IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

STATE OF NEW MEXICO,

Plaintiff-Appellant,

v. **No. S-1-SC-40478**

ALEXEE TREVIZO,

Defendant-Appellee.

On Appeal From the Fifth Judicial District Court
D-503-CR-2023-00159
Eddy County, New Mexico
The Honorable Jane Shuler Gray

BRIEF OF *AMICI CURIAE* PROFESSOR JI SEON SONG, THE ACLU OF NEW MEXICO, AND THE NATIONAL POLICE ACCOUNTABILITY PROJECT IN SUPPORT OF DEFENDANT-APPELLEE

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INTEREST OF *AMICI CURIAE*

Professor Ji Seon Song, the American Civil Liberties Union of New Mexico, and the National Police Accountability Project ("*Amici*") respectfully submit this brief as *amici curiae* in support of Defendant-Appellee Alexee Trevizo.[1]

Ji Seon Song is an assistant professor at the University of California, Irvine School of Law, where she teaches and writes about criminal law and criminal procedure. Professor Song's research focuses on the complex intersection of the criminal justice system and the healthcare system. Her article, *Policing the Emergency Room*, 134 HARV. L. REV. 2646 (2021), provides a groundbreaking examination of the ways in which police are a routine presence in emergency departments and how they impact the constitutional rights of patients. Her scholarship examines the interactions of different legal, regulatory, and ethical regimes when policing and healthcare meet.[2] Professor Song has also co-authored several medical journal articles with medical professionals examining the legal and ethical implications of law enforcement presence in emergency departments.[3]

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[1] Professor Ji Seon Song authors and files this brief on behalf of *amici curiae*. No counsel for any party authored this brief in whole or in part. No counsel or party has made a monetary contribution intended to fund the preparation or submission of this brief.

[2] Ji Seon Song, *Cops in Scrubs*, 48 FLA. ST. L. REV. 861 (2021); Ji Seon Song, *Patient or Prisoner*, 92 GEO. WASH. L. REV. 1 (2024).

[3] Hannah H. Janeway et al., *An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department*, 78 ANN. EMERG. MED. 749 (2021);

The ACLU of New Mexico is a non-profit, nonpartisan organization dedicated to upholding individual civil rights, civil liberties and principles of equality and liberty. The ACLU of New Mexico's interest in the case stems from its deep commitment to the rights of individuals to access confidential medical care without the interference of law enforcement.

The National Police Accountability Project (NPAP) was founded in 1999 by members of the National Lawyers Guild to address law enforcement conduct by coordinating and assisting civil rights lawyers. NPAP has an interest in the outcome of this matter because it is a legal membership organization that focuses specifically on the intersection of civil rights and misconduct of law enforcement and is uniquely involved in the protection of the human and civil rights of individuals in their encounters with law enforcement.

The brief of *Amici Curiae* will assist the Court by providing a comprehensive and nuanced understanding of how health privacy laws and medical ethics intersect

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Kate Gallen et al., *Health Effects of Policing in Hospital: A Narrative Review*, J. RACIAL & ETHNIC HEALTH DISPARITIES (2022); Kate M. Gallen et al., *Law Enforcement and Patient Privacy Among Survivors of Violence: A Nationwide Mixed-Methods Study of Current Practices*, 283 J. SURG. RESEARCH 283 (2023); Kate Gallen et al., *Addressing Legal Needs as Violence Prevention: A National Survey of Legal Services Offered Through Hospital-Based Violence Intervention Programs*, 34 J. HEALTH CARE POOR & UNDESERVED 1427 (2023); Emily V. Jones et al., *"You Have to Be a Doctor First": Trauma Surgeons' Perspectives on Police Interactions in the Hospital*, 90 AMER. SURGEON 2593 (2024).

with criminal procedure and policing practices, especially within healthcare settings. It underscores the importance of maintaining clear boundaries between the roles of healthcare providers and law enforcement, highlighting that these roles serve fundamentally different—and often conflicting—purposes. This brief will support the Court in evaluating the legality of police actions in medical settings, such as the emergency department in this case, where legal, regulatory, and ethical frameworks converge. By clarifying the point at which healthcare providers' involvement crosses from medical care into law enforcement, the brief shows that health privacy laws, medical ethics, and criminal procedure principles support the trial court's decision to suppress Ms. Trevizo's statements. This distinction is essential to protecting individual rights and upholding public trust in the medical system.

SUMMARY OF ARGUMENT

When police investigate patients in healthcare settings, medical providers must navigate their duties to public safety and to their patients amidst a complex array of legal and ethical obligations. Similarly, when assessing the lawfulness of police actions in healthcare settings like the emergency department, courts must reconcile a diverse legal and ethical landscape.

Amici argue that the interests of police investigations do not vitiate the privacy

rights of patients seeking medical care. The divergent purposes, laws, and ethics governing policing and healthcare, and the need to prevent patients from experiencing potential policing harms, require the careful parsing of roles between law enforcement and medical providers. When faced with issues involving this intersection, courts must determine the point at which medical providers are no longer providing care but instead are acting as law enforcement proxies, and if such actions violate patients' rights.

The trial court correctly determined the proper boundaries between law enforcement investigative work and the provision of healthcare in finding that Dr. Vaskas crossed the line from medical provider to law enforcement agent when Ms. Trevizo made the statements at issue.

ARGUMENT

Police and emergency department medical providers perform vital functions in our society. For the most part, these two professional groups conduct their work separate and apart from one another. But in the emergency department,[4] these actors

[4] The term "emergency department" is primarily used in this brief as it is the term used by the healthcare profession. "Emergency room" is the colloquial term referring to the same healthcare setting and is used in this brief when referencing a

overlap, creating the potential for tension and conflict between the work of criminal investigations and the provision of medical care, and harm to patients from the overreach of police authority.

To ensure that police and medical providers comply with their respective obligations to the public and the individual patient/suspect, careful delineation of their respective roles is necessary. This delineation is reflected in the statutory and ethical frameworks governing healthcare and in criminal procedure doctrine.

When lines are blurred between law enforcement and medical care by medical providers, however, the latter's actions are no longer within the realm of medical care and instead fall under the province of law enforcement investigations. Their actions must then be scrutinized under the rubric of constitutional criminal procedure.

I. BECAUSE POLICE AND MEDICAL PROVIDERS FULFILL DIFFERENT PURPOSES AND FUNCTIONS, ANY OVERLAP OF POLICING AND HEALTHCARE IMPLICATES IMPORTANT HEALTH PRIVACY LAWS AND FOUNDATIONAL PRINCIPLES OF MEDICAL ETHICS.

Because emergency departments treat people with unexpected and often serious illnesses and injuries, police will inevitably enter these healthcare settings. But even as their presence may be inevitable, police investigations disrupt the

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court case that employs that term.

normal course of hospital business. Law enforcement's actions, requests, and very presence are in tension with fundamental tenets of health privacy law and medical ethics. The disruption is exacerbated when law enforcement investigations breach constitutional protections.

As seen in Ms. Trevizo's case, when these two groups become intertwined in the context of a medical health emergency, with police interrogations being conducted by health providers on medically vulnerable patients suffering from acute injuries, a medical provider's ability to provide the best care possible for patients is compromised.

A. Police Officers and Medical Providers Fulfill Vital But Diametrically Opposed Functions in Society and Are Subject to Different Regulatory Regimes.

Police are tasked with protecting the public and investigating crimes. Emergency medical providers treat people who are injured or sick and require urgent attention. To put it in even starker terms, police are the only entity in our society legally authorized to use deadly force. Emergency medical providers are our society's healers.

The diametrically opposed purposes of these entities mean that police work and healthcare work differ in many ways. In service of their purpose to protect public safety, police officers are charged with conducting investigations through searches,

seizures, interrogations and other forms of evidence-gathering. Medical providers' primary job is to provide medical care to people. Police and medical providers are thus governed by different legal and ethical regimes.

Law enforcement officers operate under rules laid out in federal and state constitutional criminal procedure, a variety of state and local regulations and rules, and individual department policies. *See* Rachel A. Harmon, *Reconsidering Criminal Procedure: Teaching the Law of Police*, 60 ST. LOUIS U. L.J. 391 (2016) (describing regulatory and legal mechanisms that make up the law of police). Police accountability typically comes in the form of exclusion of evidence in criminal cases or civil rights remedies for unconstitutional police actions. *See e.g. Mapp v. Ohio*, 367 U.S. 643 (1962) (extending the exclusionary rule remedy to state law enforcement officers); *Miranda v. Arizona*, 384 U.S. 436 (1966) (requiring the suppression of suspect's statements if they are not advised of their constitutional rights); 42 U.S.C. § 1983. These remedies have been criticized as insufficient accountability measures because of doctrines like qualified immunity that shield bad law enforcement actors, and the fact that law enforcement misconduct does not always lead to criminal prosecutions, thereby avoiding judicial scrutiny. *See* Rachel A. Harmon, *The Problem of Policing*, 110 MICH. L. REV. 761 (2012) (arguing that the problem of policing is fundamentally a problem of regulating the police).

Medical providers are subject to much greater scrutiny through an array of

statutes and regulations. *See A Guide to Healthcare Compliance Regulation*, MICH. STATE UNIV. (July 12, 2023), ("Healthcare is one of the most regulated industries in the United States . . . ."). Medical providers must comply with federal and state health privacy laws. *See* Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 110 Stat. 1936 (regulating the protection and disclosure of patient health information); NMSA 1978, § 14-6-1 (2023) (Health information; confidentiality; immunity from liability for furnishing). In addition, medical professionals must abide by the state's Medical Practice Act and are subject to oversight by the state Medical Board.[5] *See* NMSA 1978 § 61-6-1 to 61-6-35 (New Mexico Medical Practice Act); NMSA 1978, § 61-6-2 (2024) (establishing the New Mexico Medical Board). Physicians and nurses are further regulated by standards of care and tort laws of medical malpractice and negligence. *See* NMSA 1978 § 41-5-1 (2023) (Medical Malpractice Act).

In addition to these laws and regulations, medical practitioners are governed by strong professional ethics and norms. Newly minted doctors and nurses take versions of the age-old Hippocratic Oath to uphold their obligations to patients. Key ethical principles include principles of nonmaleficence (to do no harm), beneficence (acting in the best interests of patients), justice (fair and equitable treatment of

[5] In New Mexico, that entity is the New Mexico Medical Board. NMSA 1978, § 61-6-2.

patients), patient confidentiality, and patient autonomy. *See* Basil Varkey, *Principles of Clinical Ethics and Their Application to Practice*, 30 MED. PRINC. & PRACT. 17 (2020) (presenting an overview of medical and clinical ethics).

The American Medical Association (AMA) is a key authority of medical ethics. It publishes numerous Ethics Opinions to help practitioners navigate their ethical obligations when faced with complex real-life scenarios. *See Principles of Medical Ethics*, Am. Med. Ass'n, https://code-medical-ethics.ama-assn.org/principles. The New Mexico Medical Board, the state agency overseeing medical professionals in New Mexico, has adopted the ethical standards and opinions issued by the AMA. *See* NMAC 1978 § 16.10.8.9 (2024).

B. Police Investigations in Medical Care Raise Important Concerns About Patient Privacy and Autonomy, and Create Ethical Conflicts for Medical Professionals.

Though it may be inevitable and necessary that police come into the emergency department, police presence can disrupt important fundamental tenets of ethics, such as patient confidentiality, privacy, and autonomy.[6] *See* Jeremy R. Simon

[6] For further discussion of the ethical implications of law enforcement presence, *see* Utsha G. Khatri, *Emergency Physician Observations and Attitudes on Law Enforcement Activities in the Emergency Department*, 24 WEST J. EMERG. MED. 160 (2023); Madison Weiss & Janet Weiner, Issue Brief, Penn Leonard Davis Institute of Health Economics, *Clarifying the Role of Law Enforcement in the Emergency* (July 14, 2023).

et al., *Law Enforcement Information Gathering in the Emergency Department: Legal and Ethical Background and Practical Approaches*, 4(2) J. AM. COLL. EMERG. PHYSICIANS OPEN e12914 (2023).

The preamble to the AMA Principles of Medical Ethics emphasize that the duty of physicians is to "patients first and foremost, as well as to society…." *See Principles of Medical Ethics,* Am. Med. Ass'n. A physician must provide medical care "with compassion and respect for human dignity and rights," "respect the law," and "safeguard patient confidences and privacy within the constraints of the law." *Id.* "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." *Id.* Patient privacy, the Code provides, is not just a value in and of itself, but a prerequisite to developing a relationship of trust with patients and a sign of respect for patient autonomy. *Privacy in Health Care: Code of Medical Ethics Opinion 3.1.1*, Am. Med. Ass'n, https://code-medical-ethics.ama-assn.org/ethics-opinions/privacy-health-care. Hence, when faced with situations where physicians must balance the patient's privacy against other competing obligations, the physician, must "seek to protect patient privacy in all settings to the greatest extent possible," which includes "minimiz[ing] intrusion on privacy when the patient's privacy must be balanced against other factors." *Id.*

Given these core ethical values and norms, police investigations in the emergency department produce profound ethical conflicts for medical providers.

When healthcare work overlaps with law enforcement investigations, medical providers are faced with diametrically opposed obligations—the duty to keep patient information confidential **and** the duty to inform law enforcement of patient information, and the duty to do no harm **and** the duty to report to police so that they can uphold their job of protecting public safety.

The most extreme yet routine scenario of law enforcement investigations in emergency departments involve police requests to have medical providers conduct medical procedures, with or without warrants, to get evidence of a crime. These "searches of the interior of the body are among the most intrusive searches law enforcement may conduct." *Young v. Gila Regional Medical Center*, 2021-NMCA-042, ¶ 14, 495 P. 3d 620 (citing *Schmerber v. California*, 384 U.S. 757 (1966)) (holding that warrant did not authorize a search of plaintiff's body that included a rectal exam and x-ray by doctor and thus the search violated plaintiff's Fourth Amendment rights). These procedures intrude on patient autonomy when they are carried out by medical providers without patient consent and when the procedures are not medically necessary or justified.

In fact, when such circumstances arise, medical providers have been advised to adhere to their ethical standards to the best of their ability, including seeking consent from patients first when confronted with law enforcement investigative requests and even refusing to carry out orders when physicians believe such action

would damage the patient's welfare and/or violate their rights. *See* American College of Emergency Physicians (ACEP), *Policy Statement: Law Enforcement Information Gathering in the Emergency Department* (June 2023) (stating that physicians' ethical and moral responsibilities should inform their response to law enforcement requests for invasive procedures).

It is not just intrusive procedures that raise ethical conflicts. The presence of police in the emergency department gives police broad access to confidential patient information, a fact that is especially concerning because police are not obligated under the law to keep medical information private.[7] Police may listen in on patient interviews with providers, observe medical examinations, or simply be present in treatment areas. In all these situations, it is difficult or impossible for medical providers to maintain patient confidentiality and protect patient privacy. Kate Gallen et al., *Health Effects of Policing in Hospitals: A Narrative Review*, J. RACIAL & ETHN. HEALTH DISP. 870, 875 (2022). Further, when—as here—police are able to interrogate patients who are suffering from acute injuries and medically vulnerable,

[7] Police are generally not included in the categories of entities who are subject to the state and federal health privacy provisions. Using the terminology of HIPAA, police are not "covered entities" like hospitals, physicians, or nurses, and hence do not have to keep information they receive in confidence except in unusual circumstances, such as when police are part of an entity that provides medical care. Office of Civil Rights, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement*, https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

the medical provider's duty to provide care and do no harm to the patient is compromised. *Id.* at 876.

The different purposes, functions, and governance structures underscore the importance of a careful deciphering of police and medical roles when police enter the emergency department.

C. The Extension of Problematic Policing Practices into the Emergency Department Causes Harm to Patients.

The presence of police in the emergency department cause issues beyond ethical conflicts. Indeed, police have caused direct harm to vulnerable patients who seek care in the emergency department in the name of public safety.

The general problems with policing range from the targeting and surveillance of racial minorities, to conducting unlawful arrests and searches, to use of excessive and often deadly force. *See* Barry Friedman, *Disaggregating the Policing Function*, 169 UNIV. PENN. L. R. 926, 935-939 (2021) (describing the direct harms of policing).

These overbroad and unlawful policing practices extend into hospitals and their emergency departments, culminating in events that have reached the public consciousness. Police have shot and killed patients. *See* Cindy Chang, *L.A. to Pay $3.9 Million to the Parents of a Man Fatally Shot by Police at Harbor-UCLA Medical Center,* L.A. TIMES (Apr. 11, 2018). In New Mexico, police have arrested and brought individuals to hospitals for invasive procedures conducted by medical

providers only for no drug contraband to be found. *See* Nicholas Kristof, *3 Enemas Later, Still No Drugs*, N.Y. TIMES (Jan. 25, 2014); *Young v. Gila Regional Medical Center*, 2021-NMCA-042, ¶ 14, 495 P. 3d 620. Other less sensational yet equally pernicious examples of police overreach include reports by medical personnel of police officers taking down names and birthdates of patients in treatment areas even when they are not in police custody and law enforcement's installation of a license plate reader at the entrance of the emergency department without notifying hospital personnel. Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646, 2650 (2021). Medical providers have also been on the receiving end of unlawful police conduct. Medical providers have been arrested for refusing to comply with what they perceive as unlawful police action. Laurel Wamley, *Utah Nurse Arrested For Doing Her Job Reaches $500,000 Settlement*, NPR THE TWO WAY (Nov. 1, 2017).

Even in cases where law enforcement acted in concert with medical personnel input and are "justified" by ostensibly medical purposes, the combined force of medical personnel and police action upon patients in case have been found to be unlawful. A 2001 United States Supreme Court case is instructive here. In *Ferguson v. City of Charleston*, a nurse employed by a hospital in Charleston, South Carolina began a program that drug-tested pregnant patients in collaboration with law enforcement. *Ferguson v. City of Charleston*, 532 U.S. 67 (2001). The Supreme

Court held that the program violated the Fourth Amendment rights of the pregnant patients as the program had a clear law enforcement purpose and the tests were conducted without patient consent. *Id.* (holding that the involuntary drug testing of women patients at the hospital violated the Fourth Amendment).

Because of such harms, emergency medical providers have mobilized, forming professional groups, publishing articles, and advocating within their hospitals and in public for patient-centered approaches to law enforcement interactions. Jennifer Tsai, Opinion, *Get Armed Police Out of Emergency Rooms*, SCI. AM. (July 14, 2020); Zainab Ahmed, *Do No Harm: A Call for Decarceration in Hospitals*, BILL OF HEALTH (Sept. 27, 2022); Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646, 2718 (2021) (describing medical provider efforts to create patient-centered approaches to law enforcement in emergency departments); Ji Seon Song, *Patient or Prisoner*, 92 GEO. WASH. L. REV. 1, 73 (2024) (describing organizing efforts by healthcare providers to limit law enforcement and center patient care).

The vastly different purposes, functions, and governing frameworks of the two professions invariably lead to major ethical conflicts and tensions when the two intersect. And the stakes are not just about ethics conundrums. Actual harm to patients can result when overbroad and unlawful policing occurs in healthcare settings dedicated to healing medically vulnerable patients.

II. MEDICAL PRIVACY LAWS AND MEDICAL ETHICS DELINEATE THE DISTINCTIONS BETWEEN MEDICAL CARE AND POLICE INVESTIGATIONS.

Because of the different purposes, regulatory frameworks, ethical issues, and the potential harms, it is especially important to delineate how and when medical providers should participate and cooperate in police investigations, particularly when the target of the police investigation is that provider's patient.[8] Such delineation exists under federal and New Mexico law. Even when the law mandates the cooperation of medical providers, such as when they must report certain types of suspected crimes and injuries, health privacy laws and ethics require that their involvement is time- and substance-limited. Moreover, ethics must continue to guide medical providers even as they comply with their legal obligations.

When the line is blurred however, and medical providers exceed the permissible scope of their legal obligations, the law provides a governing framework to determine whether those actions are lawful. That framework is constitutional

[8] A common collaboration between medical providers and law enforcement occurs in sexual assault cases. Sexual assault nursing examiners (SANE) are a type of forensic medical personnel trained to question and examine victims of sexual assault and to ensure that evidence comports with chain of custody requirements. As described in the discussion on the Sixth Amendment, *infra* Part II(C), these programs are subject to rules that decipher the purposes of the work of SANE providers as law enforcement or medical care.

criminal procedure.

A. Health Privacy Laws Create Distinct and Discrete Exceptions and Procedures, Outlining When Information Relevant to Criminal Investigations Is To Be Provided By Healthcare Providers to Law Enforcement.

A person's medical privacy rights are not unlimited. Legislatures have deemed it necessary for health providers to disclose patient health information for societal interests, such as the collection of data relating to certain diseases and criminal investigations. These exceptions are delineated by statute in both federal and state law. They are not broad permits; instead, they are circumscribed by regulation and authoritative ethical advisements.

To properly understand the law enforcement exceptions to patient privacy, it is necessary to start with the Health Insurance Portability and Accountability Act ("HIPAA"), the federal statute governing the protection and disclosure of patient health information. Public Law 104-191, 110 Stat. 1936. Contrary to the State's position, **[BIC 36-38]** HIPAA is critical to the evaluation of the behavior of the medical providers in Ms. Trevizo's case. HIPAA informs the extent of disclosures of patient health information permitted by health privacy laws to law enforcement.[9]

[9] In addition, even though HIPAA is a civil statute and any violation of HIPAA does not result in a remedy in criminal cases, its provisions are also relevant to questions in criminal cases because HIPAA contributes to our understanding of societal privacy expectations.

As both parties note, HIPAA provides instances when patient health information may be disclosed to parties. These exceptions include reports to public health authorities and, relevant to the instant case, information related to potential criminal conduct. 45 C.F.R. § 164.512(f)(1)-(6). Three exceptions contained in HIPAA are potentially applicable to the instant case.

The first exception, as the State notes, **[BIC 37]** permits the disclosure of patient information relating to a crime that occurred on the premises of a covered entity. 45 C.F.R. § 164.512(f)(6) (2024). The provision specifies that such disclosure *may* be made, as HIPAA exceptions are generally permissive in nature and not mandatory. *Id*. The provision also limits the information to be disclosed to: protected health information that would alert law enforcement of the nature and commission of the crime, the location of the crime and victim(s), and the identity, description, and location of the alleged perpetrator of the crime. 45 C.F.R. § 164.512(f)(6)(i) (2024).

The second exception highlighted by the State **[BIC 37]** falls outside the delineated exceptions contained in 45 C.F.R. § 164.512(f) and instead concerns the disclosure of patient health information of the victim of abuse, neglect, or domestic violence. 45 C.F.R. § 164.512(c)(1) (2024). This provision does not apply to Ms. Trevizo who is the one *suspected* of the abuse or neglect here and not the victim of

it.[10]

The third exception allows disclosures authorized by state law, including mandatory reporting statutes. 452 C.F.R. § 164.512(f)(1)(i) (2024) (authorizing disclosure required by law "including laws that require the reporting of certain types of wounds or other physical injuries").

Hence, in addition to these federal provisions, to properly evaluate the conduct of the medical team and law enforcement in this case, we must look to New Mexico law. Applicable New Mexico law includes its provisions on physician-patient privilege and confidentiality. Rule 11-504 NMRA; NMSA 1978, Section 14-6-1 (2023). New Mexico also follows other states in mandating that physicians and nurses report incidents where they have reason to suspect child abuse or neglect. NMSA 1978, § 32A-4-3 (2021). In such instances, the statute provides that when a reporting party knows or has reasonable suspicion that a child has been abused or neglected, they "shall report the matter immediately." *Id.*

New Mexico enacted this statute when nationwide attention was focused on increasing protections for vulnerable children. Historically, these kinds of abuses were hidden from view and not commonly reported to officials. *See* Leonard G.

[10] This provision of the HIPAA regulations also differs from the general law enforcement exceptions to the HIPAA Privacy Rule in that it is designed to protect the victim of any abuse, neglect, or domestic violence. This provision should be read with 45 C.F.R. 164.512(f)(3) which requires that the covered entity obtain the consent from the victim unless such consent cannot be obtained.

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. TOLLE LEGE 37, 40 (2014). Though the imposition of mandatory reporting obligations on medical providers was not without controversy, these professionals were included as reporters because of their unique proximity to victims and their ability to uncover suspected cases of child abuse and neglect. *See* State v. Strauch, 2015-NMSC-009 ¶ 20, 345 P.3d 317.

The language of the statute reinforces its purpose to identify instances of child abuse and to ensure that no further harm is caused to the child. NMSA 1978, § 32A-4-3(C). Once the report is made, the statute requires the *recipient* of the mandatory report to conduct the investigation, taking investigatory responsibility out of the hands of the reporting party. *Id.* ("The recipient of a report…shall take immediate steps to ensure prompt investigation of the report. The investigation shall ensure that immediate steps are taken to protect the health or welfare of the alleged abused or neglected child….").

B. The Delineated Exceptions to Patient Privacy and Confidentiality Do Not Authorize Broad and Amorphous Gathering and Transmission of Patient Information to Law Enforcement.

The statutorily delineated instances where medical providers assist and

participate in criminal investigations are time- and substance-limited.

At first blush, the New Mexico statute would seem to give law enforcement access to any and all patient health information if the crime at issue concerns child abuse or neglect. However, such broad and amorphous permission would render inapplicable large swaths of health privacy laws and the medical providers' duties of confidentiality and privacy for any patient suspected of child abuse or neglect. Rather than adopt this broad reading that would make health privacy and patient confidentiality protections largely meaningless, a thorough and contextual analysis of medical providers' legal and ethical obligations points to the opposite conclusion—namely that the exceptions to the disclosure provisions in HIPAA and the mandatory reporting obligations imposed by New Mexico do not result in the wholesale production of patient information and evisceration of patient confidentiality or privacy protections. Medical providers should not wholesale disclose information to law enforcement, but only information that is necessary for law enforcement to begin their investigations. This contextualized reconciliation of the applicable laws and ethics is not just correct, it reflects a balancing of the respective goals of public safety and patients' rights.

In the instant case, by the time Ms. Trevizo made the statements at issue, the mandatory reporting to the police under New Mexico law had already been made. The police had arrived in response to that reporting. The reading that best comports

with New Mexico law, federal and state health privacy laws, and the ethical principles governing medical providers is that the mandatory reporting requirement ended at that point. Mandatory reporting statutes are meant to help police identify when a crime has occurred and to give police relevant information that the medical provider is aware of at the time of the report. It is not meant to help police build an evidentiary case against the suspect.

How do we get to this conclusion? Here again, we begin with HIPAA. HIPAA provides a "Federal floor of patient privacy." Dep't of Health & Hum. Serv., *Health Information Privacy, Does the HIPAA Privacy Rule Preempt State Laws?*, https://www.hhs.gov/hipaa/for-professionals/faq/399/does-hipaa-preempt-state-laws/index.html. This means that states can be more protective of health privacy than HIPAA, not less. *Id*. If any state provision conflicts with HIPAA and provides less protection, that state law is preempted. *Id*.

State mandatory reporting obligations are not preempted by HIPAA. *Id*. But again, the analysis does not stop there. State mandatory reporting laws and the extent of disclosure by healthcare providers are limited to that required by law. *See* 45 C.F.R. § 164.512(a) ("A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law."). Hence, though medical providers fulfill the reporting requirements as specified by

law, the law in and of itself does not open the door for the release of any and all related patient information.

The guidance from AMA Code of Medical Ethics, adopted by the New Mexico Medical Board, comports with this balancing of disclosure and maintaining patient privacy. The Ethics Opinion on patient confidentiality highlights the need for patients "to be able to trust their physicians will protect information shared in confidence." *Confidentiality: Code of Medical Ethics Opinion 3.2.1*, Am. Med. Ass'n. The Opinion provides that generally patients "are entitled to decide whether and to whom their personal health information is disclosed." *Id.* Recognizing that patient consent is not required in all circumstances where physicians *must* disclose, the Opinion continues to emphasize the providers should "restrict disclosure to the minimum necessary information" *Id.* This ethical guidance of minimum disclosure is consistent throughout the Ethics Opinions, including when medical providers become aware of medically at-risk drivers, *see Impaired Drivers & Their Physicians: Code of Medical Ethics Opinion 8.2*, Am. Med. Ass'n., and even when the patient is the one suspected of being the victim of abuse. *See Preventing, Identifying & Treating Violence & Abuse: Code of Medical Ethics Opinion 8.10*, Am. Med. Ass'n.

The American College of Physicians Ethics Manual provides similar advisements. Affirming that reporting obligations are consistent with physicians'

duty to protect public health, the Manual also states that "[i]f breaching confidentiality is necessary, it should be done in a way that minimizes harm to the patient and heeds applicable federal and state law. *See* L. Snyder, *American College of Physicians Ethics Manual: Seventh Edition*, 170 ANN. INTERNAL MED. SUPP. S5 (2019).

In the same way that mandatory reporting laws impose discrete obligations on medical providers, courts' evaluations of physician-patient privilege in conjunction with police investigations reveal similar delineations between the law enforcement and medical role. In *State v. Roper*, a police officer was in the emergency room to question a defendant for driving a vehicle while under the influence of alcohol. The officer then asked the treating nurse for the defendant's blood test results and she disclosed that information. The court found that disclosing the results of a blood test constituted a privileged communication under SCRA 11-504 and should not have been disclosed to the police officer. 1996-NMCA-074, ¶ 19, 122 N.M. 126. The court's determination in *Roper* represents the exact kind of discernment necessary when determining the limits of policing in medical care situations.

Law enforcement presence in the emergency department is not *carte blanche* authorization to obtain patient health information that would otherwise only be disclosed subject to specific procedures in criminal cases. Indeed, it makes no sense that clear procedures for information gathering exist in criminal courts, such as

warrant applications, subpoenas, discovery processes, and court proceedings like *in camera* review for the proper adjudication of the release of private medical records, only to be sidestepped by conscripting medical providers into the criminal investigation process.

C. Healthcare Providers' Disclosure and Assistance Beyond Legal Mandates Transform Their Role from Healthcare Provider fo Agent of Law Enforcement and Opens The Door to the Violation of Individual's Rights.

When healthcare providers go beyond legally authorized and mandated disclosures and exceptions to patient confidentiality and privacy provisions in cases involving law enforcement, they do not just run afoul of health privacy laws and ethical mandates. At that point, they are no longer providing medical care. Instead, they are providing direct assistance to police in the gathering of evidence through questioning and seizure of evidence. They become agents of law enforcement. In this case, as both parties agree, the report and identification of a potential criminal incident was completed by the time Ms. Trevizo made the statements at issue. These statements made by Ms. Trevizo to Dr. Vaskas occurred after her examination, her labor and delivery, and after the police arrived.

When healthcare providers cross the line from providing treatment to participating in law enforcement investigations, constitutional criminal procedure is the governing framework for evaluating the lawfulness of the conduct vis-à-vis the

individual rights of suspects. This division between medical purpose and law enforcement can be seen in various criminal procedure doctrines, from Fourth Amendment search and seizure questions, Fifth Amendment interrogation issues, and Sixth Amendment Confrontation Clause and hearsay questions as adjudicated by New Mexico courts.

For example, in cases assessing the applicability of the Fourth Amendment to forced blood draws from criminal suspects or defendants, the constitutional question depends on if the directive came from a law enforcement actor or whether the blood draw was done for medical purposes only. In *Gallegos v. Vernier*, the Court of Appeals determined that the defendant's Fourth Amendment rights were violated when the police officer directed medical personnel to draw the defendant's blood without a warrant or valid exigent circumstances. 2019-NMCA-020 ¶¶ 14-18, 34, 458 P. 3d 533, *cert. denied*, No. S-1-SC-37431 (2019) (reversing lower court's grant of summary judgment based on qualified immunity as to the warrantless blood draw).

The line between law enforcement and medical purposes is also clearly delineated when courts determine the contours of a Fifth Amendment violation. This Court's decision in *State v. Ybarra* reflects this delineation in criminal procedure doctrine between actions taken for the purposes of medical care versus those in furtherance of police investigations. *State v. Ybarra*, 1990-NMSC-109, 111 N.M.

234. In *Ybarra*, the Court found that a nurse had conducted an interrogation of a defendant while he was in a hospital. *Ybarra*, 1990-NMSC-109, ¶ 14. The Court distinguished its conclusion from the situation in *State v. Gurule*, 1977-NMCA-138, 91 N.M. 332, *cert. denied,* 91 N.M. 491 (1978), where the defendant made statements to an ambulance driver and physician that were "merely overheard" by a nearby police officer.[11]

The delineation between law enforcement and medical purposes is relevant in cases addressing the Sixth Amendment question of the confrontation of witnesses. The most common scenario in which this issue arises involves statements made by patients to sexual assault nurse examiners. The purpose of the interview is relevant to whether the statements may come in under the Confrontation Clause. *See State v. Tsosie*, 2022-NMSC-017, ¶ 16, 516 P.3d 1116 ("the district court must… be vigilant that a SANE nurse's dual role is not used by the prosecution to end-run

[11] In a case cited by the State, *People in the Interest of R.G.*, a Colorado appellate case also maintains this delineation. In that case, the medical provider was not found to be interrogating the patient but merely asking him questions about an injury. 630 P. 2d 89, 93 (Colo. Ct. App. 1981) (finding that the questioning of patient by private physician was not an interrogation and thus the Fourth and Fifth Amendment constitutional protections were not applicable). A further point of distinction is whether the questioning is directed towards a *patient* and not someone who is at the emergency department but not subject to any kind of medical attention, the latter being the situation in *People v. Salinas*, 182 Cal.Rptr. 683 (App. 1982), the California appellate case cited by the State.

the Confrontation Clause by introducing…statements made for a testimonial primary purpose under the guise of having been made for a medical care primary purpose"). The analysis for determining the admissibility of hearsay evidence is also contextual, looking beyond the general purpose of the examination or questioning to the content of the questioning, as the Court determined in *State v. Mendez*, 2010-NMSC-044, ¶ 21, 148 N.M. 761. In either case, the inquiry is directed at whether statements were made for medical or evidence-gathering purposes. *Id* ¶ 21.

III. THE DELINEATION BETWEEN THE WORK OF LAW ENFORCEMENT AND EMERGENCY MEDICAL CARE SERVES OUR SOCIETY'S GOALS OF PUBLIC HEALTH AND PUBLIC SAFETY.

Finally, a clear delineation of roles is necessary for public policy reasons. Emergency departments are vital to healthcare access and provision. Over the decades, they have become central to the delivery of healthcare in the United States. Emergency departments now provide for nearly half of hospital-associated healthcare. *See* David Marcozzi et al., *Trends in the Contribution of Emergency Departments to the Provision of Hospital-Associated Health Care in the USA*, 48 INT'L J. HEALTH SERVS. 267, 281–83 (2018). Emergency departments have become the *de facto* and central provision of healthcare in the United States. They are society's safety net. The fundamental value of giving medical treatment to people with urgent needs is what led to the enactment of the federal law, the Emergency

Medical Treatment and Labor Act (EMTALA) which prevents hospitals from denying or limiting healthcare to individuals based upon their financial or insurance status. Emergency Medical Treatment and Labor Act, Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986).

The presence of police in treatment areas without hospital regulations and guidelines can lead to several negative social effects. *See* Kate Gallen et al., *Health Effects of Policing in Hospitals: A Narrative Review,* J. RACIAL & ETHN. HEALTH DISP. at 874 (2022). Police presence in hospitals has been shown to strain patients' relationships with providers and erode their trust in the healthcare system. *Id.* This mistrust is not just limited to the individual but has also been found to impact families and communities. *Id.*

Making clear the distinction between police investigation and medical care in healthcare settings may seem to hamper law enforcement aims. But that interpretation is short-sighted. The delineation of roles, confirmed by judicial oversight, ensures that law enforcement conduct their jobs lawfully and helps them understand how to navigate a healthcare setting with privacy considerations that are very different from how privacy is understood in the context of constitutional criminal procedure. Furthermore, such delineation ensures that the lawful gathering of evidence contributes to a criminal court process that is procedurally and constitutionally sound.

CONCLUSION

The harm to Ms. Trevizo as a result of this ordeal and the public dissemination of her medical emergency cannot be undone. Moreover, the ramifications extend beyond Ms. Trevizo to other vulnerable individuals who read her story. They may wonder—how private are their encounters with medical professionals? Are medical providers in fact working hand-in-hand with police?

The trial court could not turn back the clock to correct the missteps by the law enforcement officers and the healthcare providers the night Ms. Trevizo entered the emergency department. But the trial court did what was in its power and capability by imposing the consequence of suppression for the overreach of law enforcement and the medical team's shift from providing care to acting as law enforcement proxies. Discerning the delineation of roles and imposing consequences when such delineation is transgressed is essential to upholding the law, ethics, and public policy concerns fundamental to protecting individuals and promoting public safety. By redressing the rights violations when lines were crossed, the trial court vindicated Ms. Trevizo's rights and provided critical future guidance to police and healthcare providers who will continue to cross paths at this intersection.

Respectfully submitted,

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STATEMENT OF COMPLIANCE

As required by Rule 12-318(G), undersigned counsel certifies this brief was prepared in 14-point Times New Roman typeface using Microsoft Word, and the body of the brief contains 6,801 words.

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Brief of Professor Ji Seon Song for *Amici Curiae* was filed electronically and served to all counsel of record this 6th day of November 2024 via the Odyssey e-filing/service system.

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