colorado Town Is Untangling Behavioral Health Care from the Criminal Justice System*, COLORADOAN (Mar. 23, 2021, 12:04 PM), https://www.coloradoan.com/in-depth/news/2021/03/22/fort-collins-colorado-mental-health-untangling-criminal-justice/4624239001 [https://perma.cc/6HGK-8XWV].

[462] New York has had these for a while. Bellevue and other NYC hospitals have units that are just for mentally ill patients in their emergency units. Bryce Nelson, *Bellevue Psychiatric: Tales of Despair*, N.Y. TIMES (Sept. 20, 1983), https://www.nytimes.com/1983/09/20/science/bellevue-psychiatric-tales-of-despair.html [https://perma.cc/8B7A-P78K]; *Department of Emergency Medicine Clinical Services*, NYU LANGONE HEALTH, https://med.nyu.edu/departments-institutes/emergency-medicine/clinical-services [https://perma.cc/RD5B-JAQQ].

[463] *See, e.g.*, STEWART ET AL., *supra* note 424, at 34–35; Cornelius Frolik, *Dayton-Area Police Agencies Using Special Teams on Mental Health Calls*, DAYTON DAILY NEWS (Feb. 24, 2021), https://www.daytondailynews.com/news/dayton-area-police-agencies-usings-special-teams-on-mental-health-calls/TL34BDBMPNFJDBZOYJAWWMKUZI [https://perma.cc/D7A8-E9CQ]; Jenny Gold, *San Antonio Police Have Radical Approach to Mental Illness: Treat It*, KAISER HEALTH NEWS (Aug. 19, 2014), https://khn.org/news/san-antonio-police-treat-mental-health [https://perma.cc/P5SA-T89Z]; Erica Goode, *For Police, A Playbook for Conflicts Involving Mental Illness*, N.Y. TIMES (Apr. 25, 2016), https://www.nytimes.com/2016/04/26/health/police-mental-illness-crisis-intervention.html [https://perma.cc/ESD7-L5F3]; Laura Stewart, *Baltimore County Beefs up Non-police Resources to Respond to Mental Health Emergencies*, BALT. FISHBOWL (Apr. 7, 2021), https://baltimorefishbowl.com/stories/baltimore-county-beefs-up-non-police-resources-to-respond-to-mental-health-emergencies [https://perma.cc/9NVZ-LV3D]; Stephen Young, *Dallas Rolls Out Help for Mentally Ill "Super-Utilizers" of Public Safety Services*, DALL. OBSERVER (Jan. 23, 2018, 4:00 AM), https://www.dallasobserver.com/news/dallas-police-and-fire-role-out-new-program-for-mental-health-calls-10287604 [https://perma.cc/4BYP-8WZY].

[464] *Crisis Assistance Helping Out on the Streets (CAHOOTS)*, WHITE BIRD CLINIC, https://whitebirdclinic.org/cahoots [https://perma.cc/8LHB-K5JB].

[465] *Id.*

[466] *See id.*

other cities such as Denver and Oakland have taken notice.[467] In Oakland, the city council has launched the MACRO (Mobile Assistance Community Responders of Oakland) Civilian Response Team, which will consist of EMT workers and mental health experts, and will be run by the fire department instead of the police.[468]

In just the past few months, more cities are exploring alternatives to police responses to not just mental health, but also incidents involving substance use and other public health concerns.[469]

These proposals consider the unique vulnerability of patients in emergency rooms and the rules and notions of medical privacy. The inclusion of medical professionals, hospitals, and their separate set of legal, moral, and ethical obligations gives us a path forward toward a more protected and safer emergency room.

D. Limits to ERs as Sanctuaries

How far, however, does sanctuary take us, in terms of limiting law enforcement and corresponding harms in ERs? The sanctuary-based solutions offered here do not completely eradicate the need for security in the ER, even if they significantly reduce concerns about police acting in their investigatory capacity.

Medical staff, patients, and visitors to the ER may continue to demand police presence. In San Francisco, even as physicians and medical students call for the removal of sheriff's deputies, an ER nurse has started a petition to keep deputies in the hospital, citing their ability to ensure workplace safety.[470] An inadequate accounting for the concerns of workplace violence when defunding or limiting law enforcement could lead to the unintended consequence of hospitals relying even more

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[467] *See* LJ Dawson, *Denver Looks to Take Cops Out of Mental Health-Related 911 Rescues*, DENV. POST (Oct. 11, 2019, 6:00 AM), https://www.denverpost.com/2019/10/11/denver-police-cahoots-mental-health [https://perma.cc/MEP8-KCGZ]; Sigal Samuel, *Calling the Cops on Someone with Mental Illness Can Go Terribly Wrong. Here's a Better Idea.*, VOX (June 15, 2020, 12:10 PM), https://www.vox.com/future-perfect/2019/7/1/20677523/mental-health-police-cahoots-oregon-oakland-sweden [https://perma.cc/AP46-38GH].

[468] Julian Glover, *Oakland Launches Civilian Crisis Response Team to Handle Nonviolent Mental Health Calls*, ABC 7 NEWS (Mar. 18, 2021), https://abc7news.com/macro-oakland-civilian-crisis-response-team-mental-health-police-dept/10430680 [https://perma.cc/7S3F-2FP6].

[469] *See, e.g.*, Thomas Breen, *New Program Centers Social Workers, Not Cops*, NEW HAVEN INDEP. (Aug. 18, 2020, 7:08 PM), https://www.newhavenindependent.org/index.php/archives/entry/crisis_response_team/id_121863 [https://perma.cc/V4S2-46CS]; Chelsea Kurnick, *Santa Rosa Considers Offering Alternative to Calling the Cops*, BOHEMIAN (Aug. 12, 2020), https://bohemian.com/santa-rosa-considers-offering-alternative-to-calling-the-cops-1 [https://perma.cc/YC6E-297A]; Denver Pratt, *Bellingham City Council to Discuss Police Oversight Board, 24/7 Crisis Response Team*, BELLINGHAM HERALD (Aug. 23, 2020, 5:00 AM), https://www.bellinghamherald.com/news/local/article245153910.html [https://perma.cc/8SYS-WDX7].

[470] *See* Moench, *supra* note 431.

on unaccountable, private police forces to fill the void.[471] The security function of police, like its investigatory activities, would then continue to disproportionately harm poor, minority patients, as well as those with other vulnerabilities.[472]

This tension underlies the ongoing debate in Los Angeles about the presence and contracted services of the controversial Los Angeles County Sheriff's Department in county healthcare, and in particular, in county emergency departments. After a recent shooting and killing of a patient by a sheriff's deputy inside Harbor-UCLA Medical Center, patient advocates as well as physicians in the hospital protested the use of deadly force without more de-escalation attempts.[473] In response, the Los Angeles County Board of Supervisors, in unanimous agreement, directed the Office of the Inspector General to investigate the shooting and asked county attorneys to report on how law enforcement presence could be restricted in county hospitals.[474]

In the 2019–2020 fiscal year, Los Angeles County spent over $35 million on a contract with the Sheriff's Department for personnel at various Department of Health Services (DHS) facilities.[475] Harbor-UCLA Medical Center is among the many facilities secured by the Sheriff's Department.[476] In a memo to the Board of Supervisors, a group of health workers made a number of recommendations specifically addressing security concerns.[477] Based upon their concerns that sheriff's deputies contribute to and exacerbate violence in the ER, they called upon the Board to implement measures such as not allowing armed officers into the emergency department.[478] They recommended having a dedicated team of ER staff to secure transfer of patients from police custody to hospital staff and using patient advocates and "de-escalators" to respond to patient or visitor agitation.[479]

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[471] In addition to Professor Seth Stoughton's recent piece, *supra* note 313, see generally Elizabeth E. Joh, *Conceptualizing the Private Police*, 2005 UTAH L. REV. 573; and Stephen Spitzer & Andrew T. Scull, *Privatization and Capitalist Development: The Case of the Private Police*, 25 SOC. PROBS. 18 (1977), for discussions about private police forces.

[472] *See generally* Jamelia Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. (forthcoming 2021) (discussing the harms of aggressive law enforcement against persons with disabilities in medical facilities).

[473] 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-shot-by-sheriffs-deputy-as-he-wield-heavy-medical-device-inside-harbor-ucla-hospital-dies [https://perma.cc/H8A7-3ZBK].

[474] 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/PLN3-4QK3].

[475] Memorandum from Frontline Wellness Network to the Los Angeles Cnty. Bd. of Supervisors 4 (Jan. 29, 2021) (on file with the Harvard Law School Library).

[476] *Id.* at 2.

[477] *See id.*

[478] *Id.* at 12.

[479] *Id.* at 12–13.

The memo seeks to reorient the response to security concerns in hospitals from a law enforcement–based one to approaches that are known and employed in behavioral health and mental health contexts. Similar to the alternatives to police response to mental health calls on the street, the suggestions in the memo call for the import of such teams (Code Gold teams) to the ED itself.

As the situation unfolds in Los Angeles, we may see how well patient-first, sanctuary, or patient-privacy based approaches can protect the most vulnerable in emergency room settings. But even then, this kind of framework may minimize and restrict police activity in emergency rooms but fail to wholly solve the problems of police abuse and violence that plague society. Police are the default response to perceived threats of violence or insecurity. Those who are privileged to reap the benefits of policing are conditioned to see police as protectors from those they perceive as threatening or harmful. Reimagining the role of police in the emergency room, as explored here, can perhaps help us change that view so that we no longer see police or law enforcement as a uniform antidote, particularly when the people most affected by police-based prescriptions are those who are most subject to abuses and violence by police.

CONCLUSION

Attention must be paid to police in the emergency room where their presence has been assumed and accepted as necessary. Our nation's stratified healthcare system has led to the heavy reliance on safety-net emergency rooms by poor people, racial minorities, and those at the intersection. Future research, some of which has already begun, must study the extent of police presence in healthcare settings like ERs and the subsequent harm to patients. Such study must also incorporate the criminal legal implications of police presence in ERs. Viewing the problems of police and healthcare through a solely medical lens or a legal one has led to the current state of affairs, where courts view the ER as indistinguishable from the street. This view has allowed police to question and search patients at moments of acute medical vulnerability, with the acquiescence and participation of the very people who are charged with treating them. The consequences of this doctrinal view are borne by racial minorities and the poor, who have little choice when it comes to their medical care.

Any reexamination of policing must include the presence of police in medical settings, including emergency rooms and hospitals more generally. Even though there may be fully justifiable reasons for why police should be in emergency rooms, further privacy protections and a reframing of ERs as places of patient sanctuary are needed to safeguard the privacy and dignity of the vulnerable communities these ERs serve.

This account of police in the emergency room also has broader implications. The doctrine's inability to account for how a patient in the ER differs from a person on the street underscores the limits of Fourth Amendment doctrine in constraining overbroad police behavior. This study also provides further support for a careful delineation and delegation of police responsibilities and roles to diminish net-widening and broader surveillance consequences. Finally, policing in the ER provides yet more evidence of why we must critically reexamine the predomination of public safety and law enforcement in areas of life that particularly affect marginalized groups.