PREGNANCY'S CRIMINAL PROCEDURE PROBLEM

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ABSTRACT

Pregnancy has a criminal procedure problem. Post-Dobbs, as the private becomes ever more public, intimate details of pregnancy are protected, at the very best, by a frayed constitutional shield. But this Article argues that the opposite is also true, that criminal procedure has pregnancy problem, or more precisely that the systemic mechanisms by which pregnancy is policed are an extraordinary example of the doctrine's failure to understand and protect against the policing of intimate details of health and healthcare. Since Dobbs v. Jackson Women's Health*, prosecutors in several states have brought over 400 prosecutions against pregnant people charging crimes based on their conduct during pregnancy. More often than not, these prosecutions rely on information obtained or disclosed in a healthcare setting.*

This Article relies on an original data set, drawn from a study led by two of the authors, that contains charging and investigation documents from the criminal court files for these prosecutions.

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Through careful analysis of these files, this Article reveals deep and pervasive collaboration between healthcare providers and family regulation agencies in policing pregnancy, and exploitation of the unique vulnerability of patients. It argues that criminal procedure's doctrinal response fails to adequately account for this systemic collaborative policing, fails to recognize and address medical vulnerability, and fails to cabin the role of state and federal law in limiting patients' privacy. A wide range of doctrines – the reasonable expectation of privacy, state action, special government needs, Miranda, *and voluntariness - demonstrate these deficiencies. The Article calls for substantial doctrinal reform and policy measures to not only protect the privacy of pregnant patients but all individuals who may become subject to ever-expanding policing mechanisms and infrastructure.*

I. INTRODUCTION

The period after the Supreme Court's decision in *Dobbs v. Jackson's Women's Health* has seen a flurry of scholarly attention on the new era of abortion criminalization. Trigger laws passed by anti-abortion states, the Comstock Act, and the transformed capabilities of policing through advances in technology prompted queries about what law can do to protect pregnant people and abortion providers against surveillance, arrest, and prosecution.[1] The hypothesis, in much of this work, is that after *Dobbs*

[1] *See, e.g.*, Jolynn Dellinger & Stephanie Pell, *The Impotence of the Fourth Amendment in a Post-*Roe *World*, LAWFARE BLOG (June 13, 2022, 9:06 AM), https://www.lawfareblog.com/impotence-fourth-amendment-post-roe-world [https://perma.cc/VV9E-PJ58]; Ryan Knox, *Fourth Amendment Protections of Health Information After* Carpenter v. United States*: The Devil's in the Database*, 45 AM. J. L. & MED. 331, 345–53 (2019) (discussing potential for using *Carpenter* to protect information contained in digital health information databases); Anya E.R. Prince, *Reproductive Health Surveillance*, 64 B.C. L. REV. 1077 (2023); Danielle Keats Citrone, *Intimate Privacy in a Post-*Roe *World*, 75 FLA. L. REV. 1033 (2023); Aziz Z. Huq & Rebecca Wexler, *Digital Privacy for Reproductive Choice is the Post-Roe Era*, 98 N.Y.U. L. REV. 555 (2023); Sam Kamin, Katz *and* Dobbs*: Imagining the Fourth Amendment Without a Right to Privacy*, 101 TEX. L. REV. ONLINE 1 (2022); Elizabeth E. Joh, *Fourth Amendment Rights as Abortion Rights*, N.Y.U. L. REV. F. (Oct. 24, 2022); Mary D. Fan, *Abortion Ally or Abettor: Accomplice and Conspiracy Liability After* Dobbs, 93 GEO. WASH. L. REV. 1 (2025). This conversation focusing on the criminal legal system's response to

technological surveillance would be criminal procedure's most pressing problem when it comes to pregnancy criminalization.

While technological threats are real, data emerging from a national empirical project tracking pregnancy criminalization after *Dobbs*, led by two of the authors, points to a different set of problems.[2] The data shows that pregnancy criminalization continues at alarming rates. Since *Dobbs v. Jackson Women's Health*, prosecutors have brought over 400 prosecutions against pregnant people charging crimes based on their conduct during pregnancy. These prosecutions underscore how the criminal legal system continues to invade the pregnancies of poor women, building on a legacy of targeting poor Black women.[3]

More often than not, the prosecutions rely on information obtained or disclosed in a healthcare setting, revealing what we call here pregnancy's criminal procedure problem—the failure of the law to protect the privacy of poor women's reproductive health information from those who seek to wield it against them. But the opposite is also true. Criminal procedure has a pregnancy problem. The systemic mechanisms of pregnancy

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Dobbs coexists along emerging robust literature across legal disciplines on the abortion bans that have been passed since the *Dobbs* decision. *See e.g.* Melissa Murray & Katherine Shaw, *Dobbs and Democracy*, 137 HARV. L. REV. 728 (2024); Reva Segal & Mary Ziegler, *Abortion's New Criminalization: A History-and-Tradition Right to Healthcare Access After* Dobbs, 111 VA. L. REV. 101 (2025); Aaron Tang, *After* Dobbs: *History, Tradition, and the Uncertain Future of a Nationwide Abortion Ban*, 75 STAN. L. REV. 1051 (2023); Robyn Powell, *Disabling Abortion Bans*, 581 U.C. DAVIS L. REV. 1091 (2024); David S. Cohen, Greer Donley, and Rachel Rebouché, *Abortion Pills*, 76 STAN. L. REV. 317 (2024); David S. Cohen, Greer Donley, and Rachel Rebouché, *Abortion Shield Laws*, 2 NEW. ENG. J. MED. EVID. (2023).

[2] For example, the data from our study of pregnancy-related prosecutions reveals some use, by police, of the contents of internet searches. For example, in several cases probable cause or investigative documents pointed to a search for an abortion provider or searches about methods for abortion in support of the theory that the defendant had committed a pregnancy-related crime.

[3] Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474, 1476 (2012) [hereinafter *Systemic Punishment*]; Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420–21 (1991) [hereinafter *Punishing Drug Addicts*]MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD (2020); KHIARA BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017); Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1195–96 (2017).

criminalization lay bare the doctrine's extraordinary failure to understand and protect against the policing of intimate healthcare details.

The data in this Article are gathered from charging and investigation documents from the court files for these prosecutions. Through careful analysis of these files, this Article reveals extensive collaboration between healthcare providers, family regulation agencies, and traditional police in policing pregnancy.[4] It argues that criminal procedure's broad doctrinal response to this systemic collaborative policing is woefully inadequate. A wide range of doctrines, including the reasonable expectation of privacy, state action, special government needs, *Miranda* and voluntariness doctrines, demonstrate these deficiencies.

First, in pregnancy criminalization cases and beyond, criminal procedure assumes a division between the institutional purposes of family regulation systems, healthcare providers, and traditional police. This assumption fails to capture the extent to which these entities both collaborate in a common policing enterprise and systematically exploit health systems' access to private information. Second, in both the Fourth and Fifth Amendment contexts, the study data illuminate the doctrine's failure to adequately consider medical and analogous forms of vulnerability in evaluating expectations of privacy. Third, the data suggest a need to reevaluate how courts reconcile health privacy laws' statutory exceptions when determining what constitutes a reasonable expectation of privacy.

This Article builds on our respective prior frameworks aimed at understanding the relationship and enmeshment between the criminal legal system and our systems of caregiving.[5] Two authors, Madalyn K.

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[4] This article joins scholars and activists in referring to systems that regulate parenting through allegations of abuse, neglect and endangerment as family policing or family regulation systems and agencies. These terms more accurately reflect the operation of these entities. For a discussion of this shift, *see* Nancy D. Polikoff & Jane Spinak, Foreword*: Strengthened Bonds: Abolishing the Child Welfare System and Re-envisioning Child Well Being,* 11 COLUM. J. RACE & LAW 427, 431-32 (2021).

[5] WENDY A. BACH, PROSECUTING POVERTY, CRIMINALIZING CARE (2022) [hereinafter BACH, CRIMINALIZING CARE]; Wendy A. Bach, *The Hyperregulatory State: Women, Race, Poverty and Support*, 25 YALE J. L. & FEMINISM (2014); Madalyn K. Wasilczuk, *Fifth Amendment Rights as Abortion Rights*, HARV. L. REV. BLOG (Apr. 11, 2023), https://harvardlawreview.org/blog/2023/04/fifth-amendment-rights-as-abortion-rights/; Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV., no. 8, 2021, at 2646 [hereinafter Song, *Policing the*

Wasilczuk and Wendy A. Bach, are leading a national, ongoing empirical examination of pregnancy criminalization.[6] This empirical project builds on Bach's prior empirical and theoretical work at the site of pregnancy criminalization, in which she analyzed the means by which carceral logics affected and corrupted the provision of healthcare.[7] It also expands on Wasilczuk's work at the intersection of policing and criminal procedure critiquing the factual assumptions upon which criminal procedure and policy have been built, including her work revealing how post-*Dobbs* pregnant patients remain particularly vulnerable to self-incrimination through routine interactions with their healthcare providers.[8] This Article also extends the work of Ji Seon Song conceptualizing the relationships of our institutions of policing and punishment with healthcare institutions as a broader system of carceral care, with healthcare settings playing a central role in our policing and punishment infrastructure.[9]

Our work is informed by the work of many scholars, particularly Black women who first highlighted the policing and criminalization of pregnant people at the height of the War on Drugs.[10] This Article joins ongoing conversations on abortion criminalization and criminal procedure in

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Emergency Room]; Ji Seon Song, *Cops in Scrubs*, 48 FLA. ST. U. L. REV. 861 (2021) [hereinafter Song, *Cops in Scrubs*].

[6] WENDY A. BACH & MADALYN K. WASILCZUK, PREGNANCY AS A CRIME: A PRELIMINARY REPORT ON THE FIRST YEAR AFTER *DOBBS* (Sept. 2024), https://www.pregnancyjusticeus.org/wp-content/uploads/2024/09/Pregnancy-as-a-Crime.pdf.

[7] BACH, CRIMINALIZING CARE, *supra* note 5; Wendy A. Bach & Mishka Terplan, *Stopping Criminalization at the Bedside*, 51 J. L. MED. & ETHICS 533 (2023); Wendy A. Bach & Nicholas Terry, HIPAA v. Dobbs, 38 BERKELEY TECH. L.J. 609 (2023).

[8] Madalyn K. Wasilczuk, *The Racialized Violence of Police Canine Force*, 111 GEO. L.J. 1125 (2023); Madalyn K. Wasilczuk, *Developing Police*, 70 BUFF. L. REV. 271 (2022); Wasilczuk, *supra* note 5.

[9] Ji Seon Song, *Patient or Prisoner*, 92 GEO. WASH. L. REV. 1 (2024) [hereinafter Song, *Patient or Prisoner*]; Song, *Policing the Emergency Room*, *supra* note 5; Song, *Cops in Scrubs*, *supra* note 5.

[10] GOODWIN, *supra* note 3; BRIDGES, *supra* note 3; Ocen, *supra* note 3 at 1195–96; Roberts, *Systemic Punishment supra* note 3 at 1476; Roberts, *Punishing Drug Addicts*, *supra* note 3 at 1420–21; Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299 (2013).

response to the *Dobbs* decision.[11] More broadly, it contributes to legal scholars' and sociologists' discussion on the extension of criminalization and carceral logics beyond the formal borders of the criminal legal system. Scholars have noted how policing permeates vital social service agencies, including hospitals, public housing, and public benefits offices. Others have revealed the replication of policing and surveillance tactics in, and importation of carceral logics, to other systems like immigration and family regulation.[12]

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[11] Anya E.R. Prince, *Reproductive Health Surveillance*, 64 B.C. L. REV. 1077 (2023); Danielle Keats Citron, *Intimate Privacy in a Post*-Roe *World*, 75 FLA. L. REV. 1033 (2023); Aziz Z. Huq & Rebecca Wexler, *Digital Privacy for Reproductive Choice is the Post-Roe Era*, 98 N.Y.U. L. REV. 555 (2023); Sam Kamin, Katz *and* Dobbs*: Imagining the Fourth Amendment Without a Right to Privacy*, 101 TEX. L. REV. ONLINE 1 (2022); Elizabeth E. Joh, *Fourth Amendment Rights as Abortion Rights*, N.Y.U. L. REV. F. (Oct. 24, 2022); Mary D. Fan, *Abortion Ally or Abettor: Accomplice and Conspiracy Liability After* Dobbs, 93 GEO. WASH. L. REV. 1 (2025); Wasilczuk, *supra* note 5. This conversation focusing on the criminal legal system's response to *Dobbs* coexists along emerging robust literature across legal disciplines on the abortion bans that have been passed since the *Dobbs* decision. *See, e.g.*, Melissa Murray & Katherine Shaw, *Dobbs and Democracy*, 137 HARV. L. REV. 728 (2024); Reva Segal & Mary Ziegler, *Abortion's New Criminalization: A History-and-Tradition Right to Healthcare Access After* Dobbs, 111 VA. L. REV. 101 (2025); Aaron Tang, *After* Dobbs: *History, Tradition, and the Uncertain Future of a Nationwide Abortion Ban*, 75 STAN. L. REV. 1051 (2023); Robyn Powell, *Disabling Abortion Bans*, 581 U.C. DAVIS L. REV. 1091 (2024); David S. Cohen, Greer Donley, and Rachel Rebouché, *Abortion Pills*, 76 STAN. L. REV. 317 (2024); David S. Cohen, Greer Donley, and Rachel Rebouché, *Abortion Shield Laws*, 2 NEW. ENG. J. MED. EVID. (2023); Valena Beety & Jennifer D. Oliva, *Policing Pregnancy "Crimes,"* 98 NYU L. REV. ONLINE 29 (2023); Valena Beety, *"Unfit": Gender, Ableism and Reproductive Wrongful Convictions*, UCLA L. REV. (forthcoming 2026).

[12] *See, e.g.*, 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)[hereinafter KILLING THE BLACK BODY]; Jonathan Simon, *The Return of the Medical Model: Disease and*

This conversation is particularly relevant as healthcare providers and medical care have become the targets of social conservatives and the religious right on issues such as abortion and transgender rights. These measures include restrictions on medical providers and threatened civil and criminal liability, which heighten surveillance and criminalization in healthcare spaces to the detriment of patients and providers. These developments take place alongside the reemergence of tough on crime narratives at all levels of government and visible displays of the expansiveness of police power and discretion. While the title of this Article may suggest that our arguments pertain to pregnancy alone, the problem is not confined to that sphere. The implications of our arguments apply whenever information obtained or disclosed in healthcare settings may be wielded by the state in criminal prosecutions.

The Article develops its arguments in three parts. Part I sets out the context for pregnancy criminalization post-*Dobbs*, describing the development of policing, family policing, and healthcare that make policing pregnancy different from the pre-*Roe v. Wade* period. Part II turns

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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*, 26 FEMINIST FORMATIONS 26, 26 (2014); 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, 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); Bach, CRIMINALIZING CARE, *supra* note 5; Sunita Patel, *Transinstitutional Policing*, 137 Harv. L. Rev. 808 (2024); Ji Seon Song, Essay, *Every Hospital Is* Ferguson v. City of Charleston, 53 SW. L. REV. 286 (2024)); Song, *Cops in Scrubs*, *supra* note 5; Song, *Patient or Prisoner*, *supra* note 9; S. Lisa Washington, *Fammigration Web*, 103 B.U. L. REV. 117 (2023); DOROTHY ROBERTS, TORN APART: HOW THE CHILD WELFARE SYSTEM DESTROYS BLACK FAMILIES—AND HOW ABOLITION CAN BUILD A SAFER WORLD 162 (2022) [hereinafter TORN APART]; Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. REV. 1111, 1119–20 (2020); Teneille R. Brown, *When Doctors Become Cops*, 97 S. CAL. L. REV. 675, 679 (2024); Jennifer D. Oliva, *Prescription-Drug Policing: The Right to Health-Information Privacy Pre- And Post-*Carpenter, 69 DUKE L.J. 775 (2020); ELIZABETH CHIARELLO, POLICING PATIENTS: TREATMENT AND SURVEILLANCE ON THE FRONTLINES OF THE OPIOID CRISIS (2024).

to the original study data. The part defines key terms in the study of post-*Dobbs* pregnancy criminalization and shares depictions of the systemic and routine interactions between medical providers, family policing actors, and traditional police. Part III juxtaposes these facts against criminal procedure doctrines and critiques their failure to protect against the interdisciplinary policing of health and healthcare. Part IV then turns to the prescriptive, offering doctrinal and policy suggestions to address the interdisciplinary policing of pregnancy criminalization.

II. THE CURRENT CONTEXT

Policing today looks very different from policing in 1973. In the over fifty years since *Roe*, innovative systems have changed how police and the state can intervene in, investigate, and criminalize the actions of the working class and poor. One piece of this transformation is the development and convergence of policing, healthcare, and family regulation systems to form a collaborative form of policing. Policing today requires all three systems to carry out law enforcement functions.

Cooperative or collaborative police work is not entirely new. Leslie Reagan's history of abortion policing from 1867 to 1973 highlights how police threatened physicians who treated abortion complications with arrest and prosecution so they would furnish information on abortion providers.[13] Outside the abortion context, the Supreme Court's early criminal procedure opinions on body cavity searches also reveal an acknowledgment that medical expertise is a necessary and welcome development in modern policing.[14]

The scope and structure of policing, family regulation, healthcare, and the relationships between the three are broader and more solidified than in decades past. Today's systems, laws, bureaucracies, and practices contemplate, require, and make routine the use of other expert and professional actors in criminal investigations. Police work regularly

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[13] LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 116, 120 (2022) ("To obtain evidence against abortionists, state prosecutors needed physicians to report abortions and collect dying declarations from their patients."); JONATHAN SIMON, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIM TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR (2007).

[14] Rochin v. California, 342 U.S. 165, 174 (1952) ("We therefore 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.").

involves schoolteachers, nurses, doctors, and social workers not just as passive witnesses from whom police collect information but as active investigators. Institutional settings, such as emergency and hospital rooms, have become sites where investigative work occurs. When it comes to pregnancy criminalization, collaborative policing between system actors is pervasive and structural. As detailed below, this plays out across systems—in the criminal system itself, in the growing institutional collaborations between healthcare and traditional policing, in the changing nature of healthcare systems, and in the changing legislative and policy environments of the policing of purported child abuse.

Modern pregnancy criminalization also takes place in a far different reality than that of 1973. When the Supreme Court decided *Roe v. Wade*, U.S. criminal policy was taking a sharp punitive turn. Incarceration rates climbed. The Law Enforcement Assistance Administration, created by the Omnibus Crime Control and Safe Streets Act of 1968, had begun to inject what would amount to billions of dollars of federal funding into the criminal legal system, helping to create the sprawling infrastructure of 9-1-1, probation, and policing.

For the last several decades, policing has also become the common enterprise of a network of actors beyond traditional law enforcement agencies. LEAA funds helped develop a central and singular emergency response number, 9-1-1, for any person to call in case of emergency. The decision to place 9-1-1 dispatchers primarily in police departments not only facilitated the public's access to police but also made police the central actor in how society deals with emergencies of all types. The beginning of the *Roe* era also coincided with the onset of the War on Drugs, multiplying the policing, criminalization, and surveillance of racial minorities for the next several decades.

Law enforcement has always had some relationship with the medical profession, but for a long time, healthcare remained inaccessible to most Americans. Mid-century federal government interventions brought about multiple policy changes aimed at broadening access to healthcare. The Hill-Burton Act of 1946 authorized federal funds to help build hospitals throughout the country, including in rural and poor areas.[15] Universal healthcare reforms stalled in the mid-century as employer-based health insurance became institutionalized as the dominant form of healthcare in the United States. The passage of Medicaid and Medicare in 1965 made it possible for people without employer-based health insurance programs to

[15] Hill-Burton Act, Pub. L. No. 79–725, 60 Stat. 1040 (1946).

access such insurance.[16] In 1986, Congress passed the Emergency Medical Treatment and Labor Act which mandated that all hospitals receiving federal funds provide emergency screening and stabilizing treatment for individuals regardless of insurance status or income.

These developments to expand the health safety net fell short. A confluence of factors related to insurance coverage, provider availability, complicated healthcare procedures, and issues specific to people with less economic means has meant that hospitals and emergency departments are the default mode of medical services for under- and uninsured people. Now emergency rooms are not just for emergencies, but for many people, especially racial minorities and other vulnerable groups, the first and last resort for healthcare.[17]

Medical providers are also legally permitted and often required to break patient privacy rules for certain law enforcement purposes. Medical personnel—like social workers, teachers, law enforcement, and other mandatory reporters—must comply with a host of reporting obligations.[18] State law obligations include reporting on a range of suspect behavior, including child abuse and neglect, gunshot wounds, and prescription drug use. The imposition of these requirements on health providers has not been without criticism, including within the profession. The logic of making medical providers mandated reporters lies in their access to individuals suffering from injuries possibly related to crimes and their ability to ascertain whether the injuries resulted from criminal conduct.

From the beginning, physicians have raised concerns that reporting on their patients could negatively affect the patient-physician relationship.[19] Such reporting requirements also force providers to break their confidentiality agreements with patients and undermine patient privacy. They also open the door to biases held by medical providers.[20] Despite these criticisms and concerns, the federal statutory framework

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[16] 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).

[17] Song, *Policing the Emergency Room* at 2651, *supra* note 5.

[18] Child Welfare Information Gateway, *Mandated Reporting, https://www.childwelfare.gov/topics/safety-and-risk/mandated-reporting/?top=78.*

[19] Editorial, *Compulsory Reporting of Gunshot Wounds*, J. AM. MED. ASS'N. 404 (Feb. 5, 1927).

[20] Song, *Cops in Scrubs* at 867, *supra* note 5.

incorporates state reporting requirements and explicitly carves them out from privacy protections.[21]

In addition to reporting, healthcare professionals have taken on roles that directly assist law enforcement, as in the case of sexual assault examinations. Sexual assault nurses, commonly referred to as SART or SANE nurses, collect evidence and are key witnesses in sexual assault cases. Hospitals' policies include topics relating to law enforcement ends, such as maintaining chain of custody for evidentiary purposes and handling patients accompanied by law enforcement.

Hospitals have also become significant sites of police presence.[22] Police are routinely present at these essential healthcare sites because they play a role in emergency response, provide security to hospitals, bring incarcerated individuals in for medical care, and investigate crimes.[23] Their ready access to patient treatment areas means they can become privy to conversations between healthcare providers and between providers and patients and that police can speak to patients and healthcare providers themselves. The American College of Emergency Physicians, the national professional organization representing emergency room doctors, has recognized the need to provide guidance to its membership on how to interact with law enforcement. Even as its guidance seeks to delineate the responsibilities of healthcare providers from the work of law enforcement, its statements underscore the view that a collegial relationship between emergency personnel and law enforcement must be maintained."[24]

Social workers also have a strong presence within hospitals and emergency departments. According to the latest data from the Bureau of Labor Statistics, of the 185,020 social workers employed in healthcare,

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[21] 45 C.F.R. § 164.512(c), (f) (2019).

[22] Rucha Alur et al., *Law Enforcement in the Emergency Department*, 157 JAMA SURGERY 852 (2022) (examining social interactions of law enforcement with clinicians and patients).

[23] Song, *Patient or Prisoner*, *supra* note 9 (describing how hospitals make up for deficiencies in jail and prison healthcare).

[24] *Law Enforcement Presence in the Emergency Department: A Toolkit by the State Legislative & Regulatory Committee Developed in Collaboration with the Diversity, Equity, & Inclusion Committee*, AM. COLL. OF EMERGENCY PHYSICIANS (Oct. 3, 2024), https://www.acep.org/state-advocacy/state-advocacy-overview/. ("Promoting a collegial working relationship between [emergency department] staff and law enforcement is in the best interest of [emergency professionals] to maintain a collegial working relationship with law enforcement.")

over 45,000 work in hospital settings.[25] Social workers assist patients with their needs, such as discharge planning, housing, food access, counseling, and transportation.

The family regulation system has also been transformed. In the mid-twentieth century, the family regulation system was just beginning to take its modern shape, building on early Progressive Era reforms aimed at ameliorating conditions for poor children. The medicalization of Battered-Child Syndrome prompted the enactment of mandatory reporting statutes for child abuse.[26] By the mid-1960s, all fifty states had passed statutes requiring child abuse reporting.[27] The Child Abuse Protection and Treatment Act (CAPTA) passed one year after *Roe*, provided federal funding to localities and states and built a regulatory framework for child abuse reporting and monitoring.[28] Until the passage of CAPTA, the kind of investigations now conducted by family regulation agencies were "carried out, almost exclusively, by the criminal police."[29]

In 2016 CAPTA was amended through the Comprehensive Addiction and Recovery Act. CARA purported to address the "needs of substance-exposed newborns" and added additional reporting requirements that found their way into state-level family regulation and healthcare systems in ways that would ultimately augment pregnancy criminalization.[30] These agencies' work to assess families for abuse and neglect and conduct intrusive investigations that may result in children's separation from their families has drawn criticism from scholars. Professor Dorothy Roberts has concluded that abolition is the only remedy to the family regulation system's harms, which fall disproportionately on Black families.[31]

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[25] *Occupational Employment and Wage Statistics*, U.S. BUREAU & LAB. STATS. (May 2023), https://www.bls.gov/oes/2023/may/oes211022.htm#nat [https://perma.cc/3J2G-58LS] ("21-022 Healthcare Social Workers").

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

[27] *Id.*

[28] 42 U.S.C. § 5106a(a)(1) (2019).

[29] Tarek Z. Ismail, *Family Policing and the Fourth Amendment*, 111 CALIF. L. REV. 1485, 1491 (2024).

[30] BACH, CRIMINALIZING CARE, *supra* note 5 at 132.

[31] ROBERTS, TORN APART, *supra* note 12.

State law, policies, and procedures designed in response to CAPTA and CARA embed policing into healthcare and family regulation processes. These processes and structures begin with reporting requirements in the healthcare setting. CAPTA does not require that any entity report identifiable information to family regulation officials. While it does require the creation of plans of safe care, there is no requirement that states use their family regulation systems to provide that care. Nevertheless states have chosen both to report individually identifiable information and to entrust family regulation agencies with the creation of those plans.[32] Twenty-four states consider substance exposure alone to constitute child neglect.[33] Included among those states are Oklahoma, Alabama, South Carolina, and Tennessee, four states that have historically been the site of large numbers of pregnancy-related prosecutions.[34] In Oklahoma, Alabama, and Tennessee, once there is a report to the agency of an infant with prenatal substance exposure, the agency almost always responds by "screening in" the infant for further investigation of the family. In 2023 those three states screened in either 99% or 100% of substance-exposed infants. Over the same period, South Carolina screened in 77.5% of such infants.[35]

Once information is in the hands of the family regulation agency, the information is easily accessible to the police. For example, in Oklahoma, the law requires any healthcare professional or midwife "involved in the prenatal care of expectant mothers or the delivery or care of infants" to "promptly report to [DHS] instances in which an infant tests positive for alcohol or controlled substances."[36] Another Oklahoma statute then

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[32] For a discussion of state level variation in the implementation of CARA and plans of safe care, see CASEY FAM. PROGRAMS, HOW CAN PLANS OF SAFE CARE HELP INFANTS AND FAMILIES AFFECTED BY PRENATAL SUBSTANCE EXPOSURE (Oct. 19, 2023), https://www.casey.org/infant-plans-of-safe-care/#.

[33] 2023 NATIONAL DATA ARCHIVE ON CHILD ABUSE AND NEGLECT (NCANDS), https://acf.gov/cb/data-research/ncands [https://perma.cc/UEJ9-DDAX].

[34] LEGIS. ANAL. & PUB. POL'Y ASS'N, SUBSTANCE USE DURING PREGNANCY AND CHILD ABUSE OR NEGLECT: SUMMARY OF STATE LAWS (June 2024), https://legislativeanalysis.org/wp-content/uploads/2024/06/Substance-Use-During-Pregnancy-and-Child-Abuse-50-State-Summary.pdf [https://perma.cc/2GHZ-S655].

[35] U.S. DEP'T OF HEALTH & HUM. SERVS. ET AL., CHILD MALTREATMENT 2023 tbl.3-11 (2025), https://acf.gov/sites/default/files/documents/cb/cm2023.pdf [https://perma.cc/NMF3-PG6U]. Percentages calculated by the author.

[36] OKLA. STAT. tit. 10A, § 1-2-101(B)(3).

requires DHS to "forward a report of its . . . investigation and findings" to the district attorney's office that may have jurisdiction over the case.[37] Similarly, in Tennessee, the child welfare code is explicit about both the purpose and process of collaboration, stating that,

> It is the intent of the general assembly that the child protective investigations be conducted by the team members in a manner that not only protects the child but that also preserves any evidence for future criminal prosecutions.[38]

As there have been significant changes to healthcare provision and usage patterns and to the family regulation system, the relationships between these entities have evolved in ways that make law enforcement dependent on family regulation and healthcare systems while driving these systems to incorporate policing into their own work.

Criminal procedure has also changed in the decades since *Roe* in ways that give greater discretion to police. The Supreme Court has steadily rolled back the decisions made by the Warren Court through an ever-expanding portfolio of exigency doctrines, erosion of the warrant requirement, and development of reasonableness as the ultimate and most significant litmus test of police action.

While the Court has drawn lines between law enforcement and non-traditional police actors, it has created doctrines affirming law enforcement's varied roles beyond policing. According to the doctrine, only police can be police. Yet police can be social workers, medical personnel, mental health crisis workers, and child protectors. For example, the emergency aid and community caretaking doctrines under the Fourth Amendment allow police to enter into a home without a warrant if they have reason to believe that someone is in need of immediate assistance.[39] The community caretaking exception similarly allows police to circumvent the warrant requirement as part of their administrative functions.[40] Further, police are empowered to conduct welfare checks, a term loosely defined by law.[41] Moreover, when police act in these other capacities, nothing limits their ability to switch from their other roles to

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[37] OKLA. STAT. tit. 10A, § 1-2-102(A)(3).

[38] TENN. CODE ANN. § 37-1-607(a)(3).

[39] Brigham City, Utah v. Stuart, 547 U.S. 398, 403 (2006).

[40] Cady v. Dombrowski, 413 U.S. 433, 441 (1973).

[41] CAL. PENAL CODE § 11106.4 ("Welfare checks"); TEX. GOV'T CODE ANN. § 418.256 ("Requirements for Wellness Check").

their primary role as enforcers. As one court has stated when commenting on the caretaking functions of police: "Police officers are trained to detect crime and cannot help but be attentive to evidence of crime."[42]

Finally, criminal procedure doctrine focuses on discrete actions–searches or seizures of individuals and their property. Often, because legal issues require lawyers and judges to home in on the moment of state intervention, the larger context of regulations and the nature of the relationship between parties can be ignored not just by the litigants but also by the doctrine itself. With the policing apparatus encompassing more than formal law enforcement agents, this kind of myopic review is antiquated and not reflective of current realities. By setting its sights on the world as it was rather than the world as it is, the doctrine paves the way for overbroad policing outside the purview of constitutional review.

III. PREGNANCY CRIMINALIZATION

Pregnancy criminalization occurs "when the state wields a criminal law to render acts associated with a pregnancy, pregnancy loss, birth and/or associated healthcare the subject of criminal prosecution."[43] This definition encompasses both criminal statutes that are on the books but have not yet been charged as well as statutes charged in ongoing or completed prosecutions. Although in recent years a wide range of states have passed laws criminalizing the provision of abortion, to date very few state prosecutions have brought charges under those statutes.[44] In contrast, prosecutors have long used a variety of general criminal laws to prosecute pregnancy-related conduct. Two of the authors of this paper are the co-principal investigators in a study of pregnancy criminalization prosecutions brought during the three years after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*. That study includes gathering a data set of criminal charging and investigation documents. Currently the study team has gathered these documents for over 400 cases brought against a pregnant (or formerly pregnant) person

[42] State v. Johnson, 546 N.W.2d 580 (Ct. App. Wisc. 1996) (upholding denial of defendant's Fourth Amendment motion because police were acting in community caretaking capacity when approaching defendant who was sleeping in his car when officer's testimony indicated that he suspected defendant of being an intoxicated driver).

[43] BACH & WASILCZUK, *supra* note 6, at 6.

[44] At this point, cases in Georgia, Texas, and Louisiana.

between June 24, 2022 and the present.[45] A case is included in the data set if it includes a criminal charge that is based on allegations related to a pregnancy, pregnancy loss, birth and/or associated healthcare and the state argues that those allegations meet an element of the relevant criminal offense. We refer, in study reports, to those prosecutions as "pregnancy-related prosecutions."

Pregnancy-related prosecutions take many forms. Some are brought under statutes that require a pregnancy as a precondition to the crime. Prosecutions brought under criminal abortion or feticide statutes, for example, charge conduct that is, on the face of the statute, related to pregnancy, pregnancy outcome, birth, and/or associated healthcare. But the vast majority of pregnancy-related prosecutions are not brought under statutes that specifically target pregnancy-related conduct. Instead, charges are brought under general criminal laws, and police and prosecutors argue that pregnancy-related conduct meets an element of the offense.

Three archetypes dominate in these prosecutions. First, and most commonly, prosecutors initiate criminal charges to prosecute women for taking illegal (or sometimes legal) substances during pregnancy. Most of those cases charge some form of child abuse, neglect or endangerment. For example, in the first year after *Dobbs*, prosecutors in Alabama brought 104 prosecutions charging that a pregnant person had committed the crime of chemical endangerment of a minor by alleging that she used substances during her pregnancy, thus endangering the fetus. Similarly, prosecutors in Oklahoma brought at least 68 cases during the same period charging that the pregnant person had committed child neglect by using substances while pregnant.[46]

Without question, cases charging some form of child abuse, neglect or endangerment make up the bulk of documented pregnancy-related prosecutions after (and before) *Dobbs*. Of the 4xx cases documents in the study to date, X include a charge in this category.[47] While most of those cases charge offenses against children, some prosecutors use other theories to target the same alleged conduct. Prosecutors in Ohio, for example, turn

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[45] Because the data is embargoed until October 2025, the exact number of cases is not delineated here.

[46] BACH & WASILCZUK, *supra* note 6 at 9.

[47] Note to editors. This data is embargoed until October 2025 when it will be published and available for citation. Numbers are not specified and are instead represented by xxx.

to their drug crime statutes and charge individuals with "corrupting another with drugs" based on similar allegations.[48]

Another significant category of cases charges some form of homicide. While most cases in the child abuse/neglect/endangerment category involve a live birth, the cases charged as homicides generally break down into three basic sub-categories. One category is cases that involve a fetal demise plus an allegation that the demise occurred because of pregnancy-related conduct. Prosecutors might argue that attempted suicide or the use of a drug during pregnancy led to miscarriage or stillbirth and that those actions constitute homicide. A second category comprises cases in which the initial charge and investigation documents present a dispute over whether the pregnancy ended in a live birth and a subsequent infant demise or whether the pregnancy outcome was a miscarriage or stillbirth. Generally, in these cases, the prosecution alleges a live birth occurred and the defendant asserts that the pregnancy ended in a miscarriage or stillbirth. Regardless of the actual birth outcome, prosecutors and police maintain that some conduct by the pregnant person led to the fetal or infant demise. In the third category of cases, the parties appear to agree that the infant was born alive and subsequently died, and prosecutors again allege that some conduct by the pregnant person that took place during the pregnancy was the cause of death.

Finally, in a small but notable number of cases, prosecutors employ statutes targeting the improper handling of human remains or some form of evidence tampering charge. These "abuse of a corpse" charges are often brought when there is a discovery of human remains, and the state has yet to gather evidence sufficient to draw a conclusion about the cause of the demise. In some of those cases, prosecutors will later charge some form of child abuse or homicide. In others, all parties agree that no live birth occurred, but law enforcement asserts that the pregnant person should have dealt with the miscarriage or stillbirth differently.

Pregnancy criminalization can also target multiple actors. While crimes like criminal abortion generally target actors other than the pregnant person,[49] most other pregnancy-related prosecutions target the

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[48] OHIO REV. CODE ANN. § 2925.02(A)(3).

[49] Most statutes that criminalize abortion exempt the pregnant person from prosecution under those statutes. These statutes appear to target only providers and other individuals who might help a pregnant person get an abortion. For a detailed and nuanced discussion of abortion-specific and other criminal statutes and their actual effectiveness at protecting women from prosecution, see Joylynn

pregnant person herself. This article focuses exclusively on data from the latter set of cases.

These prosecutions rely to a tremendous degree on medical evidence—drug tests, diagnosis, opinions regarding pregnancy-related events, and the like. For that reason, in the pregnancy prosecution study, the study team systematically analyzes the charging and investigative documents to record specific pieces of information.[50] Among the data points tracked are whether the charging and/or investigation documents include information obtained or disclosed in a medical setting to support the prosecution. A case is coded as having that information if the documents include:

- Statements made to staff in a medical setting (excluding emergency medical services called to the community);
- Drug testing of the mother, infant, or fetal remains in a medical setting;
- Statements made by staff working in a medical setting;
- The subpoena of medical personnel for a hearing or trial; and/or
- The appearance of medical personnel on a witness list.[51]

Of the 4xx cases in the study's preliminary database of pregnancy-related prosecutions after *Dobbs* xxx contain one or more of these kinds of information. The study team also tracks references to drug testing more generally. In the 4xx cases, x includes a reference to drug testing. These findings echo the findings of earlier studies.[52] For example, in *Prosecuting Poverty, Criminalizing Care*, a similar study of prosecutions brought under

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Dellinger & Stephanie Pell, *Bodies of Evidence: The Criminalization of Abortion and Surveillance of Women in a Post*-Dobbs *World*, 19 DUKE J. CONST. L. & PUB. POL'Y 1, 25–72 (2024).

[50] For a full discussion of preliminary data gleaned from 210 cases brought in the first year after the *Dobbs* decision, see BACH & WASILCZUK, *supra* note 6.

[51] The data instrument also allows a coder to indicate any other reason, based on data in the file, that indicates that there was information obtained or disclosed in a medical setting but that does not fall into one of these more common categories.

[52] The exact numbers will be released after the data embargo is lifted. *See supra* note 45.

Tennessee's now expired fetal assault law revealed 80% of the criminal court charging documents contained information obtained or disclosed in a medical setting.[53]

While basic data points provide a window into the pervasive role information obtained or disclosed in a medical setting plays in pregnancy-related prosecutions, the numbers alone fail to convey either the depth and specificity of cooperation between police and providers in medical settings or the systematic interactions that take place between healthcare, family regulation, and policing personnel in the investigation and development of these prosecutions.

To more clearly understand those phenomena and to begin to explore their implications, the research team analyzed the contents of the charging and investigation documents of a preliminary subsample of cases involving fetal or infant demise. Unsurprisingly given the data above, thematic coding revealed the existence of porous boundaries between the healthcare system and other systems. Subsequent line-by-line, focused coding identified the means by which information flows out of healthcare settings. This analysis also provided insights into the role that healthcare providers play in this information flow, proffering empirical evidence for interdisciplinary investigations of behavior during pregnancy and birth. The following subsections paint a picture of these interdisciplinary investigations.

The subsections draw from two subsamples of the larger, preliminary dataset. The first includes twenty-xxx cases filed in the first two years after the *Dobbs* decision in which there was a pregnancy-related prosecution, an allegation of a fetal or infant demise, and at least one allegation that pregnancy-related conduct might be used to prove an element of the offense. The second includes a small sample of pregnancy-related prosecutions in which there was a live birth and an allegation of pregnancy-related conduct that might be used to prove an element of the

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[53] BACH, CRIMINALIZING CARE, *supra* note 5, at __. Grace Howard, the author of *The Pregnancy Police: Conceiving Crime, Arresting Personhood*, documented 1,116 pregnancy-related prosecutions brought between ___ and ____ in South Carolina, Alabama and Tennessee reported similar findings using a slightly different methodology. For example, she reports 48 occurred after a drug test administered in a health-care setting." GRACE HOWARD, THE PREGNANCY POLICE: CONCEIVING CRIME, ARRESTING PERSONHOOD 132 (2024) (noting that "health-care providers reported their patients to social services or directly to law enforcement in 853 cases . . . . [and] . . . of the 1,110 arrest cases involving substance use, 8 _____).

offense. The analysis focuses on what we can learn from early case documents (complaints, probable cause affidavits, indictments, and similar documents) about information sharing and the role of healthcare providers in policing these crimes.

We find that information sometimes flows directly from healthcare to police and sometimes is mediated, with information flowing from healthcare through family regulation and then to police. Whether mediated or not, we find several healthcare providers practicing in ways that constitute and facilitate policing. First, healthcare providers engage in acts without a clear diagnostic or treatment justification that appear to have only a policing purpose. Second, they engage in collaboration with police in the investigation of pregnancy-related conduct and pregnancy outcomes. Third, they grant police access to extensive protected health information without any apparent legal authorization. Finally, they grant police access to medical spaces and patients, thereby facilitating investigation. The data make clear that these investigative techniques are deeply instantiated into daily practice.

Our data reveals multiple ways in which healthcare providers, family policing staff, and traditional police collaboratively investigate pregnancy-related crimes. Healthcare providers frame medical evidence in terms of criminality and work, both on their own and with police, to investigate purported pregnancy crimes. Healthcare settings are transformed from presumptively confidential and protected spaces designed for the provision of healthcare into sites of policing, leading both to investigation and what we term here interdisciplinary interrogation. Finally, in the pregnancy-related prosecutions that target drug use during pregnancy, the three systems, healthcare, family policing, and traditional policing, engage in systematic and structured interdisciplinary investigations.

A. Healthcare Providers Framing and Pursuing Medical Facts as Evidence of Criminality and Collaborating with Police

When cases originate in a healthcare setting, it is often a healthcare provider who makes the series of decisions that leads to the investigation. As detailed below, providers decide whether to interpret a set of facts as evidence of a health crisis or a criminal act, to drug test, or to pick up the phone to call traditional or family policing agencies. When a provider understands what they witness as a crime, it creates a snowball effect. First, they notify the police. Even before the police arrive, medical staff may gather or preserve evidence themselves. Once the police arrive on the

scene, medical staff often collaborate with the police through joint investigation of facts, development of theories, and granting access to extensive medical information.

The files indicate that even before police arrive on the scene, once healthcare providers decide there may be criminal activity involved, they alter their behavior to support the impending police investigation. One notable example comes from a fetal or infant demise case. In that case, the patient had come to the hospital complaining of pain. She gave birth in the building but outside the presence of medical personnel, and once the hospital staff discovered the infant remains, they summoned the police. At that point the attending physician seems to have prioritized the investigation over the healthcare needs of the patient. For example, while the patient was awaiting transfer to another care facility and was in a hospital room, the police report notes that the doctor "told her team she would not talk to [the patient] until she had police present as she wanted witnesses present for [the doctor's] discussion with [the patient]."[54] Only after the "officers arrived on the scene" did the doctor reenter the patient's room. In the same case, once the deceased newborn was found and the doctor decided that the newborn was dead and that there was no reason to attempt resuscitation, she did nothing further because "she did not want to contaminate a possible crime scene."

Once police arrive at a hospital, healthcare providers act not just as passive interview subjects but as collaborators, purporting to use their expertise to help police interpret facts in ways that support the officers' theory of the case. They also share presumptively HIPAA-protected information. Several cases are striking in that respect.

In one, the alleged homicide took place in a home. Emergency responders were called to the scene, took a series of photographs of the deceased infant, and shared those photographs with nurses at the hospital. Crucial to the state's theory in that case was establishing that the baby was born alive. In the probable cause affidavit, the officer reports that he met with the nurses who emailed him the photographs and, acting outside of any possible scope of medical practice, interpreted them for the officer. Based on those photos, one nurse estimated the weight of the infant, and another opined that "the baby was born living due to the child's tone . . . . All three nurses stated that based on the images, it appeared that the baby was alive at the time of birth."

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[54] All case files are on file with the authors. This data is governed by the confidentiality rules of the University of Tennessee's Institutional Research Board.

Providers also seem willing to help officers frame the facts in terms that help police establish probable cause. For example, in one case the officer explained that "nurses were able to give a timeline to Officer X based on their initial medical entries for the baby and [defendant]. ER nurses stated that D arrived at X hour and was bleeding out." The nurses then went on to provide the police with a detailed account of the events in the hospital.

Another case alleged that a failure to obtain prenatal care, drug use during pregnancy, smoking during pregnancy, and failure to follow the physician's advice about the need for a cesarean section constituted child abuse resulting in death. The state's case appeared to rely nearly entirely on the proffered "expert" testimony of the defendant's own physician. In the motion summarizing the proffered testimony, the doctor drew extensively from the defendant's medical records and medical history across multiple institutions to establish that the defendant committed the crime.

Healthcare professionals also share extensive medical information. Take, for example, the following text from a probable cause affidavit submitted to support the arrest of a defendant for homicide and child abuse.[55] The officer in the case reports coming to the hospital the day after the events detailed in the affidavit.

> I was contacted by X [the director of labor and delivery at the hospital] in reference to an adult female that came into the room [the evening before] because she had vaginal bleeding and was cramping. She advised medical staff that she was 26 weeks pregnant. The director stated,
>
> > "Defendant was immediately moved to the Labor and Delivery Floor. Once D was in our care we immediately started monitoring D and the heart rate of the unborn child. At the time of admittance . . . D was not under prenatal care from any local doctors. It is hospital protocol to do an urinalysis when a person comes into the labor & delivery if they have not had previous prenatal care. Prior to collecting the urinalysis D was asked if she had done any kind of drugs or drank any alcohol during her pregnancy. Initially D told me "no". After getting the results of the urinalysis I returned to

[55] Note that case files are redacted to protect the identity of defendants and, in each case, names are replaced with a "D."

> D's room and advised her that the urinalysis came back with a positive test for methamphetamines. D informed me at that time that she had done meth approx. a week prior to coming into the hospital. Between the time that we began monitoring the unborn child's heart rate . . . the child's heart rate slowly became weaker and weaker until eventually the heart rate dissipated. The child was later stillborn["].[56]

The file does not indicate that the information was obtained through an administrative or court order. Instead, it appears that the officer was summoned to the hospital by the director of labor and delivery, and the director shared all the information either orally or by allowing the officer to read notes in the medical chart. This is particularly clear because the next paragraph in the affidavit states that after this conversation, the officer generated a search warrant for a hair and blood follicle from the Defendant.

Another case contains a similar notation, again in a probable cause affidavit:

> The affiant states that on [x date] D was transported by ambulance to [the] hospital in reference to her having labor contractions. The accused advised medical personnel she had obtained and consumed [a medication] in an attempt to abort her fetus. The accused delivered a stillborn baby.

Again, there is no indication in the file that the investigator obtained any sort of administrative or court order allowing the disclosure of this HIPAA-protected information.

Similarly, without any indication of a subpoena or other legal process, one officer reports that he "obtained a copy of the OBGYN records." The officer then quotes from medical record entries concerning drug use during pregnancy, prenatal appointments in which the patient expressed a desire to put the child up for adoption, a note written by the defendant to her OBGYN, and a description of her affect during a doctor's appointment.

In addition, probable cause affidavits regularly contain the results of maternal and/or infant drug testing performed in a medical setting. This was the case in __ of __ files in the study. To take just one example, one

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[56] Although it is not entirely clear from the probable cause affidavit whether this text is a direct quotation or merely a summary of what the director of labor and delivery told the officer, it is clear the information came from the director.

officer explained, "[D]uring my investigation, I obtained [D's] medical records and it does show that her urine was positive for both amphetamines and methamphetamine."

Finally, the provision of presumptively private medical information in these files is not limited to facts pertaining to the individual charged with the crime. In one case involving a fetal or infant demise, the affidavit supporting the charging document contained information about the alleged father of the infant. "Nurses advised that [he] had recently been to the ER for a fentanyl overdose."

B. Healthcare Settings as Investigative Sites

Police are often present in the hospital, leading to opportunities for investigation. As one of this Article's authors has documented, police are frequently present in healthcare settings, and the case files contain significant evidence of how physical proximity augments investigations. Sometimes, the investigator learns facts simply through their presence. In one case, for example, the defendant was due to be taken to jail but had not yet received medical clearance. Upon learning that she remained at the hospital, the investigator reported that he returned. As he reported,

> While in the emergency room with D, I heard her inform medical staff that her baby had passed away. D went on to tell the treating physician that she didn't know she was pregnant and was having intense abdominal pain that then transferred to her vagina. D stated the transition of pain from her abdomen to her vagina prompted her to go to the restroom, where she subsequently delivered the baby.

In this scenario, the police investigator returned to the hospital where the defendant was still being treated. After having been given access to the patient treatment areas, the officer overheard statements that became relevant later in the criminal investigation.

Another file describes the police officer walking into the emergency room where he "observed a purple newborn in one room and [the defendant] in the next room screaming in pain and bleeding out as the ER staff rushed to stabilize her."

C. Patient Statements

In general, the cases discussed up to this point originate through a call from a healthcare provider to the police. When police arrive, they not only garner facts from medical records and by questioning or collaborating with healthcare providers, but they also frequently question the defendant, quite often in a setting in which there is no reasonable possibility that the defendant could leave and often close in time to profoundly traumatic medical events.

Take, for example, a case in which a defendant ultimately charged with homicide was interviewed in her hospital room by police on the same day that she had experienced a stillbirth at home. She's described in the probable cause affidavit as "in shock." Nevertheless, the police questioned her, and the file contains no indication that she was warned or counseled about her rights. During questioning she provided extensive details about her birthing experience and told the police that she had previously made an appointment with Planned Parenthood to "take the plan C pill," which they presumably include in the affidavit to prove *mens rea*.

In another case, the probable cause affidavit references two bedside interrogations. In it, the defendant is facing a serious medical emergency. The report indicates that when the defendant came to the hospital she was "bleeding out," having just experienced a traumatic birth at home. Once the "ER doctors managed to stabilize her," the police questioned her and offered her statements in support of probable cause. During that conversation, she shared extensive facts about the birth, the condition of the child at birth, and her deteriorating condition during that experience, all facts that police recorded to argue that there is probable cause to arrest her for the crimes of criminally negligent homicide and child endangerment. The probable cause affidavit also refers to a second unwarned bedside interrogation during which the police stated that "she was doing better and was more lucid," strongly suggesting that she was not entirely well or lucid during the first interrogation.

Finally, both cases of live birth and fetal or infant demise provide a window into how police and family regulation staff collaborate to investigate pregnancy-related crime. For example, in one file the probable cause affidavit describes an interview of the defendant conducted by the police investigator, the child protective investigator, and a behavioral health consultant presumably employed by the family policing agency. In the interview, they discussed the defendant's pregnancy care, her mental health issues and diagnoses, her mental health medications, and her

thoughts during the pregnancy about adoption versus termination. There is no mention of any conversation about whether she had a right to refuse to answer their questions. In another case, the police report being present while the family regulation caseworker interviewed the defendant. The report goes on to include detailed incriminating statements made during that conversation.

D. Healthcare, Family Policing, and Investigations

Most of the cases discussed above appear to have originated from direct contact between a healthcare provider and law enforcement. While this is a frequent occurrence in the cases involving an alleged fetal demise and can occur even in cases without one, the information pathway tends to be slightly different when the allegation is that the defendant engaged in conduct during her pregnancy that endangered or harmed an infant who is born alive. Generally, the allegation in these circumstances is that the defendant used a substance during pregnancy that resulted in risk and or harm to the infant. In those cases, which constitute most documented pregnancy-related prosecutions after *Dobbs,* the healthcare information that underlies the charges appears to be reported first to the family policing system and subsequently by that agency to the police. As discussed in Section I, these particular cases take place within a robust institutional framework set up to respond to substance exposure during pregnancy. On the federal level, CAPTA and CARA lay out specific requirements, and on the state level, legislatures, family policing agencies and healthcare providers have designed extensive, collaborative systems. We see clear evidence of those institutional structures in the study case files.

Although some of the files simply reference drug testing results without an explanation of how those results were obtained by the police, others are clearer about the role of family regulation staff. For example, one probable cause affidavit states,

> On or about August 1, 2024, at X hospital. . . . The Defendant did give birth to an infant, who tested positive through a drug screen for amphetamines and methamphetamines. This paperwork was provided by . . . County DSS showing the positive drug screen results.

One case in the dataset is emblematic of this large category of cases. As the probable cause affidavit details:

> On [x] date, Department of HS Child Welfare specialist . . . filed an incident report with the . . . Police department. Report noted that [CWS] was contacted by X medical center case worker who advised that D delivered two children at their center . . . and one of the infants passed away. CWS further explained that she spoke with D via telephone to which D admitted to using methamphetamine three days prior to giving birth. During investigation I [the detective] learned that D was treated at X hospital and was transported to X children's hospital for higher level medical attention. D's hospital medical records showed that . . . a urine drug test showed D tested positive for amphetamines, cannabinoids, and methamphetamine. A . . . medical center toxicology for D showed her to be positive for amphetamines and that D admitted to the use of methamphetamine and THC during this pregnancy.

Lending even more specificity to the information pathways, one file, in which the study team has access both to initial charging documents and to discovery materials provided by the state, provides a clear window into how information obtained in a medical setting moves from that setting into family regulation systems and ultimately into the hands of the police. In that case, the discovery materials contain both medical and family regulation records. The medical records include the results of a urine drug screen. The drug screen result report states that "unconfirmed screening results should NOT be used for non-medical purposes." Nevertheless, these results landed in the hands of the prosecution.

The discovery materials also contain the results of an additional drug test ordered in a medical setting. The test documentation includes both the printed results of a drug test and a handwritten note regarding a statement made by the patient: "Per [defendant] taken during pregnancy. Was very depressed wanted to abort, but couldn't after thinking about it. Probably occurred around 3 mos. pregnant." The discovery materials also contain paperwork sent from the family regulation agency to police, reporting the incident and suggesting that the agency was the one to notify the police.

The sheer frequency of cases alleging some form of child abuse based on the defendant's alleged drug use during pregnancy, particularly in Alabama, South Carolina, and Oklahoma, suggest that these information pathways are well established in the administrative infrastructure of these

states.[57] The formality and regularity of these pathways is likely underpinned by the states' supreme courts' explicit sanction of these prosecutions.[58]

In addition, the files provide some evidence of the effect that these regulatory regimes have on medical practice. While the jurisprudence seems to assume that medical providers generally act for medical purposes, the cases suggest otherwise. Take, for example, the following entry in an affidavit. The defendant is charged with child neglect in one of the three states where the state supreme court has held that drug use during pregnancy constitutes neglect. This particular defendant was accused of using methamphetamine during pregnancy. The doctor reports, via the probable cause affidavit that, "D's urine tested positive for methamphetamine, so, **per state law,** I ordered a test to Baby X's urine which also tested positive for methamphetamine." (emphasis added).

IV. CRIMINAL PROCEDURE'S PREGNANCY PROBLEM

Even as policing has expanded beyond traditional law enforcement agencies, the courts have done a poor job of recognizing this reality in their jurisprudence. Courts' failures include their myopic interpretation of the privacy of patient information and patient treatment areas, a deficient account of the extent to which healthcare providers and social workers adopt and act as police proxies, and insufficient incorporation of the realities of medical vulnerability.

The setting and actors involved in pregnancy criminalization invariably prompt questions about the applicability of health privacy rules and ethics in criminal courts' adjudication of constitutional claims. But the doctrine largely ignores the ecosystem of healthcare providers, law enforcement, and family regulation that gives rise to the prosecutions. Doctrine assumes that law enforcement functions separately from other institutions like healthcare and family regulation, that its functions are distinct from the functions of those other systems, and that there is no significance to police exploitation of the nature of healthcare provision and healthcare sites to enhance the effectiveness of policing.

Ferguson v. City of Charleston, a case that arose from a systematized policy targeted at pregnancy criminalization, provides criminal procedure's most direct response to this problem. In that case, the Medical

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[57] BACH & WASILCZUK, *supra* note 6.

[58] *See* Ex Parte Ankrom, 52 So.3d 397 (Ala. 2013); State v. Green, 474 P.3d 886 (Okla. Crim. App. 2020); Whitner v. State, 492 S.E.2d 777 (S.C. 1997).

University of South Carolina Hospital (MUSC) in Charleston, South Carolina had designed a policy to identify patients who had used drugs and provided criteria for and the process by which women would be arrested and prosecuted.[59] The *Ferguson* Court characterized the program as using "the threat of criminal sanctions to deter pregnant women from using cocaine."[60] The program's operation was detailed in an extensive Memorandum of Understanding (MOU) entered after a series of meetings between MUSC, the local police, the county substance abuse commission, and the local Department of Social Services (DSS).[61] The MOU included detailed protocols about when women would be drug tested by hospital staff, how chain of custody would be preserved, and when and what charges would be brought.[62] The *Ferguson* Court held that the policy violated the Fourth Amendment because of the policing purpose at the heart of the program.[63]

Though courts have treated it as such, *Ferguson* was not an isolated incident. In earlier work, Dorothy Roberts described hospitals targeting Black women for drug testing and reporting them to child welfare and law enforcement authorities.[64] The practices recounted by Roberts and seen in *Ferguson* continue today in an expanded and systematized form.[65] Actors from different systems and disciplines form a single policing apparatus. This apparatus polices at the joint site of pregnancy and healthcare, facilitates pregnancy criminalization, and reveals a troubling set of criminal procedure problems.[66]

That the doctrine fails to address the potential overreach by health providers, social workers, and police in these pregnancy criminalization cases is even more problematic because the Fourth Amendment is the only viable avenue for individuals to push back against that overreach. HIPAA does not provide a private right of action, which eliminates it as a basis for bringing either suppression motions or § 1983 claims. Without the protections of criminal procedure, individuals have almost no other

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[59] Ferguson v. City of Charleston, 532 U.S. 67, 70-73 (2001). MUSC is a state hospital. This fact obviated the need for any discussion of state action. *Id.* at 76.

[60] *Id*. at 70.

[61] *Id.* at 71.

[62] *Id.* at 71-73.

[63] *Id.* at 79-80.

[64] Roberts, *Punishing Drug Addicts*, *supra* note 3 at 1420–21.

[65] GOODWIN, *supra* note 3; BRIDGES, *supra* note 3; Ocen, *supra* note 3 at 1195–96.

[66] Song, *supra* note 12.

remedy.[67] In this section we analyze a series of doctrines in light of these assertions and as applied to the facts described above.

A. Is There an Expectation of Privacy?

The Fourth Amendment protects citizens from the government's unreasonable searches and seizures.[68] The threshold question, then, is whether an individual has an expectation of privacy in the area searched and the items seized. The expectation of privacy test, drawn from Justice Harlan's concurrence in *Katz v. United States*, depends on the subjective expectations of the person whose privacy is in question and whether society recognizes those expectations.[69]

The facts revealed in the pregnancy criminalization cases raise unique issues surrounding this threshold question. These include how the Fourth Amendment addresses health privacy and mandatory reporting obligations and how it categorizes the actions of healthcare providers and social workers.

1. Reasonable Expectation of Privacy in the Medical Context

Fourth Amendment questions arise when investigations involve the patient's body, medical records, and medical information and both

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[67] Individuals do have the ability to file a complaint with the Office of Civil Rights if they believe that a covered entity under HIPAA has violated their rights. OCR investigates complaints and has been known to fine healthcare providers for violations of HIPAA. But first, many of these HIPAA investigations must deal with the mishandling of patient records and not the kind of on-the-ground police-medical information pathway discussed here. And second, the kinds of patients who may fall victim to police-medical-social worker overreach may not have the means or wherewithal to file such an action.

[68] U.S. CONST. amend. IV.

[69] *See, e.g.*, Orin Kerr, *Four Models of Fourth Amendment Protection*, 60 STAN. L. REV. 503, 511 n.34 (2007) (noting that the reasonable expectation of privacy test is a bit circular). *But see* Matthew B. Kugler & Lior Jacob Strahilevitz, *The Myth of Fourth Amendment Circularity*, 84 U. CHI. L. REV. 1747 (2017) (asserting that the *Katz* circularity problem is overblown because the public does not constrain its views to those blessed by Supreme Court doctrine). *See also* Raff Donelson, *The Real Problem with* Katz *Circularity*, 65 ST. LOUIS U. L.J. 809 (2021) (positing that the *Katz* circularity problem amounts to a concern that courts rely on an improperly reduced expectation of privacy to deny litigants Fourth Amendment protection and proposing elimination of step one of *Katz*).

healthcare and law enforcement personnel are involved. The Supreme Court has generally recognized that there is something different and more intrusive about the first category.[70] In body cavity searches, courts have recognized the high degree of intrusion and applied a heightened Fourth Amendment standard.[71] And in general, courts have acknowledged that patients have a reasonable expectation of privacy in the contents of their medical records and in their health information.[72]

The role of HIPAA, the federal law protecting certain disclosures of patient health information, looms large in our collective consciousness and the doctrine. Culturally, and to some extent legally, HIPAA stands for the proposition that medical providers and our medical care system must safeguard our privacy. Enacted in 1996, HIPAA responded to concerns about how to maintain patient privacy as healthcare was moving toward digitization, enacting data privacy and security measures to safeguard patient's medical information. HIPAA defines who is governed by its privacy provisions, what is protected, and the permitted uses and disclosures of patient health information (PHI). States have passed their own corollaries to the federal statute. These laws and others defining patient-physician confidentiality as well as professional ethics on patient privacy and confidentiality comprise the principle of patient privacy in health information.

Somewhat paradoxically, medical providers have been viewed and treated as typical third parties when it comes to Fourth Amendment actions, meaning that by providing information to health providers, an individual surrenders their expectation of privacy in that information.[73] Traditionally, in the Fourth Amendment context, once an individual has shared information with a "third party," the sharer assumes the risk that the third party will share that information with law enforcement and cannot assert a valid expectation of privacy in that information.[74]

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[70] Privacy in information and conversations arising from medical treatment are recognized in other ways, such as in evidentiary law. *See* Fed. R. Evid. Rule 501; Cal. Evid. Code §§ 990-1007.

[71] Schmerber v. California, 384 U.S. 757 (1966); Missouri v. McNeely, 569 U.S. 141 (2013); Winston v. Lee, 470 U.S. 753 (1985).

[72] 532 U.S. at 78.

[73] Song, *Policing the Emergency Room*, *supra* note 5 at 2679-80.

[74] The *Carpenter* court held that although the cell phone user in some senses voluntarily disclosed the information concerning his location to the provider, the third-party doctrine did not justify the lack of warrant. Instead, the court held that

The Supreme Court's decision in *Carpenter v. United States* has destabilized traditional principles of third-party doctrine and has strengthened privacy claims to medical records and information. At issue in *Carpenter* was whether law enforcement could procure cell-site location data held by a third-party private cell phone company without a warrant.[75] Putting aside its application to medical providers as third parties for a later discussion in this section, courts have noted that *Carpenter* dealt with the vast amount of intimate information law enforcement could become privy to through accessing cell-site location information and have held that the same level of intimate information is contained within medical records.

Carpenter has begun to percolate down to state court decisions. For example, in *State v. Eads*, the Ohio Court of Appeals held that obtaining test results contained within medical records pursuant to a state statute authorizing that disclosure violated the Fourth Amendment. Mr. Eads was charged with operating a vehicle while impaired. To obtain the results of a blood test administered at the hospital, the police did not seek a warrant. Instead, they requested the test results pursuant to a procedure laid out in state law. In reaching the conclusion that the records request required a warrant, the court focused on the ways that *Carpenter* changed the analysis. The court identified two factors crucial to the analysis: (1) "an inquiry into the 'nature of the particular documents sought' and (2) whether they were 'voluntar[ily] expos[ed].'"[76]

As to the first factor, citing the nature of records containing "potentially stigmatizing conditions diagnosed by a physician", the court found that the information sought was, like the information in *Carpenter*, "deeply revealing" and provided an "intimate window" into Eads's life. On the second factor, the court found that, given Eads's need for emergency treatment, his "conveyance of the information in his blood and urine to the hospital is less voluntary than the cell phone's subscriber's conveyance of cell phone location data to the wireless carrier." The *Eads* decision reflect decisions that adopt *Carpenter*'s precludes the warrantless acquisition of certain information.

Similarly, another recent case applied the rationale of *Carpenter* to the healthcare setting, holding that individuals have a privacy interest in blood

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obtaining the information from the third-party cell phone provider absent a warrant violated the Fourth Amendment.

[75] Carpenter v. United States, 585 U.S. 296 (2018).

[76] State v. Eads, 154 N.E.3d 538, 547 ¶ 30 (Ohio App. 1st Dist. 2020) (citations omitted).

already drawn for medical purposes.[77] The defendant in that case had come to the hospital after a car accident. After he left the hospital, a police officer arrived at the hospital and learned from hospital staff that they had the defendant's blood. The officer instructed the hospital staff not to destroy the blood and obtained a grand jury subpoena for the blood sample. The appellate court found that *Carpenter* dictated that given the private facts contained in blood samples and the non-voluntary nature of drawing blood from a compromised patient, a warrant was required.

The Supreme Court has not adjudicated *Carpenter*'s application to medical records and medical information. But some courts have interpreted *Carpenter* to strengthen the argument that the police need a warrant to obtain medical records when the police themselves seek those records. As one court explained,

> Here, at issue is not the *hospital's* action of testing Clark's blood or of *independently* forwarding his medical records to the police "under rules of law or ethics." Rather, the focus is on the action of the police—a state actor, searching and seizing Clark's medical records without a warrant.[78]

While this court was unequivocal that a suspect has a reasonable expectation of privacy in his medical records and that that expectation triggers the warrant requirement,[79] other courts take a different position. For example, in a Texas appellate court decision, the court applied the rationale of *Carpenter*, holding that individuals have a privacy interest in blood already drawn for medical purposes.[80] The court distinguished the actual blood, in which the patient had a reasonable expectation of privacy, from the results of the drug test sitting in the file.[81]

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[77] State v. Martinez, 570 S.W.3d 278, 292 (Tex. Crim. App. 2019).

[78] State v. Clark, 23 N.E.3d 218, 226 ¶ 24 (2014) (internal citations omitted).

[79] *Id.* at 233 ¶ 42 ("[A]n OVI suspect in Ohio enjoys a reasonable expectation of privacy in his or her medical records. . . . It follows that, prior to obtaining such medical records a law enforcement officer must comply with the warrant requirement of the Fourth Amendment.").

[80] State v. Martinez, 570 S.W.3d 278, 292 (Tex. Crim. App. 2019).

[81] *Id.* at 291 (citing State v. Hardy, 963 S.W.2d 516, 523–24 (Tex. Crim. App. 1997). The court held, in its prior ruling on the issue, that the extensive provisions in state law allowing police to conduct alcohol testing, for example, on an unconscious driver, lent weight to the diminished expectation of privacy in this context.

2. Potential Limitations

Thus, there is a general idea that patients maintain a reasonable expectation of privacy in medical information and records. There are, however, a few important exceptions reflected in the doctrine. The first is grounded in the relationship between exceptions to HIPAA and various state laws requiring healthcare providers to report or provide certain information to state agencies.

The pregnancy criminalization cases we detail showcase how investigators seem to have expanded these exceptions in a way that swallows the rule, acting far outside what is permitted by the doctrine and suggesting that the doctrine is not doing enough to curb overbroad policing. The following section describes and critiques this doctrine and then discusses the import of these rules in pregnancy-related prosecutions.

Contained within HIPAA are explicit carve-outs to the statute's privacy protections.[82] These exceptions have been interpreted by some courts to limit patients' expectations of privacy in their medical information.[83] HIPAA delineates scenarios allowing law enforcement access to certain patient health information.[84] Included among these exceptions are disclosures in response to court orders, subpoenas, warrants, and administrative requests.[85] Disclosure is also allowed, within limits, to assist law enforcement in identifying and locating suspects, fugitives, witnesses, or missing persons, and when the covered entity/health provider suspects that an individual is a victim of a crime.[86] Other delineated categories include information about a decedent whose death may have resulted from criminal conduct, for crimes that may have occurred on the covered entities' premises, and to alert law enforcement about deaths that may been caused by criminal activity.[87]

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[82] For discussions of HIPAA and its exceptions at the site of pregnancy criminalization, *see, e.g.*, Bach & Terry, *supra* note 7; Bach & Terplan, *supra* note 7.

[83] State v. Hardy, 963 S.W.2d 516 (Tex. Crim. App. 1997) (holding that defendant did have a reasonable expectation in his medical records generally but did not have an expectation of privacy in blood test results obtained by medical professionals and for medical purpose following a vehicular accident).

[84] 45 C.F.R. § 164.512(f).

[85] *Id.* § 164.512(f)(1)(ii).

[86] *Id.* § 164.512(f)(2)–(3).

[87] *Id.* § 164.512(f)(4)–(5).

The broadest of these categories is disclosures "required by law." For example, in the provision specifically dealing with disclosures for law enforcement purposes, the statute permits disclosures "as required by law including laws that require the reporting of certain types of wounds or other physical injuries."[88]

The most common laws resulting in disclosure to police are state laws requiring or allowing medical providers to report certain types of injuries or suspected forms of abuse and violence. These state laws preceded HIPAA and are not subject to the state preemption provision in HIPAA stating that state laws cannot be less protective than the federal statute. These state laws are also exempt from guardrails within HIPAA itself for the HIPAA-delineated law enforcement exceptions. For example, HIPAA's law enforcement disclosure exceptions are generally permissive in nature except when it comes to state reporting laws. HIPAA has a minimum necessary standard for disclosures, meaning that providers should share no more protected health information than they must to meet their reporting requirement. The agency guidance states that the standard does not apply in situations when "disclosures are required under the Privacy Rule for enforcement purposes" and when "required by law."[89] In all these ways, HIPAA maintained the pre-HIPAA regimes in states that carved out reporting requirements to law enforcement and public health authorities from general requirements to maintain patient privacy.[90]

Courts have addressed the interaction between the Fourth Amendment and mandatory reporting laws most directly in criminal cases involving intoxicated driving.[91] Many states have passed specific legislation enabling law enforcement to access blood test results. In at least one state

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[88] *Id.* § 164.512(f)(1)(i).

[89] Under the Biden Administration, DHHS issued an amendment to the rules prohibiting disclosure of information for any kind of investigation, imposition of liability, or for identifying any person obtaining, providing, or facilitating healthcare. These new additions explicitly state that covered entities must comply with HIPAA's minimum necessary standard. A recent Texas federal district court decision vacated these recent changes. Memorandum Opinion & Order, Carmen Purl et al. v. U.S. Dep't of Health & Hum. Serv., No. 2:24-CV-228-Z (June 18, 2025). The case is still pending.

[90] Barbara J. Evans, *Institutional Competence to Balance Privacy and Competing Values: The Forgotten Third Prong of HIPAA Preemption Analysis*, 46 U.C. DAVIS L. REV. 1175, 1200 (2018).

[91] *Physicians Disagree About Mandatory Blood-Alcohol Reporting Measures*, CLINICIAN.COM (Sept. 1, 1997), https://www.clinician.com/articles/48746-physicians-disagree-about-mandatory-blood-alcohol-reporting-measures#.

(Oregon), courts have cited specific statutory mandates to disclose blood alcohol test results as evidence that individuals do *not* have a reasonable expectation of privacy in certain kinds of medical records.[92] Other state courts, often relying on state constitutional provisions and in the absence of specific statutory authority, have been more protective, holding that, even for blood test results, patients maintains a reasonable expectation of privacy.[93]

The pervasive, casual, and seemingly systematic sharing of information evidenced in the case files contrasts with the narrow exceptions articulated in the doctrine. While this could be and likely is to some extent the result of under-litigation or lack of awareness, it also points to the failure of the doctrine to adequately guide policing conduct. Nevertheless, there are some basic principles we can draw from the current doctrine.

First, in many of these cases, medical information was obtained pursuant to specific statutory language and through a specific procedural pathway. One lesson to be drawn from these cases is that exceptions to privacy laws, for the purposes of mandatory reporting, should be governed by the specific language of the excepting law and construed narrowly.

Second, these cases do not create an exception to the general proposition that a patient has a reasonable expectation of privacy in his or her medical records and, as the *Ferguson* court stated, 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."[94]

Third, to the extent that courts have allowed general reporting obligations to admit police to healthcare settings, this interpretation is wrong and should be considered in light of the vast regulatory apparatus governing patient privacy, ethics, and norms that govern the medical

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[92] *State v. Huse*, 491 S.W. 3d 833 (Ct. App. Tex. 2016); *Rodriguez v. State*, 469 S.W. 3d 626 (Ct. App. Tex. 2015); *State v. Miller*, 395 P. 3d 584, 591-92 (Ct. App. Or. 2017) (citing *Ferguson*, 532 U.S. at 78, n.13); *State v. Hoffman*, 515 P. 3d 912, 921 (2022).

[93] *See e.g. Commonwealth v. Shaw*, 564 PA 617 (1998) (holding, based on provisions in the Pennsylvania Constitution, that patients maintain a reasonable expectation of privacy with respect to the results of blood alcohol testing results contained within a medical file); *King v. State* 272 Ga 78 (2000) (holding, on the basis of provision in the Georgia Constitution, that the police require a warrant to obtain a patient's medical record).

[94] 532 U.S. at 78.

profession. In its most optimistic form, strong medical ethics, privacy laws, and regulations governing the conduct of healthcare providers would require a more protective and less generalized approach.[95]

To better understand the implications of the exceptions and courts' interpretation of them, it may be helpful to return to the range of facts in the files. In some of the files, the disclosure is limited. Healthcare providers, presumably through hospital-based social work staff, disclose the results of a drug test to the family regulation agency. On the other end of the spectrum, healthcare providers either hand over medical records wholesale to police or disclose extensive information from those records.

To evaluate these cases under the mandatory reporting exception to the reasonable expectation of privacy, the first question is whether the healthcare provider administered the test or procedure for medical or non-medical purposes. The exception to the reasonable expectation of privacy for mandatory reporting contemplates only the first scenario—a test conducted for medical purposes. This exception is rooted in the idea that a healthcare provider, in their course of providing care, sometimes comes across information that is evidence of child abuse. As the Court in *Ferguson* explained, "hospital employees, like other citizens, may have a duty to provide the police with evidence of criminal conduct that they *inadvertently* acquire in the course of routine treatment."[96] But this

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[95] Brown, *supra* note 12 at 679 (arguing that "the blurring of health care and law enforcement violates fundamental principles of medical ethics").

[96] *Id.* at 84–85 (emphasis added). While the Court analogized hospital employees' duties with those of the public, the public has a limited duty to report crimes to law enforcement--most imposed by state law. *See, e.g.*, Graham Hughes, *Criminal Omissions*, 67 YALE L.J. 590 (1958) (explaining the development of crimes of omission in U.S. law); Zachary D. Kaufman, *Protectors of Predators or Prey: Bystanders and Upstanders Amid Sexual Crimes*, 92 S. CAL. L. REV. 1317, 1344-48 (describing the scope of "Bad Samaritan" laws in the United States and arguing they are more common than most scholars acknowledge); Sungyong Kang, *In Defense of the "Duty to Report" Crimes*, 86 UMKC L. REV. 361 (2017); Breanna Trombley, Note, *No Snitches for Stiches: The Need for a Duty-to-Report Law in Arkansas*, 34 UALR L. REV. 813 (2012); Liam Murphy, *Beneficence, Law, and Liberty: The Case of Required Rescue*, 89 GEO. L.J. 605 (2011); Patricia Smith, *Legal Liability and Criminal Omissions*, 5 BUFF. CRIM. L. REV. 69 (2001). At the same time, scholars have argued that the Supreme Court's criminal procedure jurisprudence encourages cooperation with law enforcement. *See, e.g.*, Adam A. Davidson, *The Shadow of the Law of the Police*, 122 MICH. L. REV. 1035 (2024); I. Bennett Capers, *Criminal Procedure and the Good Citizen*, 118 Colum. L. Rev. 653 (2018).

exception should remain firmly rooted in that set of factual assumptions. If a provider does not just come across evidence of potential child abuse, then the exception does not apply. Take for the example the statement in one file, that a healthcare provider performed a drug test "per state law." In that case, the justification for the exception falls away. The statement that the drug test was for a non-medical purpose would be strong evidence, for the defendant, that this disclosure was a violation of the patient's general expectation of privacy in medical records.[97]

Beyond the notation in that file, we have some reason to believe that drug testing in pregnancy criminalization cases often lacks a medical purpose. For example, a recent report from the Marshall Project explained that drug tests of infants often do not help doctors make healthcare decisions. A doctor in Connecticut, interviewed for that report, told the reporter that she regularly received requests from the local family regulation agency to test an infant's blood, a test for which, according to the doctor, there was no medical basis.[98] As the Marshall Project reported,

> Many doctors and nurses across the country have long assumed that drug testing is both a medical and legal necessity in their care of pregnant patients and newborns—even though most state laws do not require it. Yet drug testing during labor is common in America, with a positive test often triggering a report to child welfare authorities.[99]

Evidence in any case or jurisdiction of drug testing policies like those discussed in the Marshall Project's reporting and any evidence of a non-medical purpose would support a patient's argument that she retained a reasonable expectation of privacy despite a claim that the information was provided pursuant to a mandatory reporting obligation.

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[97] The specific case file reference to the drug test performed "per state law" was a reference to a test of the infant not the patient who was being charged with a pregnancy-related crime. If one were litigating this claim, the mother's expectation of privacy with respect to the infant's medical file would of course be relevant. We provide this example here simply to point out the kind of evidence that might be relevant.

[98] Shoshana Walter, *Why Some Doctors Are Pushing to End Routine Drug Testing During Childbirth*, THE MARSHALL PROJECT (Apr. 2, 2025), https://www.themarshallproject.org/2025/04/02/hospital-connecticut-colorado-pregnancy-drug-testing [https://perma.cc/YS3W-VT4F].

[99] *Id.*

The files described above, however, do not only contain evidence of drug testing result disclosure. The study also includes cases in which healthcare providers handed over files themselves or disclosed extensive information from medical files. They collaborated with police to view and interpret evidence in those files, as in the case in which the nurses showed police photos of the deceased infant and purported to help them interpret those photos for the purposes of probable cause. Similarly, doctors turned over the full contents of the file, as was the case involving the labor and delivery director and the nurses sitting with police using the files to construct a "timeline." These facts are a far cry from the scenario contemplated by the mandatory reporting exception to the expectation of privacy. The healthcare providers in this scenario are, presumably in response to police requests, turning the contents of medical records over to police without any documented process.[100] In circumstances like this, courts are likely to and should find a Fourth Amendment violation.

A discussion of *Ferguson* from a previously-referenced state court decision about the difference between compliance with mandatory reporting and police acquisition and inspection of medical records is instructive. As that court explained, "the *Ferguson* dicta about the hospital's ability to draw blood from its patient and *independently* report it to the law enforcement 'under rules of law or ethics' does not apply here."[101] The exception allowing disclosure based on a law requiring mandatory reporting governs only that scenario.

Moreover, the language in both HIPAA and in various state law reporting requirements is broad and vague, leaving courts with some difficult interpretive puzzles. As detailed above, HIPAA exempts disclosures "required by law," but the statute provides little guidance about the law to which it refers or what "required" means. To see this ambiguity, take for example, Tennessee's mandatory reporting statute, which details that:

> The report *shall* include, to the extent known by the reporter, the name, address, telephone number and age of the child, the name, address, and telephone number of the person responsible for the

[100] Here and elsewhere we admittedly make certain assumptions about what happened in any particular case in our data set. The viability of any particular claim in any particular case would, of course, depend on significantly more development of the facts.

[101] 23 N.E.3d 218 (Ohio Ct. App. 2014).

> care of the child, and the facts requiring the report. The report *may* include any other pertinent information.[102]

It is not clear from the statute what the difference is between "the facts requiring the report" and "any other pertinent information." To a patient or doctor trying to understand the scope of the HIPAA exception for disclosures required by law, though, this matters a great deal. HIPAA only exempts what is "required." To the extent that courts interpret the state reporting requirements to allow generalized entry to investigate or generalized access, this interpretation must be viewed as incorrect.

Indeed, a final problem with the mandatory exception is the apparent open-ended nature of the information medical providers must provide and courts' silence on what precisely mandatory reporting entails. In the absence of the applicability of HIPAA's minimum necessary standard to state laws, the medical profession itself has attempted to set out parameters that comport with the law and their ethical obligations to their patients.[103]

Returning to the pregnancy-related prosecutions outlined above, a few things are clear. What the police officers did and what the medical providers allowed appear to go far beyond the limited exposure of test results. Police cannot and should not simply saunter in and examine the contents of a medical record. Cases like that of the defendant whose entire medical file was handed over to police by the labor and delivery director merit scrutiny. Certainly, we do not have all the facts. It is possible that police obtained a warrant in that case. Nevertheless, broad disclosures in response to such requests are well beyond what even courts like the one in *Martinez* allow. The same Fourth Amendment prohibition applies to cases in which healthcare providers show police the contents of the files, as seemed to have occurred when nurses shared photographs from the file and when they read the files and provided information to the police.

Since courts focus more on the pieces of evidence that are eventually critical to proving some element of an offense, the details of these information pathways and wholesale disclosure of medical files escape

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[102] TENN. STAT. ANN. § 37-1-403(b) (emphasis added).

[103] *See* American Medical Ass'n, Code of Medical Ethics, Opinion 2.02(3)(b) *Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse*, and AMA, Code of Medical Ethics, Opinion 5.05 *Confidentiality*; *see also* Lois Snyder, *American College of Physicians Ethics Manual: Sixth Edition*, 156 ANN. INTERNAL MED. 73 (2012).

scrutiny from judges and attorneys. But that should not mean that such conduct falls through the cracks of privacy protections.

The interplay of federal and state statutory carve-outs to Fourth Amendment protection underscore legal scholars Erin Murphy's call over a decade ago that statutory law enforcement exceptions merit further scrutiny.[104] As Murphy points out, scholars like Orin Kerr have argued that technological advances should be regulated legislatively and not by courts.[105] Murphy argues for a "collaborative constitutionality approach" to "achieve optimal levels for protecting privacy."[106] While Murphy focused on federal law enforcement exceptions and not state mandatory reporting requirements, her argument is even more salient when applied to the use of mandatory reporting laws to undercut reasonable expectations of privacy. Without a backstop or guardrail, any legislature could determine the extent of Fourth Amendment privacy protections in their jurisdiction. Since *Dobbs*, we have seen legislatures enact abortion bans and transgender care restrictions—statutes that could be enforced by resort to law enforcement exceptions. Murphy's argument for tempering overreach by legislatures applies even more today, when courts seem like the last bulwark against executive and legislative overreach.

3. Privacy, Medical Vulnerability, and the Healthcare Setting

Place matters in criminal procedure doctrine. An expectation of privacy is not just about the object being searched or seized; it is also about where those events occur. The prototypical settings in Fourth Amendment law revolve around homes, cars, streets, and analogies to such settings. Perhaps one of Justice Scalia's most famous images is that of "the lady of the house tak[ing] her daily sauna and bath," an "intimate" activity potentially detectable by the thermal imaging device used by police to detect marijuana growing in a house in *Kyllo v. United States*. Without giving us further details, this hypothetical evokes the vulnerability of a naked person engaging in one of the more private activities that take place at home.

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[104] Erin Murphy, *The Politics of Privacy in the Criminal Justice System: Information Disclosure, the Fourth Amendment, and Statutory Law Enforcement Exemptions*, 111 MICH. L. REV. 485, 491 (2013).

[105] *Id.* at 489 (citing Orin S. Kerr, The Fourth Amendment and New Technologies: Constitutional Myths and the Case for Caution, 102 MICH. L. REV. 801, 805, 857-87 (2004)).

[106] *Id.* at 534.

Yet, even as the doctrine recognizes the sanctity of the home and the sanctity of activities that take place within its protection, courts have not applied the same kind of protections to patients seeking and receiving medical treatment. Courts have cited reporting obligations as necessarily anticipating and justifying the presence of police in patient treatment areas.[107] Conventional criminal procedure also tells us that when police are "invited in" to a location, space, or area by a third party and not the suspect or target of police suspicion, the suspect/target does not have constitutional or Fourth Amendments grounds to challenge the police officer's subsequent investigative actions. The paradigmatic scenario is the homeowner who invites police into their home with the drugs of a visiting guest in full view.

In many of the case files, police could engage in overboard actions because they were present. In some situations, police were granted access to the healthcare treatment areas. In such situations, like that of the homeowner and house guest, officers are viewed as "invited in" by hospital personnel. In such a scenario, patients are mere houseguests whose privacy is subject to the decisions of the homeowner—hospital staff and administration. Such access to healthcare treatment settings by hospital personnel allows law enforcement to overcome a threshold Fourth Amendment obstacle—permission to be on the premises. Once on the premises, a range of warrant exception doctrines allow police to gather evidence.

One particularly salient doctrine is the "plain view" doctrine. There is no Fourth Amendment violation when a police officer seizes an item if the incriminating nature of that item is immediately apparent to the officer and the officer was lawfully present at the time of the viewing.[108] The plain view doctrine has also spawned related "plain feel" and "plain hearing" doctrines, the latter of which is particularly at play when law enforcement come into healthcare areas.[109]

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[107] Song, Policing the Emergency Room, *supra* note X at 2667 (citing People v. Torres, 494 N.E.2d 752, 755 ; see Blakney v. Winters, No. 04-CV-07912, 2008 WL 4874852, at *7 (N.D. Ill. Aug. 15, 2008) (citing Torres, 494 N.E.2d 752); State v. Turner, 416 P.2d 409, 411 (Ariz. 1966)).

[108] Horton v. California, 496 U.S. 128 (1990).

[109] United States v. Yamba, 506 F.3d 251, 257 (3d Cir. 2007) ("[C]ourts have logically extended this concept to permit the admission of evidence discovered with other sensory faculties."); United States v. Pace, 709 F. Supp. 948, 954 (C.D. Cal. 1989) ("Under the 'plain hearing' exception, if police officers overhear

Another doctrine courts have applied to give law enforcement access to patients and their property is the third-party doctrine. Searches of patients' belongings by medical staff often fall outside the Fourth Amendment's purview because Fourth Amendment protections do not generally apply if staff search the patient belongings pursuant to hospital policy.[110] If hospital staff find contraband and turn it over to the police, the courts have treated such events as third party searches that do not implicate patients' constitutional rights.[111] Only in cases in which hospitals have had explicit policies safeguarding the privacy and ownership of patient property have courts ruled differently.[112] This treatment of healthcare settings as any other third-party setting seems to make little sense given the many different kinds of "private facts" that are accessible and the absence of patients' consent to police access to treatment areas. It would then seem that the same logic courts have applied in post-*Carpenter* medical records cases would apply to searches of patients and their property.

Giving law enforcement broad access in healthcare settings is also problematic because the people within these settings are compromised physically, emotionally, and mentally. Unlike a person who is a guest in a

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statements without the benefit of listening devices while they are stationed at a lawful vantage point, then those statements are admissible at trial.").

[110] United States v. Clay, No. 5:06-CR-83-S, 2006 WL 2385353, at *2 (E.D. Ky. Aug. 17, 2006); People v. Rodgers, 661 N.Y.S.2d 452, 453, 457 (Cnty. Ct. 1997), *aff'd as modified*, 670 N.Y.S.2d 600 (App. Div. 1998); Wilson v. State, 99 S.W.3d 767, 771 (Tex. App. 2003). *But see* State v. Klase, 131 N.E.3d 1054, 1057, 1067 (Ohio Ct. App. 2019). In *People v. Rodgers*, 661 N.Y.S.2d 452, upon arriving at the emergency room where the defendant was being treated, a trooper assisted medical professionals in getting the man's clothes off. *Id.* at 453. While taking his clothes off for treatment, according to hospital procedure, a syringe and a spoon fell out. *Id.* The court held that these events constituted a private search, and the involvement of the police was "purely incidental," hence the spoon and syringe could not be suppressed. *Id.* at 457.

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

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

home or other setting, a patient cannot just walk away from the law enforcement encounter without risking physical harm. Moreover, medical providers' invitation to police raises a whole host of other health privacy issues that courts do not adequately address. Once law enforcement is in an emergency room, all manner of patient health information is revealed to them—and not just that of the patient being investigated.

Any logic of access in these otherwise private areas that become less private because of an institution's decision to invite law enforcement in fails to account for how this lack of privacy will impact groups differently. A person with good insurance who can choose where and when to get medical care will likely have more privacy than the under- or uninsured person whose only option is the emergency room that has a constant police presence. As multiple scholars have noted, these socio-economic facts lead to the increased criminalization of the poor, as Kaaryn Gustafson noted in her study of welfare offices and the shrinking "zones of privacy" for poor mothers.[113] Certain emergency rooms likewise become less private not because they are innately such but because the personnel and administrators within them have developed cooperative and symbiotic relationships with law enforcement.[114]

B. State Actors, Special Needs, and Policing Purpose

Even if there is a reasonable expectation of privacy, a variety of other doctrines are implicated in analyzing whether, in the context of pregnancy-related prosecutions, there is a Fourth Amendment violation. This section turns to three other doctrines—state action, special government needs, and policing purpose—and analyzes both the relevant doctrinal framework and its specific application to pregnancy-related prosecutions. The discussion highlights criminal procedure's basic failure to see the full import of systemic collaboration between healthcare providers, family regulation agencies, and traditional police.

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[113] GUSTAFSON, *supra* note 12 at 6-7; BRIDGES, *supra* note 3, at 89.

[114] Brown, *supra* note 12 at 696; Song, *Policing the Emergency Room*, *supra* note X at 2678.

1. State Action and Non-Police Policing

Constitutional limits placed on criminal investigations apply only to state actors.[115] Searches or questioning by private actors, by contrast, face no criminal procedure boundaries. This limitation makes sense when one conceives of a strict delineation between private people and law enforcement and assumes law enforcement cannot use private individuals to accomplish their ends.

In contemporary investigations, however, private individuals and industries play a central role in law enforcement and surveillance. The doctrine, to some extent, contemplates this possibility. The state cannot evade the strictures of the Fourth and Fifth Amendment by using private parties to do what the state is otherwise prohibited from doing. Hospital personnel, not typically thought of as law enforcement agents, search records or ask patients questions in police officers' presence, sometimes at their express direction.[116] For that reason, courts have recognized that "the law does not require a badge and a gun for someone to function as an agent of law enforcement."[117] A private person may act as an agent of law enforcement if "the government knew of and acquiesced in the conduct at issue, . . . the individual sought to assist law enforcement, and . . . the individual performed the conduct at the request of the government."[118] In contrast, when a private actor is not a state employee and chooses to inform on a person with whom they have a relationship, the courts have

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[115] Colorado v. Connelly, 479 U.S. 157, 166 (1986) ("The most outrageous behavior by a private party seeking to secure evidence against a defendant does not make that evidence inadmissible under the Due Process Clause.").

[116] *See, e.g.*, State v. Ybarra, 804 P.2d 1053, 1056 (Sup. Ct. N.M. 1990); Welch v. Commonwealth, 149 S.W.3d 407 (Ky. 2004); State v. Caulder, 339 S.E.2d 876 (S.C. Ct. App. 1986). *But see* People v. Salinas, 182 Cal. Rptr. 683 (Ct. App. 1982); United States v. Romero, 897 F.2d 47, 52 (2d Cir. 1990); Powell v. Quarterman, 536 F.3d 325, 341–43 (5th Cir. 2008).

[117] United States v. Higgins-Vogt, 911 F.3d 814, 821 (7th Cir. 2018); United States v. D.F., 115 F.3d 413, 419–20 (7th Cir. 1997)l

[118] *Higgins-Vogt*, 911 F.3d at 821 (citing United States v. McAllister, 18 F.3d 1412, 1417–18 (7th Cir. 1994)). *See also* United States v. Richardson, 607 F.3d 357, 364 (4th Cir. 2010) ("The defendant shoulders the burden of establishing the existence of an agency relationship—a fact-intensive inquiry that is guided by common law agency principles."); State v. Lizotte, 197 A.3d 362, 371–72 ¶ 21.

decided that the private individual can participate in police investigation without running afoul of the Constitution.[119]

A private party can also act, "as an instrument or agent of the Government" when the individual is acting pursuant to state or federal law.[120] This can be true when the private actor is required by law to conduct a particular search, but it can also be true when the law strongly encourages a private party to act. As the Supreme Court explained in *Skinner v. Railway Labor Executives' Ass'n*, even if the private party is encouraged rather than required to conduct a particular search, whether that private party is a state actor must be "resolved 'in light of all the circumstances.'"[121] In *Skinner* the Supreme Court evaluated the state action question with regard to federal law concerning drug testing railway employees. The case involved two separate regulations, one that mandated the testing and one that encouraged the testing. As to the mandate, the Court treated it as an easy question. Once the state required a private party to do a particular search, the search was state action. With respect to the non-mandatory regulation, the court also determined that "in light of all the circumstances" and due to the strong encouragement in the statute at issue, the private railroad company's employee testing constituted state action.[122]

2. Special Needs and Policing Purpose

Generally, when police search and seize individuals and their property, they must have individualized suspicion and must have either a warrant or be acting under an exception to the warrant requirement. One such exception is the special needs doctrine, derived from *New Jersey v. T.L.O.*[123] In *T.L.O.*, Justice Blackmun, concurring in the Court's judgment that school officials can engage in warrantless searches, articulated the

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[119] *Connelly*, 479 U.S. at 166; State v. Sanders, 452 S.W.3d 300, 312 (Tenn. 2014) ("The circumstances in this case fall squarely in the line of federal and state cases in which a suspect has misplaced his or her trust in an accomplice or other confidant who is or who will be cooperating with law enforcement.").

[120] Skinner v. Ry. Lab. Execs.' Ass'n, 489 U.S. 602, 614 (1989). Scholars like Christopher Slobogin have argued that business entities, in particular, should more often be considered state actors in light of their unique motivations. *See* Christopher Slobogin, *"Volunteer" Searches*, 85 U. PITT. L. REV. 1, 19-20 (2023).

[121] *Id.* at 615 (quoting Coolidge v. New Hampshire, 403 U.S. 443, 487 (1971).

[122] *Id.*

[123] 469 U.S. 325, 351 (1985).

notion that certain "special needs, beyond the normal need for law enforcement, make the warrant and probable-cause requirement impracticable in certain instances."[124] The resulting test has two parts: first, was the search conducted for a non-law enforcement purpose and, second, if there was a non-law enforcement purpose, was the search reasonable.[125]

The doctrine justifies a whole range of searches conducted by government actors without requiring individualized suspicion. Examples are checkpoints designed to regulate drunk driving, borders, and drug interdiction.[126] The special government need for community safety and the goal of rehabilitation allow suspicionless searches of people on probation or parole.[127] The doctrine also applies to site-specific programmatic searches, including drug testing of public school students and public employees.[128] Finally, the doctrine justifies suspicion-based searches without requiring a warrant and on less than probable cause. As the Court in *T.L.O.* concluded, focusing on the particularities of the school setting, "the accommodation of the privacy interests of schoolchildren with the substantial need of teachers and administrators for freedom to maintain order in the schools does not require strict adherence to the requirement that searches be based on probable cause…. Rather, the legality of a search of a student should depend simply on the reasonableness, under all the circumstances, of the search."[129] If a Court determines that the purpose is special needs and not "policing," then it must determine reasonableness based on whether the action was "justified at its inception" and whether the way it was conducted "was reasonably related in scope to the circumstances which justified the interference in the first place."[130]

The *Ferguson* decision falls squarely within the special needs line of cases. The legal issue as framed by the Court was "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 non-

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[124] *Id*. (Blackmun, J., concurring).

[125] *Id*. at 351–54 (Blackmun, J., concurring).

[126] City of Indianapolis v. Edmond, 531 U.S. 32 (2000) (drug interdiction); Illinois v. Lidster, 540 U.S. 419 (2004) (drunk driving);

[127] Griffin v. Wisconsin, 483 U.S. 868 (1987).

[128] *See* Christopher Slobogin, *Policing as Administration*, 165 U. PENN. L. REV. 91, 103-05 (2016).

[129] New Jersey v. T.L.O., 469 U.S. 325, 341 (1985).

[130] *Id.*

consensual search is unconstitutional if not authorized by a valid warrant."[131]

In analyzing the hospital's program, the *Ferguson* Court identified three factors relevant to these questions. First, the decision turned on the question of the nature of the "special need" asserted by the state.[132] Here, however, "[t]he central and indispensable feature of the policy from its inception was the use of law enforcement to coerce the patients into substance abuse treatment."[133] The policy, therefore, was "ultimately indistinguishable from the general interest in crime control."[134] Second, and relatedly, the Court emphasized the extensive involvement of police in the development and administration of the policy. As the Court explained,

> 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 of the policy, this case simply does not fit within the closely guarded category of "special needs."[135]

Finally, the Court focused on the high level of intrusion into individuals' expectations of privacy. As they explained,

> The use of an adverse test result to disqualify one from eligibility for a particular benefit, such as a promotion or an opportunity to participate in an extracurricular activity [in prior cases], involves a less serious intrusion on privacy than the unauthorized dissemination of such results to third parties. The reasonable

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[131] 532 U.S. at 70.

[132] *Id*. at 79.

[133] *Id.* at 80–81.

[134] *Id.* at 81.

[135] *Id.* at 84. The *Ferguson* Court also took care to distinguish its holding from information subject to laws that require them to report certain categories of information to law enforcement or other agencies. As the Court stated, the information provided to law enforcement pursuant to the MOU is easily distinguished from, "circumstances in which physicians or psychologists, in the course of ordinary medical procedures aimed at helping the patient herself, come across information that under rules of law or ethics is subject to reporting requirements." *Id.* at 80–81 (Scalia, J., dissenting).

> 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.[136]

Ferguson's legacy has been somewhat mixed and has turned on the three factors relevant to policing purpose that were most important to the *Ferguson* Court— the programmatic purpose of the acts at issue, the extent of police involvement in the design and implementation of policy, and the privacy interest at stake. One set of cases focuses on the purpose of administering a medical test. These cases, which generally involve the test's use in a criminal prosecution, ask whether the testing was done for medical as opposed to policing or investigative purposes. Courts regularly hold that a medical test done at the request or direction of the police requires either a warrant or a valid exception to the warrant requirement.[137] In cases in which the police simply obtain the results of medical testing done for medical purposes or other non-investigative purposes and that information is subsequently obtained by police, courts often rely on the absence of a policing purpose to distinguish the case from *Ferguson*.[138] Importantly, courts often treat a medical provider's ordering of the test as evidence that it is not for a law enforcement purpose, despite extensive evidence that medical personnel have long ordered testing as part of what they see as their own role in law enforcement.[139] As we have described

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[136] *Id.* at 78.

[137] *See* infra Part IV(A)(2).

[138] *See, e.g.*, United States v. Clay, No. 5:06-CR-83-S, 2006 WL 2385353, at *2 (E.D. Ky. Aug. 17, 2006) (inventory of patient's personal items was for the purpose of conducting the procedure and to protect the hospital in case of a patient claims of theft); Anthony v. City of New York, 339 F.3d 129 (2d Cir. 2003) (blood and urine tests undertaken to facilitate diagnosis and treatment by ruling out drug use or other physiological conditions as a possible explanation for her delusional behavior); Makas v. Miraglia, Nos. 05 CIV 7180 DAB FM, 06 CIV 14305 DAB FM, 2007 WL 724603, at *11 (S.D.N.Y. Mar. 5, 2007) (purpose of blood tests at issue were to detect syphilis and hepatitis, to monitor his cholesterol and thyroid levels, and to check his liver function); Roe v. Marcotte, 193 F.3d 72, 78 (2d Cir. 1999) (warrantless collection of blood samples from convicted sex offenders in prisons approved under the "special needs" exception because significant governmental interest in maintaining institutional security, public safety, and order outweighed minimal intrusions on individual privacy). As discussed *supra* at ____, this fact is also relevant to the question of whether there is a reasonable expectation of privacy.

[139] Walter, *supra* note 98.

previously, the police may well need a warrant to obtain the test result, but the testing itself is not subject to the warrant requirement.

a. Special Needs, Policing Purpose, and Investigation by Family Regulation Agencies

Searches by agents of the family regulatory system have also been analyzed under the special government needs doctrine. Scholars and activists in the family regulation space have long argued that family regulation investigations should receive some or all the protections guaranteed to criminal defendants by the Fourth and Fifth Amendments. Doriane Lambelet Coleman argues that, particularly when police and family regulation staff collaborate, heightened Fourth Amendment protections should apply.[140] Josh Gupta- Kagan and Tarek Ismail focus instead of moments when there is less on-the-ground collaboration, arguing in Gupta-Kagan's case for reform of the special needs doctrine and in Ismail's case for the imposition of traditional Fourth Amendment protections for home searches conducted by family regulation agencies.[141] This article focuses on another piece of puzzle, revealing structural mechanisms by which family regulation agencies and traditional police collaborate even when both agencies are not physically present at the moment of search.

Although Justice Marshall in dissent in *Baltimore City Department of Social Services v. Bouknight*, pointed out that it is "dubious" to suggest that compliance with this "noncriminal regulatory regime" does not subject people to potential self-incrimination,[142] the Supreme Court has not adjudicated a case involving searches by family regulatory system actors. Echoing Lambelet Coleman's arguments, decisions by lower courts reveal that when police and family regulation actors work in concert, conducting joint interrogations or investigations, they are subject to

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140 Doriane Lambelet Coleman, *Storming the Castle to Save the Children: The Ironic Costs of a Child Welfare Exception to the Fourth Amendment*, 47 WM. & MARY L. REV. 413 (2005).

141 Ismail, *supra* note 29; Josh Gupta-Kagan, *Beyond Law Enforcement:* Camreta v. Greene*, Child Protection Investigations, and the Need to Reform the Fourth Amendment Special Needs Doctrine*, 87 TUL. L. REV. 353 (2011). *See also* Anna Arons, *The Empty Promise of the Fourth Amendment in the Family Regulation System*, 100 WASH. U. L. REV. 1057 (2023).

142 493 U.S. 549, 568 (1990).

traditional Fourth and Fifth amendment strictures.[143] In the case files described above we sometimes see clear evidence of such joint investigation. For example, one case file includes a description of a joint interview of the defendant conducted by a police investigator, the child protective investigator, and a behavior health consultant. In such a case it would likely be fairly easy to establish that collaborative work is policing in the traditional sense and therefore subject to the full protections of the Fifth Amendment. Similarly, had that collaborative team engaged in a search rather than questioning, the Fourth Amendment and its probable cause and warrant requirement should apply.

What is more contested and less clear, though, is whether family regulation investigations conducted solely by family regulation actors are subject to the same rules. Family regulation investigators are clearly state actors, but, as Gupta-Kagan notes, at least some courts relegate their investigations to the special needs doctrine and its less rigorous protections.[144] But, as scholars like Lisa Washington have noted, systems like these do not operate in isolation. Instead, they converge. In her critical examination of the compounding harms of family regulation and immigration enforcement, she describes how the two systems converge to enhance punitiveness and harm to individuals.[145] This type of system convergence regularly occurs between the criminal legal, healthcare, and family regulation systems in the policing of reproductive rights.[146] Police work goes far beyond the trope of the constable patrolling the street and

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[143] *See, e.g.*, Greene v. Camreta, 588 F.3d 1011 (9th Cir. 2009) (vacated on mootness grounds) ("At the time of the seizure, police were actively investigating allegations of child sexual abuse against S.G.'s father and a police officer was present at S.G.'s interview. As courts faced with similar 'dual-purpose' searches have noted, 'disentangling [the goal of protecting a child's welfare] from general law enforcement purposes' becomes particularly 'difficult' in these circumstances, as we cannot allow '[o]ther societal objectives [to] justify a program that would systematically collect information for the police.'").

[144] *See, e.g.*, Roe v. Tex. Dep't of Prot. & Regul. Servs., 299 F.3d 395, 407 (5th Cir. 2002) ("Texas law describes social workers' investigations as a tool both for gathering evidence for criminal convictions and for protecting the welfare of the child. *Ferguson* teaches that we must apply the traditional Fourth Amendment analysis where a child protective services search is so intimately intertwined with law enforcement.").

[145] Washington, *supra* note 12.

[146] Roberts, *Systemic Punishment*, *supra* note 3; Bach, CRIMINALIZING CARE, *supra* note 5.

evades the simplistic characterization of the police officer as lone investigator, finding witnesses and gathering evidence.

The deep structural and regulatory collaboration between family regulation agencies and police provide strong evidence that searches and questioning that are undertaken by family regulation staff should be viewed as policing and should be subject to full Fourth and Fifth Amendment protections.

While the special needs policing purpose question and state action are doctrinally distinct inquiries, similar facts matter to both. In both contexts, courts consider the purpose of the conduct and the extent of collaboration between the healthcare provider and the police, details which often require the same inquiries about hospital systems and policies, law enforcement's relationships with medical providers, and the circumstances of the investigation.

3. Pregnancy Criminalization: State Action, Special Needs, and Policing Purpose

Even with a permissive special needs doctrine,[147] evidence from the case files demonstrate that actions taken by hospital personnel in conjunction with family regulatory agencies and law enforcement should, in many cases, be understood as state actions undertaken for a policing purpose.

a. Healthcare Providers Gathering Information and Collaborating with Police

At the site of pregnancy criminalization, the state actor, special needs, and policing purpose questions are salient. Take for example the cases in which the files reveal healthcare providers searching a patient's healthcare records alongside police, extracting information used to prosecute their patients. Detailed above are two cases that demonstrate such a pattern. In one, the emergency room doctors consulted the medical file and as a result "were able to give a timeline to Officer X based on their initial medical entries of the baby and [the defendant]." In another, the nurses appeared to pull photos from the patient's medical record, show them to the police, and then "interpret" them to determine both the birth weight of the child

[147] *See* Slobogin, *supra* note 128 (describing special needs searches are "panvasive" because they are "pervasive, invasive, and affect large numbers of people, most of whom police know are innocent of wrongdoing.").

and whether the child had been born alive. As detailed above, police actions in these cases almost certainly violate the patients' reasonable expectations of privacy. The question, though, is whether the healthcare providers' actions constitute state action and if they do, whether those actions will be evaluated under the less rigorous *T.L.O.* reasonableness inquiry or instead deemed motivated by a "policing purpose" and therefore subject to the more rigorous warrant requirement.

Assume for a moment that these healthcare providers are private actors at a private hospital. There are two arguments available that might convince a court that these healthcare providers are in fact state actors. The first addresses the line between private citizens and a classic informant. In *Ferguson,* Justice Stevens wrote that healthcare providers are like "other citizens, [who] may have a duty to provide the police with evidence of criminal conduct that they inadvertently acquire in the course of routine treatment."[148] On the other hand, looking at these facts, a court might conclude that this is not the typical citizen reporting evidence of criminal conduct to the police but is instead a private citizen "perform[ing] the conduct at the request of the government,"[149] transforming these particular healthcare providers from private citizens into state actors.

Second, the defendant might turn to *Skinner* and its progeny, pointing to mandatory reporting laws to suggest that the healthcare providers are strongly encouraged, and sometimes even perceive themselves as required, to search the records. This argument, however, will have to overcome a series of decisions about mandatory reporting. Even as the Supreme Court has recognized that statutory encouragement can convert a private actor into a state actor, as in *Skinner*, mandatory reporting obligations on healthcare providers have not been interpreted in the same way. Courts have repeatedly held that state reporting requirements do not convert private healthcare providers into state actors.[150] Even in instances

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[148] 532 U.S. at 84–85.

[149] United States v. Higgins-Vogt, 911 F.3d 814, 821 (7th Cir. 2018) (citing United States v. McAllister, 18 F.3d 1412, 1417–18 (7th Cir. 1994)). *See also* United States v. Richardson, 607 F.3d 357, 364 (4th Cir. 2010) ("The defendant shoulders the burden of establishing the existence of an agency relationship—a fact-intensive inquiry that is guided by common law agency principles."); State v. Lizotte, 197 A.3d 362, 371–72 ¶ 21.

[150] Sawyer v. Legacy Emanuel Hosp. & Health Ctr., 418 F. Supp. 3d 566, 572 (D. Or. 2019); Gay v. Children's Hosp. of Pa., No. 18-02880, 2018 WL 3447173, at *5 (E.D. Pa. July 16, 2018) (citing cases dismissing § 1983 claims against

in which the healthcare provider acts alongside family regulation staff, some courts have been reluctant to categorize the actions of the healthcare provider as those of a state actor.[151]

But courts do draw a line. Take for example, the Second Circuit's analysis of state action in *Kia P. v. McIntyre*.[152] In that case a private hospital held an infant for one to two days while they were seeking the family regulation agency's approval to release the infant to the parents. The infant had tested positive for methadone at birth. Initially, the hospital held the infant for medical purposes—to monitor the child for signs of withdrawal—and the court was clear that the initial hold did not constitute state action. However, several days after birth the infant was medically cleared. Before releasing the child to the parents, the hospital staff waited for the family regulation caseworker's permission. The court drew a line between the first set of days, when the hold was for a medical purpose, and the last one to two when they waited for state agency approval. Citing the rule that, "conduct that is formally 'private' may become so entwined with governmental policies or so impregnated with a governmental character as to become subject to the constitutional limitations placed upon state action,"[153] the Second Circuit held that the private hospital was a state actor during the one to two day period during which they held the infant while they waited for state approval. By acting "as part of the reporting and enforcement machinery" for the family regulation agency, the hospital became a state actor.[154]

Similarly, a defendant who presents evidence of collaboration in their case or as hospital policy may be able to convince a court that the healthcare providers are not simply stumbling upon evidence of purported crime and telling the police about it but are, through their collaboration in the act of searching and analyzing the information for the purposes of criminal charging decisions, part of the investigative machinery of the police.

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private hospital defendants and physicians because they did "not become state actors solely because, as mandated reporters under state law, they reported or failed to report suspected child abuse").

[151] Evans v. Torres, No. 94 C 1078, 1996 WL 5319, at *5 (N.D. Ill. Jan. 4, 1996).

[152] Kia P. v. McIntyre, 235 F.3d 749, 756 (2d Cir. 2000).

[153] *Id*. at 757 (citing Perez v. Sugarman, 499 F.2d 761, 764–65 (2d Cir. 1974)).

[154] *Id.* at 756.

b. Wide Ranging Searches of Medical Records

Wide ranging searches pose the most straightforward criminal procedure problem, whether undertaken by healthcare providers in collaboration with police or by police when healthcare providers capitulate to their requests. Despite limited exceptions, patients almost certainly have a reasonable expectation of privacy in their records.[155] In such scenarios, a defendant could establish state action in three ways. First, the healthcare provider who is either reading or handing over the medical record could be employed by a state entity, as was the case is *Ferguson*. Second, even if the healthcare provider works for a private entity, he or she might be a state actor if she "performed the conduct at the request of the government."[156] Third, a court could determine that the collaborative investigative system encourages searches so strongly that, as in *Skinner*, the hospital's actions constitute station action.

Two scenarios from the case files demonstrate how government requests may constitute state action in pregnancy prosecutions. In one case described above, "nurses were able to give a timeline to Officer X based on their initial medical entries for the baby and [defendant]. ER nurses stated that D arrived at X hour and was bleeding out." In the second case, nurses provided photos of the infant to the police and then, seeming to examine the photos with law enforcement, speculated about the birth weight and asserted that "the baby was born living due to the child's tone. . . . [and that] it appeared that the baby was alive at the time of birth." These healthcare providers are not, in this scenario, simply providing information they inadvertently discovered. They are acting in collaboration with the police, providing evidence to a court that they are state actors regardless of their employment status. Similarly, their active collaboration with police in searching the files for evidence of a crime makes the question of policing purpose similarly clear.

c. Drug Testing Results

The case files reviewed above also contain evidence that hospitals, both public and private, regularly drug test pregnant patients and then convey the results of those drug tests to family regulation entities or police. There are three potential searches here—first the drug test itself, second the search of the medical file to share the results of the drug test, and third,

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[155] *See infra* Part IV.A.1.

[156] 18 F.3d at 1417.

the request by the police for the medical file if it had been reported to family regulation rather than the police.

As to the drug test itself, the reason for the testing matters. If it is for medical purposes and the state then "inadvertently" discovers evidence of child abuse, that may fall into a mandatory reporting exception. But if that is not the case, the defendant may have a stronger claim. There is substantial reason to believe that at least some of this testing is being done for non-medical purposes.[157] If that is the case, then a defendant is halfway to proving state action and policing purpose.

Moreover, while not sufficient on its own to prove a policing purpose, there is significant evidence that both drug testing during pregnancy and referral to family regulation systems are biased in ways that mirror the structural biases of the family regulation and criminal systems overall. A recent meta-analysis of studies showed that characteristics associated with social vulnerability, "most notably race and ethnicity, age, and public insurance lead to increased rates of detection."[158] Similarly, bias in reporting to child welfare has also been well documented.[159]

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[157] *Supra* text accompanying note 98-99.

[158] Virginia A Lijewski et al., *The Impact of Social Vulnerability on Substance Use Detection Practices in Pregnancy*, 41 AM. J. PERINATAL 2175, 2175 (2024), https://pubmed.ncbi.nlm.nih.gov/38503303/ ("Social vulnerability plays a role in substance use detection among pregnant individuals. Most notably, race and ethnicity, age, and public insurance lead to increased rates of detection, though most individual factors need to be studied in greater depth."). At the same time, universal testing, intended to curb biased drug testing, can have a net-widening effect by subjecting all pregnant people receiving medical care to unconsented-to drug tests, revealing drug use by those that might otherwise have gone undetected. Hospitals that appear in the case files with frequent positive drug screens for marijuana or THC suggest such universal testing policies are in place.

[159] Julia Readdy et al., *Prenatal substance Exposure & Multilevel Predictors of Child Protection System Reporting*, 282 J. PEDIATRICS 114546 (2025), https://pubmed.ncbi.nlm.nih.gov/40118246/ ("Among 260,525 births during 2018 in California, 2.6% had documented substance exposure, with observed racial differences in substance use and type. Nearly 4% of births to Black mothers had documented cannabis exposure compared with roughly 1% among White and Hispanic mothers. The delivery hospital explained 24% of variance in CPS reporting. Hierarchical models revealed race and insurance-type differences in the likelihood a CPS report followed a substance exposed birth. Namely, publicly-insured births in hospitals where majority births were covered by private insurance had nearly twice the probability of being reported compared with those with private insurance.").

Even if the blood test is done for medical purposes, that does not doom the state action or special needs analysis. The Fourth Amendment and its warrant requirement may still apply if police or family regulation agents extract information from the medical file when it has not been reported to them pursuant to mandatory reporting laws. If the information is in the narrow category that must be reported out under state law, courts tend to conclude that there is no reasonable expectation of privacy. But if the information goes beyond that which is required, then hospital personnel's actions might amount to both state action and policing purpose.

What happens on the ground is clear. In Oklahoma, Alabama, and South Carolina, substance exposure constitutes child endangerment. This means that a healthcare provider, usually the hospital social worker, reports toxicology results that suggest substance use during pregnancy to a family regulation agent who then reports it to police. The files demonstrate this information pathway when probable cause affidavits contain information about drug screens administered in medical settings or list family regulation agents as complainants. What happens after this report has legal significance. If the family regulation agency or police subsequently request the medical record, that—not the initial blood draw or test—is a search.

Although courts tend to view family policing actions under the special needs doctrine, mandatory reporting that flows through family policing retains a policing purpose, rather than fulfilling a need separate from law enforcement, because state statutes treat family policing agents as part of the criminal investigation team. Take, for example, the regulatory environment in Oklahoma. As detailed above, the law requires any healthcare professional or midwife "involved in the prenatal care of expectant mothers or the delivery or care of infants" to "promptly report to [DHS] instances in which an infant tests positive for alcohol or controlled substances." Another statute then requires DHS to "forward a report of its . . . investigation and findings" to the DA's office that may have jurisdiction over the case.[160] Similarly, Tennessee law is explicit in this respect when it states that, "It is the intent of the general assembly that the child protective investigations be conducted by the team members in a manner that not only protects the child but that also preserves any evidence for future criminal prosecutions."[161]

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[160] OKLA. STAT. tit. 10A, § 1-2-102(A)(3).

[161] TENN. CODE ANN. § 37-1-607.

These statutory requirements explain why so many of the case files include complaints initiated by family policing personnel. For instance, one file described a child welfare specialist being contacted by a medical center and then filing an incident report with the same information. Courts often fail to recognize the policing purpose undergirding these statutes because they are subtler and less direct than those in *Ferguson*. In *Ferguson*, the police were involved in the day-to-day operation of the testing program. Though the files suggest such a scenario is rare, regulatory frameworks often serve the same function. The key question remains whether, "the sharing of his medical information served or was intended to serve a law enforcement purpose."[162]

Courts have recognized that family regulation searches can serve law enforcement purposes. In *Roe v. Texas Department of Protective & Regulatory Services*, for example, the Fifth Circuit, citing *Ferguson*, held that a visual body cavity search of a child conducted by an employee of the Texas Department of Protective and Regulatory Services, without a warrant or probable cause, violated the Fourth Amendment. The court held that despite the child welfare purpose of the search, the series of mandates within Texas Law requiring coordination between family regulation and traditional police in child abuse investigations converted the search from a special needs search to a traditional Fourth Amendment one. As the court explained,

> [The family regulation social worker] appropriately points to the fact that Texas law compels social workers to investigate allegations of sexual abuse; she neglects, however, to mention that the Texas statute deeply involves law enforcement in the investigation. CPS has a duty to notify law enforcement of any child abuse reports it receives. The district attorney may request automatic notification of some or all types of reported physical or sexual abuse. Violating these reporting duties can result in criminal liability. Finally, investigations into allegations of physical or sexual abuse are performed jointly with law enforcement agencies.
>
> Texas law describes social workers' investigations as a tool both for gathering evidence for criminal convictions and for protecting the welfare of the child. *Ferguson* teaches that we must apply the

[162] Makas v. Miraglia, No. 05 Civ. 7180(DAB)(FM), 2007 WL 152092, at *7 (S.D.N.Y. Jan. 23, 2007).

> traditional Fourth Amendment analysis where a child protective services search is so intimately intertwined with law enforcement.[163]

To the extent that a defendant has evidence of this level of coordination, it is relevant to the question of policing purpose. For example, if the state's criminal files contain materials from the family regulation case, as was true in some files described above,[164] that supports the argument that the family regulation system collects evidence for law enforcement purposes. Statutory, regulatory, or policy mandates that require family regulation agents to provide information to police, demonstrations that family regulation and police engage in join investigations, or requirements that staff maintain chain of custody for criminal prosecution all suggest family policing actions not for a special need but for a traditional criminal investigation. In such cases, the highest level of criminal procedure protections must apply.[165]

C. Medical Vulnerability, Patient Autonomy, and Interrogations

Statements from patients fill the probable cause affidavits included in pregnancy prosecution files. These statements are often taken on the heels of medical emergencies, including pregnancy losses. Questioning under such circumstances magnifies the inherent coercion of police interrogation. Yet criminal procedure doctrine fails to capture the import of hospital settings, the collaboration of medical providers in interrogation, and the ability of vulnerable patients to waive their constitutional rights.

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[163] Roe v. Tex. Dep't of Prot. & Regul. Servs., 299 F.3d 395, 407 (5th Cir. 2002). *See also* 588 F.3d 1011 (internal citations omitted).

[164] Referencing the case that is described in the paragraph starting "Lending even more specificity…."

[165] In contrast, if the special needs exception remains, some scholars have argued that the fruits of such searches be inadmissible in criminal prosecutions. *See, e.g.*, Ric Simmons, *Searching for Terrorists: Why Public Safety is Not a Special Need*, 59 DUKE L.J. 843, 920-21 (2010) (arguing that the fruits of special needs searches be excluded from antiterrorism prosecutions).

1. Custody in hospital settings

Another common investigative scenario is when police themselves enter treatment facilities and ask patients investigatory questions. This evidence collection, a common feature of police investigations,[166] implicates patients' rights against self-incrimination when those statements are later used in a criminal case. Yet *Miranda* jurisprudence facilitates evidence-gathering from patients in hospitals in two ways. First, courts deploy a standard of custody that fails to recognize police coercive power outside of the station house, and second, they create artificial distinctions between collaborating medical personnel and police through the state action doctrine.

Under *Miranda v. Arizona*, prosecutors may not use statements that result from custodial interrogation unless *Miranda* warnings are given and the person knowingly and voluntarily waives their right to remain silent.[167] In the pregnancy criminalization context, it is often clear the patient has been subject to interrogation—"not only to express questioning, but also . . . any words or actions on the part of the police . . . that the police should know are reasonably likely to elicit an incriminating response."[168] Instead, the question is whether a patient was in custody such that *Miranda* warnings were necessary.

For purposes of *Miranda*, custody is defined as whether a reasonable person would feel free to terminate the encounter, though the Court has made clear that limitations on movement that do not amount to the "functional equivalent" of formal arrest do not, at least in some instances, equate to custody. For instance, a driver may not pull away from a traffic stop, and thus is not free to leave, yet the Court has held that such a stop lacks the coercive weight of custody because it is public and not prolonged.[169]

Courts often decide inpatient treatment in a hospital does not constitute "custody,"[170] despite the practical realities of hospital settings

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[166] Song, *Patient or Prisoner*, *supra* note 9, at 21.

[167] 384 U.S. 436, 444 (1966).

[168] Rhode Island v. Innis, 446 U.S. 291, 292 (1980).

[169] Berkemer v. McCarty, 468 U.S. 420 (1984).

[170] *See, e.g.*, United States v. Infante, 701 F.3d 386, 396 (1st Cir. 2012); United States v. Casellas, 149 F. Supp. 3d 222, 244 (D.N.H. 2016); United States v. Martin, 781 F.2d 671, 673–74 (9th Cir. 1985); People v. Vasquez, 913 N.E.2d 60, 66 (App. Ct. Ill. 2009) (noting in only one of seven cases in which hospital patients

and the lack of control patients have in those environments. In a nod to these realities, courts reframe the custody inquiry as whether the person was "at liberty to terminate the interrogation and cause the officers to leave."[171] Yet the way courts interpret facts related to that inquiry demonstrates both the utter inability of patients to exercise control in such settings and courts' lack of comprehension of the role of medical personnel in police investigation.

The traditional imagined police station interrogation looms large in courts' conception of custody. For instance, in *United States v. Infante*, the First Circuit focused on the "non-confrontational" nature of the interrogation as dispositive, stating that the hospital room was a "neutral" setting because police did not hospitalize the patient nor extend his hospital stay.[172] Further, since "hospital staff came and went freely during the course of the interviews," the court concluded that "officers 'were not in a position to dominate [the setting] as they are, for example, an interrogation room at a jailhouse.'"[173]

In *Infante*, the outcome of the patient's attempts to end the interrogation suggests otherwise. The patient invoked his right to remain silent and to have counsel present, but the officers continued to question him and reassured him that he was not under arrest or in custody.[174] Rather than find that this cut in favor of Infante's assertion that he faced involuntary custodial interrogation, the court ruled that the police were not obligated to honor those invocations because he had no constitutional right to remain silent or have a lawyer since he was not in custody.[175]

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were questioned did Illinois courts find they were in custody for purposes of *Miranda*). *But see* Effland v. People, 240 P.3d 868, 875 (Sup. Ct. Colo. 2010); State v. Hewitt, 526 P.3d 558, 569–70 (2023) (applying the *Infante* test and Hawai'i Constitution article 1, section 10, which provides "greater protection" than the Fifth Amendment); State v. Ross, 157 N.W.2d 860, 862, 864 (Sup. Ct. Neb. 1968) (holding that questioning of a man on an operating table after a shooting as he was prepared for emergency surgery amounted to custodial interrogation); State v. Ybarra, 804 P.2d 1053, 1056 (Sup. Ct. N.M. 1990); People v. Monroe, No. 357631, 2022 WL 1701952, at *5 (Mich. Ct. App. May 26, 2022).

[171] *Infante*, 701 F.3d at 396.

[172] *Id.* at 397.

[173] *Id.* (citing United States v. Jones, 1877 F.3d 210, 218 (1st Cir. 1999)).

[174] *Id.* at 398.

[175] *Id.* This pattern is a familiar one in hospital interrogation cases in which *Miranda* warnings are given. *See, e.g.*, State v. Joseph, 515 S.W.3d 735, 744 (2016) (noting that the hospital called the police after the patient was able to speak

Courts' current approach to interrogations in the healthcare setting also fails to account for how a reasonable patient perceives their hospitalization and their freedoms as constrained by that circumstance. Three flawed premises in courts' analyses of interrogation in hospital settings contribute to the distorted conclusions they reach: (1) hospitals are neutral, noncustodial settings where patients feel free to exercise autonomy; (2) hospital personnel are individual private actors rather than part of an institution that regularly interacts and cooperates with law enforcement; and (3) patients' medical vulnerability rarely rises to the level at which ability to make a free and rational choice to make statements to law enforcement would be impaired.

Courts analyzing the interrogations of the woman who had experienced a stillbirth earlier in the day and the woman who had suffered a traumatic homebirth are likely to rule that both situations amount to non-custodial interrogations in which the women's statements were voluntary, despite their medical and emotional distress. As in other custody inquiries, "[r]elevant factors include the location of the questioning, its duration, statements made during the interview, the presence or absence of physical restraints during questioning, and the release of the interviewee at the end of questioning."[176] These factors' application in a hospital setting, however, lead to distorted results.

Courts' consensus that hospitals are a neutral and nonthreatening location[177] for interrogation warps the foundation of the custody analysis.

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for the first time since his hospitalization and that the defendant tried to invoked his *Miranda* rights, but determining that he was not in custody because the defendant never told officers to leave and that he answered "no" when asked if he felt pressured by police); State v. Seibert, 103 S.W.3d 295, 300–01 (2003) (defendant, hospitalized for burn treatment, was read his *Miranda* rights and requested to speak to a lawyer, but the officer continued, and the Court held there was no *Miranda* violation because the person was in custody and "there is nothing in the record indicating that he could not have terminated the . . . interview at any time.").

[176] Howes v. Fields, 565 U.S. 499, 509 (2012) (internal citations omitted).

[177] *See, e.g.*, United States v. Infante, 701 F.3d 386, 398 (1st Cir. 2012) (concluding that a hospital room is "at least a neutral setting"); United States v. Harris, 154 F. Supp. 3d 299, 307 (E.D. Va. 2015) (characterizing the hospital room as a neutral and nonthreatening atmosphere); People v. Lewinski, No. 365350, 2024 WL 4595612, at *3 (Mich. Ct. App. Oct. 28, 2024) (hospital environment is neutral in custody analysis); Whittaker v. State, 891 S.E.2d 849, 857 (Ga. 2023) (hospital setting weighs against finding that defendant was in custody);

Patients in hospitals have limited control over their environments,[178] and reasonable patients likely perceive themselves as lacking power to countermand medical personnel or law enforcement.[179] Law enforcement and security personnel's embeddedness in hospital settings makes them appear part of the authority structure, and law enforcement and hospital personnel can appear to and do, in fact, work together closely.

The lack of understanding of the close, ongoing working relationships between law enforcement and medical personnel also leads courts to misconstrue the import of particular facts, most notably, that medical personnel are able to come and go during an interrogation.[180] While courts conclude that this means law enforcement could not dominate the setting, medical personnel's own descriptions of law enforcement roles in these settings often reflect the opposite, even when medical personnel are still permitted to do their jobs. Given their collaboration, the patient's custody status can even be imposed by medical personnel. In one case described above, the doctor "told her team she would not talk to [the patient] until she had police present as she wanted witnesses present for [the doctor's] discussion with [the patient]." In that case, the doctor stayed out of the patient's room until police arrived.

Further, courts have often emphasized that the person sought care at the hospital rather than being taken there against their will as evidence against custody.[181] Women' decisions to delay seeking formal medical care

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Commonwealth v. Welch, 167 N.E.3d 1201, 1213 (Mass. 2021) (ICU is a neutral location, unlike a stationhouse interrogation room).

[178] *See* Song, *Patient or Prisoner*, *supra* note 9, at 33 (stating that medical providers felt more assured by having police nearby); *id.* at 35 (discussing law enforcement limitations of disclosure of information to loved ones); *id.* at 46 (describing limitations of visitors by law enforcement).

[179] *See infra* Part IV.A.3.

[180] *See, e.g.*, *Infante*, 701 F.3d at 397 (noting that the ability of medical personnel to freely enter and exit the defendant's hospital room is evidence that police were not in a position to dominate the setting).

[181] *See, e.g.*, United States v. Berres, 777 F.3d 1083, 1092 (10th Cir. 2015) (concluding that defendant was not in custody when defendant was not informed that he was free to leave and questioning related to a potential crime committed by the defendant, but defendant was at the hospital at his own request, officers were not aggressive or confrontational, only one officer questioned the defendant most of the time, and officers wore plain clothes with no weapon); Creque v. State, 272 So. 3d 659, 677–778 (Ala. Crim. App. 2018) (holding that the defendant was not in police custody during questioning, despite being physically unable to leave

during a homebirth or to leave the hospital against medical advice have themselves been used to demonstrate probable cause for prosecution in pregnancy-related cases, making the true voluntariness of medical treatment precarious once a woman falls under law enforcement suspicion.

Courts's background assumptions about hospitals have rendered inquiries into whether a reasonable person would feel free (or be able) to terminate hospital interrogations into a mechanical inquiry tilted against the patient. While different circuits formulate their totality of the circumstances factors differently,[182] the factors take on a sense of unreality because courts choose to cast aside what hospitalization means as they analyze those circumstances. In fact, courts have distinguished between the actual restraints a person experienced and those imposed by the police—a distinction that is unlikely to matter to whether a reasonable person feels constrained to answer police questions. For example, Fourth Circuit reasoned, "to the extent [that an incarcerated patient] felt constrained by his injuries, the medical exigencies they created (e.g., the donning of a hospital gown and the insertion of an I.V. line), or the routine police investigation they initiated, such limitations on his freedom should not factor into our reasonable-person analysis."[183] This example of the courts' willingness to eschew consideration of the practical effects of hospitalization undermines the idea that the totality of the circumstances test reflects what a patient, even a reasonable one, experiences under hospital interrogation.

The Supreme Court has recognized that certain other settings can be distinct when it comes to police investigations, most notably schools. In *J.D.B. v. North Carolina*, the Supreme Court held that the age of a suspect is relevant when analyzing the custodial prong of the *Miranda* analysis.[184]

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his hospital room, where the officer testified he was "not sure" whether he would have permitted the defendant to leave and had been instructed not to allow him to do so after receiving pertinent information from the defendant). *But see* People v. Lewinski, 2024 WL 4595612 (noting that the defendant, though incapacitated due to his physical condition and not placed in handcuffs, was effectively under police restraint, as officers would have restrained the defendant if necessary).

[182] For instance, in the First Circuit, the court asks "'whether the suspect was questioned in a familiar or at least neutral surroundings, the number of law enforcement officers present at the scene, the degree of physical restraint placed upon the suspect, and the duration and character of the interrogation.'" United States v. Hughes, 640 F.3d 428, 435 (1st Cir. 2011) (quoting United States v. Ventura, 85 F.3d 708, 711 (1st Cir.1996)).

[183] United States v. Jamison, 509 F.3d 623, 629 (2007).

[184] J.D.B. v. North Carolina, 564 U.S. 261 (2011).

Even though age as a factor is the main doctrinal takeaway in *J.D.B.*, the interrogation setting also mattered for the Court. As Sotomayor stated, "the effect of the schoolhouse setting cannot be disentangled from the identity of the person questioned. . . . Without asking whether the person 'questioned in school' is a 'minor,' the coercive effect of the schoolhouse setting is unknowable."[185]

The same can be said of hospital settings, where collaborations with law enforcement regularly occur. Though it is hard to glean from the facts in the case files the extent to which the healthcare providers in the hospitals interact with law enforcement, it is not a stretch to assume given police presence in emergency departments in general, that that is the case for pregnancy prosecutions as well. If so, then even more than schools, where a handful of security and school resource officers may be stationed, hospitals are much more like a law enforcement-dominated custodial setting regardless of whether a door was closed or whether hospital employees could come and go. Nor should the courts discount the characteristics of the patient when evaluating the applicability of *Miranda*. The medical vulnerability of the patient, which is knowable in the same way that the age of a person is knowable to police, makes that fact a critical part of assessing that the interrogation is happening in a custodial setting.

Certainly, if medical providers *invite* law enforcement into treatment areas prior to any questioning, this also shifts the balance away from the hospital setting as a "neutral" area, particularly when this action by medical providers represents their own judgment and stands in direct contradiction to their ethical duties to their patients.[186]

2. Voluntariness

Just as patients' vulnerabilities cannot be disentangled from the hospital setting and custody determination, those vulnerabilities call into question whether patients' statements to police are voluntary. Police interrogations are regulated not only under the *Miranda* doctrine but also under the Due Process Clause. Regardless of whether a person is in custody, their statements are inadmissible if they are not voluntary.[187] Still, the jurisprudential standard for voluntariness reflects a similar unreality in the hospital context.

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[185] *Id.* at 276.

[186] Brown, *supra* note 12.

[187] Jackson v. Denno, 378 U.S. 368, 376 (1964); Haynes v. Washington, 373 U.S. 503, 518 (1963); Greenwald v. Wisconsin, 390 U.S. 519, 521 (1968).

The Supreme Court highlighted how emergency treatment may result in a patient's inability to exercise "rational intellect and a free will" in *Mincey v. Arizona*.[188] Mincey had been shot, was "depressed almost to the point of coma," and "encumbered by tubes, needles, and breathing apparatus" while answering questions in the intensive care unit, "at the complete mercy" of the detective.[189] Further, the hospital staff assisted with the questioning, both providing the paper on which Mincey answered questions and suggesting "it would be best if [he] answered" the police.[190] Yet despite the Supreme Court's admonition that "the blood of the accused is not the only hallmark of an unconstitutional inquisition," subsequent courts have often held that patients' statements made while hospitalized remain voluntary.[191]

The ability to find that people in dire medical circumstances, restrained in hospital beds, on the heels of traumatic medical emergencies, and under the influence of mind-altering substances can make "free and rational" choices to waive their constitutional rights stems from the Court's narrowing of conceptions of voluntariness since the Warren court, both in the *Miranda* context and in due process claims. In the *Miranda* context, the Court has held first that the waiver "must have been voluntary in the sense that it was the product of free and deliberate choice rather than intimidation, coercion, or deception,"[192] and second that it "must have been made with full awareness of both the nature of the right being abandoned and the consequences of the decision to abandon it."[193]

Despite this formulation, the Court has also required that "coercive police conduct" be present to conclude that a confession is involuntary such that a patient's mental state cannot be conclusive evidence that she was incapable of the level of comprehension necessary to waive her

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[188] 437 U.S. 385, 398 (1978).

[189] *Id.*

[190] *Id.* at 386, 396, 399.

[191] *See, e.g.*, United States v. Siddiqui, 699 F.3d 690, 707 (2d Cir. 2012) ("[C]ourts tend to view a hospitalized defendant's statements as voluntary where the defendant was lucid and police conduct was not overbearing.") (citing United States v. Khalil, 214 F.3d 111, 121–22 (2d Cir. 2000); Pagan v. Keane, 984 F.2d 61, 63 (2d Cir. 1993); Campaneria v. Reid, 891 F.2d 1014, 1019–20 (2d Cir. 1989)). Notably, in each of these cases, medical personnel or medical records were relied upon to establish the patient's lucidity. *See Khalil*, 214 F.3d at 122; *Pagan*, 984 F.2d at 63; *Campaneria*, 891 F.2d at 1020.

[192] Moran v. Burbine, 475 U.S. 412, 421 (1986).

[193] *Id.*

rights.[194] The Court goes so far as to claim that suppressing a statement when a suspect is impaired "would serve absolutely no purpose in enforcing constitutional guarantees."[195] This, of course, depends entirely on the Court's own formulation of the rights at stake. If there is no right to have privacy in one's hospital room or to be free from police questioning during emergency medical treatment or mental impairment, then prohibiting such police activity does not protect against violations of a constitutional right. In hospitals, this has led to courts admitting statements when patients were in the ICU,[196] had drains in their heads from recent brain surgery,[197] and were strapped to a backboard with a cervical collar in the emergency room.[198] It seems doubtful that a person in such dire straits can make a free and rational choice about waiving her constitutional rights.

Indeed, courts have generally held that the police need not inform a patient that her interrogation is voluntary, and that failure to inform a patient that she may decline interrogation is weak evidence of coercion.[199] The First Circuit has even gone so far as to suggest that an ignored invocation of rights did not matter because the person was not "in custody."[200]

The case files evince similarly questionable "voluntary" statements, most often obtained without a recitation of *Miranda* rights. In one case, the patient was described as "in shock." In another, the first interrogation took place while the patient was "bleeding out" and the second interrogation occurred when the patient was "doing better and more lucid." In both settings, the patient's vulnerability mirrors that of *Mincey* yet

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[194] Colorado v. Connelly, 479 U.S. 157, 164 (1986).

[195] *Id.* at 166.

[196] *Campaneria*, 891 F.2d at 1020.

[197] People v. Caro, 442 P.3d 316, 343 (Sup. Ct. Cal. 2019) (this case was decided based on harmless error, the court did not decide whether the patient was in custody).

[198] People v. Botsis, 902 N.E.2d 1092, 1095 (App. Ct. Ill. 2009).

[199] *See, e.g*., United States v. Berres, 777 F.3d 1083, 1092 (10th Cir. 2015) (concluding that defendant was not in custody when defendant was not informed that he was free to leave and questioning related to a potential crime committed by the defendant, but defendant was at the hospital at his own request, officers were not aggressive or confrontational, only one officer questioned the defendant most of the time, and officers wore plain clothes with no weapon).

[200] 701 F.3d at 396. *But see* United States v. New, 491 F.3d 369, 373 (8th Cir. 2007) (suggesting that officers should clarify that a patient is not in custody and inform her that she is not under arrest because her "physical condition and immobility require careful analysis of whether *Miranda* should apply").

appears to be ignored by the police carrying out their investigation. Under such circumstances, it seems impossible to believe that the patients could make a truly free and rational choice. Still, police elicit their words in the throes of medical emergencies and recite them in affidavits of probable cause used to initiate their prosecutions.

V. PRESCRIPTIONS

The failures of criminal procedure to address the overbroad conduct of medical providers, law enforcement, and family regulation give us a blueprint to envision improved jurisprudence and practice. This Part begins by sketching out doctrinal and policy interventions that reflect the realities of how family regulation and healthcare entities cooperate with police. Recognizing that doctrinal and policy changes are not easily achieved, and that ground-up changes are possible, the last set of prescriptions are directed toward lawyers and healthcare providers.

A. Doctrinal Prescriptions

The first set of doctrinal prescriptions calls for incorporating medical considerations into criminal procedure doctrine. First and foremost, the Fourth Amendment expectation of privacy doctrine must adapt to the privacy interests of patients when receiving medical care in a healthcare setting like a hospital. Building on the notion in criminal procedure that the home is most sacred, the doctrine must recognize that, due to the intimate nature of medical treatment and the vulnerability of patients in that setting, hospitals must receive comparable protections.

Courts have accorded varying degrees of protection depending on where within a medical setting law enforcement conduct takes place. For example, courts have made distinctions between waiting rooms, lobbies, hallways of treatment areas, and patient rooms. This rationale is dependent upon the foundational principle of Fourth Amendment jurisprudence that the more one exhibits to the public, the less privacy one should expect. But the application of that logic to hospital settings is wrong.

In previous writing, one of the authors has advocated for sanctuary from policing in emergency rooms as part of the expectation of privacy analysis, pointing to privacy laws, medical ethics, and the way that the medical profession views privacy.[201] Here, where we have demonstrated

[201] *Policing the Emergency Room*, *supra* note 5, at 2706

that without further patient protections, policing of the vulnerable can be heightened, that prescription has further salience.

Patients who are in hospitals should be treated as if they are in their own home. This extension of the home-as-paramount in Fourth Amendment doctrine to hospitals would recognize the patient's own privacy stake in treatment settings and that patients there are uniquely situated and vulnerable to policing because of their medical conditions.[202]

Medical vulnerability should also constrain police interrogations both by influencing the custody analysis and by recognizing medically vulnerable patients' inability to make truly "free and rational" choices about waiving their constitutional rights.

At first glance, treating the hospital as a custodial setting while giving it home-like search protections may seem contradictory. The home is not a police interrogation room, a fact that has been noted by court decisions finding that *Miranda* warnings need not be given when questioning occurs at home. But the reasons to give hospitals home-like sanctity under the Fourth Amendment are not the same reasons homes lack the characteristics of a stationhouse interrogation.

The hospital is not a home because the hospital has home-like attributes. As we have described, patients have far less control over medical settings—they do not decide who comes and goes, whether police will be stationed inside or outside their rooms, or when precisely they will leave. Instead, the hospital should be treated as a home because patients' medical vulnerability puts them in intimate situations similar to those protected in the home. Patients may be in a state of undress, in repose, and in compromised physical and mental states. The protection of an intimate space from policing is consistent with the treatment of a space as custodial when one cannot control the environs.

Courts should also be precise about how they interpret the exceptions to health information privacy and confidentiality in the various reporting requirements imposed on medical providers, especially because such reporting requirements were not meant to address the kind of on-the-ground investigations that are highlighted here. That HIPAA's minimum necessary requirement does not apply to these state laws should therefore not hold the kind of influence that courts' easy dismissal of privacy protections of medical information suggest.

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[202] *Id.* at 2653 (discussing medical vulnerability and how that potentially makes it possible for police to take advantage of patients in such conditions).

The concerns of medical professionals and the organizations that represent them further underscore the problem with courts' facile reliance on these state law exceptions. The statements and opinions of medical professional organizations like the American Medical Association, the American College of Emergency Physicians, and the American College of Obstetrics and Gynecology reveal the pressures and conflicts inherent in law enforcement investigations.[203] Given the prominence and importance of medical ethics in medical professional practice, courts should take these ethical opinions and statements into account.

Courts must also cabin mandatory reporting and HIPAA exceptions to their narrowest reading and the ethical opinions relating to patient privacy and law-compelled disclosures and fully incorporate those limitations into Fourth Amendment definitions of the expectation of privacy. In evaluating a range of Fourth Amendment doctrines—reasonable expectations of privacy, state action and special needs/policing purpose courts need to be far more rigorous in evaluating both the facts and the law with respect to mandatory reporting. Exceptions to the overall expectation of privacy in medical records need to be carefully examined in light of the specific pieces of information "required" to be reported. Courts must also look carefully at the structural reality on the ground. Particularly given the significant pressure to perform what many believe are medically unnecessary drug tests during pregnancy and delivery, it defies reality to continue to view these providers as simply "inadvertently" discovering evidence of child abuse while providing medical care.

In addition, as we've argued above, there is significant evidence that family regulation and traditional police collaborate in the investigation of purported child abuse. There are mandates to share information, there are joint task forces, and there are even clear requirements to preserve chain of custody for criminal prosecution. In the face of this pervasive regulatory schema and systemic collaboration, we join Justice Marshall in pointing out it is "dubious" to suggest that compliance with this "noncriminal regulatory regime" does not constitute policing.[204]

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[203] Am. Med. Ass'n, Code of Medical Ethics, Opinion 2.02(3)(b) *Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse;* AMA, Code of Medical Ethics, Opinion 5.05 *Confidentiality*; American College of Emergency Physicians (ACEP), *Policy Statement: Law Enforcement Information Gathering in the Emergency Department* (June 2023); American College of Obstetricians and Gynecologists, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*.

[204] 493 U.S. at 568.

B. Ground-Up Interventions

Courts and policy makers are not the only stakeholders responsible for the development of criminal procedure doctrine. Fourth and Fifth Amendment issues must be spotted by defense attorneys and litigated. Health policy experts must protect patient privacy. Putting aside for a moment the question of the adequacy of defense representation, it is probably a fair estimation that criminal defense attorneys are not health law experts. But just as criminal defense practice now involves familiarity with psychiatric diagnoses, DNA evidence, and chemical intoxication, for example, criminal defense practice must also include health privacy and medical ethics to further their clients' claims. Defense lawyers should litigate these issues. Criminal litigation is fact- and context-specific, and this area of law is underdeveloped. Further work must be done to establish the importance of health privacy laws, regulations, norms, and ethics in criminal procedure cases, especially because such laws and practices differ among states. There is also much room for attorneys to develop the factual record and litigate motions to suppress. Attorneys should become familiar with the regulations, laws, norms, and ethics governing healthcare providers in their jurisdictions.

In addition, defense lawyers litigating pregnancy criminalization cases need a deep knowledge of family regulation law, policy, and practice as it relates to collaborations with healthcare providers and traditional police. Fact investigation in pregnancy criminalization cases should include understanding the relationship between the healthcare provider, law enforcement agency, and family policing agency and whether that relationship is created by statute, policy, or informal routines. Agency policy, contracts, and traditional on-the-ground investigation are all fruitful possibilities for uncovering the institutional collaborations suggested by the data in this Article.

There is also much that healthcare systems can do. Their task is not easy, as law enforcement presence in healthcare settings is pervasive. Many hospitals and professional organizations have begun, however, to think about how to balance patient privacy, their obligations, the safety of patients and workers, and law enforcement priorities.[205] Healthcare

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[205] Am. Med. Ass'n, Code of Medical Ethics, Opinion 2.02(3)(b) *Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse;* AMA, Code of Medical Ethics, Opinion 5.05 *Confidentiality*; American College of Emergency Physicians (ACEP), *Policy Statement: Law Enforcement Information*

administrators should develop patient-centered policies that better understand and adhere to the competing obligations of criminal procedure and health privacy norms, laws, and regulations. One particularly important topic to tackle is that of law enforcement access to healthcare settings. Wholesale access to patient treatment areas, and even certain waiting rooms where some degree of treatment or medical conversations may take place, can lead hospitals to undermine their patients' constitutional rights.

Healthcare providers should also consider adopting and enforcing centralized rules and systems governing access to patient information. The practices evident in the files of widespread communication between police and healthcare providers demonstrate far too many opportunities for information transmission. Providers should require warrants as a default to access information, whether written or oral, and should centralize review mechanisms so that law enforcement know where to go and whom to ask. This would also ensure studious adherence to both constitutional and other legal requirements.

C. Policy Changes

Finally, doctrinal changes and interventions on the ground must be accompanied by policy changes. The critique and data presented here reinforce the importance of reevaluating whether healthcare providers should be required to report child abuse and neglect or other crimes to law enforcement. In previous writing, one of us has joined the call for abolishing these laws, pointing specifically to how a person's knowledge that she might be reported disincentivizes needed healthcare.[206] Abolishing mandatory reporting laws does not mean that healthcare providers cannot, in appropriate circumstances, provide a report. Instead, it restores discretion and corrects for overreporting that may result from fear of noncompliance with mandates.

In addition, we support non-punitive alternative responses to need. Bills that aim to mitigate the harms of the overbroad involvement of family policing agencies are currently pending before the California legislature.[207]

Gathering in the Emergency Department (June 2023); American College of Obstetricians and Gynecologists, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*.

[206] Bach, CRIMINALIZING CARE *supra* note 5 at 202-203.

[207] Jeremy Loudenback, *Support Don't Report, Urge California Bills Focused on Struggling Families*, THE IMPRINT (Mar. 10, 2025).

These bills propose alternate responses that rely on community-based services and support instead of system involvement.[208] This reevaluation should also include whether social workers who work regularly in healthcare settings should be more closely tied to medical ethics. By comparison, in many states, social workers employed as part of defense teams take on the attorney's ethical responsibilities and do not have mandatory reporting obligations. In hospital settings, social workers' reporting obligations should reflect doctors' medical ethics and laws governing the medical profession.

In the specific area of family regulation and drug exposure during pregnancy, we join colleagues in the field calling for the repeal of CAPTA including its requirements pertaining to substance use and pregnancy. Short of that, we strongly support state interventions that minimize contact with family policing agencies in complying with CAPTA requirements. For example, some states turn to healthcare systems rather than family regulation systems to implement mandates for plans of safe care.[209] These policies encourage a better response to any need that those mothers and children might have.

In addition, given the current risks to pregnant patients, we support the growing movement for informed consent laws that warn pregnant patients about the family regulation and criminal prosecution risks of drug screening and testing.[210]

An additional significant change relates to the information sharing pathways that have been solidified by HIPAA as demonstrated by the dynamic policing environments described in the files. The carve-outs for law enforcement purposes in health privacy law exist siloed from the doctrine and regulations that regulate criminal legal system actors. Courts, lawyers, police, and healthcare providers alike are put in the difficult position of reconciling regulatory frameworks that are not necessarily in conversation with one another. This siloing problem exists throughout the legal system. But those drafting legislation and agencies responsible for implementing and enforcing these obligations should make efforts to establish rules and guidelines that reconcile such conflicts.

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[208] Cal. Assembly Bill AB601 (Child Abuse: Reporting) (2025-26 Session).

[209] *See,* CASEY FAM. PROGRAMS, *supra* note 32(Identifying New Mexico as a state in which plans of safe care are developed and administered by the patients' managed care organization). For a more extensive discussion of New Mexico's program *see* Bach, CRIMINALIZING CARE *supra* note 5 at 200-02.

[210] S.B. 1039, 2025 (TN); S.B. S320B, 2023-24 Regular Sessions (NY); A.B. 1094, 2023-24 Regular Session (CA).

VI. CONCLUSION

Pregnancy criminalization cases underscore the profound inadequacy of criminal procedure doctrine to account for the realities of intersecting carceral systems. These problems are not unique to pregnancy. As the federal government investigates criminal charges against doctors and hospitals, the privacy of medical care and accessibility of medical records by law enforcement become all the more pertinent to patients' ability to access care without criminalization.[211]

If criminal procedure is to fulfill its promise of safeguarding individual rights against state intrusion, it must evolve to reflect the realities of collaborative policing across institutions, both public and private. This requires doctrinal recalibration to recognize and restrict criminalization within care settings, as well as policy interventions to rebuild ethical boundaries between healthcare and law enforcement. While this Article focuses on pregnancy as a site of acute vulnerability to criminal legal system overreach, the doctrinal failures it identifies pervade contemporary policing and raise questions about criminal procedure doctrine's ability to contend with the wide network of people and institutions now engaged in the project of policing. What's more, the criminal procedure problems illuminated here portend a broader crisis in the regulation of state power, one that demands attention not only from the policing actors themselves—police, doctors, social workers, and family regulation personnel—but also policymakers, advocates, and jurists.

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[211] *See, e.g.*, U.S. Department of Justice, Office of Public Affairs, *Department of Justice Subpoenas Doctors and Clinics Involved in Performing Transgender Medical Procedures on Children*, [Press release] (July 9, 2025) https://www.justice.gov/opa/pr/department-justice-subpoenas-doctors-and-clinics-involved-performing-transgender-medical; Selena Simmons-Duffin & Aaron Bolton, *States Sue Trump Administration After More Hospitals Stop Treating Transgender Youth*, NPR (Aug. 1, 2025) https://www.npr.org/sections/shots-health-news/2025/08/01/nx-s1-5490427/bonta-trump-bondi-transgender-minors-hospital.