EVERY HOSPITAL IS FERGUSON V. CITY OF CHARLESTON

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I. INTRODUCTION

In Professor Wendy Bach's powerful book, *Prosecuting Poverty, Criminalizing Care*, she tells the story of women prosecuted for a new crime passed by the Tennessee legislature in 2013—fetal assault.[1] This new law was designed to criminalize the conduct of drug use by women during their pregnancies.[2] Over the two years the law was in effect, 120 women were prosecuted for fetal assault. In nearly all the cases, vital information for the arrest and prosecution came from medical providers.[3]

More than thirty years before these prosecutions, the Medical Center of South Carolina (MUSC), a hospital in Charleston, South Carolina, instituted a policy with local law enforcement partners of drug testing pregnant patients to combat what they viewed as an epidemic of women giving birth to crack-addicted babies.[4] Pursuant to the policy, women patients who tested positive for cocaine were referred for drug treatment, arrested, and/or prosecuted.[5] Just like the women in the Tennessee prosecutions, the referred women were largely poor and suspected of harming their babies by their drug use.[6] And just like the Tennessee cases, the women had been identified for arrest and prosecution with the assistance of medical providers.[7]

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1. WENDY A. BACH, PROSECUTING POVERTY, CRIMINALIZING CARE 53 (2022).
2. *Id*. at 14.
3. *Id*. at 129.
4. Ferguson v. City of Charleston, 532 U.S. 67, 70-72 (2001).
5. *See id.* at 72.
6. *See* BACH, *supra* note 1, at 55.
7. *See id.* at 53-54.

Several of the women patients of MUSC brought a legal challenge against the city of Charleston for violating their Fourth Amendment rights.[8] They lost at jury trial and at the appellate level. But in a 6-3 decision, the Supreme Court held that the policy—developed and implemented by a public hospital in Charleston, South Carolina, with local law enforcement—violated the plaintiffs' Fourth Amendment rights.[9]

Ferguson was decided twelve years before the Tennessee prosecutions at the heart of Professor Bach's investigation. Yet how is it that events that sound like the information-sharing and cooperative arrangement between hospital staff and law enforcement in *Ferguson* still occur? And Tennessee is not an isolated event. Law enforcement routinely interacts with and receives cooperation from hospital workers across the country. Reports by news media, reproductive rights organizations, scholars, and medical reports have shown time and time again that medical providers instigated or contributed to investigations of women suspected of criminal conduct during their pregnancies.[10] Outside the reproductive context, the interactions between law enforcement and hospitals occur regularly, with law enforcement accompanying patients to emergency rooms, serving as security, guarding incarcerated patients, and conducting investigations.[11]

In my prior work, I pointed to *Ferguson v. City of Charleston* as a potential vehicle to limit policing in hospitals and protect the privacy of vulnerable patients.[12] This essay expands on that argument by positing that *Ferguson* imparts broader lessons about the regular interactions and sharing of information between hospitals and law enforcement.

At first glance, *Ferguson* would seem to have some but limited applicability. *Ferguson* dealt with a specific policy reflecting a concerted law enforcement and hospital plan to address substance abuse addiction of

8. *See Ferguson*, 532 U.S. at 67.

9. *Id.* at 86.

10. *See generally* LAURA HUSS ET AL., IF/WHEN/HOW: LAWYERING FOR REPRODUCTIVE JUSTICE, *SELF-CARE, CRIMINALIZED: AUGUST 2022 PRELIMINARY FINDINGS* (2022), https://ifwhenhow.org/wp-content/uploads/2023/06/22_08_SMA-Criminalization-Research-Preliminary-Release-Findings-Brief_FINAL.pdf.

11. *See* Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646, 2660-64 (2021); 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).

12. *See* Hannah H. Janeway, Shamsher Samra & Ji Seon Song, *An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department*, 78 ANNALS EMERGENCY MED. 1, 2 (2021); *see* Ji Seon Song, *Cops in Scrubs*, 48 FLA. STATE U. L. REV. 862, 913 (2021).

pregnant women.[13] But *Ferguson* should not be interpreted as simply promulgating the rule that what the hospital and law enforcement did was unlawful only because it was recorded in formal hospital policy and pursuant to a formal partnership with criminal legal system actors.[14] Even if relationships between hospitals and law enforcement agencies may not be based on formalized written policies, as in *Ferguson*, they can be just as routine. Informal preexisting relationships and arrangements between hospitals and law enforcement actors obviate the need to develop formal policies of cooperation and collaboration. The same arrangements may still be geared towards law enforcement purposes when informal and routine collaborations between hospitals and law enforcement lead to evidence-gathering, arrests, and prosecutions.[15] Taking a broader view of the underlying rationale behind *Ferguson* and applying it to these other scenarios allows us to begin deciphering the proper and lawful limits of collaboration between law enforcement and hospitals.

Rethinking *Ferguson*'s application to police-hospital relationships more broadly is especially necessary in this current era of abortion criminalization brought on by the Supreme Court's decision in *Dobbs v. Jackson's Women's Health Organization*.[16] Renewed and urgent attention is being paid to the role of hospitals and medical providers in abortion investigations. *Dobbs* has also brought abortion investigations back into the arena of criminal procedure and criminal law, prompting criminal legal scholars to dissect the importance of *Dobbs* on a range of criminal law and procedure questions.[17]

Part II summarizes the Court's decision in *Ferguson*, focusing on the Court's characterization of the hospital and medical professionals and their part in the drug testing program. Part III assesses the narrow interpretation of *Ferguson,* particularly by the medical community. Part IV asks what a more expansive reading of *Ferguson* means for hospitals in their interactions with police.

13. *See* Janeway, Samra & Song, *supra* note 12, at 2.

14. *See id.* at 2-3.

15. *See id.*

16. Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

17. *See e.g.* Sam Kamin, Katz *and* Dobbs*: Imagining the Fourth Amendment Without a Right to Privacy*, 101 TEX. L. REV. 1 (2022); Elizabeth E. Joh, *Fourth Amendment Rights as Abortion Rights*, N.Y.U. L. R. F. (Oct. 24, 2022); Aziz Z. Huq & Rebecca Wexler, *Digital Privacy For Reproductive-Choice in the Post-Roe Era*, 98 N.Y.U. L. REV. 555 (2023);

II. THE ROLE OF THE HOSPITAL IN *FERGUSON*

In *Ferguson v. City of Charleston*, the Supreme Court was faced with a drug testing program at the Medical University of South Carolina Hospital (MUSC) in Charleston, South Carolina.[18] The Court framed the issue in two ways. The Court asked "whether a state hospital's performance of a diagnostic test to obtain evidence of a patient's criminal conduct for law enforcement purposes is an unreasonable search if the patient has not consented to the procedure."[19] The Court also framed the issue as "whether the interest in using the threat of criminal sanctions to deter pregnant women from using cocaine can justify a departure from the general rule that an official nonconsensual search is unconstitutional if not authorized by a valid warrant."[20]

The opinion set out the hospital's involvement as follows. For some time, MUSC staff had been concerned about an "apparent increase in the use of cocaine" by pregnant patients receiving prenatal care.[21] To address the concern, the hospital ordered drug screens on urine samples taken from maternity patients and if the samples tested positive, referred those patients to a county commission for substance abuse counseling and treatment.[22] The Court recounted that "despite the referrals, the incidence of cocaine use among the patients . . . did not appear to change."[23] At some point, Nurse Shirley Brown of MUSC-Charleston heard a news story over the radio about a policy implemented by a prosecutor in a neighboring county where pregnant women who tested positive for cocaine were then arrested.[24] Her initial contact with a local Charleston prosecutor led to the convening of a task force comprised of law enforcement and hospital administration.[25] The task force developed a policy intended to identify patients who used drugs, refer them for treatment, and provided criteria for the arrest and prosecution of women who tested positive.[26]

Not all pregnant patients were tested under the policy.[27] The policy provided that a patient should be tested if she met one or more of nine criteria,

18. Ferguson v. City of Charleston, 532 U.S. 67, 69-70 (2001).
19. *Id.*
20. *Id.* at 70.
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.* at 70-71.
26. *Id.* at 71-72.
27. *Id.* at 71.

all dealing with the extent of prenatal care, the condition of the fetus, and history of substance abuse.[28]

Two protocols specifically detailed law enforcement involvement.[29] If the patient had not given birth yet, law enforcement would be notified only after a second positive test or if the patient missed an appointment with a substance abuse counselor.[30] An earlier version of the protocol for patients who had given birth provided that if a woman tested positive after birth, law enforcement would be promptly notified, and the woman arrested.[31] A modification was made to this mandatory arrest allowing a woman toavoid arrest if she consented to drug treatment.[32] As the Court noted, "[d]espite the conditional description of the first category," when the policy was first rolled out, law enforcement were notified of positive drug tests and the pregnant patients were immediately arrested.[33] The protocols included procedures for obtaining consent and details regarding possible criminal charges depending on the length of the pregnancy at the time of the positive drug results.[34]

The Court held that the drug tests under the policy violated the Fourth Amendment as they were searches conducted without consent and without a valid warrant.[35] The majority decision assumed that the tests were performed without "informed consent" and analyzed the case through the "special needs" doctrine, as had the Fourth Circuit.[36] The Court found that the "immediate objective of the searches was to generate evidence *for law enforcement purposes* in order to reach" what may have been the ultimate purpose—to get the women into substance abuse treatment and off drugs.[37] The Court stated:

> Given the primary purpose of the Charleston program, which was to use the threat of arrest and prosecution in order to force women into treatment, and given the extensive involvement of law enforcement officials at every stage

28. *Id.* n.4 ("Those criteria were as follows: 1. No prenatal care; 2. Late prenatal care after 24 weeks gestation; 3. Incomplete prenatal care; 4. Abruptio placentae; 5. Intrauterine fetal death; 6. Preterm labor 'of no obvious cause'; 7. IUGR [intrauterine growth retardation] 'of no obvious case'; 8. Previously known drug or alcohol abuse; 9. Unexplained congenital anomalies.").

29. *Id.* at 72.

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.* at 74 n.5.

34. *Id.* at 72.

35. *Id.* at 86.

36. *Id.* at 74, 76.

37. *Id.* at 82-83.

> of the policy, this case simply does not fit within the closely guarded category of "special needs."[38]

Unlike other drug-testing programs that fell within the "special needs doctrine," the e program in *Ferguson* failed the critical element that the asserted purpose be a non-law enforcement aim. On the contrary, "the central and indispensable feature of the [MUSC] policy from its inception was the use of law enforcement to coerce patients into substance abuse treatment."[39] The Court distinguished the information-sharing authorized by the policy from reporting requirements imposed on medical providers for certain types of injuries.[40] It noted that the "initial and continuing focus of the policy was on the arrest and prosecution of drug-abusing mothers."[41] As evidence of the law enforcement focus, the Court pointed out that the document codified the police operational guidelines, including chain of custody requirements, range of possible criminal charges, and logistics of police notification and arrest.[42] The policy did not mention anything about medical treatment, either for the mother or the infant; instead, it focused on addiction treatment for the mother.[43] Further, prosecutors and police were "extensively involved in the day-to-day administration of the policy," from the initial development through the application of the policy.[44] The Court noted the amount of involvement of law enforcement in administering the drug-testing program and collaboration between hospital staff and law enforcement.[45] MUSC staff called the police department, filed complaints, informed police who had tested positive, and coordinated in-hospital arrest.[46] Police and prosecutors decided who would receive reports and what would be in the reports, helped determine procedures for performing drug screens, had access to medical files, routinely attended substance abuse team meetings, regularly received copies of team documents discussing progress of women, and coordinated timing and circumstances of arrest with MUSC, in particular with Nurse Brown.[47]

As the program did not fall within the parameters of the special needs doctrine, the Court found it to be unconstitutional because the searches were conducted without a warrant andthat the nine criteria used to identify the

38. *Id.* at 84.
39. *Id.* at 80.
40. *Id.* at 80-81.
41. *Id.* at 82.
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*

women did not provide probable cause or reasonable suspicion that they used cocaine.[48]

III. THE NARROW INTERPRETATION OF *FERGUSON*

What iss the significance of *Ferguson*? The Court's decision was a victory for the plaintiffs.[49] But the decision was not needed to change MUSC's practices. By the time the decision was announced, the program at MUSC had long been put to a stop. The lawsuit had spurred regulatory investigations of the hospital's practices. In 1994, MUSC discontinued the policy after the Office of Civil Rights Division of the Department of Health and Human Services threatened to cancel federal funding.[50] The Federal Office of Protection from Research Risks conducted a separate investigation and placed MUSC on probation for unethical human experimentation.[51]

Beyond its effect on the plaintiffs and the hospital, *Ferguson* had the potential to have a broader impact on the criminalization of pregnant women and law enforcement interactions with medical providers more generally. In fact, *Ferguson* has been viewed quite narrowly. Even though *Ferguson* was a case that recognized the Fourth Amendment rights of the women subjected to drug testing, the case's criminal procedure implications have largely been confined to the special needs doctrine, as an example of a program found to be unconstitutional because of its explicit law enforcement purpose.[52]

In the medical and health fields, *Ferguson* has also been interpreted to have limited applicability. Shortly after the Court's decision, an article appeared in the *New England Journal of Medicine* providing a summary of *Ferguson*.[53] The authors concluded: "Since the university's policy was discontinued in 1994, and since no other hospital or state in the country has adopted such a policy, the Court's decision has no immediate effect on medical practice. It will, however, discourage others from adopting a similar policy."[54]

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48. *Id.* at 76-77.

49. *Id.* at 67-68.

50. Kimani Paul-Emile, *The Charleston Policy: Substance or Abuse?*, 4 MICH. J. RACE & L. 325, 329 (1999).

51. *Id.*

52. JOSHUA DRESSLER ET AL., UNDERSTANDING CRIMINAL PROCEDURE: INVESTIGATION (7th ed. 2017); WAYNE R. LAFAVE ET AL., CRIMINAL PROCEDURE 326 (6th ed. 2009); RUSSELL L. WEAVER ET AL., PRINCIPLES OF CRIMINAL PROCEDURE 205-07 (7th ed. 2021).

53. George J. Annas, *Testing Poor Pregnant Women For Cocaine – Physicians as Police Investigators*, 344 NEW ENG. J. MED. 1729 (2001).

54. *Id.* at 1730.

Ferguson most frequently appears in medical literature as guidance for drug testing pregnant patients, patients consent for those drug tests, and the medical ethics of drug testing.[55] The same is true of health law journals that focus on medicine.[56] In one medical journal article published in the *American Medical Association Journal of Ethics* a few years after the decision, the author explains how, after *Ferguson*, hospitals "are now able to craft drug testing and treatment policies [for pregnant women] that are both constitutional and ethically sound."[57] Responding directly to the Court's rationales, the author recommends that if hospitals are performing tests for the specific purpose of gathering evidence for law enforcement, hospitals must fully inform patients of their Fourth Amendment rights and to emphasize medical treatment and medical care in any drug testing policies or protocols.[58] One of the few, if only, descriptions of *Ferguson*'s broader significance to policing and privacy can be found in legal scholar Jennifer Oliva's elucidation of law enforcement surveillance of medical professionals and patients through prescription drug monitoring databases.[59]

Part of the reason why *Ferguson* has been perceived as having limited applicability is the special needs doctrine doctrinal lens through which the Court analyzed *Ferguson*.[60] The doctrine, with its origin in *New Jersey v. T.L.O.*,[61] deals specifically with programs such as law enforcement checkpoints, drug testing at schools or workplaces, or other kinds of administrative searches.[62] *Ferguson* certainly was a program in the same way as drug testing programs at schools or workplaces. Because the bulk of the law enforcement interactions in healthcare settings are not the result of specific programs or policies but larger structural factors, it may not be obvious that *Ferguson* applies.

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55. Yesenia M. Perez, Ferguson v. City of Charleston *and Criminalizing Drug Use During Pregnancy*, 15 AM. MED. ASS'N J. ETHICS 771 (2013); Mary Faith Marshall et al., *Ferguson v. City of Charleston Redux: Motivated Reasoning and Coercive Interventions in Pregnancy*, 146 PEDIATRICS S86 (2020).

56. Brian H. Bornstein, *Seize This Urine Test: The Implications of* Ferguson v. City of Charleston *for Drug Testing During Pregnancy*, 6 J. MED. & L. 65 (2001).

57. Kristin Pulatie, *The Legality of Drug-Testing Procedures for Pregnant Women*, 10 AM. MED. ASS'N J. ETHICS 41, 43 (2008).

58. *Id.*

59. Jennifer D. Oliva, *Prescription-Drug Policing: The Right to Health-Information Privacy Pre- and Post-*Carpenter, 69 DUKE L. J. 775, 811-14 (2020).

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

61. New Jersey v. T.L.O., 469 U.S. 325 (1985).

62. City of Indianapolis v. Edmond, 531 U.S. 32 (2000); Mich. Dep't of State Police v. Sitz, 496 U.S. 444 (1990); Skinner v. Ry. Lab. Execs.' Ass'n, 489 U.S. 602 (1990); O'Connor v. Ortega, 480 U.S. 709 (1987).

But *Ferguson* tells us more, particularly about the behavior of hospitals and medical providers. Now, as it is, it is true that criminal procedureis far from an ideal way of guiding conduct. Scholars have made a multitude of arguments to this effect.[63] As Professor Aziz Huq has stated, criminal procedure reflects what police do, or a bottom-up, rather than a top-down, way of determining rights.[64] Still, criminal procedure cases, and particularly Supreme Court decisions, are our prime regulator of law enforcement conduct.

Moreover, these criminal procedure rules have broader application beyond law enforcement to the conduct of non-law enforcement actors who participate in policing actions. Admittedly, the problems of criminal procedure as regulating conduct are compounded when non law-enforcement actors who are not well versed in constitutional criminal procedure, interpret and generalize the rules arising from cases to their future behavior.These problems of interpretation and generalization can be seen in medical literature. In one recent article on the legal and ethical dimensions to law enforcement information gathering in the emergency department, the authors include a brief discussion on the Fourth Amendment as a consideration in dealing with law enforcement investigations in the ED.[65] The authors do not mention *Ferguson* as part of the Fourth Amendment line of cases they should consider.[66] Instead, they focus on a set of cases dealing with surgical and diagnostic procedures, like the removal of a bullet in *Winston v. Lee*, stomach pumping in the 1957 case of *Rochin v. California*, and a series of the Supreme Court's decisions on blood draws.[67] These cases deal primarily with the privacy implications of bodily intrusions and not on the collaborative conduct of medical providers. In citing the very latest decision by the Supreme Court, *Mitchell v. Wisconsin*, the authors also imprecisely state that "the court ruled that a blood specimen drawn to obtain an alcohol level from an unconscious patient was admissible as evidence, because the phlebotomy was justified under the state's law of implied consent."[68] *Mitchell v. Wisconsin* was decided by a plurality without a controlling majority rationale.[69] Though the

63. Rachel A. Harmon, *The Problem of Policing*, 110 MICH. L. REV. 761, 763 (2012); Barry Friedman & Maria Ponomarenko, *Democratic Policing*, 90 N.Y.U. L. REV. 1827 (2015); Joanna C. Schwartz, *Qualified Immunity's Boldest Lie*, 88 U. CHI. L. REV. 605 (2021).

64. *See generally* Aziz Z. Huq, *Fourth Amendment Gloss*, 113 Nw. U. L. Rev. 701 (2019).

65. Jeremy R. Simon et al., *Law Enforcement Information Gathering in the Emergency Department: Legal and Ethical Background and Practical Approaches*, 4 J. AM. COLL. EMERGENCY PHYSICIANS OPEN 1, 2 (2023).

66. *Id.*

67. *Id.* at 2-3.

68. *Id.*

69. Mitchell v. Wisconsin, 139 S. Ct. 2525 (2019).

are unique settings when it comes to administrative searches. Medical providers are governed by an enormous array of laws and regulations, yet the Court paid little attention to this vast regulatory apparatus other than medical providers' mandatory reporting obligations.[74] Ethical principles of autonomy, beneficence, non-maleficence, and justice apply to medical providers. The Court dealt rather meagerly with questions of bioethics, giving a truncated account of the ethics and health law and regulatory system.[75] It did cite the American Medical Association's *amicus brief* when acknowledging that "[t]he reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent."[76]

Even though the Court did not fully address the uniqueness of hospitals in the context of administrative searches, the Court had before it details about MUSC that bears many similarities to the ongoing dynamics of policing in healthcare settings. Hospitals like MUSC-Charleston have a higher likelihood of law enforcement presence. MUSC-Charleston is the city's only Level I trauma center.[77] It takes on the majority of the publicly funded medical care in the Charleston area.[78] At the time of the *Ferguson* litigation, it "was the only hospital within a 50 mile radius providing obstetric care for indigent and Medicaid sponsored patients."[79] It served a large minority population. MUSC's Black patients represented seventy percent of its patients, a disproportionately greater amount than compared to Charleston's population as a whole (thirty percent Black) and compared to other hospitals where Black patients comprised only a third of their patients.[80]

MUSC-Charleston also appeared to be a site identified by law enforcement as more receptive to the kind of law enforcement collaborative policy implemented. As the plaintiffs' attorney noted in their brief before the Supreme Court, "Although the jurisdiction of the Solicitor and the police extended to several hospitals in the Charleston area, Respondents applied the Search Policy only at MUSC."[81] The general counsel at MUSC also

74. *Ferguson*, 532 U.S. at 90.

75. Schuyler Frautschi, *Understanding the Public Health Policies Behind* Ferguson, 27 N.Y.U. REV. L & SOC. CHANGE 587, 597-98 (2001); *Ferguson*, 532 U.S. at 67.

76. *See Trauma Center*, MUSC HEALTH, https://muschealth.org/medical-services/emergency/trauma (last visited Nov. 9, 2023).

77. *Id.*

78. *See* Paul-Emile, *supra* note 50, at 349.

79. *See id.* at 350.

80. *Id.*

81. Brief of Appellants at 11, Ferguson v. City of Charleston, 532 U.S. 67 (2001) (No. 99-936).

acknowledged that, given that MUSC was public, policy implementors were given "probably more latitude" than they would have at a private hospital.[82] This estimation was echoed by a MUSC physician who stated "that implementing the policy at a private hospital 'would cause too much trouble, too much of a problem.'"[83]

Police and prosecutors and medical providers at MUSC worked together to identify people who were engaged in criminal behavior for the purpose of possible prosecution.[84] It is a mistake to only draw lessons from *Ferguson* limited lessons about the lawfulness of the specific drug testing and prosecution program.. *Ferguson* should be viewed as just one example of the kind of routine collaboration between hospitals and law enforcement that occur daily in hospitals all over the United States.

IV. APPLYING A BROADER *FERGUSON* RULE

Different kinds of law enforcement agencies come into hospitals for various reasons. As emergency first responders, police enter hospitals with trauma patients.[85] Police are also there to investigate; they question patients and gather evidence. As the Court noted in *Ferguson*, medical professionals are legally obligated to report certain types of injuries to authorities.[86] These reports may lead to visits by law enforcementI as seen in the case of Lizelle Herrera , where a report by a medical provider of a suspected self-induced abortion led to Ms. Herrera's arrest and subsequent murder charge later dismissed by the prosecution.[87] Exceptions to health privacy laws allow hospitals to disclose information to law enforcement.[88] Hospitals also interact with law enforcement to provide medical care to people under law enforcement custody.[89] Just this last year, a separate arm of MUSC entered into a contract with the South Carolina Department of Corrections so that a dedicated wing of the hospital would provide care for incarcerated patients.[90]

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82. Paul-Emile, *supra* note 50, at 349 n.113.

83. *Id*. at 350 n. 113.

84. Ferguson v. City of Charleston*,* 532 U.S. 67, 71-73 (2001).

85. *See* Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646, 2661 (2021).

86. *Ferguson,* 532 U.S. at 80-81.

87. *See* Caroline Kitchener, et al., *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/.

88. *See* HIPAA Security Rule, 45 C.F.R. § 160 (2023); *id.* § 164(A); *id.* § 164(C).

89. *See* Ji Seon Song, *Patient or Prisoner*, 92 GEO. WASH. L. REV. 1, 8 (2024).

90. *MUSC Health, S.C. Dept. of Corrections Enter Partnership for Health Care of Incarcerated People*, MUSC (Apr. 28, 2021), https://web.musc.edu/about/leadership/institutional-offices/communications/pamr/news-releases/2021/musc-health-sc-dept-of-corrections-enter-partnership-for-health-care-of-incarcerated-people.

Security is another important reason that explains police presence in hospitals. Workplace safety has become a paramount concern for medical workers. Injuries to medical professionals by patients, or from visitors, prompt hospitals to seek protection by police agencies. All these interactions increase the likelihood of cooperation between law enforcement and hospital and may also engender a sense of shared affinity between these groups of professionals.

Some of these interactions may be formalized. *n.* There may be a contractual arrangement between a law enforcement agency and a hospital for providing care for inmates, or for providing security for the hospital. There may be formalized policies governing body searches, or security and custody of patients under law enforcement custody. Many interactions, however, occur outside of formal policy.

Such interactions with police by hospital workers result in a wide range of information sharing between medical providers and law enforcement. Information shared could include reports of suspected crimes pertinent to our current era of abortion criminalization, such as self-induced abortions or the use of drugs by pregnant women, as well as broader suspicions of abuse, gun violence, and alcohol-related crimes. And it's not just information. These routine interactions between hospital workers and law enforcement can lead to interrogations of patients as law enforcement are given access to treatment areas, and the handing over of patient property and other potential evidence, including evidence obtained through medical procedures.

Even without a formal policy to this effect, many interactions between hospitals and law enforcement have the law enforcement purpose of generating evidence for police investigations, and have nothing to do with medical care. Indeed, in many instances, police interactions impede medical care. If these interactions that have clear law enforcement purposes are not due to a specific policy or program, how can one apply *Ferguson* to the realities of hospitals' day-to-day interactions with law enforcement? If we took a broader view of a hospital's general approach to police presence as a type of program or policy, then how might that hospital's behavior be evaluated under *Ferguson*? This Part fleshes out the broader lessons of *Ferguson* by analyzing its applicability to a hypothetical hospital referred to as Hospital A.

A. The Hospital A is Not a State Hospital

The *Ferguson* Court quickly disposed of the state actor question: whether a hospital as a non-law enforcement actor could be subject to Fourth

Amendment liability.[91] In *Ferguson*, the state actor question was an easy call. First, the issue was already agreed to by the parties.[92] MUSC is also a state hospital, its staff members were government actors subject to the Fourth Amendment.[93] But what if a hospital is not a state hospital? Many hospitals in the United States are not public.[94] The number of public hospitals has declined in recent decades.[95] Financial pressures have also forced hospital closures and consolidations.[96] Hospitals with trauma facilities may be teaching or nonprofit hospitals.

The status of public or private does not necessarily correspond to the presence or lack of presence of law enforcement. Many private hospitals may share the same demographic of patients as public hospitals and may also have the same amount of law enforcement presence and investigation.

Hospitals may think that their non-public status means that *Ferguson* does not apply to them. It is true that the state actor question for the purposes of Fourth Amendment liability is much more clear-cut for a public hospital than a private hospital. But the question of Fourth Amendment liability and state action is not summarily resolved in favor of the hospital because the hospital is not public.[97] If a medical professional is acting at the direction of a police officer, then even a private doctor or an employee of a private hospital cannot escape constitutional liability.[98] If a hospital is acting as a government actor, or its actions are sufficiently entangled with those of a government actor, then the state action doctrine provides that the hospital qualifies as a state actor.[99]

B. The Hospital A Does Not Have Written Policies About Its Collaborations with Law Enforcement for the Purpose of Prosecuting

91. *Ferguson,* 532 U.S. at 76.

92. Ferguson v. City of Charleston, 186 F.3d 469, 477 (4th Cir. 1999) ("The parties evidently have agreed throughout this litigation that MUSC is a state hospital and that MUSC employees therefore are government actors.").

93. *Ferguson*, 532 U.S. at 76.

94. *See* Krysten Crawford, *Study: When Public Hospitals Go Private, Low-Income Patients Lose*, STAN. INST. FOR ECON. POL'Y RSCH. (Jan. 9, 2023), https://siepr.stanford.edu/news/study-when-public-hospitals-go-private-low-income-patients-lose#:~:text=As%20of%202020%2C%20roughly%2080,profit%20or%20for%2Dprofit%20organizations.

95. *See* Crawford, *supra* note 94.

96. *See id.*

97. *See* Rawson v. Recovery Innovations, Inc., 975 F.3d 742, 745-53, (9th Cir. 2020).

98. *See id.*

99. *See id.*

Patients

As mentioned above, many law enforcement interactions with hospitals are not subject to written policies.[100] But the lack of policies should not ease Hospital A's concerns. Routine presence permits at the very least passive acquiescence with the same kind of passing of information and collaboration for the purpose of law enforcement ends—arrest and prosecution—that have nothing to do with medical treatment. If Hospital A has made decisions about hospital access to police, given the green light to hospital providers facilitating police access to patient property and information, as well as to patients themselves, this amounts to an ongoing pattern or practice by Hospital A, borrowing from the civil rights lexicon. A pattern or practice by Hospital A amounting to a systematic collaboration with law enforcement for the purpose of law enforcement ends, not medical ends, could amount to the same kind of collaboration at issue in *Ferguson*.

C. Hospital A Does Not Initiate the Contact with Police

Hospital A may believe that its interactions with police are not constitutionally problematic because it has not initiated contact with law enforcement, as in the case of Nurse Brown. Instead it may characterize its interactions as Hospital A merely responding to law enforcement requests or reacting to law enforcement entry into the facility.[101] It is arguable how much who reached out to whom is the defining linchpin of *Ferguson* liability. But let's say that it is an important element. Hospital A may be correct that it is not always or even typically initiating contact with the police. Police who come in with emergency vehicles are not doing so at the behest of Hospital A. But even though Hospital A may not be responsible for police showing up, it is certainly responsible for allowing police broad access to patient treatment areas. By permitting law enforcement this kind of access, Hospital A carries out the threshold action that leads to a subsequent police investigation. For example, although Hospital A may not call police to bring in trauma patients, Hospital A's staff may regularly see police coming in with trauma patients and taking patient property, such as cell phones or clothes, when they are in the trauma bay. The police are in that position to observe and take patient property when the patient is in a medically vulnerable position and may not be able to stop the action or may give questionable consent because of Hospital A's acquiescence and permission.

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100. Sally Mahmoud-Werthmann, *Emergency Rooms Need Clear Guidelines About How to Handle Law Enforcement*, STAT (Apr. 3, 2023), https://www.statnews.com/2023/04/03/emergency-rooms-guidelines-law-enforcement/.

101. *See* Ferguson v. City of Charleston, 532 U.S. 67, 70-71 (2001).

The actions of Hospital A in other circumstances may be characterized as initiating contact with police in matters relating to hospital security. Medical providers working in hospitals experience a unique type of workplace violence.[102] Medical providers must be in close proximity to patients. They administer care to people who are compromised mentally and/or physically. To protect their workers, hospitals have deployed various security measures, including bringing police into the healthcare settings.[103] However, if Hospital A does not implement appropriate limiting measures, it is likely that police who are acting as security may continue to act in their general and policing capabilities. Further, police who are hospital security may have close relationships with hospital administration and staff and be privy to treatment areas and patient information.

D. Hospital A Contact is in Compliance With Mandatory Reporting Laws

Mandatory reporting laws give law enforcement access to information and may cause law enforcement to come to healthcare settings.[104] However, mandatory reporting laws are not general permits for broad information about the patient and access to patient treatment areas. Hospitals and medical providers may also misunderstand when they have to report information to police, which leads to circumstances like Lizelle Herrera.[105]

Moreover, mandatory reporting laws may be the reason Hospital A provides more information than needed or authorized by law. In fact, Professor Wendy Bach's study of prosecutions in Tennessee underscored how easily law enforcement got information from hospitals.[106] In one of Bach's conversations, a prosecutor recounted:

> If we needed to talk to a nurse about a situation, or we needed additional records, we could get those records. If we needed to go down to a facility, and meet with people, and talk to them about it, or needed information . . . I've never had any obstacles with the local hospitals at all.[107]

This sentiment is not unique. It is also a much more expansive view than authorized under the requirements of mandatory reporting or the authorized disclosure under health privacy laws.

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102. *See* Renuka Rayasam, *Hospitals Create Police Forces to Stem Growing Violence Against Staff*, NPR (May 15, 2023, 5:01 AM). https://www.npr.org/sections/health-shots/2023/05/15/1175889585/hospitals-create-police-forces-to-stem-growing-violence-against-staff.

103. *See id.*

104. *See* HIPAA Security Rule, 45 C.F.R. § 164(A) (2023).

105. Kitchener et al., *supra* note 87.

106. *See* BACH, *supra* note 1, at 132-33.

107. *Id.* at 133.

E. Hospital A Does Not Have a Formal Task Force Involving Law Enforcement

Hospital A may also believe that its relationship with police falls outside the scope of *Ferguson* because it did not organize any kind of formal task force to bring in police.

But if Hospital A regularly confers with its law enforcement partners, such interactions may rise to a level of formality If Hospital A reaches out to law enforcement to make policies for treatment of patients under law enforcement custody, or for payment protocols for treatment of incarcerated people, then arguably, this is a similar kind of collaborative effort as in *Ferguson*, particularly if the policy leads to the ability of police to gather evidence and arrest individuals based upon that evidence.[108] One may characterize the arrangement with law enforcement then as an ongoing informal task force to address issues relating to patients under law enforcement scrutiny or custody. This characterization is even more appropriate if Hospital A feels the need to check with law enforcement before making any changes to its policies on police access to patient care areas, patient property, or patient questioning, or consults with police in developing procedures. These acts of consultation may amount to a continuous collaboration with law enforcement that may not have the label of a task force, but operates in much the same way.

V. CONCLUSION

When hospitals have regular interactions with law enforcement that contribute to the surveillance and criminalization of their patients, they should be concerned about their Fourth Amendment liability, whether or not they work at a state, county, or city hospital. Criminal procedure doctrine is far from a panacea to the problems of policing, nor is it a perfect regulator or guide for behavior, but it does set out the rules of policing for police and other actors. It is imperative that hospitals and medical professionals who work within hospitals evaluate how their actions comport with constitutional court rules when they take on law enforcement roles. *Ferguson* does not provide answers to all the complicated issues raised by law enforcement presence in healthcare settings. But until hospitals and law enforcement get clearer guidance from courts, regulators, and legislators, *Ferguson* offers a framework for evaluating how law enforcement and medical providers should interact in hospitals in ways that recognize the realities of hospital

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

care and policing, comport with medical ethics and reuglations, and do not infringe on the rights of vulnerable patients.