COMMENTARY

Cop to Cop: Negotiating Privacy and Security in the Examining Room

Sondra S. Crosby and George J. Annas

Medical examination rooms are private places where a physician and patient can participate in a doctor-patient relationship, complete with a reasonable expectation of physical and informational privacy. This is the ordinary rule, and the usual expectation. But in this issue of the *Journal of Law, Medicine & Ethics*, Gutierrez et al. describe the case of Mr. Doe, illustrating that there is nothing ordinary about Immigration and Customs Enforcement (ICE) or other custodial authority bringing a detainee/prisoner to a private hospital to see a physician.[1] In this commentary, we outline the law governing this category of doctor-prisoner encounter, and suggest how correctional officers might be persuaded to stay out of the examining room.

The key point is that the prisoner status of the patient changes everything. The prisoner does not voluntarily come to the hospital for care; he or she is brought there. Nor does the prisoner come alone. The prisoner is accompanied by one or more correctional officers, whose job it is to make sure that the prisoner does not escape and that the prisoner does not hurt anyone. In this circumstance, it is fair to begin with a presumption that the correctional officer will stay with the prisoner during the physical examination as a matter of safety. ICE's medical care standards are consistent with this presumption, and include the following language: "Medical and mental health interviews, screenings, appraisals, examinations and procedures will be conducted in settings that respect detainees' privacy in accordance with safe and orderly operations of the facility." The standards also provide for a "same sex chaperone as appropriate or as requested." Examinations are to be conducted "in private while ensuring safety."

Courts give jailers and correctional officers wide latitude in determining what needs to be done for "safety," going so far as to hold that routine strip searches are constitutional, even on prisoners who have only been arrested and not even charged with a crime.[2] There is virtually no chance that the US Supreme Court would change this ruling, or that it would provide for more medical privacy for ICE detainees than for any other category of prisoner/detainee.[3]

The route to more privacy in custodial medical care is not through the courts, but through interpersonal relationships. As the case of Mr. Doe illustrates, the privacy of custodial medical care is compromised by the addition of a third person who comes with the patient/prisoner to the examination.[4] Typically the patient is a prisoner in a nearby prison or detention center, and has been brought to the hospital by a correctional officer from that facility. In this case, we can say there is an existing prisoner-corrections officer relationship. The question is how (if at all) this relationship can be transformed into a doctor-patient relationship by adding a physician and subtracting, at least temporarily, the corrections officer. The goal is to permit the medical exam to proceed in private. One way, for example, would be to ask the corrections officer to stand outside the door, and to neither witness nor overhear the examination itself. There are five parties who can take part in deciding if a "private examination" in a medical examining room can be done, and under what circumstances: the hospital administration, the prison administration, the correc-

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The Journal of Law, Medicine & Ethics, 48 (2020): 169-171. © 2020 The Author(s)
DOI: 10.1177/1073110520917006

tions officer, the physician, and the patient. Of course, if all of these parties agree, there is no conflict and no privacy problem.

The most promising, and most pragmatic, way to resolve any conflict is to have the correctional officer speak directly to a senior security agent at the hospital, and have the two of them, work out a solution "cop to cop." This could result in a compromise that would be acceptable to all parties. To continue with the scenario, however, let us assume that we could not achieve a satisfactory compromise. Then we are back to having the physician deal directly with the corrections officer. The physician can bargain and accept a worked-out compromise. For example, in the case of a potentially violent prisoner, it seems reasonable to conclude that the corrections officer should stay close enough to protect the physician, and that the physician would generally appreciate this. Physicians should not be put in a position to determine "dangerousness" of prisoners, however, and should rely on corrections officers' expertise. This is especially important if the physician is meeting the prisoner for the first time.

In our opinion, based on the information given, a reasonable solution in Mr. Doe's case would have been for hospital officials to work out an agreement with the correctional officers and physician for officers to remain outside the exam room, respecting the privacy of the physician-patient meeting, but being immediately available if the physician's safety was threatened.

By contrast, is the case different when the physician has had prior contact with the prisoner, and "knows" the prisoner? One of us (SSC) had this situation in an admittedly extreme case, in Guantanamo prison. After seeking and obtaining prior permission for an "unshackled" physical examination at the prison, at the last minute, this permission was denied by the base commander. When the physician refused to examine the prisoner with shackles, the base commander, through a messenger, told the physician that if the prisoner was unshackled, guards must be posted inside the exam room. When the physician continued to refuse to conduct an examination under these circumstances, a compromise was eventually reached which involved posting guards outside the door. The physician's reasonable goal was to communicate with her patient/prisoner in private. No reader is likely to be surprised that the physician was required to sign a release of liability form for injuries to her by her patient, who was classified in Guantanamo as a "dangerous terrorist."

Guantanamo has its own rules for medical examinations — all of which take place on the military base, and all of which are classified. Prison systems, both publicly and privately run, also have their own rules. In all of these settings, rules for medical examinations are likely to be similar and primarily based on balancing medical privacy with safety and security. If a hospital does not have its own institutional policies for protecting prisoner privacy and negotiating safety with correctional officers when conflict arises, it should develop them. Rules should apply equally to prisoners brought to a private or public hospital for examination, and for examination conducted by a physician brought to the prison to examine a prisoner. It also seems reasonable that institutional policies should apply to all persons in detention accompanied by a correctional officers, and should not be limited to persons held in immigration detention.

In Massachusetts for example, the Department of Corrections policy provides that Inmates shall be "examined in a room which provides for privacy and dignity to the inmate and examiner. When necessitated for security reasons, a correctional officer may be present."[5] This is almost always the tension that must be directly addressed by the principals: can the patient be provided with "privacy and dignity" in a way that ensures the "safety and security" of the physician and others in the hospital? This will almost always be a judgment call that the correctional officer can make — perhaps at least partially under the influence of the physician, and will need to be determined on a case-to case basis.

In the case of Mr. Doe, institutional policy should have triggered the physician to consult with senior hospital security personnel and/or legal counsel after the conflict arose. The goal of involving these additional people is still to try to work out a solution that all parties can live with. Physicians should be informed of institutional privacy and safety policies, as well as the identity of institutional personnel who are authorized to apply the policies in real time. In our opinion, based on the information given, a reasonable solution in Mr. Doe's case would have been for hospital officials to work out an agreement with the correctional officers and physician for officers to remain outside the exam room, respecting the privacy of the physician-patient

The Journal of Law, Medicine & Ethics, 48 (2020): 169-171. © 2020 The Author(s)

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Note

The authors have no conflicts to disclose.

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