Patient or Prisoner

*Ji Seon Song**

Abstract

Carceral power expands into many institutions vital to social life. This Article focuses on one such important institution: the hospital in the free world. Hospitals outside of carceral institutions routinely treat, diagnose, screen, and discharge people under law enforcement and correctional control. Just as hospitals serve an important function for society as a whole, hospitals are indispensable to the United States's system of policing and incarceration. Hospitals take up the slack for inadequate correctional health care by treating injured or sick people in police custody and provide critical support in criminal investigations and incarceration.

The use of hospitals by police and correctional institutions, however, is more than incidental or situational. The Article argues that hospitals have become part of the infrastructure of mass incarceration. Despite popular conceptions of the hospital as a place of care, this Article posits that hospitals perform functions essential to the operations of mass incarceration by identifying criminals, helping build criminal cases, preparing people for incarceration, and certifying that arrested and incarcerated people are fit for imprisonment. Law enforcement and correctional actors alter the complex, structured, and regulated hospital workplace through their immense formal and informal powers. Their rules and norms on security, isolation, and control trump hospital regulations, practices, and ethics on patient privacy, autonomy, and dignity. This Article articulates this deference to and incorporation of carceral rules and practices as an expansion of the modalities of policing and custodial practices. Further evidence of hospitals inclusion in carceral infrastructure can be seen in how hospitals perpetuate

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problems of mass incarceration, such as racial and class-based subordination and loyalty to carceral logic of "public safety."

Highlighting the role of hospitals in mass incarceration is particularly important now when public health and care-based institutions and solutions are offered as alternatives to incarceration and policing, and abortion criminalization brings further attention to the intersection of law enforcement and health care. Close scrutiny of this intersection is also important not just to expose the problems, but because the indispensability of hospitals presents us with an opportunity. The exposure of correctional and law enforcement practices to the outside world through hospitals breaches the divide between the too-often unaccountable correctional environments. These outside institutions therefore have an opportunity to reimagine a different kind of patient prisoner care. The Article concludes by proposing ways to do so through institutional, regulatory, and doctrinal measures.

Table of Contents

Introduction

Three months after the murder of George Floyd in 2020, police officers in Kenosha, Wisconsin, shot Jacob Blake seven times in the back.[1] He was taken to the hospital where he lay paralyzed and handcuffed to the hospital bed.[2] The police justified the use of handcuffs by pointing to an outstanding warrant.[3] In 2022, before the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*,[4] sheriff deputies in the Texas Rio Grande Valley arrested Lizelle Herrera for murder based upon an allegation of self-induced abortion.[5] The initial tip came from the hospital where Ms. Herrera sought medical treatment after a miscarriage.[6] Last year, New York City's mayor announced a policy directing emergency responders, including police, to take into custody and involuntarily hospitalize those who appear mentally ill even when they are not posing an immediate threat to themselves or others.[7] California has passed a law permitting courts to order involuntary confinement and treatment for people with mental health disabilities.[8] With psychiatric bed space severely limited, mental health advocates and civil liberties organizations warn that the plan could result in people being shuffled between the street, shelters, jails, and crowded emergency rooms.[9]

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1 John Eligon, Sarah Mervosh & Rhichard A. Oppel Jr., *Jacob Blake Was Shackled in Hospital Bed After Police Shot Him*, N.Y. Times (Aug. 28, 2020), https://www.nytimes.com/2020/08/28/us/jacob-blake-shackles-assault.html [https://perma.cc/ZCP9-6AFY].

2 Nicole Chavez, Christina Maxouris & Eric Levenson, *Jacob Blake Is Handcuffed to his Hospital Bed, Family Says*, CNN (Aug. 28, 2020, 12:00 AM), https://www.cnn.com/2020/08/27/us/jacob-blake-wisconsin-thursday/index.html [https://perma.cc/4PG2-VT5J]. Only after pressure and with the help of the Kenosha District Attorney did the Kenosha Police Department vacate the warrant. Jackson Danbeck, *Authorities Take Handcuffs Off of Jacob Blake While He Remains in the Hospital Paralyzed from the Waist Down*, TMJ4, WTMJ Milwaukee (Aug. 29, 2020, 12:00 AM), https://www.tmj4.com/news/local-news/authorities-take-handcuffs-off-of-jacob-blake-while-he-remains-in-the-hospital-paralyzed-from-the-waist-down [https://perma.cc/9WZ8-PY7L].

3 Graham Kates, *Jacob Blake No Longer Handcuffed to His Hospital Bed, Attorney Says*, CBS News (Aug. 28, 2020, 7:20 PM), https://www.cbsnews.com/news/jacob-blake-warrant-arrest-vacated-no-handcuffs-hospital-bed [https://perma.cc/JCB2-ZWM9].

4 142 S. Ct. 2228 (2022).

5 Caroline Kitchener, Beth Reinhard & Alice Crites, *A Call, a Text, an Apology: How an Abortion Arrest Shook Up a Texas Town*, Wash. Post (Apr. 13, 2022, 10:35 AM), https://www.washingtonpost.com/nation/2022/04/13/texas-abortion-arrest [https://perma.cc/4YZJ-2MXH].

6 *Id.*

7 Sarah Maslin Nir, *On City Streets, Fear and Hope as Mayor Pushes to Remove Mentally Ill*, N.Y. Times (Nov. 30, 2022), https://www.nytimes.com/2022/11/30/nyregion/new-york-mental-illness-homeless-reaction.html [https://perma.cc/GT5U-XWHY].

8 Thomas Curwen, *CARE Courts Open in a Month, Promising Hope for Families. Not Everyone Is So Sure*, L.A. Times (Sept. 4, 2023, 5:00 AM), https://www.latimes.com/california/story/2023-09-04/care-courts-families-voluntary-compliance [https://perma.cc/4DGX-YK9R].

9 *See* Ayesha Rascoe & Caroline Lewis, *A New Policy in New York City Makes It Easier for Homeless People to be Forcibly Hospitalized*, NPR (Dec. 4, 2022, 7:48 AM), https://www.npr.org/2022/12/04/1140630177/a-new-policy-in-new-york-city-makes-it-easier-for-homeless-people-

All four examples have a common thread: the hospital. That hospital is at the heart of this study. This Article examines the relationship of hospitals in the "free world"—that is the world outside of jails, prisons, and institutions of incarcerations—to our institutions of policing and punishment. These hospitals include nonprofit, private, public, teaching and other types of hospitals that are not part of a law enforcement agency, or jail or prison facility.[10]

This Article continues my study of the intersection between criminal legal and health-care systems. My previous research delved into police actions in emergency rooms and how medical professionals can become part of policing in contravention of their medical judgment and norms.[11] Here, the study is at the institutional level. When individual actors, such as police officers, correctional guards, physicians, and nurses, interact directly with each other and exercise broad discretion in carrying out their duties, they do so as part of larger institutions.[12] These institutions are separate bureaucratic institutions in and of themselves with distinct legal obligations, regulations, and policies.[13]

Just as hospitals serve a life-saving function for society at large, hospitals provide that same function for people who are being treated while under carceral authority. Hospitals often step in to care for sick and injured prisoners because of the inadequacies of correctional health care and because jails and prisons may not supply the specialized care required. People under arrest also require medical attention if they are sick, injured, or have preexisting medical conditions.

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to-be-forcibly [https://perma.cc/22JF-CR3B]; Jennifer Peltz & Bobby Caina Calvan, *With Adams's Plan for Mentally Ill, NYC Hospitals Face Complex Task*, NBC New York (Dec. 11, 2022, 3:56 PM), https://www.nbcnewyork.com/news/local/with-adamss-plan-for-mentally-ill-nyc-hospitals-face-complex-task [https://perma.cc/WJ7F-VYZD].

10 This term is often used by scholars, corrections officials, and prisoners to denote the part of society and people who are not physically deprived of liberty by the state through incarceration. The use of the word "free" here is not meant to suggest that there are no other forms of confinement and liberty deprivation for people who are not under police or correctional authority. Such carceral forms include probation, parole, home confinement, electronic monitoring, and other permutations of surveillance. This term "free world" is used to describe the world outside jails and prisons by imprisoned people, advocacy organizations, correctional institutions, and scholars. *See, e.g.*, *About Us*, Free World, https://www.joinfreeworld.com/about [https://perma.cc/HK9M-RDW5]; Aaron Littman, *Free-World Law Behind Bars*, 131 Yale L.J. 1385 (2022); *Kilby Correctional Facility (Receiving Unit)*, Ala. Dep't of Corr., http://www.doc.state.al.us/facility?loc=36 [https://perma.cc/EW2H-JD36] (noting the use of "free world" medical care); Press Release, Prison Policy Initiative, Stephen Raher, The Company Store: A Deeper Look at Prison Commissaries (May 2018), https://www.prisonpolicy.org/reports/commissary.html [https://perma.cc/PH8A-5HM8].

11 *See* Ji Seon Song, *Policing the Emergency Room*, 134 Harv. L. Rev. 2646 (2021) [hereinafter Song, *Policing the Emergency Room*]; Ji Seon Song, *Cops in Scrubs*, 48 Fla. St. L. Rev. 861 (2021).

12 Michael Lipsky, Street-Level Bureaucracy 13 (1980).

13 *Id.* at 18, 125–33.

But hospitals do more than provide health care. The Article argues that the use of hospitals by law enforcement and correctional authorities is more than incidental and situational. Hospitals outside of these carceral institutions are an integral part of the infrastructure of mass incarceration. Hospitals participate in the business of policing and punishment, aiding in criminal investigations and clearing arrestees and inmates of medical issues for incarceration, even when they may know that the carceral environment may cause further harm to the patient. Moreover, when law enforcement and correctional institutions interact with hospitals, the powerful and innate coercive nature of carceral authorities alters hospitals' practices and leads to hospitals' adaptation to carceral institutions. Carceral rules and norms on security, isolation, and control trump well-established hospitals regulations, practices, and ethics on patient privacy, autonomy, and dignity. Medical providers treat patients in handcuffs. They cooperate with law enforcement and correctional edicts to cut off patient access to family and loved ones. Providers may conduct procedures on patients without consent and perhaps even at the direction of a police officer or warden. This Article posits that this deference, adaption, and incorporation of carceral rules, practices, and logics reveal an expansion of the modalities of policing and custodial practices that must be taken seriously by stakeholders particularly in the health-care system.

At first blush, one may ask whether this dynamic is actually a problem. Though hospitals' deference and adaption may not be the ideal result, perhaps the rules and practices of law enforcement and correctional authorities apply is inevitable—where the prisoner goes, obviously the prison follows. Or maybe the current state is a reasonable trade-off, especially considering the benefits of having outside hospitals provide health care. Hospitals can provide better and specialized care to patients in carceral custody. Because providers in these hospitals do not normally treat imprisoned people, perhaps they do not carry the cynicisms or biased attitudes of correctional health-care providers, which should theoretically improve the quality of care. When treated in "free world" hospitals, patients in carceral custody should be exposed to the breadth and depth of medical ethics and regulations governing hospitals. Moreover, medical providers—particularly medical students, interns, and residents—can have interactions with patients in custody, bringing fresh eyes to the ethics and possibilities of treating people under law enforcement and correctional custody.

To fully realize both the benefits and harms, a critical examination of how hospitals are affected by law enforcement and correctional authorities is necessary. This Article's critical analysis of hospitals' role in mass incarceration puts the systematic use of hospitals by carceral authorities in full view. This examination reveals how the characteristics and problems of carceral institutions replicate in the hospital, a critical

health-care and safety net institution. Just as importantly, understanding hospitals' place within the carceral structure allows us to think about how to change the treatment of patient prisoners caught at this intersection by amplifying the benefits of having an outside institution breach the cinderblock walls of confinement and ameliorating the values of carceral authorities and institutions. Could this intersection be an opportunity to nudge our system of punishment toward a better recognition of humanity?

To make its arguments, this Article draws from laws, regulations, and policies of hospitals, law enforcement, and correctional institutions. The points made here are also informed by interviews with thirty-one medical professionals representing twenty-six hospitals in eleven states.[14] In an area that is gaining more attention from researchers, their experiences provide valuable insight into the on-the-ground effects of laws, regulations, and policies. Additionally, the efforts of physicians, medical students, nurses, and social workers to improve hospital policies and practices have shaped the proposed interventions.

This Article situates itself among various strands of literature examining the expansion of carceral power in society. Scholars have given us theoretical and historical accounts of carceral expansion.[15] Recent sociological and legal studies have examined the expansion of policing and carceral surveillance into civil domains, schools, public housing, public benefits offices, transportation hubs, and other medical settings, several highlighting the ways that race and class intersect with policing and punishment institutions.[16] This Article also engages with scholars

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14 List on file with Author. These interviews provide insight into the on-the-ground realities of hospitals and law enforcement. All of the hospitals have trauma facilities.

15 *See generally* Michel Foucault, Discipline and Punish: The Birth of the Prison (1975); Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961); David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (1971).

16 *See generally* Katherine Beckett & Naomi Murakawa, *Mapping the Shadow Carceral State: Toward an Institutionally Capacious Approach to Punishment*, 16 Theoretical Criminology 221 (2012); Armando Lara-Millán, Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity (2021); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 Calif. L. Rev. 1239 (2012); Sunita Patel, *Embedded Healthcare Policing*, 69 UCLA L. Rev. 808 (2022); Osagie K. Obasogie & Anna Zaret, *Medical Professionals, Excessive Force, and the Fourth Amendment*, 109 Calif. L. Rev. 1 (2021); Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 Mich. L. Rev. 938 (1997); Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (1997); Jonathan Simon, *The Return of the Medical Model: Disease and the Meaning of Imprisonment from John Howard to* Brown v. Plata, 48 Harv. C.R.-C.L. L. Rev. 217 (2013); Emily Thuma, *Against the "Prison/Psychiatric State": Anti-Violence Feminisms and the Politics of Confinement in the 1970s*, Feminist Formations, Summer 2014, at 26; Kimberlé Williams Crenshaw, Priscilla Ocen & Jyoti Nanda, Black Girls Matter: Pushed Out, Overpoliced and Underprotected (2015); Catherine Y. Kim, *Policing School Discipline*, 77 Brook. L. Rev. 861 (2012); Kaaryn S. Gustafson, Cheating Welfare: Public Assistance and the Criminalization of Poverty (2011); Loïc Wacquant,

who have also highlighted problems with the oversight and monitoring of law enforcement actors and institutions[17]

The Article's three contributions are laid out in four parts. In Part I, the Article analyzes how laws, regulations, and the realities of jails and prisons lead people in law enforcement and correctional custody to hospitals in the "free world." Hospitals certainly provide much needed medical care for people under police and correctional custody. But they do much more for carceral actors. Hospitals perform functions essential to the continued operations of policing and imprisonment by treating injured and sick prisoners, helping identify criminals, building criminal cases, giving the all-clear for arrested people to be taken to the jail, and treating those imprisoned so they can go return to their cells.

Part II provides a comparative study of the hospital and carceral systems, describing how hospitals' deference and adaption to carceral rules, practices, and norms reveal hospitals' place within the carceral infrastructure. Hospitals are heavily regulated and filled with similarly regulated professional medical providers governed by established rules, norms, and ethics that are directly at odds with those of carceral actors.[18] Yet law enforcement and correctional authorities alter this highly complex, structured, and regulated hospital workplace by their immense formal and informal powers. Despite hospitals' distinct rules and regulations concerning patient care, hospitals adopt and abide by law enforcement and correctional practices and policies. Hospital values and rules of patient confidentiality and privacy are infringed upon by the presence of police and guards during patient care consultations. Hospitals' rules on medical restraints fall to the routine shackling of people under custody. Health-care regulations on visitation access and patients' ability to make decisions about their medical care defer to law enforcement and correctional security rules and broad discretion. Hospital actors are also subsumed and erased by the laws and accountability structure of law enforcement and correctional authorities.

Punishing the Poor: The Neoliberal Government of Social Insecurity (2009); Alexis Karteron, *When Stop and Frisk Comes Home: Policing Public and Patrolled Housing*, 69 Case W. Rsrv. L. Rev. 669 (2019); Sam McCann & Aaron Stagoff-Belfort, *More Police Won't Make Public Transit Safer. Housing and Social Services Will*, Vera Inst. of Just. (June 17, 2022), https://www.vera.org/news/more-police-wont-make-public-transit-safer-housing-and-social-services-will [https://perma.cc/7RHS-9EJM].

17 *See, e.g.*, Rachel Harmon, *The Problem of Policing*, 110 Mich. L. Rev. 761, 765 (2012); Giovanna Shay, *Ad Law Incarcerated*, 14 Berkeley J. Crim. L. 329, 330 (2009); Barry Friedman & Maria Ponomarenko, *Democratic Policing*, 90 N.Y.U. L. Rev. 1827 (2015); Margo Schlanger, *The Constitutional Law of Incarceration, Reconfigured*, 103 Cornell L. Rev. 357 (2018); Sharon Dolovich, *The Failed Regulation and Oversight of American Prisons*, 5 Ann. Rev. Criminology 153, 155 (2022); Aaron Littman, *supra* note 10.

18 *See infra* Part II.

Part III presents the central argument that hospitals must be viewed as part of the infrastructure of the carceral system. Hospitals participate in mass incarceration by helping police and correctional authorities fill, incarcerate, and maintain "bodies" in this country's jails and prisons.[19] Their medical expertise, specialized technology, and access to vulnerable patients make them a particularly valuable resource for carceral institutions. When hospitals are viewed as part of mass incarceration, their actions can be seen as displaying characteristics of mass incarceration, including the kind of racial and class-based subordination endemic in mass incarceration, and the same loyalty to carceral logics as health-care workers inside correctional facilities. This transformation of hospitals is perhaps not surprising given the many ways medicine has contributed to and perpetuated racial bias and discrimination.

Finally, this Article contributes to ongoing scholarly and policy debates on how to solve the problems of policing and punishment.[20] Many current proposals offer up care institutions as alternatives.[21] But when care institutions are already part of the carceral system, mapping the extent of hospitals' position within that system is necessary to address the root problems these proposals seek to fix. Part IV proposes ways that hospitals could exert their influence to ameliorate care of patient prisoners. It suggests that medical professionals and hospitals begin by divesting from a police-as-public-safety perspective and centering patient care in their approaches to patient prisoners. The Article concludes with recommendations on how hospitals can improve

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19 I use this problematic term "bodies" intentionally. I am well-aware of the dehumanizing aspects of that word. I use it here to denote the perspective of the carceral system where people are bodies and numbers to be counted. *See* Bennett Capers, *Bringing Up the Bodies*, 2023 U. CHI. LEGAL F. 83, 84–86.

20 *See, e.g.*, *id.* at 85 (suggesting that certain problems of incarceration can be traced to "the rules we have created to protect the rights of defendants"); Allegra McLeod, *Prison Abolition and Grounded Justice*, 62 UCLA L. REV. 1156, 1156 (2015) (proposing a departure from traditional methods of policing and advocating for "an aspirational ethic and a framework of gradual decarceration"); Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CALIF. L. REV. 1781, 1844 n.286 (2020) (highlighting the longstanding "debate on the possibility and limits of law reform"); Jocelyn Simonson, *Police Reform Through a Power Lens*, 130 YALE L.J. 778, 778 (2021) (proposing a "power shifting" dynamic in the design of policing institutions); RUTHIE WILSON GILMORE, ABOLITION GEOGRAPHY 3 (Brenna Bhandar & Alberto Toscano eds., 2022) (reimagining academic scholarship on prisons as a study involving the "nexus between racialization, criminalization, class, and state-building"). *See generally* ANGELA Y. DAVIS, ABOLITION DEMOCRACY: BEYOND EMPIRE, PRISONS, AND TORTURE (2005) (asserting policing practices and institutions formed as a continuation of the injustices of slavery and advocating for a new series of social relations).

21 *See* Maura Ewing, *When Prisons Need to Be More Like Nursing Homes*, THE MARSHALL PROJECT (Aug. 27, 2015), https://www.themarshallproject.org/2015/08/27/when-prisons-need-to-be-more-like-nursing-homes [https://perma.cc/DUP5-75JM]; Aaron Leathley, *An 'Alternative to Law Enforcement:' Stockton's New Care Team on the Streets Full-Time*, THE REC. (Feb. 16, 2023, 4:01 AM), https://www.recordnet.com/story/news/local/2023/02/16/an-alternative-to-police-stockton-care-team-on-the-streets-full-time/69901047007 [https://perma.cc/MN8J-7K8A].

policies and practices and legal and regulatory measures to improve accountability and oversight of carceral institutions and hospitals.

Finally, a fuller description of the hospital's role in mass incarceration is necessary to underscore the humanity of the person at the center of these institutional forces—the patient prisoner subject to the surveillance of medical and carceral actors. The term "patient prisoner" is used broadly to refer to the person brought in under formal custody of a law enforcement or correctional agent, or who may be perceived to be under this carceral authority by the hospital. The patient prisoner is vulnerable to the actions of the combined authority of medical and carceral actors. Patient prisoners in hospitals are subject to carceral authority authorized to use force, and a health-care system that has often exhibited racial bias and discrimination.[22] Patient prisoners are thus vulnerable to compounded depreciation of their autonomy, privacy, and humanity. Examining hospitals' role in the carceral system allows us to imagine how we could improve the care and conditions of these patients by importing beneficial health-based values to carceral actions, amplifying the ideals of bioethics principles, and shoring up the legal, regulatory, and institutional structures that govern these patient prisoners.

I. The Role of Hospitals in Policing and Corrections

Throughout civilization, societies have grappled with how to quell disorder and house the sick, poor, mad, and otherwise infirm. History's jails, workhouses, poorhouses, and asylums have been replaced by today's vast sprawl of police lockups, jails, and prisons, and a patchwork of public, private, state-owned, nonprofit, and for-profit hospitals.

Just as in the early days of the asylum and poorhouses, similar populations continue to circulate between social welfare and penal institutions. This Part focuses on the role of hospitals when people are arrested by police and when they are held in jails or prisons. Hospitals provide medical treatment to arrested and imprisoned people, examine people prior to and as a precondition to incarceration, and assist in the process of scrutinizing people's bodies as sites of critical importance for police investigations.

The hospitals described here are heterogeneous.[23] They may be public, private; for-profit or nonprofit; community-level, state, or federal; and teaching or nonteaching.[24] These hospitals are not primarily

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22 *See* Osagie K. Obasogie, *Toward Abolitionist Approaches in Medicine*, 24 AMA J. Ethics 167, 167 (2022).

23 *See* The Pew Charitable Trs., State Prisons and the Delivery of Hospital Care: How States Set Up and Finance Off-Site Care for Incarcerated Individuals 2 & n.2 (2018) (citing Douglas C. McDonald, *Medical Care in Prison*, 26 Crime & Justice 427, 443–44 (1999)).

24 *See* Jason B. Liu & Rachel R. Keiz, *Types of Hospitals in the United States*, 320 JAMA 1074, 1074 (2018).

associated with the criminal system and provide a wide range of emergency and specialized service to the community. The focus of this Article is not on psychiatric hospitals or those that are formally part of the criminal system, like state and federal prison hospitals.[25] These latter two groups are also certainly examples of the overlap of health-care and carceral systems.

A. Medical Treatment Provider

Hospitals are necessary to treat people who are sick and injured during their incarceration. With state imprisonment comes the state's responsibility to care for those taken into their custody including providing medical care.[26] This responsibility is enshrined in the constitutional right to access adequate health care as declared by the Supreme Court in *Estelle v. Gamble*.[27] Access to adequate health care has come to include access to free world health care because of the inadequacies, and or nonexistence, of health care in custodial settings.[28]

Prisons have existed in the United States in some form or another since the country's founding.[29] Throughout, penal institutions have struggled to provide adequate health care to prisoners.[30] Early prison reformers envisioned new penal institutions that would address the illness and blight of eighteenth-century jails and prisons.[31] Although

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25 *Id.*; *Psychiatric Hospitals*, Ctrs. For Medicare & Medicaid Servs. (Dec. 1, 2021, 7:02 PM), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliancanc/PsychHospitals [https://perma.cc/7HQT-UZGS]; Substance Abuse & Mental Health Servs. Admin., Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 1–11 (2019); *see also* Joseph D. Bloom, Thomas E. Hansen & Amela Blekic, *Competency to Stand Trial, Civil Commitment, and Oregon State Hospital*, 50 J. Am. Acad. Psych. Law 67, 67 (2022) (describing the growth of individuals referred for competency to stand trial to Oregon State Hospital between 2000 and 2020). For a more historical overview, see R.B. Sheldon & W.B. Norman, *Comprehensive Survey of Forensic Psychiatric Facilities in the United States*, 7 Bull. Am. Acad. Psych. Law 93 (1978).

26 *See* Dolovich, *supra* note 17, at 154 ("With the decision to incarcerate, the polity acquires a burden.").

27 429 U.S. 97, 102 (1976).

28 *Id.* at 103–04 ("The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common-law view that '[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'" (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926))).

29 *See* Ashley T. Rubin, *Early U.S. Prison History Beyond Rothman: Revising the Discovery of the Asylum*, 15 Ann. Rev. L. & Soc. Sci. 137, 142 (2019).

30 *See* Spencer Headworth & Callie Zaborenko, *Legal Reactivity: Correctional Health Care Certifications as Responses to Litigation*, 46 Law & Soc. Inquiry 1173, 1174 (2021).

31 *See* Simon, *supra* note 16, at 219 (describing this first period as "miasma," where the penal model was that of the penitentiary and punitive discipline and the medical paradigm "jail fever" as the "exemplary disease").

physicians were at the center of this reform movement, the medical profession had very little to do with day-to-day correctional health care.[32] These early iterations of correctional health care were ad hoc in nature, some with prisoner-staffed medical units.[33] Only in the latter part of the nineteenth century did correctional facilities include physicians formally in correctional health care.[34]

Formal correctional health care did not lead to significant improvements. Lawsuits beginning in the mid-twentieth century starkly demonstrated the poor conditions of jails and prisons.[35] Professor Judith Resnik described prisons before the 1960s as "ruin[ing] people by leaving them in filth and darkness, feeding them rotten food, and giving no medical care."[36] Investigations revealed instances where inmates provided medical care to fellow inmates, including performing surgery and suturing, and accounts of prisoners' dying, covered in maggots.[37] Seth Goldsmith, a health-care administrator in the 1970s, described the medical department at an Arkansas prison as having "algae growing on the floor, condemned electrical wiring, poor sanitation, and unreliable flood protection that often resulted in fecal matter floating around and through the surgical and ward areas."[38] A contemporaneous survey by the American Medical Association ("AMA") collected responses from jails in the United States. More than a thousand responses by sheriffs revealed that close to two-thirds of jails reported having only first-aid facilities.[39] Nearly a third had no physicians available, meaning that physicians were not present on either a regularly scheduled or on-call basis.[40]

Multiple lawsuits eventually led to the Supreme Court's 1976 decision in *Estelle v. Gamble* that the Eighth Amendment's Cruel and Unusual Punishment Clause prohibits prison officials from being "deliberate[ly] indifferen[t]" to the "serious medical needs" of prisoners in their custody.[41] *Estelle* protections have been extended to pretrial detainees.[42]

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32 *See* Headworth & Zaborenko, *supra* note 30, at 1176.

33 *See id.* at 1177.

34 *See id.* at 1177–78.

35 *See id.* at 1177.

36 Judith Resnik, *(Un)Constitutional Punishments: Eighth Amendment Silos, Penological Purposes, and People's "Ruin*,*"* 129 Yale L.J.F. 365, 368 (2020).

37 Newman v. Alabama, 349 F. Supp. 278, 283, 285 (M.D. Ala. 1972).

38 Seth B. Goldsmith, *The Status of Prison Health Care: A Review of the Literature*, 89 Pub. Health Reps 569, 570 (1974).

39 *See* C. Steinwald & G. Alevizos, Medical Care in U.S. Jails (1973).

40 *See id.*

41 429 U.S. 97, 104 (1976).

42 *See* Carnell v. Grimm, 74 F.3d 977, 978–79 (9th Cir. 1996), *abrogation recognized in* Gordon v. County of Orange, 888 F.3d 1118, 1122 (9th Cir. 2018) (noting that deliberate indifference should be analyzed under an objective standard).

Since *Estelle*, jails and prisons have sought to comply with their constitutional obligation to provide access to adequate health care. Correctional health care typically falls into one of four categories.[43] One category is a direct model where health care is provided by state-employed correctional department clinicians.[44] An alternative model can be found in jurisdictions like the Federal Bureau of Prisons or the state prison system in California where prisoners with acute or chronic medical conditions are held in designated medical facilities.[45] Other models include ones where the correctional institutions contract with private companies or medical schools.[46] The final type is a hybrid of these three models.[47]

But problems with correctional health care continue.[48] Correctional medical units suffer from inadequate staffing, lack of qualified staff, or limited medical services.[49] Less stringent licensing standards for medical professionals inside correctional institutions mean that jails and prisons can employ doctors who would not be able to practice medicine

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43 *See* The Pew Charitable Trs., *supra* note 23, at 4; Jeffrey Natterman & Pamela Rayne, *The Prisoner in a Private Hospital Setting: What Providers Should Know*, 19 J. Health Care L. & Pol'y 119, 121 (2016) (stating that jurisdictions can choose between prison health staff, contracted health workers, or external private hospitals).

44 *See* The Pew Charitable Trs., *supra* note 23, at 4; Alan Ellis & Samuel Shummon, Alan Ellis' Federal Prison Guidebook 5 (1998 ed.).

45 Ellis & Shummon, *supra* note 44. These hospitals also include state hospitals like the medical facilities operated by the North Carolina Department of Public Safety, which decrease reliance on community hospitals. *New Prison Medical Facilities*, N.C. Dep't of Pub. Safety, https://www.doc.state.nc.us/DOP/health/new_facilities.html [https://perma.cc/FEF9-V2EU]. This description does not include state-owned mental health facilities, such as California's state hospitals, which hold people mandated for treatment by a criminal or civil court order. *See About Us*, Cal. Dep't of State Hosps., https://www.dsh.ca.gov/About_Us/index.html [https://perma.cc/2HLY-J5L6].

46 *See, e.g.*, Blake Ellis & Melanie Hicken, *CNN Investigation Exposes Preventable Deaths and Dangerous Care in Jails and Prisons Across the Country*, CNN (June 25, 2019), https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/ [https://perma.cc/E8F2-TYFQ] (noting that one private company won government contracts that "span[ned] more than 500 facilities in 34 states"); Ben G. Raimer & John D. Stobo, *Health Care Delivery in the Texas Prison System: The Role of Academic Medicine*, 292 JAMA 485, 486 (2004).

47 The Pew Charitable Trs., *supra* note 23, at 4.

48 Peter Wagner & Wendy Sawyer, Prison Policy Initiative, Mass Incarceration: The Whole Pie 2020 (Mar. 24, 2020), https://www.prisonpolicy.org/reports/pie2020.html [https://perma.cc/L3L7-ZG2E]; *see also* Sojourner Ahebee, *How Bad Is Prison Health Care in the United States?*, WHYY (Apr. 9, 2021), https://whyy.org/segments/why-good-health-care-in-u-s-prisons-may-be-hard-to-come-by/ [https://perma.cc/L3BJ-2FDD].

49 Keri Blakinger & The Marshall Project, *Disgraced Doctors, Unlicensed Officials: Prisons Face Criticism Over Health Care*, NBC News (July 1, 2021, 6:00 AM), https://www.nbcnews.com/news/us-news/disgraced-doctors-unlicensed-officials-prisons-face-criticism-over-health-care-n1272743 [https://perma.cc/8EXA-B5P6] ("From California to Alabama, news reports and public records show that prisons routinely hire underqualified and even disgraced medical staff."); Off. of the Inspector Gen., U.S. Dep't of Just., Review of the Federal Bureau of Prisons' Medical Staffing Challenges 1 (2016).

otherwise.[50] Inadequate responses by correctional staff to imprisoned people's requests for health care exacerbate their suffering and have led to deaths.[51] In California, problems with correctional health care led to a multiyear lawsuit spanning three governors. In its 2011 decision of *Brown v. Plata*,[52] the Supreme Court upheld a lower court order to decrease California's prisons by thousands due to the clear constitutional violations.[53] Justice Kennedy, writing for the majority, stated that "[f]or years the medical and mental health care provided by California's prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners' basic health needs."[54] The result was realignment, a state law that shifted thousands of California's prison population to the county jails.[55] Professor Margo Schlanger warned of the "hydra" threat that the problems of prison health care would multiply at the county level.[56] Her words were prescient. The problems merely shifted from prison to jails. Lawsuits have been filed against counties alleging similar problems of overcrowding and inadequate health care.[57]

Private health companies contracted to provide health care within jails and prisons have compounded problems. Media reports have exposed how these companies cut costs by ignoring inmate

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50 Littman, *supra* note 10, at 1403 (describing how state licensure laws permit doctors who lack full medical licenses to practice in prisons and jails under limited licenses, including those who had been disciplined for misconduct such as sexual assault or being intoxicated).

51 *See* E. Ann Carson & Mary P. Cowhig, U.S. Dep't of Just., Mortality in State and Federal Prisons, 2001–2016—Statistical Tables (2020), https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6766 [https://perma.cc/7PKW-HF72] (providing number and rate of deaths among state and federal prisoners); Abigail Leonard & Adam May, *Whistleblower: Arizona Inmates Are Dying from Inadequate Health Care*, Al Jazeera America (May 2, 2014, 3:45 PM), http://america.aljazeera.com/watch/shows/america-tonight/articles/2014/5/27/whistleblower-arizonainmatesaredyingfrominadequatehealthcare.html [https://perma.cc/94YV-C7M4]; Christine Willmsen & Beth Healy, *When Inmates Die of Poor Medical Care, Jails Often Keep It Secret*, WBUR (Mar. 23, 2020), https://www.wbur.org/news/2020/03/23/county-jail-deaths-sheriffs-watch [https://perma.cc/6WRZ-TFSV].

52 563 U.S. 493 (2011).

53 *Id.*

54 *Id.* at 501.

55 Magnus Lofstrom & Brandon Martin, Pub. Pol'y Inst. of Cal., Public Safety Realignment: Impacts So Far (2015), https://www.ppic.org/publication/public-safety-realignment-impacts-so-far/ [https://perma.cc/2YDA-8LTE].

56 Margo Schlanger, Plata v. Brown *and Realignment: Jails, Prisons, Courts, and Politics*, 48 Harv. C.R.-C.L. L. Rev. 165, 210–11 (2013).

57 *See Counties Facing Lawsuits Over Inadequate Medical Care for Jail Inmates*, Cal. Healthline (Mar. 19, 2013), https://californiahealthline.org/morning-breakout/counties-facing-lawsuits-over-inadequate-medical-care-for-jail-inmates/ [https://perma.cc/B6VP-63FH]; Matthew Clarke, *California County Settles Class-action Lawsuit Over Jail Medical and Mental Health Care*, Prison Legal News (Jan. 10, 2017), https://www.prisonlegalnews.org/news/2017/jan/10/california-county-settles-class-action-lawsuit-over-jail-medical-and-mental-health-care/ [https://perma.cc/6T4J-KZGW].

medical requests and providing minimal or shoddy care.[58] They have also attracted numerous lawsuits. One of these private companies, Corizon, has been the target of more than 1,000 lawsuits across the country.[59] A review of over 500 jails by *Reuters* found death rates of eighteen to fifty-eight percent higher in facilities run by private health-care contractors like Corizon than those run by government agencies.[60] Even after controlling for the size of the jail and the area's mortality rate, Reuters found a statistically significant difference.[61]

The problems with correctional health care are further exacerbated by the medical needs of people in jails and prisons. People in jails and prisons suffer chronic health problems at high rates.[62] Incarcerated people are more likely to be from low-income households and from minority communities, and as a result face structural barriers to health.[63]

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58 *See* Leonard & May, *supra* note 51; Pat Beall, *Privatizing Prison Health Care Leaves Inmates in Pain, Sometimes Dying*, Palm Beach Post (Sept. 30, 2014, 11:32 PM), https://www.palmbeachpost.com/story/news/2014/09/27/privatizing-prison-health-care-leaves/6803234007/ [https://perma.cc/233V-CX4Q]; *see also* Jason Meisner, *Independent Experts Blast Quality of Medical Care in Illinois Prisons*, Chi. Trib. (May 19, 2015, 10:14 PM), https://www.chicagotribune.com/news/ct-illinois-prison-medical-care-met-20150519-story.html [https://perma.cc/52XK-RTTS]; Michael Winerip & Michael Schwirtz, *New York City to End Contract with Rikers Health Care Provider*, N.Y. Times (June 10, 2015), https://www.nytimes.com/2015/06/11/nyregion/report-details-failings-of-corizon-rikers-island-health-provider.html [https://perma.cc/5TDK-66RK]; Willmsen & Healy, *supra* note 51.

59 Rachel Weiner, *Arlington Cuts Ties with Jail Health-Care Provider*, Wash. Post (Oct. 25, 2021, 6:41 PM), https://www.washingtonpost.com/local/legal-issues/arlington-jail-corizon/2021/10/25/53ce61a0-35bd-11ec-91dc-551d44733e2d_story.html [https://perma.cc/7GKD-HLMQ].

60 Joseph Szep, Ned Parker, Linda So, Peter Eisler & Grant Smith, *Special Report: U.S. Jails Are Outsourcing Medical Care—And the Death Toll is Rising*, Reuters (Oct. 26, 2020, 9:42 AM), https://www.reuters.com/article/us-usa-jails-privatization-special-repor/special-report-u-s-jails-are-outsourcing-medical-care-and-the-death-toll-is-rising-idUSKBN27B1DH [https://perma.cc/ZP88-876B]. Other companies include Wellpath Holdings Inc., NaphCare, PrimeCare Medical Inc., and Armor Correctional Health Services Inc. This is not to say that there cannot be improvements with private company involvement. As one attorney stated in an interview for this piece, in one county where Wellpath took over mental health, services improved. *See* E-mail from Anonymous Attorney 1 to author (Jan. 25, 2023) (on file with author).

61 Szep et al., *supra* note 60. The article did not specify the size of the mortality difference after inclusion of statistical controls.

62 Andrew P. Wilper, Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor & David U. Himmelstein, *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 Am. J. Pub. Health 666, 668–69 & tbls.1 & 2 (2009) (using 2002 and 2004 survey of jail and prison populations to decipher that 38.5% of federal inmates, 42.8% of state prison inmates, and 38.7% of jail inmates suffer from a chronic medical condition); Laura M. Maruschak & Marcus Berzofsky, U.S. Dep't of Just., Special Report: Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12, at 1 (2016) (stating that in 2011–2012, half of federal and local inmates reported having a chronic health condition).

63 Natasha Camhi, Dan Mistak & Vikki Wachino, *Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System*, Commonwealth Fund Issue Briefs (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system [https://perma.cc/5DDQ-E24T]; C. André

A recent study of longitudinal county-level mortality data in the United States between 1987 and 2017 and county jail rate found a strong association between incarceration and death rates due to infectious diseases, chronic lower respiratory disease, drug use, and suicide.[64] People with disabilities face even greater dangers and difficulties when arrested and incarcerated.[65]

Another issue is the fact that the number of older people in prison has increased over the years, now accounting for ten percent of the incarcerated populations in most states.[66] Though sick and elderly prisoners may be eligible for release, this form of relief is rarely granted. For example, in Wisconsin, more than 1,200 people in their prisons were sixty years or older and in 2017, only six inmates were released.[67] Commutation and clemency are also theoretically available but these processes are slow-moving and granted to very few.[68] Poor

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Christie-Mizell, *Neighborhood Disadvantage and Poor Health: The Consequences of Race, Gender, and Age Among Young Adults*, 19 Int. J. Environ. Res. Pub. Health 1, 1–2 (2022). *See generally* Arline T. Geronimus, *To Mitigate, Resist or Undo: Addressing Structural Influences on the Health of Urban Populations*, 90 Am. J. Pub. Health 867, 867–69 (2000); Jo C. Phelan & Bruce G. Link, *Is Racism a Fundamental Cause of Inequalities in Health?*, 41 Annu. Rev. Sociol. 311, 320–24 (2015); Raj Chetty, Michael Stepner, Sarah Abraham, Shelby Lin, Benjamin Scuderi, Nicholas Turner, Augustin Bergeron & David Cutler, *The Association Between Income and Life Expectancy in the United States, 2001–2014*, 315 JAMA 1750, 1758–59 (2016).

64 Sandhya Kajeepeta, Pia M. Mauro, Katherine M. Keyes, Abdulrahman M. El-Sayed, Caroline G. Rutherford & Seth J. Prins, *Association Between County Jail Incarceration and Cause-Specific County Mortality in the USA, 1987–2017: A Retrospective, Longitudinal Study*, 6 Lancet Pub. Health e240, e245 (2021).

65 Margo Schlanger, *Anti-Incarcerative Remedies for Illegal Conditions of Confinement*, 6 U. Mia. Race & Soc. Just. L. Rev. 1, 2–3 (2016); Margo Schlanger, *Prisoners with Disabilities*, *in* Reforming Criminal Justice: Punishment, Incarceration and Release 295, 298–301 (Eric Luna ed., 2017); Jamelia N. Morgan, *Disability's Fourth Amendment*, 122 Colum. L. Rev. 489, 504–06 (2022).

66 *Old Behind Bars: The Aging Prison Population in the United States*, Human Rights Watch (Jan. 27, 2012), https://www.hrw.org/report/2012/01/28/old-behind-bars/aging-prison-population-united-states [https://perma.cc/9AHU-5N3D]; Matt McKillop & Alex Boucher, *Aging Prison Populations Drive Up Costs*, Pew Report (Feb. 20, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs [https://perma.cc/Y4S4-CUKR].

67 Gina Barton, *Release Programs for Sick and Elderly Prisoners Could Save Millions. But States Rarely Use Them*, Milwaukee J. Sentinel (Apr. 18, 2018), https://projects.jsonline.com/news/2018/4/18/release-programs-for-sick-elderly-prisoners-could-save-millions.html [https://perma.cc/LRJ4-U9B3].

68 Though states could save lives and money through compassionate release, such relief is granted at low rates. *The Answer Is No: Too Little Compassionate Release in Federal Prisons*, Hum. Rts. Watch (Nov 30, 2012), https://www.hrw.org/report/2012/11/30/answer-no/too-little-compassionate-release-us-federal-prisons [https://perma.cc/S98E-EVU9]; Andreas Mitchell & Brie Williams, *Compassionate Release Policy Reform: Physicians as Advocates for Human Dignity*, 19 AMA J. Ethics 854, 854–56 (2017). At the beginning of the COVID-19 pandemic, Professor Rachel Barkow argued that the President of the United States could grant commutations and reprieves to people in prison. *Clemency and the Office of the Pardon Attorney*: *Oversight Hearing*

conditions in jails and prisons compound these existing problems and contribute to increased illness and disease.[69] Jails and prisons are also violent places.[70]

Outside health-care providers thus provide a critical role in supplementing and shoring up correctional health care. State and federal correctional authorities are permitted to contract with outside health-care providers. The federal corrections agency, the Bureau of Prisons, allows people held in federal prisons to seek treatment at outside medical facilities for either in-patient or out-patient emergency and nonemergency visits.[71] States have similar provisions, allowing prisoners to be removed for emergencies and when the facilities cannot accommodate the necessary medical treatment.[72] Other arrangements allow for seriously ill patients to access outside health-care facilities like the "open ward releases" in Los Angeles County for inmates with serious health issues to be released to emergency departments.[73]

Though the exact extent of external hospital use by correctional authorities is not known, data on health-care spending provides some insight. During the period of 2007 through 2011, a PEW report found that hospital care by correctional departments accounted for twenty percent of all health spending.[74] Federal data also gives us a picture for how much the Federal Bureau of Prisons relies on outside medical services.[75] A 2017 report by the Government Accountability Office revealed that "outside medical services made up about 40 percent

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Before the Subcomm. on Crime, Terrorism, and Homeland Sec. of the H. Comm. on the Judiciary, 117th Cong. 43–56 (2022) (statement of Rachel E. Barkow).

69 Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, Prison Policy Initiative (May 13, 2021), https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts [https://perma.cc/X86B-F74X]; Lela Nargi, *Poor Food in Prison and Jails Cause or Worsen Eating and Health Problems. And the Effects Linger Long After Release*, The Counter (Feb. 1, 2022, 3:11 PM), https://thecounter.org/poor-food-prison-jail-causes-health-problems-trauma/ [https://perma.cc/RJ83-PYRP]; *see also* Anne S. Douds, Eileen M. Ahlin, Nicholas S. Fiori & Nicholas J. Barissh, *Why Prison Dental Care Matters: Legal, Policy, and Practical Concerns*, 29 Annals Health L. & Life Sci. 101, 103–04 (2020).

70 C.R. Div., U.S. Dep't of Just., Investigation of Alabama's State Prisons for Men 2 (Apr. 2, 2019).

71 Medical Escorted Trips, 28 C.F.R. § 570.41.

72 *See* Cal. Penal Code §§ 849(b)(3)–(5), 4007, 4011.5 (West 2017); N.Y. Correct. 43-20 § 508 (Mckinney 2021); Tenn. Code Ann. § 4-6-109 (West 2015); Wash. Rev. Code Ann. § 72.10.030 (West 2012).

73 Los Angeles Sheriff's Dep't, Manual of Policy and Procedures, 5-03/107.00 (2021) (LAC/USC Medical Center Release to Open Ward); *see also* E-mail from Anonymous Physician XX to author (April 2, 2023) (on file with author).

74 The Pew Charitable Trs., *supra* note 23, at 2.

75 Off. of the Inspector Gen., U.S. Dep't of Just., The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care, at i (2016).

of medical services" for federal prisoners from 2009 to 2016.[76] An Inspector General report in 2014 found that from 2010 to 2014, the Bureau's spending for outside medical services rose from $263 million to $327 million, an increase of twenty-four percent.[77] The report noted that prisons in rural areas relied more on outside medical care due to staffing problems in their medical care units.[78] The state picture is less clear because of the lack of data, but the data that does exist suggests that states follow the same pattern. A review of Maryland's data over a twelve-month period suggests that during that time, approximately twenty-eight percent of prisoners in Maryland were treated at private facilities.[79]

Outside hospitals also provide a separate category of medical treatment: involuntary commitment of mentally ill people. Psychiatric beds in emergency rooms are used for people on seventy-two-hour mental health holds.[80] These mental health holds in hospitals have increased over the years.[81] These mental health patients are often brought in by police since police are the primary agency responding to mental health crises and have the authority to place people on these holds.[82] The typical standard is that the person must be a danger to themselves or others.[83] These mental health holds are not necessarily a precursor to

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76 U.S. Gov't Accountability Off., GAO-17-379, Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs 28 (June 2017).

77 Off. of the Inspector Gen., *supra* note 75, at 1 (2016).

78 *See* U.S. Gov't Accountability Off., *supra* note 76, at 28–29.

79 Natterman & Rayne, *supra* note 43, at 123–24. The authors arrived at this estimate based upon 5,944 prisoners who were seen in private settings in 2014 and a total number of sentenced prisoners in 2013 as 20,998. *Id.* at 123–24 & n.37. The authors compared this data to the Bureau of Justice Statistics Report 2013. *Id.* The 2014 BJS report lists Maryland's sentenced prisoners at 21,011 which still places the overall percentage at 28.29%.

80 *See* Nathaniel P. Morris, *Reasonable or Random: 72-Hour Limits to Psychiatric Holds*, 72 Psychiatric Servs. 121, 121 (2021) ("Estimates suggest that more than [one] million emergency psychiatric holds are placed in the United States each year.").

81 Gi Lee & David Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*, 72 Psychiatric. Servs. 61 (2021) (finding that the mean state rate of incidences of involuntary psychiatric detentions increased by three times the mean state population increase in a study of 25 states). *See generally* Audrey J. Weiss, Marguerite L. Barrett, Kevin C. Heslin & Carol Stocks, Healthcare Cost And Utilization Project, Statistical Brief No. 216, Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013, at 2 (2016) (noting a substantial increase in emergency department visits related to mental and substance use between 2006 and 2013).

82 *See, e.g.*, N.Y. Mental Hyg. Law § 9.41 (McKinney 2021) (emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers); Leslie C. Hedman, John Petrila, William H. Fisher, Jeffrey W. Swanson & Deirdre A. Dingman, *State Laws on Emergency Holds for Mental Health Stabilization*, 67 Psychiatric Servs. 529, 530–31 (2016); Cal. Welf. & Inst. Code § 5150.

83 *See, e.g.*, Cal. Welf. & Inst. Code § 5150; N.Y. Mental Hyg. § 9.41.

incarceration but they could coincide with the arrest of the person.[84] In some tragic instances, mental health holds have resulted in bodily injury and death due to police use of violence.[85]

B. Clearance for Incarceration

A corollary to being a treatment provider for carceral authorities is the hospitals' antecedent role to incarceration through "medical clearance." Jails may, and often do, deny admission for obviously sick and injured future prisoners until they have been medically cleared. Injured, intoxicated, or sick people under police custody and arrest are hence not usually taken directly to the county jail and are instead brought to outside hospitals by law enforcement agents. Hospitals also provide medical clearance or stabilization for people under law enforcement custody in mental health crises.

This prejail use of hospitals is not necessarily mandated by law. In California, the statute permits the sheriff to refuse to book someone until they have "been transported to a hospital or medical facility so that his or her medical needs can be addressed prior to booking into county jail."[86] Other authority on the use of hospital pretrial can be found in police policies and case law on the booking of arrestees in hospitals.[87] Arraignment statutes and laws are one such source. Generally, a person who is arrested without a warrant must have a probable cause determination by court to remain in custody within forty-eight hours.[88] The person must then be presented for arraignment within a set period of days from the time of arrest.[89] Courts have permitted patients to be held in hospitals pending arraignments.[90] Arraignments can be conducted at hospitals, and just like arraignments in court, can be open to

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84 *See* Jamelia N. Morgan, *Policing Under Disability Law*, 73 Stan. L. Rev. 1401, 1416 (2021).

85 *See, e.g.*, 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/FZ2Q-7KKB]; Molly Gamble, *Police Fatally Shoot Man in Cleveland Clinic Florida ER*, Becker's Hosp. Rev. (Mar. 28, 2022), https://www.beckershospitalreview.com/care-coordination/police-fatally-shoot-man-in-cleveland-clinic-florida-er.html [https://perma.cc/B5DZ-ZBUM].

86 Cal. Penal Code § 4015(b).

87 *See, e.g.*, Mia., Fla., Police Departmental Orders § 16.4.23 (2022); Johnson v. Meltzer, 134 F. 3d 1393, 1395, 1398 (9th Cir. 1998) (defendant taken to hospital for injuries suffered in a car accident and was fingerprinted and booked).

88 County of Riverside v. McLaughlin, 500 U.S. 44, 47 (1991).

89 *See* People *ex rel*. Maxian v. Brown, 570 N.E.2d 223, 225 (N.Y. 1991) (citing a twenty-four-hour limit in New York); Cal. Penal Code § 825 (citing a forty-eight-hour limit in California); La. Code Crim. Proc. Ann. art. 701 (2022) (citing a thirty-day limit in Louisiana).

90 *See In re* Walker, 518 P.2d 1129, 1137–38 (Cal. 1974); People v. Frazier, 354 N.W.2d 332, 36 (Ct. App. Mich. 1984); United States v. Murray, 197 F.R.D. 421, 423 (S.D. Cal. 2000); State v. Brown, 310 P.3d 29, 35 (Ariz. Ct. App. 2013).

the public.[91] Courts have also approved the delay of arraignments while defendants are being treated in hospitals.[92]

Though the criminal process's recognition that hospitals may be part of the equation when defendants are sick or injured, hospitals are not explicitly mandated by law to conduct medical clearances. The closest legal requirement for hospitals is the Emergency Treatment and Labor Act ("EMTALA").[93] EMTALA requires hospitals taking federal money to at least do a health screening of everyone who comes to their doors.[94] Law enforcement have pointed to this broad mandate as justification for their use of hospitals in this manner.[95]

In fact, the term "medical clearance" is referred to frequently in correctional resources, sometimes in emergency medical literature, but very little in legal resources. This is not surprising given the possible liability for jails if they do admit a person with severe medical conditions.[96]

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91 *See Directive 4.13, Detainees in Hospitals*, Phila. Police Dep't (Apr. 10, 2020), https://www.phillypolice.com/assets/directives/D4.13-DetaineesInHospitals.pdf [https://perma.cc/A8ZL-37N7]; Melissa Etehad, *Suspect in Killing of Boston Doctors Is Arraigned in His Hospital Bed*, L.A. Times (May 8, 2017, 6:20 PM), https://www.latimes.com/nation/la-na-boston-doctor-killings-20170508-story.html [https://perma.cc/EWW9-XQLT]; People v. Armento, 114 N.Y.S. 3d 46, 46 (Sup. Ct. App. Div. 2019) (finding that the inculpatory statements were voluntary, despite arraignment in hospital); Cornell Barnard, *Suspect in Bodega Bay Rampage Arraigned in Hospital Bed*, ABC7 News (July 12, 2019), https://abc7news.com/bodega-bay-shooting-sonoma-county-sheriffs-office-officer-involved/5390141/ [https://perma.cc/9Q5L-BNCG]; Emily Shapiro, *No Evidence That Man Accused of Killing Two Boston Doctors Knew Victims: District Attorney*, ABC News (May 8, 2017, 6:50 PM), https://abcnews.go.com/US/man-charged-counts-murder-deaths-boston-doctors/story?id=47272941 [https://perma.cc/83R9-GXE4] (video of hospital arraignment); Patrick Johnson, *Dauda Handan, Shot By Chicopee Police, Pleads Innocent to Assault Charges*, MassLive (June 5, 2019, 1:54 PM), https://www.masslive.com/police-fire/2019/06/dauda-handan-shot-by-chicopee-police-pleads-innocent-to-assault-charges.html [https://perma.cc/WWA6-RXMY] (photographs taken by media).

92 *See* United States v. Fritts, 5 F. App'x 765, 766 (9th Cir. 2001); United States v. Murray, 197 F.R.D. 421, 422 (S.D. Cal. 2000); State v. Plouffe, 646 P.2d 533, 537 (Mont. 1982); State v. Brown, 310 P.3d 29, 35 (Ct. App. Ariz. 2013); *In re* Walker, 518 P.2d 1129, 1138 (Cal. 1974).

93 *See* 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).

94 42 U.S.C. § 1395dd(a).

95 *See* Robert A. Bitterman, *Federal Law, EMTALA, and State Law Enforcement: Conflict in the ED?*, Relias Media (Jan. 1, 2006), https://www.reliasmedia.com/articles/120641-federal-law-emtala-and-state-law-enforcement-conflict-in-the-ed [https://perma.cc/8H2B-7JLY]; *see also, e.g.*, Kristin E. Malcolm, James G. Malcolm, Daniel T. Wu, Kevin A. Spainhour & Kevin P. Race, *Cops and Docs: The Challenges for ED Physicians Balancing the Police, State Laws, and EMTALA*, 37 J. Healthcare Risk Mgmt. 29, 30 (2017). EMTALA is often characterized as an unfunded mandate, but hospitals do receive Medicare/Medicaid funding from the government for screening eligible patients. *See Emergency Department Services*, U.S. Ctrs. for Medicare & Medicaid Servs., https://www.medicare.gov/coverage/emergency-department-services [https://perma.cc/7SQN-WG2V].

96 *See* ACLU National Prison Project, *Know Your Rights: Medical, Dental and Mental Health Care*, ACLU (Nov. 2005) https://www.aclu.org/sites/default/files/images/asset_upload_file690_25743.pdf [https://perma.cc/R4G3-W4ZJ].

Just as "medical clearance" merits little to no statutory, regulatory, or doctrinal attention, the same goes for what "medical clearance" actually entails. The strongest guidance consists of EMTALA's statutory language that medical needs be addressed or that hospitals conduct screenings.[97] With no other guidance, it is not surprising that medical professionals have varied ways of approaching medical clearance, as reflected in interviews. One physician did not see anything different about their practice of medical clearance compared to the usual emergency screening.[98] A resident expressed discomfort with the assumption that an all-clear from them would be perceived as that person being cleared to be incarcerated, particularly when they had knowledge of the conditions of the local jail or prison or that conditions of confinement would exacerbate nonserious but latent medical conditions.[99] One doctor responded that they approach medical clearance through the lens of patient autonomy and ask patients if they want an examination and ultimately follow the patient's directive.[100] One emergency physician recounted instances where law enforcement asked for specific language that a person be cleared for incarceration or certain diagnoses and made requests to clear people who were still being held in patrol cars.[101]

C. Sites of Crime Investigation

Finally, hospitals are important to law enforcement for the kinds of criminal evidence that can be gleaned from diagnostic tests, medical professional diagnoses, and patient statements to medical providers. Police conduct a variety of investigations in emergency rooms.[102] Investigative methods include the kind of investigations that might occur in nonhospital settings, such as police questioning and searches of patients and their belongings.[103] The policies of the Minneapolis Police Department are one example of an agency outlining investigation procedures in hospitals. On the topic of interviewing suspects in hospital, the policy specifies that permission must be obtained from the Administrative Office of the hospital, the doctor, or the head nurse, except if the person is in the emergency room for follow-up investigation, and that if the suspect is a juvenile, the hospital can give permission after an attempt has been made to contact the parents.[104] The policies also cover bodily

97 *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121.

98 Interview with Anonymous Physician 23 (Nov. 2, 2022) (on file with author).

99 Interview with Anonymous Physician 8 (May 28, 2022) (on file with author).

100 Interview with Anonymous Physician 2 (Mar. 11, 2022) (on file with author).

101 E-mail from Anonymous Physician XX to author (Apr. 2, 2023) (on file with author).

102 Song, *Policing the Emergency Room*, *supra* note 11, at 2660.

103 *Id.* at 2661–63.

104 Minneapolis, Minn., Police Department Policy and Procedure Manual § 10-205 (2021).

fluid samples from victims and inventorying of evidence or property received from the hospital.[105]

Hospitals are particularly valuable criminal investigative value to police because of the ease of access to evidence. Medically vulnerable patients may be particularly susceptible to questioning that they would have otherwise resisted. Patients may be separated from their belongings when they are brought in for treatment and hospital staff may give police access to patients' clothing, bags, and other belongings.[106]

Hospitals are also valuable for investigation because of the people within them. Medical professionals in hospitals can identify evidence of criminal conduct because of their medical expertise and position as medical providers. For instance, medical professionals can surmise whether an injury is due to a gunshot wound or stabbing. They can assess whether someone is a victim of sexual or physical abuse and determine whether a person has undergone an abortion. Apart from their medical diagnosis, medical professionals are privy to patient confidences and the circumstances surrounding the reason for the medical visit. This information can also be conveyed to the police and serve as potentially useful evidence. Medical professionals' contributions are helpful at both the preliminary investigative stage as well as in the adjudicative stages.[107]

The investigative role by medical professionals and hospitals is due in no small part to the mandatory reporting obligations imposed on medical providers and institutions not just to law enforcement but also to public health and child welfare authorities.[108] These legal mandates are broad and general, requiring that hospitals and medical professionals provide information immediately and to any law enforcement agent.[109] Exceptions to the federal Health Information Portability and

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105 *Id.* §§ 7-349(IV), 10-400(D).

106 Song, *Policing the Emergency Room*, *supra* note 11, at 2678–81.

107 *See, e.g.*, Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. Rev. 1111, 1119–20 (2020); Keith A. Findley, D. Michael Risinger, Patrick D. Barnes, Julie A. Mack, David A. Moran, Barry C. Scheck & Thomas L. Bohan, *Feigned Consensus: Usurping the Law in Shaken Baby Syndrome/Abusive Head Trauma Prosecutions*, 2019 Wis. L. Rev. 1211, 1236–37; Deborah Tuerkheimer, Flawed Convictions: "Shaken Baby Syndrome" and the Inertia of Justice 36–37 (2014).

108 *See* Haw. Rev. Stat § 453-14 (2022). Only Alabama, New Mexico, and Wyoming have no mandatory reporting requirement statutes. Victim Rts. L. Ctr., Mandatory Reporting of Non-Accident Injuries: A State-by-State Guide (2014) (fifty-state survey of mandatory reporting requirements for health-care practitioners); *see, e.g.*, Mich. Comp. Laws § 750.411 (mandatory reporting of injuries by deadly weapons or other means of violence, violation is a misdemeanor, good faith is presumed); *id.* § 722.623(1) (to child abuse hotline).

109 Hospital records may also be gathered during investigations, but this Section deals not with these *ex-post* records but with investigations prior to the commencement of a criminal action. *See generally* Victim Rts. L. Ctr., *supra* note 108.

Accountability Act ("HIPAA")[110] include state laws such as these as well as other discretionary disclosures to law enforcement and other law enforcement-based exceptions to patient privacy in response to subpoenas and court orders.[111] HIPAA protections also do not apply when information is provided for the purposes of treatment, payment, or operation, which may be the case for jails or prisons who are providing medical care for prisoners, and who thus are authorized to obtain medical information for providing health care to the inmate, for the health and safety of inmates, and for the administration and maintenance of security, safety, and order in correctional institutions.[112] The broad and general nature of these exceptions may also lead medical professionals to overdisclose, even when they do not need to, perhaps because they believe HIPAA exceptions are mandates, fear noncompliance, or confusion.

Criminal procedure doctrine also underscores this permission to investigate in hospitals. This is particularly apparent in courts' adjudications of cases involving drug offenses and drunk driving. In an early case assessing the constitutionality of a body cavity search, Justice Frankfurter found the stomach pumping of the defendant to have "shock[ed] the conscience" in violation of the Due Process Clause.[113] But he made sure to "put to one side cases which have arisen in the State courts through use of modern methods and devices for discovering wrongdoers and bringing them to book."[114] A few years later, in a case involving a blood draw from an unconscious person accused of involuntary manslaughter, the Court reiterated this principle, stating that "[m]odern community living requires modern scientific methods of crime detection lest the public go unprotected."[115] Thirty years later, in his dissent to the Court's decision in a case involving the body search of a person suspected of transporting drugs in her body, Justice Marshall declared, "We have learned in our lifetimes, time and again, the inherent dangers that result from coupling unchecked 'law enforcement' discretion with the tools of medical technology."[116]

That hospitals are important to criminal investigations is not surprising. In many ways, police and hospitals have grown up together. Since the 1950s, police agencies have changed drastically, growing

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110 Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.).

111 45 C.F.R. § 164.512(2) (2002).

112 *Id.* § 164.512(k)(5).

113 *See* Rochin v. California, 342 U.S. 165, 172 (1952).

114 *Id.* at 173.

115 Breithaupt v. Abram, 352 U.S. 432, 439 (1957).

116 United States v. Montoya de Hernandez, 473 U.S. 531, 562 (1985) (Brennan, J., dissenting).

into today's politically powerful bureaucracies with robust funding.[117] During that same period, hospitals have grown in number and increasingly become an important and central part of the health-care delivery system, particularly for the poor and marginalized groups.[118]

Little to no data captures exactly how often law enforcement use hospitals for front-end reasons, such as investigation and medical clearance. But law enforcement policies, facts drawn from case law, correctional resources, and medical literature indicate that law enforcement regularly use hospitals in this manner.[119]

II. Carceral Power in Hospitals

When law enforcement and correctional authorities bring people into hospitals, they bring the full force of their power. They enter hospitals with their badges and guns, the lawful ability to use deadly force, their own accountability structures, and institutional power. Police and correctional officers add to the complex and diverse hospital workplace comprised of multiple and varied stakeholders and characterized by quick decision-making and pressures to meet financial bottom lines. Yet hospitals as highly regulated and complex organizations adapt to carceral authorities in ways that alter their workplace and regulatory ecosystem, revealing gaps in accountability and the power of carceral laws, regulations, and practice overtake those of hospitals.

A. Hospital-Carceral Workplace

Law enforcement and correctional authorities add a dominating layer to the intricate organizational dynamic existing in hospitals.

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117 *See* Elizabeth Hinton, *"A War Within Our Own Boundaries": Lyndon Johnson's Great Society and the Rise of the Carceral State*, 102 J. Am. Hist. 100, 103 (2015); *State and Local Backgrounders, Criminal Justice Expenditures: Police, Corrections, and Courts*, Urb. Inst., https://www.urban.org/policy-centers/cross-center-initiatives/state-and-local-finance-initiative/state-and-local-backgrounders/criminal-justice-police-corrections-courts-expenditures [https://perma.cc/RGT2-FSYQ].

118 *See* Barbra Mann Wall, *History of Hospitals*, Univ. of Pa. Nursing, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/ [https://perma.cc/WZH5-BX3E].

119 *See* Phila., Pa., Police Dep't Directive § 4.13 (2020); Mia., Fla., Police Departmental Orders § 16.4.23 (2022); N.Y.C., N.Y., Police Dep't Patrol Guide § 210–03 (2019); Minneapolis, Minn., Police Department Policy and Procedure Manual § 9-108 (2023); Megan Y. Harada, Armando Lara-Millán & Lauren E. Chalwell, *Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care*, 78 Annals Emergency Med. 738, 741 (2021); Rucha Alur, Erin Hall, Utsha Khatri, Sara Jacoby, Eugenia South & Elinore J. Kaufman, *Law Enforcement in the Emergency Department*, 157 JAMA Surg. 852, 852–53 (2022); *In re* Walker, 518 P.2d 1129, 1135–36 (Cal. 1974); People v. Frazier, 354 N.W.2d 332, 334, 336 (Mich. Ct. App. 1984); United States v. Murray, 197 F.R.D. 421, 423–24 (S.D. Cal. 2000); State v. Brown, 310 P.3d 29, 32–33 (Ariz. Ct. App. 2013).

1. The Hospital Work Environment

Hospitals play a vital role in our society and in the communities they serve.[120] They anchor communities and provide health services to a broad range of people, including those who are under- or uninsured.[121] They are a one-stop shop in many ways, centralizing a wide range of health-care services in one setting, from emergency services, trauma, surgery, medical specialties, pharmacies, psychiatry treatment, and physical therapy.[122] As a result, hospitals are comprised of many individuals with diverse skill sets, obligations and protections, and employment arrangements. Hospital staff includes medical personnel of different types, including physicians, nurse practitioners, nurses, residents, interns, and rotating medical students.[123] Their employment relationships are also varied. Nurses and certain physicians may be employees of the hospital while others may be independent contractors or solo practitioners with hospital privileges.[124]

Hospitals require coordination of these medical professionals. Medical providers must often make fast and consequential decisions when treating patients. To help the different actors and departments collaborate on patient care, standardize care, and maximize efficiency, hospitals have implemented different tools such as hospital checklists and clinical

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120 Leonard L. Berry, Sunjay Letchuman, Joneigh Khaldun & Michael K. Hole, *How Hospitals Improve Health Equity Through Community–Centered Innovation*, 4 NEJM Catalyst 1, 1 (2023).

121 *See* Howard K. Koh, Amy Bantham, Alan C. Geller, Mark A. Rukavina, Karen M. Emmons, Pamela Yatsko & Robert Restuccia, *Anchor Institutions: Best Practices to Address Social Needs and Social Determinants of Health*, 110 Am. J. Pub. Health 309, 309 (2020); Dhruv Khullar, Zirui Song, Dave A. Chokshi, *Safety-Net Health Systems At Risk: Who Bears the Buren of Uncompensated Care?*, Health Affs. Blog (May 10, 2018), https://www.healthaffairs.org/content/forefront/safety-net-health-systems-risk-bears-burden-uncompensated-care [https://perma.cc/BE83-PTG6].

122 *Sample Hospital-Departments*, Am. Hosp. Directory, https://www.ahd.com/departments.php?hcfa_id=0e6ed911d02223fd12ca9d585a2c3af1&ek=ffe02bdbd3b34e4c3fb3fccb1bf5682b [https://perma.cc/VGC7-NXN4].

123 Maria Yang, *These Are the People Who Work in a Hospital*, MedPage Today's KevinMD.com (Dec. 26, 2013), https://www.kevinmd.com/2013/12/people-work-hospital.html [https://perma.cc/TY9M-CFRB].

124 *See* Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII or the ADA Act when Alleging an Employment Discrimination Claim?*, 1 DePaul J. Health Care L. 119, 121 (1996); Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 221 (2d Cir. 2008) (holding that there was an issue of material fact whether a doctor with hospital privileges was an "employee" of the hospital); Nathan Eddy, *Nearly 70% of U.S. Physicians Are Employed by Hospitals or Corporate Entities*, Healthcare Fin. (July 13, 2021), https://www.healthcarefinancenews.com/news/nearly-70-us-physicians-are-employed-hospitals-or-corporate-entities [https://perma.cc/35F9-T9KH]; Leonard L. Berry & Paul Barach, *Hospital Outsourcing Often Prioritizes Profit over Patients*, Tex. A&M Today (Aug. 20, 2021), https://today.tamu.edu/2021/08/20/hospital-outsourcing-often-prioritizes-profit-over-patients/ [https://perma.cc/L2EV-GNJN].

pathways, detailing treatment through multidisciplinary care plans.[125] Medical providers are supported by technicians and other professionals like violence prevention workers and social workers.[126] Managing these institutions are executives and administrators, risk management, legal, compliance and privacy officers, and billing departments.[127]

The modern-day hospital often includes hospital security. Hospital administrators are having to address a growing concern of workplace violence. Prepandemic data revealed that health-care workers experienced workplace violence at rates five times higher than any other employment category.[128] The stresses of the pandemic have only worsened the problem as recent reports by medical providers indicate.[129] This reality can be attributed to many factors. Injured and sick patients

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125 *See* OECD & Eur. Observatory on Health Sys. & Pol'ys, Improving Healthcare Quality in Europe 309 (2019) (defining "clinical pathways" as a "structured multidisciplinary care plan" that standardizes care with detailed steps and guidelines). *See generally* Emma Aspland, Daniell Gartner & Paul Harper, *Clinical Pathway Modelling: A Literature Review*, 10 Health Sys. 1, 1 (2021) (describing issues related to clinical pathways and related research); Am. Hosp. Ass'n, *Checklists to Improve Patient Safety*, https://www.aha.org/ahahret-guides/2013-07-10-checklists-improve-patient-safety [https://perma.cc/N5NJ-UVKE] (providing a list of checklists available for the care and treatment of various conditions through the American Hospital Association).

126 *See* Yang, *supra* note 123; *see also* Kate M. Gallen, Michael J. Smith, Joshua Crane, Carly Loughran, Kirsten Schuster, Jake Sonnenberg, Mildred Reese, Vicki G. Girard, Ji Seon Song, & Eric C. Hall, *Law Enforcement and Patient Privacy Among Survivors of Violence: A Nationwide Mixed-Methods Study*, 283 J. Surgical Rsch. 648, 649 (2023); NASW Ctr. for Workforce Stud. & Soc. Work Prac., Soc. Workers in Hospitals & Medical Ctrs. 1 (2011).

127 *See What Is Risk Management in Healthcare?*, NEJM Catalyst (Apr. 25, 2018), https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0197 [https://perma.cc/AZH6-XFER]; Amanda Walden, Kendall Cortelyou-Ward & Alice Noblin, *Privacy Officers: Who They Are and Where They Work*, 18 Persps. Health Info. Mgmt. 1, 2–3 (2021); Werner Boel, *From Outsider to Team Member: The Evolution of the Healthcare Legal Counsel*, Witt/Kieffer (2016) (on file with author); *see also Hospital Billing Explained*, Am. Hosp. Ass'n, https://www.aha.org/factsheet/2015-03-18-hospital-billing-explained [https://perma.cc/RCV5-B233]; Stephen C. Schimpff & Morton I. Rapoport, *Ownership and Governance of University Teaching Hospitals: Let Form Follow Function*, 72 Acad. Med. 576, 585 (1997); Farzan Bharucha & Shelley Oberlin, Governance Models Among California Public Hospitals, at 7–10 (May 2009), https://www.chcf.org/wp-content/uploads/2017/12/PDF-GovernanceModelsCAPublicHospitals.pdf [https://perma.cc/TB7S-9LJA].

128 *See Injuries, Illness, & Fatalities: Workplace Violence in Healthcare*, Bureau of Lab. Stat. (April 2020), https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm [https://perma.cc/6YDZ-VH2J]; Michelle A. Dressner, *Hospital Workers: An Assessment of Occupational Injuries and Illnesses*, June 2017, at 1; Julie Stene, Erin Larson, Maria Levy & Michon Dohlman, *Workplace Violence in the Emergency Department: Giving Staff the Tools and Support to Report*, 18 Perm. J. e113 (Spring 2015); Am. Coll. of Emergency Physicians, ACEP Emergency Department Violence Poll Research Results 6 (2018).

129 *See Workplace Violence on the Rise; COVID-19 Partly to Blame*, Relias Media (Feb. 1, 2022), https://www.reliasmedia.com/articles/149008-workplace-violence-on-the-rise-covid-19-partly-to-blame [https://perma.cc/CE53-ECDE]; John Yang & Claire Mufson, *What's Behind an Alarming Rise in Violent Incidents in Health Care Facilities*, PBS (Sept. 17, 2023, 5:40 PM), https://www.pbs.org/newshour/show/whats-behind-an-alarming-rise-in-violent-incidents-in-health-care-facilities [https://perma.cc/FG8B-L7AE].

are vulnerable, stressed, upset, scared, and worried. Environmental and structural factors are also to blame, including overcrowding, the need to compensate for the lack of mental health treatment beds, prolonged stays, crowded treatment facilities, understaffing and the lack of preexisting relationships between patient and provider.[130]

To address safety in hospitals, many hospitals directly employ law enforcement as security. Over fifty percent of states and the District of Columbia allow hospitals in their jurisdictions to form their own police departments.[131] As of 2018, forty hospitals had their own police departments.[132] Hospitals often contract with private security firms[133] or employ off-duty police officers because of their abilities to arrest and use their training as police officers.[134]

Hospital security takes many forms. Hospital security monitor entryways and waiting areas, perhaps aided by metal detectors at entrances.[135] Police in hospitals may be armed with an array of weapons from K-9 units, pepper spray, tasers, and guns, though this has not been without controversy.[136] Armed hospital police have been controversial, particularly when incidents of use of force occur.[137] One study of hospital-based shootings in the United States revealed that twenty-three percent of emergency department shootings involved a person attempting to take a weapon from a hospital security officer.[138]

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130 *See* Creagh Boulger, Howard Werman & April Jessica Pinto, *Management of the Violent Patient in the Emergency Department*, Emergency Med. Reps. (2017).

131 John Diedric, Raquel Rutledge & Daphne Chen, *New Police Force in America: More Hospitals Are Creating Private Departments, Raising Concerns About Secrecy and Abuse*, Milwaukee J. Sentinel (Jan. 13, 2021), https://www.jsonline.com/in-depth/news/investigations/2020/12/15/hospital-police-have-power-officers-but-little-oversight/6362900002/ [https://perma.cc/5GZX-HGKQ]; *see, e.g.*, S. 582, 118th Gen. Assemb., 1st Reg. Sess. (Ind. 2013).

132 Andrea M. Gardner & Kevin M. Scott, U.S. Dep't of Just., NCJ 302187, Census of Local and State Law Enforcement Agencies, 2018—Statistical Tables 16 (2022). This number on table 15 combines the total number of police forces and offices in public medical school campuses and public hospitals.

133 *See, e.g.*, *Healthcare Security*, Health & Hosp. Sec., https://hss-us.com/security-services/healthcare-security [https://perma.cc/F7CF-3HUM].

134 *See* Seth W. Stoughton, *Moonlighting: The Private Employment of Off-Duty Officers*, 2017 U. Ill. L. Rev. 1848, 1855–56 (2017); *see also* Rosenthal, *supra* note 85; Nancy M. Nachreiner, Susan G. Gerberich, Andrew D. Ryan & Patricia M. McGovern, *Minnesota Nurses' Study: Perceptions of Violence and the Work Environment*, 45 Indust. Health 672, 676 (2007).

135 *See Metal Detectors, Security Guards Are Precautions Departments Are Taking in Response to an Increase in Violent Incidents*, ED Mgmt. (Oct. 1, 1997), https://www.reliasmedia.com/articles/36653-metal-detectors-security-guards-are-precautions-departments-are-taking-in-respo [https://perma.cc/BHB3-D9VV].

136 *See id.*; Rosenthal, *supra* note 85.

137 *See* Jennifer Tsai, *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/ZRL7-J9BX].

138 Gabor D. Kelen, Christina L. Catlett, Joshua G. Kubit & Yu-Hsiang Hsieh, *Hospital-Based Shootings in the United States: 2000 to 2011*, 60 Annals Emergency Med. 790, 793 (2012).

2. *Health-Care Costs*

On top of managing complicated employment, patient care, and safety dynamics, finances are a perennial concern for hospitals.[139] Rising costs and privatization threaten more hospital closures.[140] Again, the pandemic has only exacerbated the situation.[141] The question of who bears the cost of care to patients in custody is a predominant one, reflected in policies and statutes.

From its start in 1966, Medicaid and Medicare have accounted for a significant source of hospital funding.[142] But Medicaid and Medicare funding is far from automatic for people in law enforcement custody. Even though many would be eligible for Medicaid based upon their economic status, the Medicaid Inmate Exclusion Policy prohibits these health benefits once people are incarcerated.[143] That prohibition has lessened to some extent after an exception to the exclusion was carved out in 1997 for those who left the correctional facility to an inpatient facility for twenty-four hours or longer.[144] At least thirteen states have taken advantage of this exception, such as California's Medi-Cal Inmate

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139 *New Report Highlights Financial Challenges Facing Hospitals That Are Jeopardizing Access to Care*, Am. Hosp. Ass'n (Sept. 15, 2022), https://www.aha.org/special-bulletin/2022-09-15-new-report-highlights-financial-challenges-facing-hospitals-are [https://perma.cc/RL4P-V9XE] [hereinafter *Report Highlights Financial Challenges*].

140 *See* David G. Whiteis, *Hospital and Community Characteristics in Closures of Urban Hospitals, 1980–87*, 107 Pub. Health Rpts. 409, 409 (1992); George M. Holmes, Rebecca T. Slifkin, Randy K. Randolph & Stephanie Poley, *The Effect of Rural Hospital Closures on Community Economic Health*, 41 Health Servs. Res. 467, 468 (2006); *Report Highlights Financial Challenges*, *supra* note 139.

141 *See* Sarah Jane Tribble, *Rural Hospitals Are Sinking Under COVID-19 Financial Pressures*, NPR (Aug. 22, 2020, 7:00 AM), https://www.npr.org/sections/health-shots/2020/08/22/904455215/rural-hospitals-are-sinking-under-covid-19-financial-pressures [https://perma.cc/KKH7-NRRZ]; Jordan Rau & Emmarie Huetteman, *Some Urban Hospitals Face Closure or Cutbacks as the Pandemic Adds to Fiscal Woes*, NPR (Sept. 15, 2020, 5:00 AM), https://www.npr.org/sections/health-shots/2020/09/15/912866179/some-urban-hospitals-face-closure-or-cutbacks-as-the-pandemic-adds-to-fiscal-woe [https://perma.cc/DK2J-B4D4]; *The Current State of Hospital Finances: Fall 2022 Update*, KaufmanHall (Sept. 15, 2022), https://www.kaufmanhall.com/insights/research-report/current-state-hospital-finances-fall-2022-update [https://perma.cc/GN3R-8NX2].

142 *Infographic—US Health Care Spending: Who Pays?*, Cal. Health Care Founds, (June 30, 2022), https://www.chcf.org/publication/us-health-care-spending-who-pays/ [https://perma.cc/MX7Y-DUQM].

143 42 U.S. § 1396d(a)(xvii)(31)(A).

144 Memorandum from Mark B. McClellan, Administrator for the Centers for Medicare & Medicaid Services to Joseph E. Vengrin, Deputy Inspector Gen. for Audit Services (June 7, 2004) (available at https://oig.hhs.gov/oas/reports/region4/40206002.pdf [https://perma.cc/HG3D-LGPP]); *Connecting Recently Released Prisoners to Health Care—How to Leverage Medicaid*, Nat'l Conf. of State Legislatures (Jan. 16, 2023) [hereinafter NCSL], https://www.ncsl.org/civil-and-criminal-justice/connecting-recently-released-prisoners-to-health-carehow-to-leverage-medicaid [https://perma.cc/SG2M-R5UG].

Program, which allows both county and state prisoners to be eligible for Medi-Cal for hospital stays longer than twenty-four hours.[145]

Without reliable Medicaid coverage, federal and state laws reflect surprising amount of detail on who bears the costs of medical care for patients in law enforcement custody and under what circumstances.[146] The federal Bureau of Prisons allows an assessment and collection of fees for health-care visits, which include visits to "noninstitutional" health-care providers.[147] Indigency does not prevent prisoners from assessment and collection of fees for health-care visits.[148] Indigency also does not prevent prisoners from getting treated by outside hospitals.[149] States have similar provisions requiring some payment by the inmate or authorizing jurisdictions to seek reimbursement from inmates.[150] Until

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145 NCSL, *supra* note 144; *Medi-Cal State Inmate Program and Medi-Cal County Inmate Program*, Cal. Dep't. of Health Care Services, https://www.dhcs.ca.gov/provgovpart/Pages/MIP.aspx [https://perma.cc/ZR4W-WZG9].

146 *See, e.g.*, Va. Code Ann. § 53.1-93 (2023) (providing for state payment of security escort to medical facility); La. Stat. Ann. § 15:713 (2023) ("Medical expenses of prisoners in extraordinary circumstances"); W. Va. Code § 15A-4-12 (2023) ("Limitations on reimbursement rate to medical service providers for services outside division facilities"); Kan. Stat. Ann. § 19-4444 (2023) ("Approval of expenditures and claim; costs of medical care of prisoners paid from county general fund or by the state; reimbursement from prisoner"); Col. Rev. Stat. § 17-26-104.5 (2023) ("Medical visits—charge to persons in custody—providers charges—state hospital in Pueblo"); Cal. Gov't Code § 29602 (West 2023) (designating medical services for prisoners without health insurance, but not those who are privately insured, as a county expense); 730 Ill. Comp. Stat. 127/17 (2023) ("Bedding, clothing, fuel, and medical aid; reimbursement for medical expenses"); Tenn. Code Ann. § 41-4-115 (2023) ("Medical care of prisoners"); Or. Rev. Stat. § 169.152 (2023) ("Liability for costs of medical care for persons in county facility"); Mich. Comp. Laws § 801-4 ("Safekeeping and maintaining prisoners and persons charged with offense; charges and expenses; payment; medical care or treatment"); Tex. Code Crim. Pro. Ann. art. 104.002(d) (West 2023) ("A person who is or was a prisoner in a county jail and received medical, dental, or health related services from a county or hospital district shall be required to pay a reimbursement fee for such services when they are rendered."); Iowa Code § 356.15A (2023) ("Responsibility for payment of required medical aid").

147 18 U.S.C. § 4048(a)(4), (b)(1).

148 *Id.*

149 *Id.* § 4048(f).

150 *See, e.g.*, Fla. Stat. § 945.6037 (2023) (requiring copayments from inmates for nonemergency visits initiated by the inmate); Miss. Code Ann. § 47-5-179 (2023)(allowing the Department of Corrections to deduct payment from an inmate's account for nonemergency care); Nev. Rev. Stat. § 211.2415 (2023) (permitting the governing body of a county or city to seek reimbursement from nonindigent prisoners); N.H. Rev. Stat. Ann. § 622:31-a (2023) (permitting the commissioner to charge inmates "a reasonable fee for medical and mental health services"); N.J. Stat. Ann. § 30:7E-2 (West, 2023) (providing that an inmate "shall be liable for the cost of, and be charged a nominal fee for, any medical care, surgery, dental care, hospitalization or treatment provided to the inmate during the inmate's term of incarceration"); N.C. Gen. Stat. § 153A-224 (2023) ("The county shall only be liable for costs not reimbursed by the third-party insurer, in which event the county may recover from the inmate the cost of the non-reimbursed medical services."); S.C. Code Ann. § 24-13-80 (2023) (providing guidance for when the Department of Corrections may establish criteria for deduction of money credit from an inmates account, including "medical treatment

recently, inmates in Utah were charged ten percent for any hospitalization outside of prison facilities, up to $2,000.[151] In other jurisdictions, states or counties largely bear the cost of outside medical care.[152]

The question of who bears responsibility becomes less clear in the more fluid situation of an arrested individual who is brought in for medical treatment. In California, when the person is on their way to jail, by law, the law enforcement or municipality is not obligated to pay for the costs during that interim period before a person is delivered for booking.[153] Costs are borne by the person in custody or whatever other medical insurance is available.[154] Without clear legal guidance, some jurisdictions have taken advantage of this cost loophole. Sheriffs in Alabama have been reported as releasing arrested people on medical bond so the county facility would be able to avoid paying for the medical costs of care.[155] Sheriffs would release inmates on bond—without obtaining judicial approval, only to rearrest them immediately or to rearrest them on a warrant.[156] Some imprisoned people have responded with lawsuits or requests for investigations to the practice of "patient dumping" where police officers may bring in an arrested suspect, then release them from custody, and then arrest them upon discharge.[157] Perhaps in an attempt to avoid these workarounds, California prohibits law enforcement from requesting the release of an inmate in custody for the purpose of allowing the inmate to seek medical care and then

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for injuries inflicted by the inmate upon himself or others"); Tenn. Att. Gen., Op. No. 95-095, Liability of Inmates in County Jails for Medical Expenses Incurred (September 15, 1995), 1995 WL 559536 ("The county may attempt to recover such medical costs from the prisoner after the prisoner is released from the county jail."); Utah Code Ann. § 64-13-30 (LexisNexis 2023) ("The department or county jail may require an inmate to make a copayment for medical and dental services provided by the department or county jail."); W. Va. Code § 7-8-2 (2022) ("The county commission is hereby authorized to seek reimbursement from every person who receives medical, dental, hospital or eye care or any type of nursing care while incarcerated in the jail"); Wis. Stat. § 302.38 (2023) ("The prisoner is liable for the costs of medical and hospital care outside of the jail or house of corrections.").

151 Michael Ollove, *No Escaping Medical Copayments, Even in Prison*, Stateline (July 22, 2015, 12:00 AM), https://stateline.org/2015/07/22/no-escaping-medical-copayments-even-in-prison/ [https://perma.cc/NBC4-52Q6].

152 *See, e.g.*, Ariz. Rev. Stat. Ann. § 31-165 (2023); Cal. Penal Code § 4011 (West 2023); La. Stat. Ann. § 15:831 (2023); Mich. Comp. Laws § 801.4 (2023); N.C. Gen. Stat. Ann. § 153A-224 (2023); Ohio Rev. Code Ann. § 341.192 (2019); Tenn. Code Ann. § 41-4-115 (2014); Wash. Rev. Code Ann. § 70.48.130 (2022).

153 Cal. Penal Code § 4015(c) (West 2023).

154 *Id.* § 4015(d).

155 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/TE4B-ZTQL].

156 *See id.*

157 *Id.*

rearresting the same person upon discharge unless the hospital determines that it would then enable billing from a third-party payment source, though anecdotal evidence seems to indicate that these practices persist there too.[158]

3. Types of Arrangements

Costs may be one of the reasons why jurisdictions make formal arrangements with outside hospitals for the provision of care for incarcerated people, especially in larger metropolitan areas.

In some instances, outside hospitals take on responsibility for correctional health care, providing care in sites that are quasi-carceral, quasi-outside hospitals. One example of this set-up is Bellevue Hospital in New York City, one of the oldest hospitals in the United States.[159] Bellevue is now part of New York City Health & Hospitals.[160] The mismanagement of New York City jails resulting in tragic human loss, and a push by city leaders to decrease the size of the jail population, led to the City's takeover of jail health care.[161] New York City has since announced that New York City Health & Hospital's Correctional Health operates "Outposted Therapeutic Housing Units" located at Bellevue and other hospitals throughout the boroughs.[162]

New York City is not alone in having this formalized arrangement where carceral institutions and hospitals share physical sites. In Los Angeles County, a county with an imprisoned population comparable to most states, collaboration between the Los Angeles County Department of Health Services, L.A. County Sheriff's Department, and the Keck School of Medicine at University of Southern California ("USC") resulted in the Inmate Care Services Program.[163] A labyrinthine hallway in the basement of the LA County-USC hospital connects to the

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158 Cal. Penal Code § 4011.10 (West 2023).

159 NYC Health + Hospitals, *Bellevue History*, https://www.nychealthandhospitals.org/bellevue/history/ [https://perma.cc/NR5D-V5VD].

160 *See* NYC Health + Hospitals, *Correctional Health Services*, https://www.nychealthandhospitals.org/correctionalhealthservices/our-services/ [https://perma.cc/Q3W3-QT9G].

161 *See* Press Release, City of New York, De Blasio Administration Announces New Outposted Therapeutic Housing Unit to Serve Patients in Custody with Serious Health Conditions (Nov. 4, 2021); Rachel Sherman, *Rikers Staffing Crisis Limits Access to Medical Care*, The City (Aug. 16, 2021, 2:00 PM), https://www.thecity.nyc/health/2021/8/26/22643199/rikers-staffing-crisis-medical-care [https://perma.cc/7SS5-3QXD]; Jan Ransom & Bianca Pallaro, *Behind the Violence at Rikers, Decades of Mismanagement and Dysfunction*, N.Y. Times (Dec. 31, 2021), https://www.nytimes.com/2021/12/31/nyregion/rikers-island-correction-officers.html [https://perma.cc/8AKT-RYHY].

162 Press Release, City of New York, *supra* note 161.

163 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/KZF6-XDSY].

separate LA County-USC jail ward. The ward contains 16 emergency room beds and 24 inpatient beds and is separate from the correctional health-care system of the county jail.[164] Similar formal arrangements exist even in nonurban areas. Doctor's Hospital in Manteca, California has provided medical services for Department of Correction facilities since the 1990s, after the Department solicited bids from hospitals to lower health-care costs.[165]

Texas has implemented this partnership model statewide for their prison system in partnership with their state hospital systems. These hospital systems include John Sealy Hospital in Galveston, which is part of the University of Texas medical system. John Sealy Hospital has provided tertiary care to prisons for decades.[166] That responsibility transferred to the stand-alone facility of the University of Texas Medical Branch— Texas Department of Justice Hospital ("UTMB") in 1983, described as "the first and only hospital specializing in offender care on the campus of a major medical center and teaching institution."[167] Prisoners in Texas have access to all of UTMB's health services.[168] Texas Tech University also provides medical services for Texas prisons.[169] Similar arrangements can be found at the county level in metropolitan areas like Dallas County. Parkland Health & Hospital System, provides medical care for the incarcerated people in Dallas County jail.[170] The health system undertook a major renovation in the last several years, using $44 million of county money to turn three floors of the jail into medical and mental health infirmaries with nearly 300 beds.[171]

These kinds of shared physical site arrangements are not the norm, however, and are more likely to exist in large and well-resourced

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164 *See id.*

165 *See* Nancy Price, *Doctors Hospital Wins Contract Extension to Treat Prison Inmates*, Recordnet.com (July 6, 1996, 12:00 AM), https://www.recordnet.com/story/news/1996/07/06/doctors-hospital-wins-contract-extension/50846206007/ [https://perma.cc/8LDE-KGS4].

166 *See* Ben G. Raimer & John D. Stobo, *Health Care Delivery in the Texas Prison System: The Role of Academic Medicine*, 292 JAMA 485, 486 (2004).

167 Megan Seaholm, *Texas Department of Criminal Justice Hospital*, Tex. State Hist. Ass'n (Aug. 5, 2020), https://www.tshaonline.org/handbook/entries/texas-department-of-criminal-justice-hospital [https://perma.cc/Q8V8-XPGB].

168 *See* Raimer & Stobo, *supra* note 166, at 486 (asserting that the hospital gives "a full range of acute care services and specialty consultations").

169 *Id.* at 487.

170 *Dallas County Jail*, Parkland Health, https://www.parklandhealth.org/dallas-county-jail [https://perma.cc/6XDQ-9Q34].

171 *2017 Justice Facilities Review: Dallas County Jail Medical and Mental Health Modifications*, Am. Inst. of Architects, https://new.aia.org/showcases/146136-dallas-county-jail-medical-and-mental-healt [https://perma.cc/JCK4-XGU5]; Sherry Jacobson, *New Medical Facility in Dallas County Jail Prompted by Past Inmate Neglect*, Dall. Morning News (Mar. 16, 2015, 10:58 AM), https://www.dallasnews.com/news/2015/03/16/new-medical-facility-in-dallas-county-jail-prompted-by-past-inmate-neglect/ [https://perma.cc/HZH2-4Y4Q].

jurisdictions. Though investigations into the use of private health companies have resulted in a switch to established outside hospital care systems, as in the case of New York City, such takeovers are rare.[172] Instead, facilities have simply swapped out one private provider for another.[173] In such instances, informal arrangements with hospitals may exist by virtue of whichever hospital is the closest trauma or emergency facility to the jail.

Formal arrangements are also less prevalent between police agencies and hospitals. This may be due to practical concerns as the urgent nature of an injury or sickness requires law enforcement to pick the hospital based upon convenience, level of services, or proximity.[174] For example, according to the Philadelphia Police Department's policy on hospitalized detained individuals, police are directed to take the detained person to the "nearest accredited trauma center."[175]

4. Adaption and Incorporation

Hospitals must manage a complicated array of priorities and interests when they provide services to people under some form of law enforcement custody. In addition to concerns about costs and fiscal and organizational arrangements, the entry of law enforcement and correctional guards complicates the hospital workplace environment in many ways. The presence of law enforcement and correctional authorities is commonplace and routine, especially in urban hospitals providing trauma and emergency care.[176] In some sense, the normalcy of their presence explains how hospitals have adapted to their presence. Police provide security and investigate. But police officers and sheriff deputies,

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172 *See* City of New York, *Health and Hospitals Corporation to Run City Correctional Health Service* (June 10, 2015), https://www1.nyc.gov/office-of-the-mayor/news/383-15/health-hospitals-corporation-run-city-correctional-health-service [https://perma.cc/57RL-MDGS].

173 *See* Simone Aponte, *2 Investigates: Jail Medical Company Corizon Loses Alameda Co. Contract*, FOX 2 KTVU (Aug. 5, 2016), https://www.ktvu.com/news/2-investigates-jail-medical-company-corizon-loses-alameda-co-contract [https://perma.cc/7J96-EMG6]; Dan Scanlan & Nichole Manna, *Jacksonville Sheriff Explains Change in Jail's Health Care Provider After Inmate Death*, Health News Fla. (July 26, 2023), https://health.wusf.usf.edu/health-news-florida/2023-07-26/jacksonville-sheriff-explains-change-in-jails-health-care-provider-after-inmates-death [https://perma.cc/W5J5-Y3MS].

174 *See, e.g.*, Phila., Pa., Police Dep't Directive § 4.13 (2015).

175 *Id.* § 2.

176 Rucha Alur, Erin Hall, Utsha Khatri, Sara Jacoby, Eugenia South, & Elinor J. Kaufman, *Law Enforcement in the Emergency Department*, 157 JAMA Surg. 852, 852–53 (2022) (observational study of law enforcement presence in ED in Philadelphia where during 348 total observed hours, at least one law enforcement was present for thirty-one percent of the time); *see also* Sara F. Jacoby, Therese S. Richond, Daniel N. Holena & Elinore J. Kaufman, *A Safe Haven for the Injured? Urban Trauma Care at the Intersection of Healthcare, Law Enforcement, and Race*, 199 Soc. Sci. & Med. 115, 116 (2017).

like firefighters and paramedics, are also first responders. Though police first responders are technically not part of the hospital, they have similar roles in handling emergencies and providing vital services to society, which may increase a shared sense of affinity between law enforcement and medical professionals, especially nurses who provide the bulk of direct patient care.[177] The routine and normalcy of police presence may also lead to medical providers homogenizing all law enforcement and custody status of patients. Police and correctional guards are not interchangeable. Yet it is unclear whether medical personnel can or do distinguish law enforcement who are coming in as first responders, investigators, law enforcement, or correctional guards, let alone whether they can distinguish the custody status of patients.[178]

Even as law enforcement presence may be routine, their presence provokes various responses from individual medical providers. In a recent study of emergency department physicians' interactions with law enforcement, common themes emerged. Participants reported feeling assured and comforted when police officers were nearby.[179] Several participants stated that law enforcement was professional and would step away from patient interactions, but only after being asked to do so.[180]

Participants also reported downsides to police presence. For example, they observed patients feeling discomfort or apprehension with sharing information because of the presence of law enforcement.[181] One physician recounted patients declining treatment because of a perceived association between the hospital staff and law enforcement.[182]

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177 *See* Jason Lee, *How Nurses and Law Enforcement Can Work Together*, KevinMD.com (Sept. 7, 2016), https://www.kevinmd.com/2016/09/nurses-law-enforcement-can-work-together.html [https://perma.cc/Z9R4-FQCD] (recognizing racialized policing and the often close relationships between nurses and police officers); *see also* Luke Ramseth, *Salt Lake Valley Police, Nursing Group Announce Policy for Hospital Interactions After Utah Nurse's Arrest*, Salt Lake Trib. (Oct. 12, 2017, 3:35 PM), https://www.sltrib.com/news/2017/10/12/salt-lake-area-police-nursing-group-announce-valley-wide-policy-for-hospital-interactions-after-nurse-wubbels-arrest/ [https://perma.cc/BCP5-ZZFM] (describing policy created after police arrest of nurse and quoting police chief as saying "'[w]e are cut from the same cloth,'" and "that both professions are about 'love and service.'"); *see also* Marlene J. Shockley, *Love in Uniform: Exploring the Dynamics of Nurses Dating Cops*, The Nursing Site Blog (June 13, 2023), https://thenursingsiteblog.com/love-in-uniform-exploring-the-dynamics-of-nurses-dating-cops/ [https://perma.cc/YJ9U-75RH].

178 Hospital policies may refer to either correctional or law enforcement custody as "forensic patients." *Forensic Patient Management,* HCA Health Care (March 1, 2021), https://hcahealthcare.com/util/forms/ethics/policies/information-protection/IPPS010-a.pdf [https://perma.cc/K6U3-GTCB]. Additionally, they can be referred to as "prisoner patients." *See, e.g.*, UMass Memorial Medical Center, *Prisoner-Patient Protocols*, City of Worcester, https://www.worcesterma.gov/wpd-policy-manual/prisoners/umass-prisoner-patient-protocols.pdf [https://perma.cc/2BYL-MCXV].

179 *See* Harada et al., *supra* note 119, at 741.

180 *Id.* at 741, 742.

181 *See id.* at 743 tbl.2.

182 *Id.* at 743.

The physicians also felt that law enforcement got in the way of medical treatment and evaluations even during trauma resuscitations.[183] Another physician recounted seeing potentially inappropriate or problematic disclosures of patient information, such as observing other hospital personnel reveal information to law enforcement when asked and seeing officers take registration stickers from patients to run warrants.[184] Several participants expressed discomfort with not knowing how to handle requests by law enforcement, such as how much information they were allowed or required to disclose to law enforcement, cooperate with law enforcement requests, and whether their actions curtailed their patients' rights.[185]

These concerns are echoed by physicians in interviews and reflected in medical literature. Physicians and medical providers have expressed being intimidated by police and their arrest power, wondering whether they would be arrested if they defied or pushed backed against police.[186] In clinical grand rounds, at least one participant in every training would ask whether they could be arrested if they pushed back against police.[187]

It may be that the age and status of the medical professional affect the dynamics of these interactions. For instance, law enforcement may feel like a nurse, medical intern, or resident may be more likely to give them information than the supervising surgeon or physician. One physician stated, "[t]hey look for the person who makes the mistake of making eye contact and most of us who've been around know not to."[188] Differences also may exist between how law enforcement interacts with physicians versus nurses. At one hospital, a physician stated that when they declined to give law enforcement the requested information, they would see the law enforcement go to a nurse or clerk instead.[189] There may be a difference between how nurses see the cost-benefits of law enforcement from physicians, as nurses deal with patients directly. In the same hospital as in the previous example, a nurse was seen wearing a police department t-shirt over her scrubs. In another hospital where the emergency department included a separate jail wing, the nurse on

183 *Id.* at 741, 742 tbl.2.

184 *Id.* at 742.

185 *Id.* at 743–44.

186 *See id.* at 743–44. A recent Twitter thread by a registered nurse provides an example of how this kind of message persists. She attended a Sexual Assault Nurse Examiner ("SANE") training and reported being told by the doctor running the program that she should not speak out against police brutality online because "cops won't work with nurses who do that on their social media." goose the nurse (@thanksgoose), Twitter (Jan. 28, 2023, 4:39 PM), https://twitter.com/thanksgoose/status/1619450016040620032?s=42&t=TzFbzPpGH4VCNyz-YNQjUw [https://perma.cc/XX9B-AAFP].

187 These trainings were facilitated by the Author at seven medical institutions over a period of twenty-five months. Notes on Grand Round Trainings at Hospitals 528 (on file with author).

188 Interview with Physician 211 (Jan. 27, 2023) (on file with author).

189 Reports from Hospital A 214 (on file with author) (hospital name withheld).

duty stated that he preferred working there because he felt safer due to the constant police presence and handcuffs on patients.[190]

Directions or orders from law enforcement directives can also interfere with medical providers' abilities to contact family of patients.[191] Physicians at one hospital had repeated issues with law enforcement directing the hospital to remove patients from hospital directories, making it difficult for family members to get information about loved ones.[192] Medical professionals, who would have otherwise contacted family members to update them on severely injured or sick patients, are often told by law enforcement that they cannot because of safety or security reasons.[193]

Law enforcement and correctional guards influence triage and intake. Law enforcement may directly intervene while physicians are performing acute trauma interventions.[194] Hospital personnel at times rely on law enforcement to provide information about patients that can be important to triage and medical treatment.[195] Law enforcement can also influence triage and waiting rooms in other ways. Police often have to spend time at the emergency room waiting for the people they accompany to get treatment, whether they are victims, suspects, or psychiatric patients on mental health holds. Police administrators have advocated using laws like EMTALA to "generate hospital cooperation" and speed up the processing of "victims, prisoners, suspects, and psychiatric patients in . . . local emergency departments" to alleviate officers' wait time.[196] In one large public hospital, nurses admitted to giving higher priority to police-accompanied patients even if their medical issues were not as urgent as other waiting patients, thus contributing to overcrowding and long wait times.[197]

Physicians have had difficulty getting the administration to respond to concerns about law enforcement presence. One physician who heads

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190 Interview with Physician 106 (May 28, 2022) (on file with author).

191 Interview with Physicians 13 (Dec. 2, 2022) (on file with author); Interview with Physician and Violence Coordinator 216 (Sept. 3, 2020) (on file with author); Interview with Physician 10 (Jan. 30, 2023) (on file with author).

192 Interview with Physicians 13 (Dec. 2, 2022) (on file with author).

193 Interview with Physician 14 (June 1, 2021) (on file with author).

194 Physicians from five different hospitals in major metropolitan areas reported police officers asking questions of patients or medical professionals while physicians and other hospital staff are treating trauma patients. Research Memo on Law Enforcement Access to Trauma (Oct. 5, 2023) (on file with author). A prominent example of this in caselaw is the police questioning of the plaintiff in *Chavez v. Martinez*, 538 U.S. 760 (2003).

195 Harada et al., *supra* note 119, at 742.

196 Dean J. Collins & Stephen A. Frew, *How Police Can Use Hospital Laws to Speed Processing in Hospital Emergency Departments*, Police Chief Mag., https://www.policechiefmagazine.org/how-police-can-use-hospital-laws-to-speed-processing/ [https://perma.cc/G76A-C5RG].

197 Armando Lara-Millán, *Public Emergency Overcrowding in the Era of Mass Imprisonment*, 79 Am. Socio. Rev. 866, 873 (2014).

the emergency department in an urban hospital recounted an instance when a medical resident was charged with obstructing an officer when the resident grabbed an officer's arm to stop him from punching an already-restrained patient.[198] When the physician reported this to the hospital administration, he was told that if a patient was under law enforcement custody, law enforcement policies on the use of force and restraints applied.[199] Other physicians have been trying to implement patient-centered policies for those in law enforcement custody, including limiting police presence in trauma bays and prohibiting law enforcement from easily accessing patient belongings but progress has been slow.[200]

B. Hospital-Carceral Regulatory Ecosystem

Law enforcement and correctional authorities affect more than just the day-to-day work in hospitals. These actors enter with their own separate laws and regulatory and accountability systems that differ substantially from those of hospitals. Just as law enforcement and correctional authorities affect clinical care, these actors impact the hospital regulatory ecosystem. Hospitals adapt to the regulations and practices of the carceral authorities even when carceral practices and rules directly conflict with hospital regulations and health laws and when there is no or unclear legal guidance.

1. Regulation of Hospitals

Hospitals and medical professionals are subject to a complex web of regulations.[201] These regulations cover a broad range of categories including medical recordkeeping and confidentiality of patient records, licensing and accreditation, risk mitigation, patients' rights and quality of care, human research, health insurance, pharmaceutical regulations, and regulations relating to the provision of emergency services.

The American Hospital Association has noted that hospitals must comply with 341 hospital-related requirements.[202] These regulations are

198 Interview with Physician 25 (June 28, 2021) (on file with author).

199 *Id.*

200 This observation is based upon my work with medical professionals on developing hospital policies over the last three years.

201 *A Guide to Healthcare Compliance Regulations*, Mich. State Univ. (July 12, 2023), https://www.michiganstateuniversityonline.com/resources/healthcare-management/a-guide-to-healthcare-compliance-regulations/ [https://perma.cc/8KJL-498E] ("Healthcare is one of the most regulated industries in the United States . . . ."); *see also* New York v. Burger, 482 U.S. 691, 701 (1987) (quoting Donovan v. Dewey, 452 U.S. 594, 606 (1981)).

202 *See* Am. Hosp. Ass'n, Regulatory Overload: Assessing the Regulatory Burden on Healthcare Providers 10 (2017), https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf [https://perma.cc/QR6W-REVK].

promulgated by different agencies including the Centers for Medicare & Medicaid Services, the Office of Inspector General, the Office for Civil Rights of the Department of Health & Human Services, and the Office of the National Coordinator for Health Information Technology.[203] An average-sized hospital spends nearly $7.6 million annually to comply with all these regulations and other requirements.[204] The following are just a few examples. Federal regulations and policies and the nonprofit Joint Commission on the Accreditation of Healthcare Organizations impose restrictions on how facilities can use physical and chemical restraints.[205] The Department of Health and Human Services issues rules on visitation.[206] Hospitals that receive funds from Medicare must comply with rules issued by the Department of Health and Human Services.[207] They must follow the privacy and data collection provisions of HIPAA.[208] The Clinical Laboratory Improvement Amendments governs the laboratory testing of blood, body fluid, tissue, or other specimens from humans for the treatment, diagnosis, assessment, and prevention.[209] States have similar regulations and mandates for hospitals.[210]

The medical workers inside hospitals must also adhere to their own set of regulations, including professional licensing and other requirements.[211] States have also promulgated laws on patients' rights on confidentiality of treatment, privacy, discharge information, receiving information about treatment and procedures, the ability to participate in medical decision-making, and continuity of care.[212]

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203 *Id.* at 3.

204 *Id.*

205 *See, e.g.*, 42 C.F.R. § 482.13(e) ("Standard: Restraint or seclusion"); *Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention Training Program*, Crisis Prevention Inst. (2009), https://www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2011.pdf [https://perma.cc/TY5H-R8WW].

206 *See Frequently Asked Questions About New Federal Hospital Visitation Rules,* National Center for Lesbian Rights (2010), https://www.nclrights.org/wp-content/uploads/2014/01/FAQ-New-Fed-Hospital-Visitation-Rules.pdf [https://perma.cc/FE8Y-KGGW].

207 42 C.F.R. § 482.1.

208 *See* Health Insurance Portability and Accountability Act of 1966, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of the U.S. Code).

209 *CLIA Laws and Regulations*, CDC (Nov. 14, 2022), https://www.cdc.gov/clia/law-regulations.html [https://perma.cc/T6BT-B8WD].

210 *See, e.g.*, Minn. R. ch. 4640 (2019); *Laws and Regulations – Hospitals*, Wash. State Dep't of Health, https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/hospitals/laws [https://perma.cc/4YSF-QWG3]; Kan. Admin. Regs. art. 34 (2001); 10 N.Y. Reg. 405 (2023).

211 *See About Physician Licensure*, Fed'n of State Med. Bds., https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/ [https://perma.cc/MB34-HQTR]; *Nursing Licensure*, NCSBN, https://www.ncsbn.org/nursing-regulation/licensure.page [https://perma.cc/DK6Z-VSR8].

212 *See generally* Robin Cheryl Miller, *Construction and Application of State Patient Bill of Rights Statutes*, 87 Am. L. Reps. 5th 277 (2001).

In addition, hospitals and medical professionals must comply with a certain standard of care. The standard of care generally refers to the negligence standard for medical practice: the degree of care exercised by an average, prudent provider.[213] Hospital policies can inform the standard of care.[214] The same standard of care applies to patients who are under carceral authority.[215] Correctional guidelines can assist in determining standard of care, but they are rarely dispositive.[216]

Though some states may codify the standard of care, it is largely regulated through tort liability.[217] Patients under law enforcement or correctional authority have avenues for relief if they believe they received poor medical treatment. Prisoners can bring federal and state statutory claims for medical malpractice though punitive damages may not be available.[218] When the allegations involve intentional conduct by the medical provider, patients may also file medical assault and battery tort claims.[219]

Hospitals and medical professionals can also be charged with constitutional violations even when they are not employed by the state. When private physicians provide medical services to incarcerated people in a prison hospital, they are considered state actors for the purposes of section 1983 civil liability.[220] This rule has been extended

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213 Brian K. Cooke, Elizabeth Worsham & Gary M. Reisfield, *The Elusive Standard of Care*, 45 J. Am. Acad. Psych. & L. 358, 358 (2017); Donna Vanderpool, *The Standard of Care*, 18 Innov. Clin. Neurosci. 50, 51 (2021).

214 Kakligian v. Henry Ford Hosp., 210 N.W.2d 463, 466–67 (Mich. Ct. App. 1973) (stating that violation of hospital protocols or failure to write regulation can be evidence of negligence); Reed v. Granbury Hosp. Corp., 117 S.W.3d 404, 413 (Tex. App. 2003) (stating that "[w]hile a hospital's internal policies and procedures do not, alone, determine the standard of care, they may be considered in determining that standard").

215 *See, e.g.*, Wilson v. Manning, 880 So. 2d 1101, 1110 (Ala. 2003); Sloan v. Ohio Dep't of Rehab. & Corr., 695 N.E.2d 298, 300–01 (Ohio Ct. App. 1997); McCool v. Dep't of Corr., 984 A.2d 565, 569 (Pa. Commw. Ct. 2009) (stating that in cases involving medical care to state prisoners in Pennsylvania, a medical malpractice complaint is subject to additional requirements); *see also* Michael P. Penick, Medical Malpractice § 17:13 (4th ed. 2022).

216 *See, e.g.*, Nolan v. United States, No. 12-C-0247, 2015 WL 5159888, at *4 (N.D. Ill. Sept. 1, 2015) (discussing the Federal Bureau of Prisons Clinical Practice Guidelines).

217 *See, e.g.*, David Hricik & Charles R. Adams III, Ga. Law of Torts § 12:5(d) (2022) (breach of duty); Bernard v. Char, 903 P.2d 676, 683 (Haw. 1995); Bruni v. Tatsumi, 346 N.E.2d 673, 677–78 (Ohio 1976); Wash. Rev. Code § 4.24.290 (2019); S. Gerald Litvin, Gerald Austin McHugh, Jr., & Joseph Z. Traub, Torts: Law and Advocacy § 7.1 (2022) (standard of care for medical professionals generally).

218 *See* Carlson v. Green, 446 U.S. 14, 22 (1980); *see also* Bianca Moorman, *Federal Inmate Wins Lawsuit Against United States of America; Awarded $90,000 in Damages*, Aiken Standard (Aug. 29, 2023) https://www.postandcourier.com/aikenstandard/news/crime/federal-inmate-wins-lawsuit-against-united-states-of-america-awarded-90-000-in-damages/article_7130961e-466e-11ee-acdb-63af94e220b9.html [https://perma.cc/B6PP-TXGC].

219 *See* 8 Stuart M. Speiser, Charles F. Krause, Alfred W. Gans, American Law of Torts § 26:17 (Monique C. M. Leahy ed., 2023).

220 West v. Atkins, 487 U.S. 42, 54 (1988).

in some jurisdictions to any private physician or medical entities delegated to provide medical care, regardless of where that treatment has taken place.[221] This question of delegation or state actor is less clear in prebooking, postarrest, or prearrest scenarios when a private physician provides medical care.[222] Unlike statutes and regulations however, these individual actions are less likely to result in definitive guidelines or rules. Part of the reason is that many of these cases, just like other civil cases, resolve in settlements or some other kind of nonadjudicative disposition.[223] Moreover, this case-by-case litigation necessarily may be seen as case-specific and lack a broader application.

2. Regulation of Law Enforcement & Correctional Authorities

Law enforcement and correctional authorities have their own set of regulations and monitoring regimes that differ from those of medical providers. These regulatory frameworks have been criticized by scholars as inadequate measures of accountability. Though health-care providers may be subject to results that result from litigation, that is not the norm. In contrast, as scholar Giovanna Shay has described, the combination of legal authority regulating jails and prisons including constitutional rules, statutes, and regulations is the result of decades of litigation.[224] Such constitutes "the administrative law of the 'carceral state.'"[225] Professor Sharon Dolovich has characterized the state of prisons in the United States as "map[ping] a profound regulatory failure" by all branches of the government—judicial, executive, and legislative.[226]

The mandatory provision of medical care in jails and prisons stems from the Constitution. All inmates under the care and custody

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221 *See* George v. Sonoma Cnty. Sheriff's Dep't, 732 F. Supp. 2d 922, 935 (N.D. Cal. 2010).

222 *See* Song, *Policing the Emergency Room*, *supra* note 11, at 2678–92. *Ferguson v. City of Charleston*, 532 U.S. 67, 69–70 (2001), is one example where the hospital was found to be a state actor in a Fourth Amendment action brought by plaintiffs who were patients subject to a drug testing protocol administered by the hospital and local law enforcement. But in *Ferguson*, the question of state actor was addressed perfunctorily and based upon the fact that the hospital in question was a state hospital.

223 *See* Nora Freeman Engstrom, *The Diminished Trial*, 86 Fordham L. Rev. 2131, 2133 (2018) ("As the number of trials dwindles, the few that are left have an outsized and ever-larger effect—when it comes to enforcing laws, setting precedent, establishing settlement rates, promoting accountability and transparency, and, more broadly, shaping Americans' interactions with, and conception of, the civil justice system.").

224 *See generally* Giovanna Shay, *Ad Law Incarcerated*, 14 Berkeley J. Crim. L. 329, 330–32 (2009) (examining part of the "legal regime" of mass incarceration through prison policies and regulations). *See also* Justin Driver & Emma Kaufman, *The Incoherence of Prison Law*, 135 Harv. L. Rev. 515, 520 (2022) (describing prisons as "intensely legal institutions").

225 Shay, *supra* note 224 ("The story of prison regulation is best understood against the backdrop of prison reform efforts.").

226 Dolovich, *supra* note 17, at 154.

of corrections, whether that be in the pretrial or posttrial context, have the right to adequate medical care under the Eighth Amendment's Cruel and Unusual Punishment Clause. In *Estelle*, the Court found that a "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain.'"[227] This standard has been applied to failure-to-protect claims, including claims by pretrial inmates of inadequate medical care.[228]

The constitutional right to adequate health care is seen as the floor or minimum of what police and correctional authorities must provide to people in their custody. Further elaboration of medical treatment in custody since *Estelle* stems from injunctive orders and consent decrees resulting from continuing lawsuits against jails and prisons for inadequate medical care. These orders and decrees provide more specificity on what prison officials must do to uphold their constitutional obligations.[229]

Typical consent decrees emphasize the need for timely access to care for emergencies and at various points throughout a prisoner's period of incarceration.[230] Access to external medical care is part of what constitutes adequate health care. These decrees include the provision of follow-up medical care in the form of visits to outside health-care settings, such as emergency departments and other clinics, though they do not further delineate requirements of those outside facilities.[231]

Prisons, like health-care providers, are also subject to administrative oversight through rules, regulations, and policies.[232] Depending on the jurisdiction, correctional health care may be overseen by correctional agencies or health departments.[233] Prisons and jails have extensive standard operating procedures. But these are not typical administrative agencies as you might find in other administrative contexts. The Federal Bureau of Prisons is subject to rulemaking requirements of

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227 Estelle v. Gamble, 429 U.S. 97, 104 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

228 Castro v. Los Angeles, 833 F.3d 1060, 1070–71 (9th Cir. 2016).

229 *See, e.g.*, Margo Schlanger, Plata v. Brown *and Realignment: Jails, Prisons, Courts, and Politics*, 48 Harv. C.R.-C.L. L. Rev. 165, 165–66 (2013).

230 *See, e.g.*, Consent Decree at 5, 11–12, Lippert v. Baldwin, No. 10-cv-4603 (N.D. Ill. 2018) (on file with author); Amended Consent Decree at 13–21, Hedrick v. Grant, No. 2:76-CV-00162-EF (E.D. Cal. Jan. 30, 2019); Hernandez v. County of Monterey, 110 F. Supp. 3d 929, 934 (N.D. Cal. 2015) (injunctive relief granted in cases involving conditions at county jail).

231 Consent Decree, *supra* note 230, at 12–13; Amended Consent Decree, *supra* note 230, at 13–21, 29–31; *Hernandez*, 110 F. Supp. 3d at 939 (injunctive relief granted in cases involving conditions at county jail).

232 *See* Dolovich, *supra* note 17, at 155–56 (describing how state prisons "are meant to work" through executive, judicial, and legislative oversight).

233 Marin G. Olson, Utsha G. Khatri & Tyler N.A. Winkelman, *Aligning Correctional Health Standards with Medicaid-Covered Benefits*, JAMA Health F. e200885 (2020).

the Administrative Procedure Act.[234] But state jails and prisons do not necessarily have these same requirements. Shay has described jail regulation as "administrative documents containing corrections policies encompass[ing] a wide-range of edicts, ranging from full-fledged state regulations subject to notice-and-comment rulemaking to informal memoranda circulated by sheriffs."[235] Hence, as Shay states, "[w]hen courts defer to corrections officials and their policies, they are deferring to judgments that are often unchecked by the type of rulemaking procedures that are the norm in other contexts."[236]

Police accountability and regulatory oversight are even less like that of hospitals and medical professionals. The Constitution—and mainly the Fourth Amendment—operates as the prime regulator of police conduct.[237] But the effectiveness of the Fourth Amendment to regulate and monitor police has been roundly criticized and questioned. Part of the criticism is that the Fourth Amendment has been construed broadly by the courts to maximize police discretion, while constraints on police authority are few.[238]

In theory, the exclusionary rule is one constraint on police authority and has been proffered by the court as a way to deter police misconduct.[239] But the actual deterrence value through evidence suppression is far from clear. The effect of the exclusionary rule has been further watered down by the increasing number of exceptions to when the rule must be applied.[240] Additionally, the exclusionary rule only applies in criminal cases.[241] The regulatory effect of the Fourth Amendment in civil cases is also questionable. Plaintiffs in civil rights suits against police face significant hurdles, not least of them, the doctrine of qualified immunity.[242] Nonlitigation monitoring mechanisms also have significant drawbacks. Civilian oversight groups are hampered by structural flaws, like their limited authority and difficulties proving wrongful past conduct. Despite recent high-profile criminal prosecutions of police officers, successful methods of regulating police conduct are few and far between. Scholars have highlighted the problems of

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234 Shay, *supra* note 224, at 344 (citing 5 U.S.C. § 553 (2006)).

235 *Id.* at 333.

236 *Id.*

237 *See* U.S. Const. amend. IV.

238 *See, e.g.*, Hudson v. Michigan, 547 U.S. 586, 590, 595–96 (2006); Kentucky v. King, 563 U.S. 452, 468–69 (2011).

239 Deterrence is cited as the principal rationale for the exclusionary rule. United States v. Leon, 468 U.S. 897, 916 (1984) ("[T]he exclusionary rule is designed to deter police misconduct . . . ."); *see also* United States v. Calandra, 414 U.S. 338, 347 (1974).

240 *See, e.g.*, Hudson v. Michigan, 547 U.S. 586 (2006).

241 *See* Mapp v. Ohio, 367 U.S. 643 (1961) (applying exclusionary rule to state criminal cases).

242 Joanna C. Schwartz, *Qualified Immunity's Boldest Lie*, 88 U. Chi. L. Rev. 605, 607–08 (2021).

policing as a democratic accountability issue. Police have policies or protocols that outline their own operations but even more than prison regulations, these policies and protocols are developed in-house with little to no input from other stakeholders or the broader community.[243] Professors Barry Friedman and Maria Ponomarenko have argued that an important reform is to require the police, like other administrative agencies, to be subject to democratic governance, like other administrative agencies.[244]

3. Application of Carceral Rules

Different outcomes could result from the meeting of these differently regulated, structured, and purposed institutions and respective professionals. Hospital rules could dominate; there could be a compromised and balanced approach; or carceral rules could dominate. It is the third option that prevails.

When it comes to the treatment of patient prisoners, hospitals and carceral authorities operate under different rules, regulations, and policies. At times those rules, regulations, and policies are incongruous, meaning that they do not necessarily match or speak directly to one another. Other times, the respective rules, regulations, and policies directly conflict. In many of these circumstances, hospitals defer to carceral authorities, ultimately implementing a different kind of care. Examples include hospital deference in the areas of patient privacy and confidentiality in communications, the use of carceral restraints, impeded access to family or close ones during treatment, and limiting patient's autonomy and ability to make treatment decisions.

Let us take the important medical ethical principle of patient privacy and confidentiality. In hospital care, at least in theory, the patient-provider relationship is shaped by patient expectations, and the duties and obligations of the health-care provider. Primary among them are the confidentiality of communications between the patient and provider, and privacy surrounding their medical status and treatment.[245]

But for patients who are under law enforcement or correctional custody, privacy during treatment or communications with the medical team is not the rule. People who are brought into hospitals from facilities are transported by guards.[246] Those who are arrested by police are accompanied by police officers and guarded by them.[247] Often,

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243 *See id.* at 1835, 1843.

244 Barry Friedman & Maria Ponomarenko, *Democratic Policing*, 90 N.Y.U. L. Rev. 1827, 1832 (2015).

245 AMA Code of Ethics, Op. 3.1.1 ("Privacy in Health Care").

246 Pew Report, *supra* note 23, at 11.

247 Cal. Penal Code § 831.5(g) (West 2023).

law enforcement policies, and sometimes hospital policies themselves, mandate police remain present and stand guard in the hospital until the person is brought back to the correctional setting.[248]

The presence of correctional personnel or police officers breaks the confidentiality of communications.[249] The consequences are not just that the conversations are no longer kept private between patient and provider. Confidentiality provisos are intended to encourage honest communications from patients to determine the best and most accurate treatment course. The presence of law enforcement disincentives free conversation between patient and provider, and compounds any already existing mistrust the patient may hold.

California is an example of a state where laws seem to indicate that medical providers have some flexibility and authority to exclude law enforcement from patient conversations. The applicable law leaves open the possibility of excusing custodial authorities from guarding a person at a hospital if security is not needed due to the medical condition.[250] A sheriff or jailer may also direct that a guard can be removed when "it reasonably appears that the prisoner is physically unable to effectuate an escape or the prisoner does not constitute a danger to life or property."[251] California's statutory provision seems rare. No other states provide as much statutory specificity. Idaho does mention transport and guarding of prisoners, but only to provide that the sheriff can hire a temporary guard to transport or "safely keep prisoners" at places including hospitals.[252] But even with its laws, anecdotal evidence and studies of California suggest that law enforcement presence is still very much a problem in health-care settings.

A related security measure, the use of carceral restraints or handcuffs in hospitals, also conflicts with hospitals' rules, regulations, and bioethics principles of patient autonomy and nonmaleficence ("do no harm"). Hospitals do use their own restraints when necessary in treating patients. The deployment of medical restraints, however, is highly regulated.[253] Some examples of those regulations include allowing restraints to be used only when alternative means "are not sufficient to protect the patient or others from injury";[254] requiring a physician's order with

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248 *See, e.g.*, Mia., Fla., Police Departmental Orders § 16.4.23.2 (2022); Phila., Pa., Police Dep't Directive § 4.13 (2020); Minneapolis, Minn., Police Dep't Policy and Procedure Manual § 9–108 (2023); Hospital Policies (on file with author).

249 Harada et al., *supra* note 119, at 741.

250 Cal. Penal Code § 4011.9 (West 2023); *see also id.* § 4011.7.

251 *Id.* § 4011.9.

252 Idaho Code § 20-611 (2022) ("Temporary guards").

253 42 C.F.R. § 482.13(e) ("Condition of participation: Patient's rights – Standard: Restraint or Seclusion").

254 Cal. Code Regs. tit. 22, § 70577(j)(1) (2023).

specified reasons for the restraint and for the type of restraint used;[255] allowing restraints without a verbal or written order only in the event of an emergency;[256] mandating regular monitoring at intervals no greater than fifteen minutes;[257] requiring restraints that are easily removable in case of fire or another emergency;[258] mandating a note in the patient's medical record about the restraint, including the time it was applied and removed;[259] requiring a physician to reexamine the restraint order for every twenty-four hours of continuous restraint or seclusion;[260] and ordering an evaluation by a mental health professional for anyone restrained for more than two hours with a reevaluation of once every eight hours after.[261]

In hospitals, law enforcement or carceral restraints, or handcuffs and shackles, are routinely employed.[262] This may be a logical result of transportation policies, such as the policy mandating that federal prisoners who are on medically escorted trips be secured using "conventional restraints" or the more restrictive "Electronic Custody Control Belt" for maximum custody inmates with no precluding medical condition.[263] It could also be the result of law enforcement policies that set out security measures like guard presence, handcuffs, and leg restraints for arrestees.[264]

These carceral restraints are not generally regulated except in the case of incarcerated pregnant people. Women have successfully brought challenges to the practice under the Eighth Amendment prohibition against clear and unusual punishment.[265] As one district court stated, "Common sense, and the [Department of Correction's] own policy, tells us that it is not good practice to shackle women to a hospital bed while

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255 *Id.* § 70577(j)(2).

256 *Id.*

257 *Id.* § 70577(j)(3).

258 *Id.* § 70577(j)(4).

259 *Id.* § 70577(j)(5).

260 Wash. Admin. Code § 246-322-180 (Patient safety and seclusion care).

261 *Id.*

262 *See, e.g.*, Lawrence A. Haber, Lisa A. Pratt, Hans P. Erickson & Brie A. Williams, *Shackling in the Hospital*, 37 J. Gen. Internal Med. 1258, 1258 (2022); Int'l Assoc. for Healthcare Security & Safety § 05.02 (Security Role in Patient Care); Jessica Nutik Zitter, *Replace the 'Cold Steel' of Hospital-Bed Shackles with the Warmth of Compassion*, Stat (Dec. 4, 2020), https://www.statnews.com/2020/12/04/replace-cold-steel-of-hospital-bed-shackles-with-warmth-of-compassion/ [https://perma.cc/B79J-NDM2]; Marc Robinson, Kristen Lavere & Esmaeil Porsa, *End the Routine Shackling of Incarcerated Inpatients*, 16 J. Hosp. Med. 376, 376 (2021).

263 *See* Fed. Bureau of Prisons, U.S. Dep't of Just., Escorted Trips, Program Statement 5538.07, at 2, 15 (Dec. 10, 2015).

264 *See, e.g.*, N.Y.C., N.Y., Police Dep't Patrol Guide § 210-03 (2019) ("Hospitalized Prisoners - Arrests by Members of Other Police Agencies"); *id.* at § 210-04 ("Prisoners Requiring Medical/Psychiatric Treatment": "[R]ear cuff and place leg restraints before transporting to hospital"); *see also* Minneapolis, Minn., Police Dep't Policy and Procedure Manual § 9-108 (2023).

265 *See* Brawley v. Washington, 712 F. Supp. 2d 1208, 1221 (W.D. Wash. 2010).

they are in labor."[266] As part of the First Step Act, Congress passed legislation curtailing shackling of incarcerated pregnant women.[267] Though nearly half of the states have similar prohibitions, all contain exceptions if the prisoner is a security or flight risk that make shackling of pregnant women still very much a common occurrence.[268]

It is noteworthy that similar legislation has not expanded to include incarcerated people generally. Hence, people who are in custody are shackled even when their medical conditions make it unlikely that they pose safety or security risks, as exemplified by the circumstances of Jacob Blake's hospitalization.[269] Legal challenges outside the pregnancy context are rarely, if ever, successful, as courts defer to penal expertise.[270]

It is not difficult to imagine the harms resulting from the widescale employment of these kinds of carceral restraints in hospitals. Patient stigma, the possibility of biased treatment by providers, and health problems to patients such as nerve damage or handcuff neuropathy are all potential consequences.[271] In a recent article, two surgeons reported operating on incarcerated patients who were anesthetized, shackled, and guarded by armed corrections officers.[272] The patients remained secured by armed guards or shackled for the duration of the anesthesia process and operation.[273] In a separate piece, a medical resident described how an incarcerated patient was shackled to his bed "despite being intubated, sedated, and sometimes paralyzed" and showing no sign of agitation.[274] These examples underscore the point that shackles may not even be used in service of their intended purposes: ensuring safety or preventing escape.[275] The routine shackling of medically

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266 *Id.* at 1219. Some jurisdictions have declined to find that shackling of pregnant women is a *per se* Eighth Amendment violation. *See, e.g.*, Mendiola-Martinez v. Arpaio, 836 F.3d 1239, 1240 (9th Cir. 2016); Villegas v. Metro. Gov't of Nashville, 709 F.3d 563, 574 (6th Cir. 2013).

267 FIRST STEP Act, Pub. L. No. 115-391, 132 Stat. 5217 § 4322(a) (2018); Pregnant Women in Custody Act, H.R. 6805, 115th Cong. (2018); Dignity for Incarcerated Women Act, S. 1524, 115th Cong. § 4050(d) (2017).

268 *See, e.g.*, Cal. Penal Code §§ 6030, 3407 (West 2023); Nelson v. Corr. Med. Servs., 583 F.3d 522, 534 (8th Cir. 2009); Amy Fettig, *New Bill Would Ensure No Woman Is Forced to Give Birth in Chains*, ACLU (Sept. 19, 2018), https://www.aclu.org/news/prisoners-rights/new-bill-would-ensure-no-woman-forced-give-birth-chains [https://perma.cc/H8SH-N55M]; Lilya Dishchyan, *Shackled During Labor: The Cruel and Unusual Truth*, 14 Whittier J. Child & Fam. Advoc. 140, 145–51 (2015).

269 Eligon et al., *supra* note 1.

270 *See* Robinson, supra note 262.

271 *See id.* at 377; Haber et al., *supra* note 262, at 1259.

272 Sara Scarlet & Elizabeth Dreesen, *Surgery in Shackles: What Are Surgeons' Obligations to Incarcerated Patients in the Operating Room?*, 19 AMA. J. Ethics 939, 941 (Sept. 2017).

273 *See id.*

274 Zainab Ahmed, *Do No Harm: A Call for Decarceration in Hospitals*, Bill of Health (Sept. 27, 2022), https://blog.petrieflom.law.harvard.edu/2022/09/27/decarceration-in-hospitals/ [https://perma.cc/94DX-DL3R].

275 *See* Haber et al., *supra* note 262, at 1259.

vulnerable patients is all the more surprising since restraints are not always imposed whenever prisoners are taken outside of prison walls. For example, in court, especially during the trial, defendants have a right to request that restraints be removed, though this is obviously subject to court's approval of the request.[276]

A third area of conflict between hospital rules and carceral practices involves patients' ability to have visitors or contact with loved ones while being treated. Generally, people can visit patients in hospitals or contact sick relatives or friends by phone or internet. Hospitals may restrict visitation to certain hours or for certain departments or require visitors to show identification and check in with security. But for the most part, visitors are welcome and desired. The presence of loved ones and those who can act as patient surrogate decision-makers and advocates is an important part of patient care and contributes to better patient outcomes.

Regulations require hospitals to develop written policies on visitation.[277] Patients, or support persons, must be informed of their visitation rights including any restrictions or limitations, and they must also be informed of their right to have a spouse, domestic partner, family, or friend visit them, and the right to deny any visitors.[278]

People who are under correctional custody in hospitals do not fall under these rules. Instead, they are subject to correctional rules, with limited access to family based upon security and medical need, and upon correctional approval.[279] No inmate has a constitutional right to visitation.[280] Visitor access is not typically protected or even mentioned in state statutes.[281] Visiting rules for prisons are based upon administrative regulations, policy directives, and facility-specific rules.[282] Jail visiting procedures are similarly facility-specific rules where visits and visitors are regulated, and phones and other communications are monitored.[283]

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276 United States v. Sanchez-Gomez, 859 F.3d 649, 666 (9th Cir. 2017) ("Thus, we hold that if the government seeks to shackle a defendant, it must first justify the infringement with specific security needs as to that particular defendant.").

277 42 C.F.R. § 482.13(h).

278 *Id.*

279 *See, e.g.*, Fla. Admin. Code Ann. § 33-601.733 (2023); Md. Code Regs. § 12.12.18.02 (2023); 103 Mass. Code Regs. § 483.10 (2023); 240-20-00 R.I. Code § 1.14 (LexisNexis 2023).

280 *See, e.g.*, Bedingfield *ex rel.* Bedingfield v. Deen, 487 F. Appx. 219, 232 (5th Cir. 2012).

281 *See* Chesa Boudin, Trevor Stutz & Aaron Littman, *Prison Visitation Policies: A Fifty-State Survey*, 32 Yale L. & Pol'y Rev. 149, 157 (2012).

282 *Id.*

283 *See* Alicia H. Sitren, Hayden P. Smith, Brandon K. Applegate & Laurie A. Gould, *Jail Visitation: An Assessment of Organizational Policy and Information Availability*, 4 Sw. J. Crim. Just. 207, 212–13 (2009) (assessing information availability of visiting policies at thirty small and thirty large jails); Prison Policy Initiative, *Prison and Jail Visitation*, https://www.prisonpolicy.org/visitation/ [https://perma.cc/P2S9-NMNU]; Tex. Dep't of Just., *Executive Directive § 03-32* (Offender Access to Telephones) (Oct. 31, 2019); Lauren Gill, *Federal Prison's Switch to Scanning*

Incarcerated people have brought lawsuits for the denial of visitation during their hospitalization based on their First Amendment right to intimate associations.[284] Though some courts have allowed these cases to proceed in early stages of litigation, their reasoning highlights the penal interests in security as a reason for denying visits.[285]

There are exceptions. The First Step Act grants federal prisoners who are diagnosed with terminal illnesses a visit with family members within seven days of their diagnosis.[286] California also came close to passing a bill that would have made family visitation a civil right, spurred partly by the many problems with family notification and suspension of visits during the COVID-19 pandemic.[287] California Governor Gavin Newsom vetoed the bill, citing litigation concerns, and urging the legislator who proposed the bill to work with the corrections department for a solution.[288]

When people are in formal correctional custody, it is not surprising that these rules would apply. Police restriction such as imposing blackouts, ordering patients be delisted from hospital directories or other restrictions for patients who may not even be arrested could be necessary from a security point of view. Perhaps limiting access could stave off further violence against injured patients or discourage escapes. But these restrictions affect not only patients but also their family members who are kept from finding out about their loved one's medical condition and from being by their side.

The restriction on visitation has more than an emotional cost on patients and families. Visitor restriction can result in family and friends not getting vital information when a loved one is injured or sick and is

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Mail Is A Surveillance Nightmare, The Intercept (Sept. 26, 2021, 7:00AM), https://theintercept.com/2021/09/26/surveillance-privacy-prisons-mail-scan/ [https://perma.cc/9KMR-BKT2].

284 *See, e.g.*, Abu-Jamal v. Kerestes, no. 3:15-CV-00967, 2016 WL 4204539, at *11 (M.D. Pa. Aug. 5, 2016) (allowing plaintiff's freedom of association count to proceed based upon allegation of near-total ban of visits at hospital); Thurman v. Unknown Cook Cnty. Sheriff Emps., No. 18-CV-2720, 2018 WL 5315208, at *8 (N.D. Ill. Oct. 16, 2018).

285 Cordova v. City of Albuquerque, 618 F. 3d 645 (10th Cir. 2016) (granting defendants qualified immunity on freedom of association claim, citing in part security in the hospital as a reason to prohibit visitation); Payne v. State, 301 N.E. 2d 514, 516 (Ind. 1973) (noting that family restrictions were necessary security precaution).

286 18 U.S.C. § 3582(d)(2)(A)(ii).

287 Cal. Assem. B. 990, 2021-2022 Reg. Sess. (2021); Nate Gartrell, *California Prisons Suspend Visiting Indefinitely, over Coronavirus Scares*, The Mercury News (Mar. 11, 2020, 6:39 PM), https://www.mercurynews.com/2020/03/11/california-prisons-suspend-visiting-indefinitely-over-coronavirus-scares/ [https://perma.cc/KT9D-PPHA].

288 Bob Egelko, *Newsom Vetoes Bill Giving California Prisoners a Right to Visitation*, S.F. Chron. (Oct. 7, 2021, 7:07 PM), https://www.sfchronicle.com/bayarea/article/Newsom-vetoes-bill-giving-California-prisoners-a-16517413.php [https://perma.cc/CP3S-R6A4]. At the time of this writing, a revised bill is pending before the California legislature. *See* Cal. Assem. B. 958, 2023–2024 Reg. Sess. (2023).

taken to a hospital, or is close to death. For example, Jessica Mayo had been arrested on a two-year-old misdemeanor bench warrant and was being held in the Allegheny County Jail.[289] Her mother got a phone call two days later that she was on life support in a Pittsburgh hospital.[290] The jail chaplain who called her would not tell the mother any details about the hospital.[291] After a week with no further information from the jail, Mayo's mother and another family member flew to Pittsburgh and went to the Allegheny General Hospital where they were escorted out by security guards and a police officer told them they would be arrested if they returned.[292] In another case, a woman got a phone call from a friend of her incarcerated son telling her that her son had been taken out of his cell on a gurney and had not been brought back.[293] She called the prison and found out later that he suffered massive brain injuries.[294] It took hours before she found out where he was being treated.[295] She arrived to find him handcuffed, unconscious, bandaged and bruised, connected to a life support machine with a Do Not Resuscitate ("DNR") bracelet.[296]

Visitation restrictions or lack of family notification may lead to situations where patients in custody have decisions about their treatment made by law enforcement authorities. Marquette Cummings, Jr., a prisoner in Alabama, was stabbed in the eye and airlifted to the University of Alabama at Birmingham Hospital.[297] The prison informed Mr. Cumming's mother, Ms. Gaines, but did not immediately give her the name of the hospital.[298] When she finally got the name of the hospital and went there, she was repeatedly denied access.[299] At some point, the warden had a conversation with the hospital personnel and directed

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289 Shelly Bradbury, *Family of Hospitalized Inmate Unable to Visit or Get Information About Her*, Pitt. Post-Gazette (Apr. 5, 2018, 7:11 PM), https://www.post-gazette.com/local/city/2018/04/05/Family-of-hospitalized-inmate-allegheny-county-jail-no-information-visit-jessica-mayo-linda-brownell/stories/201804050192 [https://perma.cc/ANH3-HECP].

290 *Id.*

291 *Id.*

292 *Id.*

293 Adeshina Emmanuel, *"They Told Me He Belonged to the State': Slain Alabama Prisoner's Mother Kept in Dark as Her Son Lay Dying*, InjusticeWatch (Mar. 4, 2020), https://www.injusticewatch.org/projects/2020/billy-smith-mom/ [https://perma.cc/VF2G-7V7E].

294 *Id.*

295 *Id.*

296 *Id.*

297 Est. of Cummings v. Davenport, 906 F.3d 934, 937 (11th Cir. 2018). The circuit court upheld the district court's decision denying the warden qualified immunity. *Id.*

298 *Id.*

299 Brief for Appellee at 12, *Est. of Cummings*, 906 F.3d 934 (No. 17-13999-EE), 2018 WL 480337, at *3; Brief for Appellant, *Est. of Cummings*, 906 F.3d 934 (No. 17-13999-EE), 2017 WL 6206248 at *4.

a DNR order and the removal of life support.[300] Ms. Gaines informed the hospital personnel that she disagreed but was told "'it was not her call" because "the State had legal custody over [the inmate], and that the decision to let her son die was the warden's."[301] Mr. Cummings died a few hours after the removal of life support.[302] A lawsuit filed by his family resulted in a court finding that the warden was not entitled to qualified immunity as Alabama state law did not grant the warden this authority.[303] The Eleventh Circuit determined that state law "compels the conclusion that the office of a prison warden grants no authority to enter a do-not-resuscitate order or to order the withdrawal of artificial life support on behalf of a dying inmate."[304]

As the Eleventh Circuit affirmed, though these end-of-life decisions should not be made by correctional officers, the lack of clarity on when carceral authority ends could very well lead to similar instances in other hospitals. These issues came to the forefront during the COVID-19 pandemic when families of incarcerated people were not notified when their loved ones were taken to the hospital in acute condition.[305] This led AMEND, an organization based out of the San Francisco Bay Area, to release a guide to educate medical providers on with the proper process of designating surrogate decision-makers.[306]

The experience of Mr. Cummings and his family cannot be considered an isolated one, given the statements by medical providers that they have difficulties with contacting family because of restrictions imposed by law enforcement.[307] To contact family members in these instances, providers had to circumvent law enforcement or make requests up the chain of command to get institutional approval.[308]

These kinds of restrictions can also affect patients' legal cases, particularly when they are applying for compassionate release or some other form of relief based upon their medical condition. An advocacy organization specializing in compassionate release has had cases where the hospital has prohibited attorneys from getting information about or

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300 Brief for Appellee, *supra* note 299, at 13; Brief for Appellant, *supra* note 299, at 16.

301 Brief for Appellant, *supra* note 299, at 16.

302 Brief for Appellee, *supra* note 299, at 13.

303 *Est. of Cummings*, 906 F.3d at 937; *see also* Ala. Code § 22-8A-11 (2022).

304 *Est. of Cummings*, 906 F.3d at 941.

305 Leah Rorvig & Brie Williams, *Providing Ethical and Humane Care to Hospitalized, Incarcerated Patients with COVID-19*, 38 Am. J. Hospice & Palliative Med. 1–3 (2021).

306 *Providing Acute Care for Seriously Ill Incarcerated Patients: Frequently Asked Questions*, AMEND (July 8, 2020), https://amend.us/wp-content/uploads/2020/07/Caring-for-Seriously-Ill-CDCR-Patients-7.8-LBR.pdf [https://perma.cc/7RRQ-8RX3] (highlighting how a surrogate decision-maker can be appointed and what their role entails).

307 *See supra* text accompanying notes 191–93; *see also* Interview with Physicians 13 (Dec. 2, 2022) (on file with author); Interview with Physician and Violence Coordinator 216 (Sept. 3, 2020) (on file with author); Interview with Physician 10 (Jan. 30, 2023) (on file with author).

308 *Id.*

access to their clients, even if such information would be critical to the patient's legal matter.[309]

Lastly, outside of family assistance with end-of-life decision-making, patient autonomy and participation in their own treatment is another category of conflict between hospital and carceral practice. Patients' medical decision-making is the prerogative of the patient unless patient incapacity or emergency requires medical providers to bypass patient or surrogate consent.[310] Patients in law enforcement custody and control are in theory allowed to exercise consent or nonconsent to treatment as they would if they were not in custody.[311] But this ability to consent is subject to limitations. For example, prisoners may be forcibly medicated or fed.[312] Treatment decisions can be made based upon the law enforcement need or at the request of the carceral authority and not the patient. Medical providers may use ketamine to subdue patients without their consent.[313] They may be called upon to perform cavity searches or other diagnostic testing, typically for contraband.[314] The law generally requires warrants for these types of procedures, or the existence of certain exigencies to be present for procedures conducted without a warrant, but none of these requests require or even consider patient consent.[315]

4. Elision of Hospitals

Hospitals adapt their practice to police and correctional work, subordinating hospital regulations and medical ethics and norms. Much of this is due to the explicit or implicit elision of hospitals and medical providers in regulatory directives, statutes, and doctrines, in addition to

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309 Interview with Attorneys 340 (May 3, 2023) (on file with author).

310 *See Code of Medical Ethics: Consent, Communication & Decision Making*, AMA, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-consent-communication-decision-making [https://perma.cc/3B3C-6QYR]; *Code of Medical Ethics: Decisions for Adult Patients Who Lack Capacity*, AMA, https://www.ama-assn.org/delivering-care/ethics/decisions-adult-patients-who-lack-capacity [https://perma.cc/H4VJ-5K4E].

311 Jeffrey Natterman & Pamela Rayne, *The Prisoner in a Private Hospital Setting; What Providers Should Know*, 19 J. Health Care L. & Pol'y 119, 126–27 & n.57 (gathering cases).

312 Jason Feldman, *Piercing the Veil of Dangerousness in Forcible Medication: Why Pretrial Detainees Are Due More Process Than* Washington v. Harper, 63 Syracuse L. Rev. 467, 471–72, 480 (2013)*; see also* Aviva Stahl, *Force-Feeding is Cruel, Painful, and Degrading—and American Prisons Won't Stop*, The Nation (June 4, 2019), https://www.thenation.com/article/archive/force-feeding-prison-supermax-torture/ [https://perma.cc/9Y5A-4YWX].

313 Buckley v. Hennepin Cnty., 9 F.4th 747, 760, 763 (8th Cir. 2021).

314 Song, *Policing the Emergency Room*, *supra* note 11, at 2678–84; *see also* Sanchez v. Periera-Castillo, 590 F.3d 31, 42–43 (1st Cir. 2009).

315 Schmerber v. California, 384 U.S. 757, 770–71 (1966); McNeely v. Missouri, 569 U.S. 141, 148–49 (2013).

asymmetrical legal guidance skewing the balance toward compliance with law enforcement norms and practices.

The Centers for Medicare & Medicaid Services is a powerful regulatory agency because they provide significant funding to hospitals. This funding comes with strings attached in the form of regulatory compliance and agency oversight. But CMS has abdicated its role here. In 2016, the Department of Health & Human Service issued a *Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals*.[316] The Guidance underscores that hospitals must accept patients in custody since EMTALA prohibits them from refusing services to "justice involved individuals."[317] The Guidance states that because hospitals are not "criminal justice or law enforcement institutions," they cannot maintain custody of those patients. Instead, law enforcement "must be physically present" with the patient at all times.[318] Recognizing that hospitals have different kinds of restraint protocols, the agency affirms the law enforcement's ability to use those restraints as long as those measures are imposed by law enforcement personnel and not hospitals.[319] The Guidance further states that "[t]he use of [restraints or restrictive] devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients."[320] The law enforcement officers are responsible for maintaining and monitoring the use of those restraints.[321] The Guidance also clarifies that law enforcement-related medical interventions are not a health-care service, without commenting on the proprietary of those interventions under its agency regulations.[322] The only recommendations that the Guidance makes is that the hospital ensures that there is a lawful order to conduct any searches and that there be hospital policies to address the legal authority and the criteria for when such requests and directives need to be delivered.[323]

This statement by one of the main federal agencies governing hospitals sends a clear message to hospital administrations: that patients in law enforcement custody are to be dealt with separately, and what happens with those patients is ultimately the responsibility of the correctional authority.

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316 Dep't of Health & Human Serv., Center for Clinical Standards and Quality/Survey & Certification Group, Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals 8 (2016).

317 *Id.*

318 *Id.*

319 *Id.* at 9.

320 *Id.*

321 *Id.*

322 *Id.* at 10.

323 *Id.*

The health privacy laws similarly minimize incentives for hospitals and their administrators to prioritize the privacy of patients under law enforcement custody. HIPAA and state privacy protections signal to hospitals and medical providers that they should cooperate by allowing exceptions to their privacy measures when it comes to law enforcement and correctional-related patient scenarios. HIPAA contains exceptions to its protections for law enforcement disclosures, including those disclosures allowed under state law.[324] In addition, enforcement actions based on improper law enforcement-based disclosures are not common.[325] Even though physicians and medical providers casual observations of broad law enforcement access to treatment areas indicate potential of HIPAA violations—not just of the patient in custody but other patients as well—violations of this nature seem to be rarely reported if at all. It is not surprising then that privacy officers in hospitals are not more assertive.

The practice of "medical clearance" escapes regulatory guidance and legal scrutiny almost entirely. EMTALA requires them to at least screen the person.[326] But neither the Department of Health & Human Services nor CMS has guidance on how hospitals should "medically clear" patients heading to correctional institutions. An additional problem is that medical clearance is also unlikely to result in a lawsuit against the hospital. This makes sense since "medical clearance" is designed to relieve jail and the carceral authority of potential liability. Indeed, lawsuits concerning patients who suffered or died after being sent back to jail or prison are typically directed to the carceral authority and not the treating hospital.[327] And there are also reasonable and good policy reasons to not discourage the practice of law enforcement from taking patients to hospitals before jail. Of course, it would be preferable to have someone who is sick or injured to be seen by hospitals instead of being accepted to the jail with serious medical issues with serious or deadly consequences. But the lack of guidance by either regulations or caselaw contribute to the deference to law enforcement and correctional directions and tensions with medical ethics.

Another key factor is that hospitals generally fail to draw sufficient legal scrutiny in court decisions about patients treated in outside hospitals who are also under law enforcement or correctional custody. Law

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324 *See* 45 C.F.R. § 160.512(f), k(5) (2017).

325 *See Enforcement Process*, U.S. Dep't of Health & Hum. Serv. (Sep. 17, 2021), https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/enforcement-process/index.html [https://perma.cc/4CPE-VVK6] (noting that the process of evaluating HIPAA complaints requires investigation and compliance reviews).

326 42 U.S.C. § 1395dd.

327 *See, e.g.*, Adkins v. Morgan County, 798 F. App'x 858, 860 (6th Cir. 2020); Woods v. Maryland Casualty Co., 322 F. Supp. 436, 437 (W.D. La. 1971); Stevens v. Gooch, 48 F. Supp. 3d 992, 1000 (E.D. Ky. 2014).

enforcement and correctional authorities are on notice that they must provide a minimum level of care to pretrial and postsentence prisoners to avoid constitutional liability.[328] But the constitutional rules in this arena fail to properly incentivize hospitals from ceding decision-making to carceral authorities. First, as previously noted, the constitutional mandate to provide adequate medical care is a minimal requirement.[329] Caselaw is full of examples where people received objectively bad—but not constitutionally deficient—medical treatment.[330] In addition to the minimal level of constitutional protection, the inclusion of hospitals in the carceral map also leads to constitutional underprotection. Treatment or access to a hospital, almost by definition, constitutes adequate health care under an *Estelle* analysis.[331] Treatment at the hospital is often the last step in a series of bad or nonexistent health-care decisions by correctional authorities. When there is inspection of the hospital's provision of care, it is so infected by whatever health-care decisions are made by the correctional authorities that it is rare that free world hospital workers would even be held liable for any damages to the prisoner.

There is also less concern by hospitals about constitutional liability because *Estelle*-based challenges are primarily directed to the correctional authority. These constitutional questions are aimed at correcting the behavior of the law enforcement actors. Rarely, if ever, are hospitals found culpable for Eighth Amendment claims in civil actions. One example of this can be found in *Brown v. Polk County*,[332] an opinion by Justice Sotomayor on the denial of cert.[333] Police arrested Sharon Brown, a Native American woman, for shoplifting and took her to the county jail.[334] In response to a tip from two inmates that Ms. Brown was holding drugs in her body, the jail administrator authorized a cavity search.[335] The jail staff took her to a local hospital where a male physician performed an ultrasound. When that did not reveal any "foreign objects," the physician inserted a speculum into her vagina and her anus.[336] He did not find any contraband.[337] The district court granted summary judgment for the county and jail defendants based on its finding that the

328 *See* Estelle v. Gamble 429 U.S. 97, 104 (1976).

329 *See* Williams v. First Corr. Med., 377 F. Supp. 2d 473, 477 (D. Del. 2005).

330 *See, e.g.*, Gonzalez v. McHenry County, Ill., 40 F.4th 824 (7th Cir. 2022).

331 *See, e.g.*, *Williams*, 377 F. Supp. 2d at 477 (noting that the inmate received "some care" and failed to satisfy the *Estelle* test).

332 141 S. Ct. 1304 (2021) (mem.) (Sotomayor, J. respecting the denial of certiorari).

333 *Id.*

334 *Id.* at 1304, 1307 n.3. These facts are taken from Justice Sotomayor's statement respecting the denial of cert. *Id.*

335 *Id.* at 1305.

336 *Id.*

337 *Id.*

penetrative search required only reasonable suspicion.[338] The Seventh Circuit agreed.[339] Justice Sotomayor issued a statement respecting the denial of cert and adding that "the degree of suspicion required for a search should be substantially informed by the availability of less intrusive alternatives" and further, that the Court should not "lightly permit an entire category of warrantless, invasive searches when less offensive options exist."[340]

In all this litigation, the issue of the doctor who conducted the search never came up. Neither did the role of the hospital. Ms. Brown sued the correctional officers and the county.[341] She did not sue the doctor or the hospital because of the immunity statute in place in Wisconsin, shielding hospitals and medical providers from liability for law enforcement-related cavity searches.[342]

Moreover, Fourth Amendment protections have little practical effect in hospitals. The state-actor doctrine and the third-party nature of medical providers make their Fourth Amendment liability a slippery concept.[343] The remedy of the exclusionary rule provides virtually no incentive to hospitals or their personnel, other than the broader societal interest of ensuring constitutional police behavior. Medical providers and hospitals can be conscripted to serve state needs.[344] Yet, in many situations, they are protected from constitutional analyses. Courts have not characterized emergency rooms as protected Fourth Amendment spaces and have affirmed and condoned medical providers' cooperation with law enforcement or liberally interpreted their actions as separate from law enforcement investigatory purposes.[345]

Finally, an overarching consideration of these gaps is the matter of access to justice. Patients who are in carceral custody are likely from vulnerable groups and are comparatively politically powerless. They are less likely to have the means to get lawyers to challenge harmful treatment.[346] Constitutional challenges, HIPAA complaints, medical malpractice, or other civil suits, all require the patients themselves, or

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338 *Id.*

339 Brown v. Polk County, 965 F.3d 534, 541 (7th Cir. 2020).

340 *Brown*, 141 S. Ct. at 1304.

341 Complaint and Demand for a Jury Trial at 2–4, Brown v. Polk County, 2019 WL 3858159 (W.D. Wis. 2018) (No. 18-cv-391).

342 Interview with Attorney for S. Brown (May 19, 2021) (on file with author); WIS. STAT. ANN. § 895.535 (West 2022) ("Civil and criminal liability exemption; body cavity search").

343 *See* Song, *Policing the Emergency Room, supra* note 11, at 267880.

344 *Id.*

345 *See id.* at 2665, 2669, 2678; Saulsberry v. Maricopa Cnty., 151 F. Supp. 2d 1109, 1119 (D. Ariz. 2001); United States v. Attson, 900 F.2d 1427, 1433 (9th Cir. 1990); United States v. Chukwubike, 956 F.2d 209, 212 (9th Cir. 1992).

346 Melissa Barragan, Gabriela Gonzalez, Justin Donald Strong, Dallas Augustine, Kelsie Chesnut, Keramet Reiter & Natalie A. Pifer, *Triaged Out of Care*, 10 HEALTHCARE 289 (2022).

their families, to take action, and have adequate resources, including access to good lawyers.

III. Hospitals and Mass Incarceration

Carceral authorities' use of hospitals is more than incidental and situational. Hospitals are a key part of mass incarceration, perpetuating the same racial and class-based subordination replicating the carceral loyalty of medical providers in correctional facilities.

A. Carceral Infrastructure

Hospitals do more than fill the need or gap in medical and expert services for law enforcement and correctional institutions. They identify people as criminals for police, retrieve evidence from people's bodies for the police, clear prisoners for incarceration, and treat them for harms incurred while incarcerated just to send them back. Their ability to fix and medicate people makes it necessary to gather certain kinds of physical evidence. These outside hospitals fulfill an important service for law enforcement and correctional authorities. Their permanence in the carceral infrastructure is not due to a specific mandate but a combination of laws, regulations, practices, and custom that turns the hospital bed into temporary extensions of the police station, jail, or prison cell.

Perhaps the reason for this is because, as many scholars have theorized, hospitals themselves exhibit characteristics of carcerality. Foucault's carceral continuum described the spread of the state's power to discipline and punish other institutions, including hospitals.[347] Sociologist Erving Goffman described hospitals as total institutions, like prisons—sites of spatial exclusion where people live, congregate, sleep, play, and eat in one place.[348] But hospitals being *like* a carceral entity is very different from hospitals *actually being part* of the institutions of policing and incarceration.

Perhaps one could say that the hospital is actually part of the "shadow carceral state" conceptualized by sociologists Katherine Beckett and Naomi Murakawa.[349] According to Beckett and Murakawa, carceral power now extends beyond "visible tentacles of penal power."[350] Using the concepts of legal hybridity and institutional annexation, they describe the shadow carceral state as consisting of policy and

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347 *See* Michel Foucault, Discipline and Punish 297–98 (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1975).

348 *See* Erving Goffman, Asylums 4–5, 14 (Anchor Books ed. 1961); *see also* Foucault, *supra* note 347; David J. Rothman, The Discovery of the Asylum xiii (Little, Brown and Co. 1971).

349 Katherine Beckett & Naomi Murakawa, *Mapping the Shadow Carceral State: Toward an Institutionally Capacious Approach to Punishment*, 16 Theoretical Criminology 221, 222 (2012).

350 *Id.*

institutional innovations that "mimic traditional punishment . . . [and] creat[ing] pathways to, and entanglement in, the criminal justice system."[351] The shadow carceral state, they argue, takes advantage of "*legally liminal authority*" where power can expand because of "the blending of civil, administrative, and criminal legal authority."[352] Their examples of this extension of penal power include civil alternatives to criminal sanctions, administrative pathways to incarceration such as immigration enforcement and parole revocation, and civil pathways to incarceration through civil contempt.[353]

In applying their definition to hospitals, the use of hospitals to investigate suspects or arrestees and treat prisoners may be viewed as policy innovations. The carceral actor's use of the hospital may be seen as an annexation of an institution adjacent to the criminal system, where carceral power is able to expand because of the different and complex legal authority at issue.

Hospitals' work with police and corrections, however, is not just a mimicking of the central system of punishment or the mere creation of pathways to the criminal justice system. The work of hospitals for police and correctional authorities *is* in furtherance of the mainstays of traditional punishment—arrest, criminal charges, and prosecution. Hospitals do not just create pathways or entanglements to the criminal justice system like the civil contempt system. They facilitate *the* pathway to jail and prison. To adopt the language of Foucault again, police and correctional authorities need the "medical gaze" of medical professionals and the site of the hospital to gather evidence and make sure people are ready for incarceration, and stay relatively healthy during incarceration.[354] Patients become "bodies" ready for incarceration rather than people; their condition is referred to as "stable" rather than healthy. The primary concern for the carceral authority is to address serious or acute medical conditions and decompensation, rather than to promote healing. Characterizing hospitals' role as part of a shadow carceral state downplays their importance and participation in the central work of mass incarceration, including the ultimate power of carceral authorities to take away liberty.

When hospitals are viewed as part of the infrastructure of mass incarceration, or carceral infrastructure, it is not surprising then that they are sites of policing and criminalization. Such hospitals would of course contribute to the policing in the emergency room and the criminalization of Black people, including that of Black women accused of

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351 *Id.*

352 *Id.*

353 *Id.* at 225–30.

354 Michel Foucault, The Birth of the Clinic 9 (A.M. Sheridan trans., Routledge 2003) (1963).

drug use during pregnancy, identifying pregnant people suspected of possible abortions, and shackling of pregnant women in labor and paralyzed arrestees.[355]

As part of carceral infrastructure, hospitals also naturally act as sites to hold people in custody. This extension of physical carceral sites is similar to the shifting of incarcerated people between state hospitals and prisons such as when a defendant is incompetent or mentally ill.[356] Professor Emily Thuma observed a similar symbiosis between hospital and prison in her study of women prisoners who were declared unfit and transferred to the mental hospital for protesting institution violence in what she termed a "prison-hospital pipeline."[357] State mental hospitals, however, may be considered formally part of the state carceral structure. Sociologist Armando Lara-Millán observed this same shuttling of people, or a circular loop happening between outside hospitals and jails, and attributed this to fiscal crises and legal pressures resulting from litigation.[358] Costs and legal pressures are part of the reasons for this circular loop. But outside hospitals are more than just *alternative* or *spillover* sites for jails. As part of policing and correctional routines, they act as simultaneous sites of policing and punishment.

Why this has come to pass is certainly an important question. Professor Jonathan Simon's theory of medical paradigms provides at least a partial explain of why we have come to a point where outside hospitals operate as simultaneous sites of policing and punishment.[359] Simon identified four medical models coinciding with different penological eras.[360] At the time of his writing, in 2013, he described that period as one governed by a penology of total incapacitation through the supermax prison.[361] Simon characterized this period as "anti-medicine" or "zombie

355 *See* Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 Mich. L. Rev. 938, 938 (1997); Dorothy E. Roberts, Killing the Black Body 24–25 (Vintage Books 1st ed. 1999) (1997); Song, *Policing the Emergency Room*, *supra* note 11, at 2660; Ocen, *supra* note 16, at 1243; Ji Seon Song & Aziza Ahmed, Anatomy of an Abortion Investigation (draft on file with author); Laura Huss, Farah Diaz-Tello, Goleen Samari, If/When/How, Self-Care, Criminalized: August 2022 Preliminary Findings (2022), https://www.ifwhenhow.org/wp-content/uploads/2023/06/22_08_SMA-Criminalization-Research-Preliminary-Release-Findings-Brief_FINAL.pdf [https://perma.cc/LYH9-AMXY] (discussing how many investigations of pregnant women began with notification by hospitals).

356 Nat'l Ctr. for State Courts, Competence to Stand Trial 6 (Apr. 2020).

357 Emily Thuma, *Against the "Prison/Psychiatric State": Anti-Violence Feminisms and the Politics of Confinement in the 1970s*, 26 Feminist Formations 26, 29–31 (2014).

358 *See* Armando Lara-Millán, Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity 23, 40 (2021).

359 Jonathan Simon, *The Return of the Medical Model: Disease and the Meaning of Imprisonment from John Howard to* Brown v. Plata, 48 Harv. C.R.-C.L. L. Rev. 217, 219 (2013).

360 *Id.* at 222.

361 *Id.* at 241–43.

medicine" to deal with monsters or super-predators.[362] As a result, Simon argued, jails and prisons had become filled with chronically ill prisoners, leading to the current medical paradigm of correctional geriatrics as expressed through correctional health maintenance centers.[363]

Certainly, we are still in that "correctional health maintenance center" period.[364] The medical needs of incarcerated people have made hospitals necessary and the need will only grow as the imprisoned populations continue to age.[365] Penal trends and sentencing policies are certainly part of the story. Just as important, however, is the courts' policing doctrine, and the history and development of policing and medicine in why hospitals are embedded in our carceral system.

Hospitals' role in mass incarceration is also unique. They are different from other social institutions like schools, public benefits offices, and public housing, and even other health-care settings like veteran's hospitals that have been described as subsumed by carceral expansion.[366] These other sites are very much part of a widening field of policing authority and criminalization. In some ways, the spread of carcerality to hospitals mimics the pattern in these other sites. But hospitals are distinct among this group. Yes, teachers, housing authorities, and public benefits agents, like medical professionals, can take on the role of police officer. But unlike these other institutions, the professional expertise of hospital personnel and the apparatus of patient treatment areas are necessary and integral to these carceral institutions. Further, unlike schools, public housing, and public benefits offices, where the suspect or defendant may ultimately be pushed into the criminal system, in the case of the patient prisoner, the state's power is exerted through the hospital and its professionals is sited within the criminal process. The hospitals discussed here are distinct even from settings like veteran's hospitals where the policing apparatus is built into the administrative structure, or state mental hospitals where patients are held there under court order.[367] The hospitals are

362 *Id.* at 219.

363 *Id.*

364 *Id.* at 251, 253 (citing Jeremy Bentham, Panopticon; or the Inspection-House 31 (1791)).

365 *See* Egon Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 Social Problems 278, 278 (1967); Heather Barr, Crim. Legal News, Prisons and Jails: Hospitals of Last Resort 2 (1999).

366 Kimberlé W. Crenshaw, Priscilla Ocen & Jyoti Nanda, Black Girls Matter: Pushed Out, Overpoliced and Underprotected 5 (2015) (schools); Kaaryn S. Gustafson, Cheating Welfare: Public Assistance and the Criminalization Of Poverty 1–2 (2011) (welfare offices); Alexis Karteron, *When Stop and Frisk Comes Home: Policing Public and Patrolled Housing*, 69 Case W. Rsrv. L. Rev. 669, 669 (2019) (housing); *see also* Catherine Y. Kim, *Policing School Discipline*, 77 Brook. L. Rev. 861, 861–64 (2012); Loïc Wacquant, Punishing the Poor: The Neoliberal Government of Social Insecurity 41–43 (2009).

367 See Sunita Patel, *Embedded Healthcare Policing*, 69 UCLA L. Rev. 808, 808 (2022); *Treatment*, Cal. Dep't of State Hosps., https://www.dsh.ca.gov/Treatment/index.html

folded into the normal course of policing and punishment even as they formally exist outside of these systems.

B. Racial and Class-Based Subordination

Hospitals' position as part of the infrastructure of mass incarceration is not just important because they expand the carceral footprint. Viewing hospitals through this lens allows us to view their treatment of patient prisoners through the lens of mass incarceration.

When hospital administrators acquiesce to law enforcement, and when medical providers choose or feel compelled to follow treatment and care according to law enforcement priorities, the ultimate burden of those choices fall on the patient. Given the reality that Black people and people of color are arrested and imprisoned at higher rates than white people,[368] the burden borne by these patients is not just a generally punitive care, but a racialized punitive care that compounds the already existing bias in both the carceral and health-care systems.

Modern-day mass incarceration reflects a racial hierarchy embedded in our country since the time of slavery.[369] Scholars have argued that slavery indeed continues in some form today through the free prison labor of imprisoned people.[370] Echoes of slavery are apparent in the hospital as well. The images of Black people under arrest or imprisoned and shackled to hospital beds are inescapable reminders of slavery and continuing racial oppression and discrimination. Professor Priscilla Ocen made just that point about the shackling of pregnant Black women, which she described as yet another instance of racial subordination.[371] As she stated, the continued and persistent practice

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[https://perma.cc/9Q7A-9HM8]; *Public Psychiatric Hospitals*, Neb. Dep't of Health & Hum. Servs., https://dhhs.ne.gov/Pages/Regional-Centers.aspx [https://perma.cc/ZE3E-3SYJ]; *Treatment Programs,* Utah Dep't of Health & Hum. Servs., https://ush.utah.gov/treatment-programs/ [https://perma.cc/4MPG-GHRD].

368 See Kim Gilmore, *Slavery and Prison—Understanding the Connections*, 27 Soc. Just. 194, 195 (2000).

369 *See id.* at 195–97; Samantha Pereira, *Mass Incarceration: Slavery Renamed*, 6 Rsch. J. Just. Stud. & Forensic Sci. 42, 42 (2018). *See generally* Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of colorblindness (The New Press, 2010).

370 *See* Michele Goodwin, *The Thirteenth Amendment: Modern Slavery, Capitalism, and Mass Incarceration*, 104 Cornell L. Rev. 899, 908, 952 (2019); James Gray Pope, *Mass Incarceration, Convict Leasing, and the Thirteenth Amendment: A Revisionist Account*, 94 N.Y.U. L. Rev. 1465, 1534 (2019); Hannah Knowles, *As Juneteenth Marks the End of Slavery, Lawmakers Turn Their Focus to Forced Prison Labor*, Wash. Post (June 19, 2021, 11:18 PM), https://www.washingtonpost.com/history/2021/06/19/13th-amendment-prisons-juneteenth/ [https://perma.cc/XC3F-FW42]; Daniele Selby, *How the 13th Amendment Kept Slavery Alive: Perspectives From the Prison Where Slavery Never Ended*, Innocence Project (Sept. 17, 2021), https://innocenceproject.org/news/how-the-13th-amendment-kept-slavery-alive-perspectives-from-the-prison-where-slavery-never-ended/ [https://perma.cc/TC6P-S2ZJ].

371 Ocen, *supra* note 16, at 1247.

of shackling women during pregnancy—despite legal protections on the books—must be viewed through the historical lens of Black slavery, Black women's reproductive value and regulation during slavery.[372]

The relationship of the doctor, the guard or police officer, and the patient in custody is also reminiscent of Sharla Fett's description of health-care relationships during slavery where the "idealized" doctor-patient relationship was actually a triangulated relationship between patient, physician, and slave owner.[373] The slave was without a voice or viewed as "medically incompetent" and the resulting treatment was callous and exploitative.[374] One can see a similarity between the slave doctor who made sick and injured enslaved people fit for forced labor and the modern-day doctor responding to law enforcement's request for a defendant to be medically cleared for incarceration.

Parallels can also be drawn between the treatment of prisoners today and the historic experimentation of Black people for medical research or scientific theories. In Texas, the UTMB at Galveston is a teaching hospital and has students provide prison care as part of the curriculum. The school has espoused the benefits of this kind of education because of the range of experiences students can get from providing care to inmates.[375] As one of the doctors and administrators of the UTMB stated, "[t]hese cases offer such rich teaching opportunities that the school actually uses them as a recruiting tool."[376] Another resident physician also commented, "[t]here's such a diverse range of pathologies [among the prisoners] . . . [y]ou get to see pancreatic cancer in a twenty-year-old. It's a great asset.'"[377]

These sentiments were echoed in a study of thirty medical students and residents at UTMB of their perspective on caring for incarcerated patients.[378] The trainees experienced a sense of freedom when treating

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372 *Id.* at 1285–87.

373 *See* Sharla M. Fett, Working Cures: Healing, Health, and Power on Southern Slave Plantations 145 (2002).

374 *See id.*

375 David Theis, *Big House Health Care: Why and How UTMB Treats the Incarcerated*, UTMB Mag., Fall 2007, at 6.

376 *Id.*

377 *Id.*; *see also General Psychiatric Residency Clinical Training Sites*, UC Davis Health, https://health.ucdavis.edu/psychiatry/education/residency/adult/clinsites.html [https://perma.cc/HH63-85TG] (describing how the Department of Psychiatry and Behavioral Services provides a variety of services to the Sacramento County jail, stating, "[m]edical students and general residents work primarily on the JPS Acute Psychiatric Unit (APU) of the Main Jail in downtown Sacramento . . . in *an exciting, education-focused environment* that provides direct contact with pre-sentenced, sentenced and individuals awaiting transfer to State Hospital or other placements in the community." (emphasis added)).

378 Jason E. Glenn, Alina M Bennett, Rebecca J. Hester, Nadeem N. Tajuddin & Ahmar Hashmi, *"It's Like Heaven over There": Medicine as Discipline and the Production of the Carceral Body*, 8 Health & Just., art. 5, 2020, at 1.

these patients and the ability to practice medical skills more than in other units.[379] The sense of freedom also came from a perception that there would be little or no legal or medical consequences if things went wrong, and because less family were involved with patient care decision-making.[380]

Outside medical providers can be beneficial to the care of people in custody because they are less likely to bear cynical attitudes of correctional health-care workers.[381] But they are still prone to biases, stereotypes, and cynicism.

The UTMB example illustrates this tension. Some of the students' comments already revealed a degree of cynicism toward incarcerated patients:

> TDC patients have no choice or they don't care. . . . [I]t was a good learning experience to . . . do [rectal] exams with no pressure of 'if you mess this up, they're going to complain to the hospital or complain to the attending' or something like that. There's no threat of . . . [r]epercussions . . . .[382]

Students at UTMB also made statements revealing their assumptions about patients' malingering, although some expressing that these assumptions were also relayed to them by their supervisors.[383] Other students revealed stereotypical views of their own that prisoners had ill health because of personal irresponsibility.[384] On the other hand, the study revealed that trainees' exposure to the correctional health-care system and incarcerated patients had benefits.[385] The experiences raised their awareness of how institutional neglect contributed to the poor health of patients.[386] Some expressed that their experiences with patients challenged their previously held views about prisoners, finding their patients to be "completely normal," with "really great attitudes," and some "much nicer . . . [and] less demanding."[387]

These kinds of assumptions, stereotypes, exposure, and learning opportunities for medical professionals are not so different from what might occur in hospitals without any connection to police or prisons. But unlike prisoners getting treated by correctional health care, those getting treated by medical professionals in outside hospitals who also treat patients who are free. Physical markers of incarceration like guards,

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379 *Id.* at 8.

380 *Id.* at 8.

381 *See* Margo Schlanger, *Prisoners with Disabilities*, 4 Reforming Crim. Just. 295, 320 (2017).

382 Glenn et al., *supra* note 378, at 8.

383 *Id.* at 5–6.

384 *Id.* at 6.

385 *Id.* at 6.

386 *Id.* at 6.

387 *Id.* at 7–8.

shackles, and even different colored hospital gowns make incarcerated patients immediately identifiable to medical providers as patients in custody. Their visible status makes them vulnerable to the potential for minimal treatment based upon medical provider racial bias and bias against "criminals" who are less than deserving. Even in UTMB, where presumably providers treated only prisoners in that one facility, providers checked criminal records of patients (which were public records) online before treating them, reflecting that they were at least curious about the kind of person they were treating.[388] A less generous interpretation is that they were trying to figure out who might be deserving of treatment and who might not.

As Professor Elizabeth Chiarello has described, health-care institutions operate as key sites of "moral meaning making and practice."[389] Law and morality surface on multiple levels in health-care institutions where providers assess patients of their "deservingness" and patients try to demonstrate their moral worth.[390] Race, gender, and class of patients influence providers' decisions. In a publication highlighting the needs of incarcerated patients published by the American College of Emergency Physicians ("ACEP"), ACEP warned that "[i]f an incarcerated patient does manage to enter an ED [emergency department], his chances of obtaining equal treatment compared to non-incarcerated patients may be jeopardized by the very fact that he or she is incarcerated."[391] ACEP's public health committee highlighted this kind of morality-tinged decision-making by emergency health providers: incarcerated patients may be viewed as "unreliable . . . , dangerous, and manipulative malingers[]" by health-care providers or as "'social outcasts' whose diseases are 'well deserved.'"[392] Such sentiment was in fact expressed by the medical director at the Texas Department of Criminal Justice Hospital. The medical director said in an interview, "Whenever I'm dealing with a patient, I imagine that he would slit my throat and kill me if he could. I give him the same level of medical care I would anyone else, but there's no fluffy talk."[393]

The experiences of a pediatric emergency physician working in an urban tertiary trauma center in the largest city in his state further illustrate this moral meaning making, and how assessments of deservingness

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388 *Id.* at 10.

389 Elizabeth Chiarello, *Law, Morality, and Health Care Professionals: A Multilevel Framework*, 15 Ann. Rev. L. & Soc. Sci. 117, 117 (2019).

390 *Id.* at 120.

391 ACEP Public Health Committee, *Recognizing the Needs of Incarcerated Patients in the Emergency Department*, ACEP (April 2006), https://www.acep.org/administration/resources/recognizing-the-needs-of-incarcerated-patients-in-the-emergency-department [https://perma.cc/79K8-T3UB].

392 *Id.*

393 Theis, *supra* note 375.

may play a part in clinical care. The vast majority of the young patients in custody at his hospital are Black while all the hospital administration and nursing staff are white.[394] He felt that hospital policies deferring to police are more strictly applied to Black children. He described it as a "racist trope we fall into as an organization."[395] His conclusions are consistent with social science, showing that Black youth are more likely to be viewed as criminal and adult.[396] As the physician described, the general attitude seems to be that they cannot see "this kid as [their] kid because they are different, [and so] it is okay to treat them differently."[397]

Finally, punitive care in this context cannot just be viewed through a race lens but a class lens as well. In the health-care context, obstacles and limited access to health care mean that poor people come to rely upon hospitals and emergency rooms for their health care, where they experience bias and discrimination based upon their socioeconomic status.[398] Policing and mass incarceration also affect the poor more. Policing practices target people in welfare offices[399] and homeless encampments.[400] Poor people are more likely to be arrested, charged, and sentenced to longer sentences.[401] Other aspects of the criminal system, like the imposition of fines and fees and money bail, fuel a cycle

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394 Interview with Physician 10 (Jan. 30, 2023) (on file with author).

395 *Id.*

396 *See, e.g.*, Jennifer L. Eberhardt, Phillip Atiba Goff, Valerie J. Purdie & Paul G. Davies, *Seeing Black: Race, Crime, and Visual Processing*, 87 J. Personality & Soc. Psych. 876, 887 (2004); Phillip Atiba Goff, Matthew Christian Jackson, Brooke Allison Lewis Di Leone, Carmen Marie Culotta & Natalie Ann DiTomasso, *The Essence of Innocence: Consequences of Dehumanizing Black Children*, 106 J. Personality & Soc. Psych. 526, 535 (2014).

397 Interview with Physician 10 (Jan. 30, 2023) (on file with author).

398 *See, e.g.*, Comm. on Health Care Util. & Adults with Disabilities, Health & Med. Div., Health-Care Utilization as a Proxy in Disability Determination 21–33 (2018); Irena Stepanikaova & Karen S. Cook, *Effects of Poverty and Lack of Insurance on Perceptions of Racial and Ethnic Bias in Health Care*, 43 Health Serv. Res. 915, 915–30 (2008).

399 Kaaryn Gustafson, *The Criminalization of Poverty*, 99 J. Crim. L. & Criminology 643, 669–70 (2009).

400 Andy Newman, *The Police Take Down a Homeless Encampment*, N.Y. Times (March 28, 2022), https://www.nytimes.com/interactive/2022/03/28/nyregion/homeless-encampment-removed.html [https://perma.cc/9VAP-2WP9]; Priya Sridhar, *San Diego Police Sweeps Homeless Encampment One Week Before Ban Starts*, NBC 7 San Diego (July 24, 2023, 10:42 PM), https://www.nbcsandiego.com/news/local/san-diego-police-sweeps-homeless-encampment-one-week-before-ban-starts/3270579/ [https://perma.cc/8ZDP-P6FK].

401 *Connections Among Poverty, Incarceration, and Inequality*, Inst. for Rsch. on Poverty (May 2020), https://www.irp.wisc.edu/resource/connections-among-poverty-incarceration-and-inequality/ [https://perma.cc/SCR2-BGP9]; Alexi Jones & Wendy Sawyer, *Arrest, Release, Repeat: How Police and Jails Are Misused to Respond to Social Problems*, Prison Pol'y Initiative (Aug. 2019), https://www.prisonpolicy.org/reports/repeatarrests.html [https://perma.cc/FD48-8QQ2]; Bernadette Rabuy & Daniel Kopf, *Prisons of Poverty: Uncovering the Pre-Incarceration Incomes of the Imprisoned*, Prison Pol'y Initiative (July 9, 2015), https://www.prisonpolicy.org/reports/income.html [https://perma.cc/48UQ-7QV3].

of poverty and incarceration for people without economic means.[402] On one hand, it might be said that poor people being treated in hospitals while in custody is actually a positive measure for access to health care. At least they are getting medical care. But missing from that point of view, however, is the very real possibility that a poor person under arrest or incarcerated, who is treated by an outside health provider will see that provider as part of the carceral authority arm. Any existing mistrust may be compounded and such perceptions could decrease willingness to seek care by that person in the future.

C. Carceral Loyalty

Finally, when outside hospitals are seen as part of mass incarceration, the deference and adaption becomes legible as the kind of "dual loyalty" problems often in correctional health care.[403] Dual loyalty in the medical arena has been defined as "clinical role conflict between professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state."[404] In the case of correctional health care, the third party is the state as represented by the correctional authority. The same problems of "dual loyalty" in correctional health care extend to medical providers who work in external hospitals, even though they are not formally subject to carceral authority through an employment agreement, contract, or other formal arrangement.

The term dual loyalty, however, does not completely capture what is happening in this context. In hospital care of patients under custody—whether it be outside or inside correctional facilities—the loyalty toward the state well exceeds that to the patient. The term dual loyalty implies equal albeit conflicting loyalties where medical providers may end up abiding by policies and practices of law enforcement correctional authority or not. In outside hospitals that provide services for carceral authorities, just as in correctional health care, loyalty to carceral authority and their logics of "public safety" predominates.[405] A more precise term is then carceral loyalty.

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402 Press Release, Bernadette Rabuy & Daniel Kopf, Detaining the Poor: How Money Bail Perpetuates an Endless Cycle of Poverty and Jail Time (May 10, 2016), https://www.prisonpolicy.org/reports/incomejails.html [https://perma.cc/6KR3-D6VD]; Matthew Menendez, Michael F. Crowley, Lauren-Brooke Eisen & Noah Atchison, Brennan Ctr. for Just., The Steep Cost of Criminal Justice Fees and Fines (2019), https://www.brennancenter.org/our-work/research-reports/steep-costs-criminal-justice-fees-and-fines [https://perma.cc/F24Y-BBV7].

403 *See* Jörg Point, Heino Stöver & Hans Wolff, *Dual Loyalty in Prison Health Care*, 102 Am. J. Pub. Health 475 (2012).

404 *See id.*

405 *See infra* Section IV.C.

Hospitals have created policies or guidelines that fall in line with correctional policies, even when they conflict with medical ethics, health law, or the norms and standards of health care.[406] Professor Teneille Brown highlights the many principles of medical ethics that are undermined by this "blurring" between law enforcement and health-care roles, particularly the principles of patient privacy and autonomy, accountability, efficacy, and honesty.[407]

Using the term carceral loyalty to describe the dynamics explained here does not mean that individual providers do not feel tension and discomfort. They do. For instance, the practice of "medical clearance" puts the provider in the position of clearing a patient, or declaring them fit for incarceration. This practice does not seem dissimilar to the medical ethical quandaries raised by situations like the resuscitation of people who are sentenced to death, the health monitoring of people who were being tortured and interrogated in Guantanamo Bay, physicians who take part in implementing the death penalty, or the force feeding of imprisoned people on hunger strikes.

Providers face a quandary if they are aware of the general problems of medical care in jails and prisons. Physicians have stated that they are uncomfortable with complying with medical clearance requests.[408] The problems of continuing care in correctional settings *known* to the provider makes for an especially muddled ethical situation. Given the poor state of health care in carceral facilities and the violence within them, medical providers are, in essence, giving a green light to bad government conduct. Similar concerns arise when physicians discharge incarcerated patients back to jail or prison. As one physician stated in an interview, "No one is healthy enough to go to jail."[409] Even though physicians resist or feel uncomfortable with these requests, they will have seen the arrested person which in effect fulfills the need to have them cleared by a hospital.

Despite individual providers who may feel conflicted, the laws and systems are structured toward loyalty to carceral logic. This is largely due to the overwhelmingly punitive approach by the U.S. criminal legal system, even when aspects of care are involved. This point is made even clearer when the United States is compared to other countries' practices. Norway is a country frequently held up as an example by advocates of prison reform. A study examined how correctional and

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406 Hospital Policies (on file with author).

407 Teneille R. Brown, When Doctors Become Cops 1 (Oct. 6, 2023) (unpublished manuscript) (on file with author) (examining "how the blurring of law enforcement and health care undermines core principles of medical ethics—such as privacy, autonomy, public accountability, and honesty").

408 Interviews with Anonymous Physicians 8 (May 28, 2022) (on file with author).

409 Interview with Anonymous Physician 19 (Apr. 27, 2022) (on file with author).

medical actors work together in a low-security prison.[410] The professionals in the prison, instead of keeping their respective logics separate, unified them or compromised logics internally.[411] They developed a set of "living with" practices that did not modify respective professional logics.[412] These professionals thus existed in parallel, "leav[ing] space for a non-hierarchical configuration, where one logic does not dominate the other."[413] Key to the separation of logics, however, was a "shared vision" of resocialization.[414]

Rehabilitation is not the dominant purpose of the criminal system in the United States. Reintegration and transitional programs exist in the form of parole and halfway houses, and facilities may include educational, religious, vocational, and other programming.[415] These kinds of "rehabilitative" offerings, however, vary by jurisdiction and are not available to every inmate.[416] Jails and prisons in the United States are not primarily constructed with resocialization or reintegration in mind. Hospitals in the United States do have separate logics than law enforcement and correctional authorities. But there is no sharing of this vision of patient care by law enforcement and correctional authorities.

Moreover, that hospitals turn to carceral loyalty is not surprising given the structure of the law. The laws and regulations that currently exist tell hospitals to do the following: allow restraints of people in law enforcement custody; implement restrictions on visitation and family access; permit release of patient information for criminal investigations; and comply with law enforcement arrest and direction in patient care decisions.[417]

Individual medical professionals have expressed discomfort with the deference to carceral authorities in hospital policy and practice.[418] Physicians at one hospital described their displeasure at how their hospital has taken one step further than requested by law enforcement, even distributing different food to patients under law enforcement or

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410 Tine Murphy, Marie Aakjar, Eva Pallesen & Charlotte Rosenberg, *"Living With" Interagency Collaboration—Three Sustaining Practices*, *in* Improving Interagency Collaboration, Innovation and Learning in Criminal Justice Systems 88, 90–91 (Sarah Hean, Beril Johnsen, Anu Kajamaa & Laure Kloetzer eds., 2021).

411 *Id.* at 88–89.

412 *Id.* at 88.

413 *Id.* at 89.

414 *Id.* at 98.

415 *See Incarceration and Reentry*, Off. of the Assistant Secretary for Plan. & Evaluation, https://aspe.hhs.gov/topics/human-services/incarceration-reentry-0 [https://perma.cc/PL7Q-MPWW]. *See generally* Nat'l Inst. Justice, The Use and Impact of Correctional Programming for Inmates on Pre- and Post-Release Outcomes (2017).

416 *See id.*

417 *See supra* Part I.

418 *See* discussion *infra* Section III.C.

correctional custody than that given to other patients.[419] Medical students and residents have raised concerns about what they perceive to be problematic practices.[420] Physicians of more senior rank have similarly sought to bring about better balance with law enforcement presence and patient care with varying degrees of success.[421]

That hospital administrators might respond this way is unsurprising. The laws and regulations, and absence of laws and regulations, create pressures and incentives for hospitals to abide by carceral rules and practices. At the same time, the absence of positive law and regulations disincentivizes hospitals from interrogating aspects such as medical clearance or law enforcement investigatory methods in their workplace. Insufficient accountability and liability also mean that that hospitals can more easily abdicate responsibilities to patient care.

Things like clinical care for patient prisoners become less of a concern than sorting out costs of care, which are perennial concerns of hospitals to be financially viable (or profitable).[422] As a result, hospitals create silos of clinical care within their hospitals, separating the treatment of patients under law enforcement or correctional custody from that of other patients.

The balance toward carceral logics and loyalty is tilted even more because workplace safety has also emerged as a dominant concern of hospital administrators and staff.[423] Even as there are medical professionals who want to have more control over the treatment of patients in custody, there may be others who prefer to have security around when they deal with patients whom they deem potentially violent. Hospital administrators may also be hesitant to limit law enforcement access or challenge them, especially if routine access has become customary, and

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419 Interview with Physician 14 (June 1, 2022) (on file with author).

420 Interview with Physician 23 (Nov. 2, 2022) (on file with author); Interview with Medical Student 467 (Jan. 25, 2023) (on file with author); Interview with Physician 23 (June 16, 2022) (on file with author); Email from Medical Students 467 (July 26, 2023) (on file with author).

421 Interview with Physician 19 (Apr. 27, 2022); Hospital Observation 8 (May 28, 2022). This information is also based upon my work with physicians who are working on changing policies and practices in their hospitals.

422 *See, e.g.*, Sabrina Tavernise, *How Nonprofit Hospitals Put Profits over Patients*, N.Y. Times: The Daily (Jan. 25, 2023), https://www.nytimes.com/2023/01/25/podcasts/the-daily/nonprofit-hospitals-investigation.html [https://perma.cc/AS4P-DJ4W]; Jessica Silver-Greenberg & Katie Thomas, *They Were Entitled to Free Healthcare. Hospitals Hounded Them to Pay*, N.Y. Times (Sept. 24, 2022, 9:02 AM), https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html [https://perma.cc/5QYS-TUMA]; Noam Levey, *Some Hospitals Rake in High Profits While Their Patients Are Loaded with Medical Debt*, NPR (Sept. 28, 2022, 5:01 AM), https://www.npr.org/sections/health-shots/2022/09/28/1125176699/some-hospitals-rake-in-high-profits-while-their-patients-are-loaded-with-medical [https://perma.cc/ABP3-VG8R].

423 *See Workplace Violence in Healthcare 2018,* U.S. Bureau of Lab. Stat. (April 2020), https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm [https://perma.cc/J7TM-L27N].

when they also feel like they need law enforcement to protect the hospital in other situations.

In response to these safety concerns, hospitals themselves require the presence of law enforcement and the use of law enforcement restraints.[424] Though hospitals do have other noncarceral strategies to deal with patients in distress or who may pose a risk of harm to themselves or others through means such as medication, hospital restraints, and trained mental health professionals, hospitals may prefer to have law enforcement because of their ability to arrest and use force.

IV. A Different Patient Prisoner Care

If necessity, laws, customs, preference, and other dynamics have made hospitals part of the carceral project, can hospitals—problematic and carceral institutions in and of themselves—separate from the project of mass incarceration? Is that separation even possible? This Part proposes ways of structuring a different kind of patient prisoner care.

The Part begins by positing that a different kind of patient prisoner care is desirable and possible. One response to the inclusion of hospitals in the carceral infrastructure may be that it is an imperfect but necessary solution. Hospitals are necessary to address the medical health of prisoners; otherwise, sick and injured incarcerated people will face worse outcomes if they cannot access outside hospitals. Hospital treatment of prisoners mitigates the problems of access to health care by treating uninsured or underinsured people. Legitimate safety and security concerns justify differences in treatment and procedure. As Professor Margo Schlanger has written, there are many good reasons why correctional health care should include medical treatment by outside hospitals, because of their provision of continued care, their expertise, and their "nonprison attitude"—the latter being a more cynical or less empathetic approach due to the environments in which they work.[425] But it is because hospitals are necessary and beneficial in some respects that hospitals should not abdicate their responsibilities to patients under their care who are also under law enforcement and correctional control.

Another response could be that the expansion of carceral authority into health-care settings is inevitable and reflects fundamental flaws with both the health-care system and mass incarceration system. These systems are doing what they are meant to do: control and subjugate poor

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424 *See* Hospital Policies (on file with author).

425 *See* Margo Schlanger, *Prisoners with Disabilities: Law and Policy, in* Public Health Behind Bars 43, 56–58 (Robert B. Greifinger ed.) (2d ed. 2022).

and minority groups. Scholars have long argued that the persistence of racial inequalities is because of law and not despite it.[426]

Acknowledging that human solutions and systems will inevitably contain flaws, this Part of the Article operates from the perspective that a different kind of patient prisoner care is possible. There are ways in which the ameliorative side of hospitals and the benefits they can offer may improve the problems of mass incarceration. This optimism stems partly from the work of many people who are trying to change the status quo in hospitals—from acts of resistance like a midwife's hunger strike in San Francisco,[427] to national and local organizing,[428] and young medical students seeking a better and different way.[429]

At the outset, one might be tempted to separate health care from the carceral world completely, in other words, to create a clean break or division between the two. But such a separation would present even further problems. First, it is questionable whether such a clean break could be made, especially when there are reasons why law enforcement and carceral authorities may end up at hospitals—for example, when they need to accompany injured or sick people who cannot be cared for at a jail or prison. Second, with the state of correctional health care being what it is, cutting off prisoners' access to better health care in hospitals would be inhumane and unjust. Third, setting up a parallel medical care system would pour more resources into the carceral system, providing justification for those who make the argument that our poor, sick, and mentally ill are better served when they are incarcerated than not. Lastly, a parallel system would still perpetuate the continuing problems of the carceral system but keep hidden the injustice and inhumane treatment in our jails and prisons.[430]

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426 *See* Paul Butler, *The System Is Working the Way It Is Supposed to: The Limits of Criminal Justice Reform*, 104 Geo. L.J. 1419, 1425 (2016) (stating the problems in the criminal legal system "are not actually problems, but are instead integral features of policing and punishment in the United States"); *see also* Ian F. Haney López, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 Harv. C.R.-C.L. L. Rev. 1, 3–4 (1994); Devon W. Carbado, *Critical What What?*, 43 Conn. L. Rev. 1593, 1609 (2011).

427 *See* Mallory Moench, *Defund the Police? Debate Rages at SF General over Use of Sheriff's Deputies*, S.F. Chron. (Aug. 6, 2020, 2:16 PM), https://www.sfchronicle.com/health/article/Defund-the-police-Debate-rages-at-SF-General-15465734.php [https://perma.cc/NDB3-RRUX].

428 *See, e.g.*, New Resources, *Cops Out of Care*, Interrupting Criminalization, https://www.interruptingcriminalization.com/cops-out-of-care [https://perma.cc/EUB5-UP65]; Press Release, DPH Must Divest, Following Calls from Advocates, SF Department of Public Health to Announce Reduction of Sheriffs and Investment in Community Safety Alternatives (May 3, 2021), https://www.dphmustdivest.com/ [https://perma.cc/2KEU-N4WV].

429 Research Memorandum (Jan. 25, 2023) (on file with author).

430 *See* Eyal Press, *A Fight to Expose the Hidden Human Costs of Incarceration*, New Yorker (Aug. 16, 2021), https://www.newyorker.com/magazine/2021/08/23/a-fight-to-expose-the-hidden-human-costs-of-incarceration [https://perma.cc/8A3Y-C47P]; Teneille A. Brown, *When Doctors*

The proposals laid out in this Part have two intentions. First, the proposals aim to shrink and mitigate the expansion of coercive and harmful carceral power in hospitals. Second, they seek to augment the benefits of these health-care institutions to the carceral system—the regulatory oversight, patient-centered values, and recognition of the humanity of the patients. This Part is mainly derived from my continuing work with physicians and health workers across the country who are working toward lessening the harms of mass incarceration inflicted on their patients.

Ideological divestment is used as a starting point of thinking through how to structure a different kind of patient prisoner care. It then proceeds with proposals for patient-centered care solutions and increased oversight and accountability measures for hospitals and carceral authorities.

A. Ideological Divestment

Medical providers who are working to address law enforcement harms in their workplaces may find that their administrators want law enforcement partners to be consulted in any changes. This sense of partnership may stem from a sense that hospitals and law enforcement share a common mission toward public safety and against violence. Race and class allegiances between law enforcement and health providers can be a further reason for alliance between the two institutions. Political reasons may also further relationships between hospitals and law enforcement, for instance when law enforcement unions or political actors have connections with hospital administrators. There also may be a subtext that hospitals do not want to antagonize law enforcement who they may need in security situations. Hospitals are also employers and, like any other employer, may believe that law enforcement is necessary to respond to their workers concerns of workplace safety.

In a panel discussing law enforcement presence in hospitals, scholar and advocate Jared Martin Drake posited that ideological divestment from law enforcement and carceral authorities is paramount if hospitals are to change their approach.[431] The concept of ideological divestment can be a tool to shift this default response to thinking through how hospitals can be places of sanctuary, reprieve, and refuge from carceral harms, instead of replicating and perpetuating those harms.[432]

Become Cops 1, 41–44 (Univ. of Utah Coll. of Law Rsch. Paper No. 566, 2023) (examining the harms when law enforcement take on medical roles, such as administering ketamine shots).

431 Doctors for America, *Advocacy Grand Rounds: Law Enforcement Presence and Divestment in Hospital Settings*, YouTube, at 14:26 (May 11, 2022), https://www.youtube.com/watch?app=desktop&v=JCtM6QarRWg [https://perma.cc/HPJ6-ZDCB].

432 This concept of sanctuary is borrowed from the immigration context. *See generally* Susan Bibler Coutin, The Culture of Protest: Religious Activism and the U.S. Sanctuary Movement

The need for ideological divestment is justified by medical ethics. Medical ethics of beneficence, justice, patient privacy, and autonomy all point toward a patient-centered approach, and steer away from an approach that is too deferential to law enforcement.[433] Medical ethics, for instance, has been the basis for medical professionals to ignore or not comply with laws that are unjust and that conflict with their duties to patients, like Dr. Adam Ash refusing a forcible search of David Eckert's rectum on ethical grounds and Dr. Michelle Harper who refused a police officer's request to conduct a cavity search after a patient refused to be treated.[434]

An example of using ethics in response to perceived injustice or state harm can be seen in the abortion context. A recent essay in the *New England Journal of Medicine* advocates an ethics-based approach to treatment of patients who may have had abortions now deemed illegal.[435] The authors recognize the ethical dilemmas posed if states were to pass laws mandating reporting of patients with suspected abortions.[436] The response, they argue, should be one based upon the medical profession's codes of ethics.[437] Both the code of ethics promulgated by the ACEP and the AMA contain language, the authors note, that would justify a medical provider's noncompliance with an "unjust" law.[438] The ACEP Code of Ethics states that "[p]ersonal information may only be disclosed when such disclosure is necessary to carry out a stronger conflicting duty, such as a duty to protect an identifiable third party from

(Scott Whiteford & William Derman eds., 1993); Bill Ong Hing, *Immigration Sanctuary Policies: Constitutional and Representative of Good Policing and Good Public Policy*, 2 U.C. Irvine L. Rev. 247 (2012); Medha D. Makhlouf, *Health Care Sanctuaries*, 20 Yale J. Health Pol'y L. & Ethics 1, 6–10 (2021); Song, *Policing the Emergency Room*, *supra* note 11, at 2704. In the United States, hospitals are considered "sensitive locations" where ICE agents cannot enter. *See* U.S. Immigr. and Customs Enf't, U.S. Dep't of Homeland Sec., Immigration Enforcement at Sensitive Locations 2 (2022). However, reports indicate that violations of this protection frequently occur. *See* Physicians for Hum. Rts, Not in my Exam Room: How U.S. Immigration Enforcement is Obstructing Medical Care 3–4 (2019).

433 *See generally* Thomas R. McCormick, *Principles of Bioethics*, Univ. of Wash. Dep't of Bioethics and Humanities, https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics [https://perma.cc/5GW8-5XWD]; *What are the Basic Principles of Medical Ethics?*, Infertility Treatment: An Overview, http://web.stanford.edu/class/siw198q/websites/reprotech/New%20Ways%20of%20Making%20Babies/EthicVoc.htm [https://perma.cc/SNE7-WKS9].

434 Nicholas Kristof, *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/7K5U-635E]; Michelle Harper, The Beauty in Breaking 100–02 (2020).

435 Katie Watson, Maureen Paul, Susan Yanow & Jay Baruch, *Supporting, Not Reporting—Emergency Department Ethics in a Post-*Roe *Era*, 387 New Eng. J. Med. 861, 861 (2022).

436 *Id.*

437 *Id.*

438 *Id.*

serious harm or to comply with a just law."[439] The AMA Code states that "[i]n exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties."[440]

In addition to strengthening an ethics-based approach, centering the concept of dignity can also help hospitals separate carceral logics and practices in their approach toward patient prisoners. Dignity is an important value in patient-centered care. Human dignity has also been suggested as a principle for interpreting constitutional rights and for future criminal justice reform.[441] Dignity can be a powerful frame of thinking through the harms against racial minorities, as can be seen in Professor Fareed Nassor Hayat's conception of "[d]ignity [t]akings upon Black men every time they are confronted by police and forced to choose between dignity and submission."[442]

Centering dignity then could be a way forward. But that is far easier said than done, especially when patients in law enforcement custody and brought before medical professionals are uninsured, Black or of another racial minority group, and labeled a suspect or criminal.[443] Professor Sharon Dolovich identified as a barrier to any progress in prison conditions

> palpable hostility and contempt toward the incarcerated . . . [with] deep roots in the scorn and disgust long evinced in the national consciousness toward a potentially demonized underclass . . . and especially in the virulent race hatred that drove the American carceral project from the start.[444]

Doctors and nurses in outside hospitals are certainly not immune from having such views.

But though difficult, recent mobilization by health professionals shows that a dignity-based approach is not impossible. Professor Dorothy Roberts has defined the abolitionist mission as

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439 *Id.* (quoting *Code of Ethics for Emergency Physicians*, ACEP (Jan. 2017), https://www.acep.org/globalassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf [https://perma.cc/39GG-AP93]).

440 *Id.* Watson et al., *supra* note 435, at 862.

441 Jonathan Simon, *Knowing What We Want: A Decent Society, A Civilized Society, A Civilized System of Justice & A Condition of Dignity*, 151 DAEDALUS 170, 170 (2022) (highlighting Justice Kennedy's statement in *Brown v. Plata* that "prisoners retain the essence of human dignity inherent in all persons"); John D. Castiglione, *Human Dignity Under the Fourth Amendment*, 655 WISC. L. REV. 655, 661 (2008) (positing that dignity offers an important interpretive principle to Fourth Amendment jurisprudence); Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PA. L. REV. 169, 169 (2011) (noting the increasing reliance on dignity and providing a typology of dignity within constitutional jurisprudence).

442 Fareed Nassor Hayat, *Dignity or Death: The Black Male Assertion of the Fourth Amendment*, 83 OHIO ST. L.J. 857, 863 (2022).

443 Simon, *supra* note 441, at 170.

444 Dolovich, *supra* note 17, at 155.

> both dismantling piece by piece the unjust, punitive, terroristic, carceral systems we have now that do not keep people safe or meet their needs, and at the same time simultaneously . . . we have to be building different resources, different networks, different approaches, different ways of thinking that are based on caring and support, and human equality and dignity . . . .[445]

People in the medical arena are beginning this kind of work. Cops Out of Care is grounded in the abolitionist mission.[446] Beginning in 2021, Cops Out of Care convened a nationwide group of health-care providers, public health workers, community members, and organizers. Interrupting Criminalization, an abolitionist movement resource hub for organizers, practitioners, and advocates facilitated discussions and workshops for Cops Out of Care.[447] Cops Out of Care has created various resources based on these sessions, including the "Beyond Do No Harm Principles," to encourage health-care workers to interrupt criminalization by refusing to participate in criminalization and recommitting to caring for people.[448]

In Los Angeles, prompted by concerns of law enforcement and correctional presence in patient treatment settings, physicians have begun a series of community focus groups to gather people's views on law enforcement presence in health care and their ideas for more accessible and better health care at their local hospitals.[449] Their work is guided by the belief that any solution based in human dignity, equality, and a commitment to respect individual humanity must involve the perspectives of people who are most affected by criminalization and mass incarceration.

B. Hospital Solutions

But ethics and principles alone are not enough. Ethics, norms, and principles, without guidance or accountability, allow room for

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445 Ctr. for Racial Just., *Dorothy Roberts: Masterclass in Activism—"Torn Apart,"* Univ. of Mich., at 53:05 (Apr. 5, 2022), https://fordschool.umich.edu/video/2022/dorothy-roberts-masterclass-activism-torn-apart [https://perma.cc/FF4Z-GNQL].

446 The Author participated in the first strategy meeting. *See also Cops Out of Care*, Interrupting Criminalization, https://www.interruptingcriminalization.com/cops-out-of-care [https://perma.cc/LV6M-F5XJ].

447 *See id.* Interrupting Criminalization was founded by Mariame Kaba and Andrea Ritchie. *About Us*, Interrupting Criminalization, https://www.interruptingcriminalization.com/about [https://perma.cc/RLP5-8272].

448 *Beyond Do No Harm*, Interrupting Criminalization (Oct. 27, 2020), https://www.interruptingcriminalization.com/do-no-harm [https://perma.cc/7Q7S-LWWK]; *see also Cops Out of Care*, Interrupting Criminalization, https://www.interruptingcriminalization.com/cops-out-of-care [https://perma.cc/DT8L-TSZ2].

449 The Author is part of this initiative as part of an NIH-funded study.

individual biases or allegiances. A physician could very well state that their ethics lead them to assist police officers in conducting searches and questioning, or to only treat imprisoned patients when they are in guard presence or shackled.[450] Indeed, medical ethics did not stop the experimentation of Black people for medical advancement and other kinds of exploitative actions against racial minority groups and indeed allowed these harms.[451]

Hence, something more definitive than ethics is necessary. Additionally, institutional solutions are critical because the issue itself is an institution-wide one. This is particularly important in hospitals with diverse professional groups and staff, and similarly diverse views. In addition, without institutional guidance, medical providers are put in the position of addressing questions regarding law enforcement presence in an ad hoc manner. Institution-wide solutions would make it so that individual medical staff would not have to make split-decisions based on instinct, bias, or pressure from the carceral authority. This Section sketches out areas in which hospitals can make changes.

To begin with, hospitals should think about how emphasizing patient care could realign current practices and inform policies. In simple terms, hospitals should first think about how they would normally implement clinical care before assessing how to accommodate mandatory and necessary public safety measures. In essence, hospitals should take the position that people are patients first and resist any impulse to uncritically accept police or carceral-based public safety rationales as the norm. When there is not a formal legal mandate or requirement, hospitals should use their own regulations and established patient care, with careful consideration of medical ethics of privacy, autonomy, and dignity. Though this may seem like a negligible point, grounding hospital policies in this way can help hospitals figure out the divergent points between typical patient care and that of patients under carceral custody.

Because patients are under law enforcement custody, hospital policies must also accurately reflect or consider criminal procedure rules. Without their own evaluation of patients' rights vis-à-vis law enforcement, and if they rely on law enforcement policies and representation of criminal procedure, hospitals could be party to infringements of those rights. Law enforcement representations could be erroneous. In one recent example, a physician was told by a law enforcement officer liaison that police officers can take cell phones without warrants; they

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450 For instance, after Dr. Ash refused an invasive search on his patient, the next doctor agreed to conduct numerous procedures on David Eckert. Kristof, *supra* note 434.

451 Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, 8 Hastings Ctr. Rep. 21, 27 (1978).

just cannot access them.[452] Of course, *Riley v. California*[453] does say that warrants are required for cell phone searches, but in *Riley*, the defendant's phone was recovered during a search incident to arrest.[454] *Riley* does not stand for the principle that any person who is *not* under arrest must yield their cell phones to the police. Taking this example, relying on police advice would violate the rights of patients whose phones were taken, just not searched (yet). Hospital lawyers must have a clear understanding of the privacy implications, not just for HIPAA but also for the Fourth Amendment. Otherwise, medical professionals and hospitals could become inadvertent third parties, by acting as the go-between actor relinquishing patient property, conveying patient information, and otherwise asserting themselves in ways that waive patients' constitutional rights.

It may be that hospitals currently develop hospitals with law enforcement input or collaboration.[455] Law enforcement involvement at a certain point may be beneficial to inform law enforcement and to increase the likelihood of buy-in and compliance with hospital protocol. But this approach has many downsides. Policies that try to sync hospital practice with law enforcement obligations will very likely conflict with or be inconsistent with health-care laws and requirements, with the added consideration that law enforcement policies may not always be accurate, or at least more protective interpretations of criminal procedure.

In addition to these general steps, hospitals should take account of specific areas where law enforcement presence affects hospital operations. The below categories sketch out some considerations. This list offers a good starting point for hospitals. The categories are not exhaustive, nor are the solutions offered comprehensive

Use of Hospital Ethicists. Hospitals can draw on their own existing resources on how to deal with difficult conflicts between carceral authorities and patient care. Hospital ethicists routinely provide consultation to determine the best course of action in complicated ethical situations. Such scenarios may include medical aid in dying, withholding and withdrawing treatment, forced feeding, organ donation, and abortion.[456] Medical ethicists have also opined on the implementation of the

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452 Interview with Physician 211 (Jan. 27, 2023) (on file with author).

453 573 U.S. 373 (2014).

454 *Id.* at 378, 403.

455 *See, e.g.*, *Quality & Patient Safety, Health Care and Law Enforcement Collaboration*, Minn. Hosp. Assoc., https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-improvement-topics/workplace-violence-prevention/health-care-law-enforcement-collaborative [https://perma.cc/34CF-728J].

456 *See, e.g.*, Jacob M. Appel, *Ethics Consult: Force-Feed Prisoner on Hunger Strike? MD/JD Weighs In*, MedPageToday (Sept. 25, 2020), https://www.medpagetoday.com/opinion/ethics-consult/88820 [https://perma.cc/LM4L-HFYH]; George J. Annas, *Hunger Strikes at*

death penalty. Thus, it is not unknown territory for a medical ethicist to weigh the interests of the state against the rights and interests of the individual. Hospitals can incorporate already-existing practices of ethical consultations on key questions such as when shackling can or should occur, when guards should or should not be present, and generally when law enforcement or correctional interests are outweighed by minimal risks to safety and the harms to the patient. Some hospitals have already taken such steps to bring in the hospital's ethics committee to weigh in on these issues.[457]

Incorporating Hospital-Based Violence Intervention Programs. Hospitals could bring in hospital-based violent intervention programs ("HVIP") to law enforcement-involved cases. HVIP programs provide patient support, and in that capacity, they can act as intermediaries between police and patients.[458] Already, HVIP programs frequently come into contact with law enforcement and have been critical in identifying the problems with law enforcement presence when dealing with victims of violence.[459] Their program workers are adept at dealing with patients, their families, and law enforcement. These programs can be an important partner and asset for hospitals as they navigate law enforcement presence and patient care.

Law Enforcement Access. The question of access is also an important one to resolve because once law enforcement access treatment areas within the hospital, they are privy to patient belongings, patient statements, and information. Their access to trauma bays, especially in acute trauma interventions, can impinge on care given in those critical moments.

Hospitals are already rethinking patient treatment areas to be more conducive to patient care and privacy.[460] Because access to hospitals is the threshold point from which other issues emanate, this rethinking should include reassessing police access to hospitals. As part of this reassessment hospitals should consider implementing a method of keeping track of police officers or correctional guards as they come

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Guantanamo—Medical Ethics and Human Rights in a "Legal Black Hole," 355 New Eng. J. Med. 1377, 1379 (2006).

457 Interview with Physician 211 (Jan. 27, 2023) (on file with author); Notes on Grand Round Trainings at Hospitals (on file with author).

458 Interview with HVIP Coordinator 28 (June 16, 2022) (on file with author); Interview with Physician 28 (Oct. 7, 2021) (on file with author); Interview with Physician 13 (Dec. 2, 2022) (on file with author).

459 *See* Gallen et al., *supra* note 126, at 649.

460 *See generally* Dana Dubbs, *Privacy Please! Hospitals Take a Closer Look at the Design Implications of Patient Confidentiality*, 16 Health Facilities Mgmt. 20 (2003); Lisa Cisneros, *UC Regents Approve Plan for New Hospital at Parnassus Heights*, UCSF Campus News (May 19, 2022), https://www.ucsf.edu/news/2022/05/422836/uc-regents-approve-plan-new-hospital-parnassus-heights [https://perma.cc/P4VA-QEVN].

in and for or with which patient. This tracking and monitoring by the hospital would alleviate any confusion about the actual legal custody of a patient, whether they are under arrest or not, whether they are incarcerated or not, or whether they are simply part of a criminal investigation. Moreover, even if other areas of law enforcement clinical care are not fully addressed, at least the hospitals and medical providers will know who is in the hospital and why.

Requiring Warrants for Information. Prudent hospitals would also be wise to require court orders, subpoenas, or warrants for disclosures of patient information, especially when a subpoena would normally be required if a party were to seek medical records during litigation. If law enforcement insists on information without subpoenas or warrants, hospitals should record the justification given by law enforcement regarding why formal channels are not available. This is not to say that the requirement of a warrant will sufficiently protect patients but at least warrants provide a layer of oversight and require law enforcement to lay out their justifications for their request

In some circumstances, law enforcement will be able to access information just because they are there. Hospitals should assess how their policies on law enforcement access allow police to overhear information without needing to go through formal channels, and make efforts to eliminate or at least limit those situations.

Patient Belongings. Hospitals should require warrants when police seek to retrieve patient belongings. In addition to this level of protections, hospitals need to think about how police are able to access patient belongings, such as wallets, purses, cell phones, or patient clothing including bloody clothing cut away during trauma interventions. If police are in the position to observe these items, such as in the trauma bay, the police may think they can take these items because they are either discarded or because they were lawfully in a position to observe the incriminating nature. Special care must be given to the trauma bay because trauma patients are acutely vulnerable and are likely to be unable to assert their privacy rights.

Possible measures could include securing patient belongings in bags or in secure areas and make explicit in policies that these belongings continue to belong to patients for the duration of their stay.

One issue may be that patient belongings contain possible contraband. Hospitals could post signs warning patients that contraband is not allowed on hospital premises, giving notice to patients. Such notices, however, will not be sufficient for people who come in with trauma injuries, or unhoused people who may have no choice but to bring all their belongings into the hospital. Some solutions include procedures where hospital staff can discard items. Even in the case of guns, especially in states with open-carry laws, hospitals have an obligation to think

through how they handle these items without defaulting to handing them over to police.

Body Cavity Searches. Requiring warrants must be the default policy for law enforcement requests to have medical procedures conducted without patient consent.[461] Even then, warrants are often not enough of a protection for patients, particularly when it comes to requests for cavity searches. Intrusive procedures on patients have been conducted, including rectal exams and other diagnostic treatment measures pursuant to a warrant, without patient consent and with no incriminating evidence discovered.[462] Hospitals should make it explicit that providers can abstain or decline from invasive procedures that they view as against their medical ethics and that they do not see as being medically warranted.

Security. For security concerns, hospitals should consider how security practices affect patient care. Hospitals should weigh the use of health-based solutions to security against purely law enforcement responses. For instance, hospitals can draw upon their own resources and expertise in dealing with potentially violent or disruptive patients. Even when patients are under handcuffs or shackles, policies could include directions on how to accommodate security while giving patients the space to have private conversations with their medical team. Hospitals could have areas where guards could observe patients but not be in the position to hear their statements. There may even be lower cost steps, like placing white noise machines in certain areas to decrease the likelihood of breaking confidentiality.

Use of Restraints. One place to start with law enforcement handcuffs and shackles may be the existing provisions on shackling of pregnant patients who are under law enforcement custody. But that the fact that problems persist in this area despite legal protections for such patients means that further measures are required. Hospitals may draw from protections accorded to prisoners in the criminal and juvenile legal systems. The government may not indiscriminately shackle adults and young people charged in the criminal and juvenile systems during certain court proceedings.[463] In the juvenile justice arena, many jurisdictions have adopted measures against indiscriminate shackling in court and protections during police interrogations because of the vulnerabilities

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461 *See* Schmerber v. California, 384 U.S. 757, 757–58 (1966); Missouri v. McNeely, 569 U.S. 141, 141 (2013).

462 *See, e.g.*, Sanchez v. Pereira-Castilo, 590 F.3d 31 (1st Cir. 2009); Eckert v. Deming, No. CIV 13–0727, 2015 WL 10383783 (D.N.M. Oct. 31, 2015).

463 *See*, *e.g.*, Deck v. Missouri, 544 U.S. 622, 624 (2005) (holding unconstitutional use of visible shackles during penalty phase of death penalty case); People v. Cruz, 960 N.E.2d 430, 432 (N.Y. 2011) (holding that shackles during trial were in violation of defendant's constitutional rights); Md. Code Ann., Cts. & Jud. Proc. § 3-8A-14.2 (West 2022) (custodial interrogation of a child); Cal. Welf. & Inst. Code § 625.6 (West 2021); 705 Ill. Comp. Stat. 405/5-401.5.

of young people.[464] The same arguments about vulnerability can be made for young patients coming to hospitals in law enforcement or correctional custody, and can also be extended to adult patients who are vulnerable because of their physical and mental condition.

Hospitals can also take intermediate measures to ensure that restraints and shackles do not impede patient recovery. As an example, hospitals can state that medical providers should issue ambulatory orders to ensure that patients who require frequent movement as part of their healing are not unable to leave their bed.

Protecting Physician-Patient Confidentiality. In addition to requiring warrants for patient information, and enacting measures to protect patient conversations with providers from law enforcement, hospitals should figure out other ways to make sure patient confidentiality is preserved. Providers should convey communications to jail or prison staff through electronic means (shared hospital databases or email) rather than through physical papers given to guards.

In addition, if patients are not under formal law enforcement custody, law enforcement should not be allowed to be in the room when patients are meeting with providers or are undergoing tests. Police may be present because the patient is a victim or under investigation, but without some kind of formal custody, hospitals should ensure that patients are not exposed to law enforcement presence in their vulnerable state.

Visits. Access to loved ones, family members, and attorneys is critical to patients. At the same time, security protocols, particularly for people coming from jails or prisons, require changes to hospital policies on visitor access. There are things hospitals can still do. First, hospitals again must make a clear delineation between patients who are under formal police or correctional custody (under arrest or incarcerated), from those that who are not. For the latter category, limitations on visitor access by law enforcement should not be permitted. Any visitation restrictions, or visitor blackouts for these patients need to be justified by law enforcement, preferably in some kind of written form or by law enforcement supervisor approval. In terms of the former category, visitor access has to account for law enforcement policies and security needs. But even then, some measure of access that would help patients' health and their decision-making should be made available that would not compromise security. For instance, conversations on the phone or Zoom facilitated by the care nurse, social worker, or HVIP staff could alleviate the security concerns raised by law enforcement or correctional staff but still allow for vital information and emotional support.

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464 *See* Nat'l Juv. Def. Ctr., Ending the Indiscriminate Shackling of Youth 1 (2014), https://www.defendyouthrights.org/wp-content/uploads/2014/10/Shackling-HR-10.9.14.pdf [https://perma.cc/L9HN-38BA].

End-of-Life Decision-Making. By law, law enforcement cannot make end-of-life determinations unless specifically designated as a surrogate. Yet they do, as seen in the case of Mr. Cummings.[465] Another reason why such situations may arise is because people who have been incarcerated, especially for long periods of time, no longer have friends or family members who can act as surrogates. In those instances, the hospital ethics committee can play a critical role in these end-of-life decision-making scenarios.

Tools for Staff. Hospitals should also make it easy for medical professionals and other staff to respond to law enforcement and correctional presence. In San Francisco, a team of doctors has created a badge buddy—a laminated card listing common scenarios and potential responses to law enforcement requests.[466] Hospitals could also make sure that directions on how to deal with law enforcement and guards are included in hospital checklists or clinical pathways particularly in departments where law enforcement and correctional guards are more prevalent.

Tools for Patients. Finally, patients should be empowered to know their rights when their care intersects with law enforcement and correctional authorities. Hospitals could provide patients with information, similar to a patients' bill of rights, that would complement the protective actions by providers. Some of these educational developments are happening in places across the country.[467]

Data. Hospitals and law enforcement and correctional institutions should be required by the state or federal government to keep data on law enforcement use of hospitals. Hospitals should also track carceral presence and how treatment for carceral patients differs from regular patient care: What kind of restraints are used and how do they interfere with clinical care and treatment? What are the restrictions on visitor access and how did they hinder the treatment of the patient? Another important area is police use of force. Staff should document how law enforcement specifically hindered patient care and the degree to which hospital staff must navigate and witness harmful law enforcement practices.

One concern may be about where this data should be stored at a time when data privacy is a big concern. If the records are kept in a patient's file, notes about law enforcement presence could be harmful to the patient if the records are disclosed to a third party. There are ways to protect patients and collect data. For example, like other public health data collection, this kind of information could be deanonymized

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465 *See supra* Section II.B.3.

466 Notes on Grand Round Trainings at Hospitals (on file with author).

467 Am. C.L. Union of S. Cal. & Frontline Wellness United, Patient Rights: What to Know If You Are Approached by Law Enforcement Officers (2024) (on file with author).

and reported in the same manner as other information hospitals must collect. There may also be good reasons for why a patient might want to access such information, such as if a police officer interrogates them when they are heavily medicated or uses force. Cases against hospitals and medical professionals have been dismissed because the plaintiff did not know who was involved, which is not surprising in situations where the person is a patient undergoing medical treatment.[468] In those instances, hospital records on law enforcement access, such as who entered and why, could be critical and would not have to be recorded in patient health records.

C. More Law and Regulation

The final suggestions offered here are for legal and regulatory measures. Professor Aaron Littman has asserted that "free-world law" has much to offer to improve the oversight of jails and prisons.[469] Littman argues that "free-world regulatory law," including regulatory law in the health law context, "would hold promise as a tool for ameliorating conditions" in jails and prisons."[470] That is certainly true, but when "free-world" law does not sufficiently protect incarcerated people when they enter the free world as prisoners, that free-world law has to do more.

Laws play a major role in integrating and structuring the use of hospitals by correctional and police agencies. EMTALA tells law enforcement and correctional authorities that hospital doors will be open to them.[471] Laws emphasizing security and safety, and the investigatory needs of law enforcement, separately affirm the predominance of law enforcement and correctional authority in these health-care settings where carceral actors do not otherwise have formal authority.

Laws, then, seem to be the basis for the problems outlined here. But more law could also be the solution. One approach could be one that we are now seeing in the post-*Dobbs* world. Some states have passed laws protecting doctors who refuse to perform abortions.[472] In Professor Nadia Sawicki's study of abortion conscience laws, she discovered that most states have a "conscience defense" law, protecting medical providers from medical malpractice suits based upon their refusal to perform abortions.[473] Though these kinds of "conscientious refusal" laws arise

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468 *See* Pratt v. Carroll, No. CV–13–01605, 2015 WL 363283, at *2 (D. Ariz. Jan. 27, 2015) (dismissal of second amended complaint where plaintiff made "no mention of who ordered the urinalysis to be conducted or the catheters to be placed").

469 *See* Littman, *supra* note 10, at 1390–91.

470 *Id.* at 1391.

471 *See supra* section I.B.

472 *See* Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CALIF. L. REV. 1255, 1262 (2020).

473 *Id.*

most frequently in the reproductive health context, laws immunize or protect medical providers from refusal of other kinds of services as well. Such services include end-of-life decision-making, research on embryonic or human stem cells, or the refusal to treat LGBTQ patients.[474]

In the policing arena, the immunity laws are in reverse: if medical providers act against the interests of the patient but in compliance with some law enforcement purpose, they are immunized from civil and criminal liability.[475] Hence, medical providers cannot be held liable for body cavity searches and blood draws conducted without patient consent.[476] With this in mind, one solution could be immunity statutes for medical providers who refuse to acquiesce to state-inflicted violence. An added benefit of these laws is that they signal or affirm that medical providers can act based on their own ethical opinion. Making this ethical decision explicit in law would also educate medical professionals and inform professional guidelines.

But even more than these piecemeal types of legislative measures, broader regulatory and legal measures could increase accountability and oversight of the carceral and hospital institutions. By integrating these more highly regulated entities and professions, and a more pronounced regulatory mechanism, increased law enforcement and correctional accountability could result. This integration can come from regulatory or court oversight.

Health regulatory bodies at both the federal and state levels should address the tension between carceral and health-care differences in approaches to patient care. As Professor Littman states, "Robust application of free-world regulatory law to the carceral state would go a substantial way toward addressing the plight of incarcerated people."[477]

For instance, since EMTALA is one reason why hospitals must take in arrestees and incarcerated people, CMS should promulgate guidance and regulations reconciling the conflicting obligations, standards and practices between health-care settings and correctional environments. Instead of CMS merely recognizing that law enforcement restraints are contrary to health regulations and practice, CMS should issue regulations that balance the competing needs between the health-care system and the correctional and law enforcement authority. CMS can do this

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474 *Id.* at 1264.

475 *See, e.g.*, Ala. Admin Code § 32-5A-194(d) (2023); Ariz. Rev. Stat. Ann. § 28-8283(c) (2023); Alaska Stat. § 09.65.095(a) (2023); Ark. Code Ann. § 16-82-303; Wis. Stat. Ann. § 895.535(1) (2023).

476 *See* Ala. Admin Code § 32-5A-194(d) (2023); Ariz. Rev. Stat. Ann. § 28-8283(c) (2023); Alaska Stat. § 09.65.095(a) (2023); Ark. Code Ann. § 16-82-303; Wis. Stat. Ann. § 895.535(1) (2023).

477 Littman, *supra* note 10, at 1477.

and has done this before.[478] CMS guidance on compassionate care for people on medical parole shows how CMS provides a way to assess medical vulnerability of patients and affirm patient dignity of those under carceral custody.[479] CMS has even weighed in on issues similar to the problems raised here. CMS conducted an investigation of a hospital for conducting procedures on a young patient in juvenile custody without alerting the family and found that the hospital had violated their regulations.[480]

Some steps by CMS could include issuing regulations and guidance on what exactly medical clearance means, especially if the jail where the patient will be discharged to has documented problems with their correctional health care. For instance, if a patient has chronic or serious conditions, any discharge planning to the jail should be reconsidered. Building out health regulations to explicitly incorporate and account for the care of patients in law enforcement custody can also serve as a model for a regulatory framework for correctional health care itself.[481] A more proactive stance by CMS would allow and encourage providers to report violations of standards in care in correctional settings such as delays in care or withholding needed medication. A tangential action could be an expansion of prerelease billing, such as that being piloted in California, which would give CMS even more ability and mandate to provide necessary oversight as the payments will overlap with carceral care.

Another possible CMS intervention is creating an Ombudsman position to mediate incidents between patients who are in law enforcement custody and hospitals, and to offer assistance and advocacy. Similar Medicaid Ombudsman programs already exist for those in nursing homes, assisted living facilities, and care homes.[482] Other Medicaid Ombudsman programs help Medicaid recipients navigate the Medicaid

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478 Dep't of Health & Human Serv., Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals (Dec. 23, 2016) https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-16-21.pdf [https://perma.cc/7PSK-TKZE].

479 *Id.* at 5.

480 CMS Statement of Deficiencies, Case No. 53226 (July 7, 2022) (on file with author).

481 *See* Andrea Armstrong, *Carceral Health Care Is Designed to Fail*, Harvard L. Petrie-Flom Ctr., Bill of Health Blog (Sept. 9, 2022), https://blog.petrieflom.law.harvard.edu/2022/09/09/carceral-health-care-is-designed-to-fail/ [https://perma.cc/8R9T-JEMP]; Michele Dietch, *Independent Oversight Is Essential for a Safe and Healthy Prison System*, Brennan Ctr. for Just. (Nov. 3, 2021), https://www.brennancenter.org/our-work/analysis-opinion/independent-oversight-essential-safe-and-healthy-prison-system [https://perma.cc/GZJ7-E77V].

482 *See* Nancy Archibald Danielle Perra, Alena Tourtellotte & Kenneth Lim, Integrative Care Res. Ctr., State Approaches to Developing and Operating Ombudsman Programs for Demonstrations under the Financial Alignment Initiative (Mar. 2021), https://www.integratedcareresourcecenter.com/sites/default/files/Ombudsman%20Programs%20brief.pdf [https://perma.cc/TM4M-NGZW].

program and help them access different services, housing, legal aid, and programs.[483]

Just as hospitals should collect data, CMS and corresponding state authorities, state attorney general's offices and correctional agencies, and other research entities should collect data on the use of hospitals by law enforcement and correctional authorities. Law enforcement and correctional authorities should be required to keep track of when they bring someone to the hospital under arrest, for how long, and why. This could include when they access patient treatment or diagnostic areas, when they seek information or ask for diagnostic testing, or body cavity searches, and how often reports are made to police and why.

The next set of proposals is directed to the courts. Currently, the courts view the hospital and the emergency rooms as sites not under police control. For example, in *Miranda* inquiries, police questioning in hospitals are not always viewed as custodial interrogations.[484] Medical providers are typically viewed as nonstate actor third parties who can turn over patient belongings or consent to access patients in treatment areas in police seizure of belongings and access to patient treatment areas.[485] If hospitals are part of the carceral infrastructure, these doctrinal rules should change. That outcome would have the dual benefit of allowing carceral actors to be more accountable under the Fourth Amendment as well as hospitals. Such liability would likely incentivize hospitals to develop policies to avoid liability from civil rights claims or other civil actions.

Current criminal procedure doctrines offer other ways to provide new ways of accountability and oversight. As previously discussed, *Estelle v. Gamble* and its progeny are the floor of adequate medical treatment provided to prisoners.[486] Constitutional claims for prison cases also revolve heavily around judicial deference to prison officials under *Turner v. Safley*.[487] The rationale behind prison deference is the expertise of prison authorities: "Running a prison is an inordinately

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483 *See, e.g.*, *Your Advocate for Quality Care*, NC Medicaid Ombudsman, https://ncmedicaidombudsman.org/ [https://perma.cc/F5AX-AAQP].

484 See 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).

485 *See, e.g.*, United States v. Clay, No. 06-CR-83-S, 2006 WL 2385353, at *2 (E.D. Ky. Aug. 17, 2006).

486 Estelle v. Gamble, 429 U.S. 97, 102 (1976).

487 The test in *Turner v. Safley* is the following: (1) whether there is a "'valid, rational connection' between the prison regulation and the legitimate governmental interest put forward to justify it," (2) "whether there is an alternative means of exercising the right that remain open to prison inmates," (3) "the impact accommodation of the asserted constitutional right will have on guards and other inmates," and (4) whether there are "ready alternatives" to the regulation. 482 U.S. 78, 89–90 (1986) (quoting Block v. Rutherford, 468 U.S. 576, 586 (1984)).

difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government."[488] The *Turner* test applies to corrections regulations as well as correctional policies and practices.[489] *Turner* deference is not dissimilar from the deference to police discretion accorded to police in doctrine. Constitutional criminal procedure is replete with examples of courts wary of formulating rules that hamper the on-the-ground dynamic work of law enforcement.

When it comes to medical care, the deference logic should have limits. Prison officials and police officers are not medical experts. Deference should be accorded to health law and medical authorities. Keeping in mind security considerations, questions about restraints, visitor restrictions, and other aspects of medical care for prisoners in hospitals should defer to *both* medical expertise as well as penal expertise. Certainly, *Turner* deference has been criticized as a weak check on the problems in jails and prisons.[490] But modifying *Turner* to encompass other types of expertise paves the way for a more robust accountability measure for correctional authorities.

Another doctrine stemming from the Fifth and Sixth Amendment right to counsel could be applied to the medical providers to shore up accountability and incentives in this area.[491] *Strickland v. Washington*[492] provides a standard of "reasonable competence" by defense counsel.[493] The standard has been much criticized from all sides as insufficient, with even drunk and asleep counsel passing the low bar.[494] But even though the bar is set low for attorney conduct, *Strickland* puts attorney conduct on the table for consideration. Partly because of *Strickland*, we have attorney standards, practice guidelines, and other incentives for attorneys to prepare for cases, adhere to client loyalty, and maintain professional standards. A similar *Strickland*-type of rule for medical professionals could have the same kind of effects in the health arena: first, opening another pathway of constitutional liability directly on the

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488 *Id.* at 84–85.

489 Shay, *supra* note 224, at 341; *see also* Von Minden v. Jankowski, 268 Fed. App'x 352, 354 (5th Cir. 2008); Veney v. Wyche, 293 F.3d 726, 732, 734 (4th Cir. 2002); Bowman v. Beasley, 8 Fed. App'x 175, 178–79 (4th Cir. 2001).

490 *See, e.g.*, William M. Roth, Note, Turner v. Safley: *The Supreme Court Further Confuses Prisoners' Constitutional Rights*, 22 Loy. L.A. L. Rev. 667, 686–91 (1989).

491 U.S. Const. amends. V–VI.

492 466 U.S. 668 (1984).

493 *Id.* at 690–91.

494 *See* Jeffrey L. Kirchmeier, *Drink,* Drugs, and *Drowsiness: The Constitutional Right to Effective Assistance of Counsel and the* Strickland *Prejudice Requirement*, 75 Neb. L. Rev. 425, 455–60 (1996) (citing Berry v. King, 765 F.2d 451, 454 (5th Cir. 1985), *cert. denied*, 476 U.S. 1164 (1986)); Burnett v. Collins, 982 F.2d 922, 930 (5th Cir. 1993); Fowler v. Parratt, 682 F.2d 746, 750 (8th Cir. 1982); Young v. Zant, 727 F.2d 1489, 1492–93 (11th Cir. 1984), *cert. denied*, 470 U.S. 1009 (1985); McFarland v. Scott, 512 U.S. 1256, 1259–60 (1994) (Blackmun, J., dissenting).

medical provider; and second, again incentivizing hospitals and medical professional organizations to meaningfully take up the charge of setting up guidelines for medical professionals who interact with law enforcement.

Lastly, just as hospitals and medical professionals need to shift their mentality on how to treat patient prisoners, police and correctional authorities must undergo that same shift too. Ultimately, the byproduct of these interventions could be beneficial in areas beyond police and carceral authorities' interactions with social institutions by educating them on the boundaries of their power.

Conclusion

By laying out the case that hospitals are part of the carceral infrastructure, this Article hopes to invigorate stakeholders to reexamine the relationship between hospitals and carceral agencies. More and more medical professions are paying attention. But their actions are not enough.

Hospital administrations should assess the harms to patient care, and the degree their providers are drawn into ethical, moral, and legal quandaries because of hospital administrations' hands-off approach to law enforcement and correctional involvement. Law enforcement and correctional authorities, especially the rank-and-file, should be educated on medical decision-making and the reasons behind privacy rules and norms. Advocacy groups should pay more attention to this space to resolve uncertainty and gaps in the laws. And, finally, legislatures and courts must recognize that giving police and correctional authorities too much discretion in hospitals leads to harms not just for the patients under carceral control but for society as a whole.