An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department

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A 1927 *Journal of the American Medical Association* editorial warned that the very first US law requiring physicians to report gunshot wounds to police could "lead persons so injured to postpone or even to avoid medical treatment."[1] Fast forward almost a century later, and physicians do not just report injuries but, as Harada et al's article "Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care" shows, the relationship between physicians and law enforcement has become increasingly intertwined. Ott et al[2] described this relationship as "an important reciprocal relationship," Tahouni et al[3] as "collegial camaraderie," and some participants in Harada et al's study as "team members," where there is an assumed—and equal—benefit to patients, clinicians, and law enforcement. However, this premise erroneously assumes that law enforcement is society's best response to health and safety crises, with little consideration for the repercussions on an individual's rights and society's overall health. Based on conversations with physicians, prior literature, and the Harada article itself, we suggest that policies regulating law enforcement presence in emergency departments (EDs) are rare and existing policies seem to favor law enforcement goals over those of patients.[3,4] Harada et al's study fills an important gap in the literature by illustrating these contradictions, including how emergency physicians, like those in the study, can give law enforcement the "benefit of the doubt" with the "assumed power" to control and dominate interactions with clinicians and patients. However, a working theoretical framework is needed to guide medical clinicians through the complexities of the overlap with law enforcement and set important boundaries against law enforcement actors in patient care spaces. We propose the beginning of a framework rooted in medical ethics, human rights, and constitutional law and grounded in an understanding of structural relationships.

Harada et al's study highlights how emergency physicians struggle to reconcile personal and professional ethical responsibilities to patients with the perceived demands of state policing priorities. One physician in the study felt "cornered" by law enforcement personnel, leading to potential privacy violations, and another was intimidated by the presence of firearms. The World Medical Association was created in response to similar concerns regarding physician participation in state-sanctioned violence during World War II. The organization promulgated an international code of medical ethics and the Declaration of Geneva, a modernization of the Hippocratic Oath. Three of the declaration's components are particularly pertinent to discussions about ethical considerations of third-party state actors in the medical setting.

The first, "the health and well-being of my patient will be my first consideration," speaks clearly to the ethical duty to prioritize the patient over competing interests and claims. In fact, physicians have long demarcated these ethical boundaries when it comes to other non–law enforcement third parties attempting to interfere with care (eg, insurance companies, corporate health care systems, or partisan politics). These ethical boundaries should also apply to law enforcement third-party actors, particularly when ethical deviations allow the state to violate fundamental constitutional or human rights. In fact, in the second regard, the Declaration of Geneva also clearly states that physicians should "not use my medical knowledge to violate human rights and civil liberties, even under threat." As noted above, the participants in Harada et al's study felt pressured by state actors, including one physician who was threatened with arrest for trying to protect a patient's constitutional rights. These examples illustrate that some physicians find it difficult to uphold professional ethical responsibilities in clinical settings.

Third, the declaration asks physicians to "respect the secrets that are confided in me, even after the patient has died." Unless uncoerced consent is obtained, physicians should maintain privacy of information, including private spaces for history taking, physical examination, and treatment, unless specifically obligated by law. Even when required by law, history has illustrated the necessity for physicians to challenge potentially unethical or oppressive laws.

The routine presence of police in the ED also has important legal implications. Laws govern the intersection of law enforcement and medical care—laws that regulate police, laws that regulate medical personnel, and laws that protect patients, even when they are arrested or incarcerated. Medical clinicians must not just carefully balance "the health interests of individuals and the criminal justice interests of the state." They must also account for and respect key constitutional and legal safeguards that exist to protect individuals from overbroad police authority.

Medical clinicians bear great responsibility when it comes to protecting patient rights. Correspondingly, medical clinicians are at risk of diminishing the legal rights of people from overpoliced and surveilled communities. In *Ferguson v. City of Charleston*, the Supreme Court struck down a hospital policy developed with law enforcement that routinely drug tested pregnant women. Acknowledging the health-based objectives of the program, the Court found that "the immediate objective of the searches was to generate evidence for law enforcement purposes." The Court noted the "extensive involvement of law enforcement officials at every stage" of the policy.[5] Even absent formal policies, in EDs throughout the country, interactions between hospitals, medical clinicians, and law enforcement bear close resemblance to the program in *Ferguson* deemed unlawful.

By allowing police into "trauma bays, clinicians imaging areas, treatment spaces, hallways and provider workstations," medical clinicians give law enforcement broader access to patients and their health information than legally required. Workplace safety may be one reason for the routine presence of police in patient care settings. But police cannot be expected to separate their security role from their investigatory purpose. The failure to demarcate appropriate boundaries between law enforcement's security, emergency response, and policing functions results in confidential patient information disclosures that go well beyond statutory mandates and permissions.[6-8] With free-flowing access to patients, their confidential communications, and their health information, police can bypass formal procedures required for warrants, subpoenas, or other court orders. Medical personnel may end up inserting *themselves* as third parties with seemingly inconsequential actions: turning over property that belongs to the patient or acquiescing to police questioning when the patient is under physical distress. These actions undermine patients' constitutional rights under the Fourth and Fifth Amendments.[9]

Clinicians have an individual responsibility to protect their patients from unlawful and overbroad police conduct. But it is ultimately the hospital's responsibility to protect patients' privacy, dignity, and autonomy. Hospitals must develop clear policies and protocols regarding police presence and law enforcement requests for patient information. Current policies have largely been developed with law enforcement partners. Though medical clinicians and law enforcement may align at times, their purposes and obligations diverge significantly. Medical clinicians' responsibilities to patients should not be compromised or subordinated to law enforcement priorities except in clearly delineated circumstances. This is especially because such policies hold great weight in courts' adjudication of patients' rights. Hospitals should be gatekeepers of privacy. Instead, hospitals have made patient care spaces public, and courts have deferred to hospitals' delineations.

Lastly, it is imperative to recognize the structural and historic context that shapes health care and law enforcement interactions. Over the past few decades, expenditures in the public safety net and community-based systems of care have continued to atrophy while government policies have led to a ballooning of investment in policing and mass incarceration. Disproportionately impacting poor communities of color, the carceral apparatus has become an integral, if not primary, response to societal ills.

The legacy of this history reveals itself in EDs around the country. Due to the lack of robust community-based systems of care, EDs (and, unfortunately, jails) become the primary touch point for those experiencing crises related to addiction, housing insecurity, mental illness, and other chronic structural vulnerabilities. While EDs have assumed the de facto role of accepting these crises, scarce resources prohibit an optimal response, contributing to staff concerns regarding safety. Law enforcement has become the readily accessible solution for ED staff, while behavioral response teams, substance abuse counselors, community-based violence intervention workers, and mental health and housing services are secondary solutions or, more often, absent.

Furthermore, the disproportionate policing of care spaces that serve the poor and communities of color—where racial and socioeconomic discordance between clinicians and patients is often greatest—must be recognized as a manifestation of structural racism. The

findings of Harada et al complement important literature on patient experiences demonstrating how policing of care spaces acts as a barrier to accessing care and may contribute to medical mistrust.[10-12] Underlying these findings is a fundamental conflict between policing and carceral logics on one hand and the ethics of harm reduction, social medicine, and efforts to remedy the social determinants of illness on the other.

The ubiquity of law enforcement presence in care settings and the simultaneous absence of patient supportive services should be viewed as closely intertwined phenomena—consequences of decades of modifiable policy rather than inevitable truths. The remedy is not only adhering to professional ethics and upholding of patient legal rights but a transformation of existing structural conditions.

We must recognize the medical profession's complicity in harmful structural arrangements with the carceral system and historic abandonment of those most vulnerable. By uncritically accepting routine police presence and practice in health care settings, we perpetuate harms on the very populations that rely on us for their health and well-being. Reclaiming our professional mission to do no harm is contingent on centering those most vulnerable and affected by policing in our decisionmaking, reform, and research. Critical to this will be the formation of new allyships, extending from the ED to the community, to create systems of care free of the carceral logics of policing and punishment.

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