SANCTUARY CLINICS: USING THE PATIENT-PHYSICIAN RELATIONSHIP TO DISCUSS IMMIGRATION POLICY AS A PUBLIC HEALTH CONCERN

[W]e didn't know how they had ended up that way
on that *side*
we didn't know how we had ended up here
we didn't know but we understood why they walk
the opposite direction to buy food on this side
this side we all know is hunger
—*Javier Zamora*[1]

Tensions between the federal government and local "sanctuary cities" have risen throughout the Trump Administration. While Immigration and Customs Enforcement still describes health care centers as "sensitive locations," undocumented immigrants have demonstrated a cautious unwillingness to use health care services for which they may be eligible due to fear of deportation or other immigration-related consequences. Such avoidance of health care services may lead to adverse results, such as worsening health care conditions or increased emergency medical spending. While health care debates are often framed as an exclusively federal policy concern, health care policy consistently reflects collaboration between federal, state, and local efforts. This Comment attempts to address why immigration should be treated as a public health issue. It affirms the patient-physician relationship as a safeguard for protecting undocumented immigrants' privacy when seeking health care. Using analogies to the prosecution of pregnant women who use drugs and the criminalization of HIV status, this Comment illustrates the need to promote inclusive health care protections. Although it is unlikely that such protections will emerge at the federal level during this Administration, there are numerous pathways local clinics may pursue to protect their undocumented immigrant populations.

1. Javier Zamora, *Citizenship, reprinted in Poems of Resistance: A Primer*, N.Y. TIMES (Apr. 21, 2017), https://www.nytimes.com/2017/04/21/books/review/poltical-poetry-sampler.html.

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I. INTRODUCTION

Blanca Borrego was forty-four-years-old when she was handcuffed in front of her eight-year-old at her gynecologist's office.[2] She had been living in the United States as an undocumented immigrant for over a decade.[3] Her husband had private health insurance, so she did not think that she was risking arrest when she went to her gynecologist's office.[4] Borrego wanted to see her doctor, Dr. David Bonilla, for a cyst that was causing her abdominal pain.[5]

Borrego normally saw Dr. Bonilla at a different office.[6] When she arrived at the Memorial Hermann Medical Group Northeast Women's Healthcare clinic outside of Houston, a staff member asked her to fill

2. Molly Hennessy-Fiske, *Advocates Protest Latina Immigrant's Arrest at Texas Doctor's Office*, L.A. TIMES (Sept. 15, 2015, 5:39 PM), http://www.latimes.com/nation/nationnow/la-na-houston-immigrant-clinic-arrest-20150914-story.html.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

out new paperwork, submit identification, and provide her insurance card.[7] At this time, Borrego, originally from Monterrey, Mexico, gave the staff a fake Texas driver's license as identification.[8] She waited to be called in to see the doctor. Two hours passed. The local Texas sheriff's deputies surprised the mother of three: she was taken to jail and held in lieu of a $35,000 bond for tampering with a government record, a felony.[9] Clinic staff had alerted deputies after receiving the fake driver's license, and the deputies found a fake Social Security card in her purse.[10]

Increasingly, undocumented immigrant families have been unwilling to seek health services, fearing potential deportation threats or questioning by immigration officials.[11] Throughout the country, advocates note the growing number of American children that are dropping out of Medicaid and other government programs because their parents are undocumented.[12] While anxiety regarding confrontation with immigration officials is not new within immigrant communities, people repeatedly express new concerns securing health care services.[13] Fear of deportation puts significant stress on families, and the enduring health effects on undocumented immigrants and their loved ones are significant.[14]

This Comment explores how the politicization of immigration status undermines public health. By analogizing to the prosecution of pregnant women who use drugs and the criminalization of HIV status, this Comment affirms the value of the patient-physician

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7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *See* Rebecca Adams, *Immigration Crackdown Raises Fears of Seeking Health Care*, ROLL CALL (Jan. 25, 2018, 11:22 AM), https://www.rollcall.com/news/politics/immigration-crackdown-raises-fears-seeking-health-care; *see also* Samantha Artiga & Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*, KAISER FAM. FOUND. 1, 5 (Dec. 2017), https://www.kff.org/report-section/living-in-an-immigrant-family-in-america-issue-brief/ (describing that parents and pediatricians alike have noted that fears of deportation and "overall feelings of uncertainty have increased" since the 2016 presidential election).
12. *Compare* Alexia Elejalde-Ruiz, *Fear, Anxiety, Apprehension: Immigrants Fear Doctor Visits Could Leave Them Vulnerable to Deportation*, CHI. TRIB. (Feb. 22, 2018, 9:15 PM), http://www.chicagotribune.com/business/ct-biz-immigration-fears-hurt-health-care-access-0225-story.html (detailing patient concerns regarding Medicaid enrollment with future lawful permanent resident eligibility), *with* Artiga & Ubri, *supra* note 11, at 2, 15 (noting that while participation in Medicaid is stable, some parents and pediatricians describe decreased interest in new enrollment; meanwhile, both the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children have had sharp declines in participants).
13. *See, e.g.*, Artiga & Ubri, *supra* note 11, at 2.
14. *See, e.g.*, Sarah Elizabeth Richards, *How Fear of Deportation Puts Stress on Families*, ATLANTIC (Mar. 22, 2017), https://www.theatlantic.com/family/archive/2017/03/deportation-stress/520008/.

relationship as a vehicle for supporting the health of undocumented immigrant populations during a particularly politically charged time. Although both the prosecution of pregnant women using drugs and criminalization of HIV status have moved in recent years to being discussed as public health issues, their origins share strong connections in politicized debates.[15] Not only do these related public health topics carry similar moral connotations in shaping debate, they also involve distinct patient-physician privacy questions.[16]

Part II of this Comment describes the medical community's role in addressing barriers to health care for certain criminalized populations. It explains how the evolving understanding of criminal political questions has morphed into health policy concerns for physicians. To demonstrate how the politicization of immigration impacts public health, this Comment uses the prosecution of women who use drugs and criminalization of HIV status as frameworks for change. Part III explores the recent tensions with respect to the criminalization of immigration status. It briefly details how "sensitive location" policies are still in effect but immigrants throughout different states share hesitation for using health care services. Part IV shows how the patient-physician relationship may be used to shape health policy for undocumented immigrants. By showcasing the role of physicians who critique the prosecution of pregnant women who use drugs and criminalization of patients living with HIV, this Comment shows that the patient-physician relationship may similarly be used to shift the immigration debate to one that may be more concerned with public health implications. This Comment concludes that physicians have numerous options to support not only their undocumented immigrant populations but also that of their surrounding communities.

II. INTERSECTIONS BETWEEN CRIMINALIZED-BEHAVIOR STATUS AND HEALTH

While immigration status may not initially appear to be an immediate concern for health policy, other recently recognized public health issues may help shape this debate. Both the prosecution of

15. *See generally* Zita Lazzarini, *Assessing the Public Health Response During and After the Emergency: Lessons from the HIV Epidemic*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 187 (2010) (describing the intersections between public health law, constitutional system of checks and balances, and stigmatization in HIV/AIDS cases for assessing best practices in health care delivery); DARLA BISHOP ET AL., PREGNANT WOMEN AND SUBSTANCE USE, JACOBS INST. WOMEN'S HEALTH 1, 4–5 (Feb. 2017), https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf (examining the current literature and policy implications of substance use and substance use disorders among pregnant and parenting women and concluding that policies promoting punishment tend to promote worse outcomes for mothers and children).

16. *See infra* Part IV.

pregnant women who use drugs and criminalization of HIV status show a pathway for immigrant status to move within the sector of public health discussion. The intersection between immigration status, the existence of pregnant women using drugs, and HIV status showcase that public policy has previously led to the criminalization of these behavior-based statuses.[17] These criminalized statuses harm not only individuals seeking care but also broader communities by disrupting the patient-physician relationship.

A. Public Health and Immigration

The United States immigrant population has grown considerably, from 9.6 million in 1970 to nearly 40 million in 2010.[18] The rapid increase in the immigrant population since 1970 reflects large-scale immigration from Latin America and Asia.[19] With increasing immigration over the last few decades, public health research for immigrant populations has also increased. Latinos are less likely to receive evidence-based care and more likely to have chronic diseases, such as diabetes, cancer, and HIV/AIDS, compared with other Americans.[20] Approximately one-third of Latinos with diabetes lack health insurance.[21] The comorbidity of diabetes and depression is common among Latino adults, with some studies finding upwards of thirty percent of Latino patients with diabetes also having clinical depression.[22] Smoking cessation advice, colorectal cancer screening, and the influenza vaccination are inconsistently provided to Latinos.[23] Citizen children of undocumented immigrants lag in health insurance enrollment, despite their eligibility for the Child Health Insurance Program ("CHIP"), and experience difficulty in accessing care.[24] Undocumented immigrants may express hesitation

17. While immigration has only recently been treated as a criminal infraction, the "crimmigration" framework describes the increasing treatment of undocumented immigrants as criminals. *See infra* Part IV.

18. ELIZABETH M. GRIECO, THE FOREIGN-BORN POPULATION IN THE UNITED STATES: 2010 1 (May 2012), https://www.census.gov/library/publications/2012/acs/acs-19.html.

19. DIANNE SHMIDLEY, U.S. BUREAU OF THE CENSUS, THE FOREIGN-BORN POPULATION IN THE UNITED STATES: MARCH 2002 2 (2003), https://www.census.gov/prod/2003pubs/p20-539.pdf.

20. Alexander N. Ortega et al., *Policy Dilemmas in Latino Health Care and Implementation of the Affordable Care Act*, 36 ANN. REV. PUB. HEALTH 525, 532–33 (2015) (describing the changing Latino demographic in the United States and presenting a number of challenges to health care policymakers, clinicians, organizations, and other stakeholders to address in providing care).

21. *Id.* at 533.

22. *Id.*

23. *Id.* at 534.

24. Nancy Berlinger & Michael K. Gusmano, *Undocumented Patients: Undocumented Immigrants & Access to Health Care*, HASTINGS CTR. (Mar. 2013), http://undocumentedpatients.org/wp-content/uploads/2013/03/Undocumented-Patients-Executive-Summary.pdf.

to use preventative health services that they may be eligible for due to concerns that their citizenship status may be revealed.[25]

Immigration status is used as a screening tool to access certain health care benefits and services.[26] Undocumented immigrants in the United States are generally excluded from government benefits programs.[27] Public insurance programs, such as Medicaid, require proof of citizenship or legal residency.[28] Undocumented immigrants are not covered under the Patient Protection and Affordable Care Act.[29] Undocumented immigrants continue to seek and receive health care under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals to treat all patients, including undocumented immigrants, in emergency situations.[30]

This dependence on EMTALA is both costly and ineffective for supporting public health. The United States General Accounting Office has reported that states with high immigration rates have experienced a rapid rise in Emergency Medicaid expenditures in recent years.[31] Uncompensated care costs at US hospitals soared by more than sixty percent to twenty-six billion dollars between 1994

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25. *See* Scott D. Rhodes et al., *The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States*, 105 AM. J. PUB. HEALTH 329, 332 (2015).

26. *See* Luis Larrea, *Taxation Inequality and Undocumented Immigrants*, 5 WM. MITCHELL L. RAZA J. 2, 28–29 (2013).

27. *See, e.g.*, *id.* at 28–33 (describing the numerous ways in which the Personal Responsibility and Work Opportunity Reconciliation Act and similar legislation excluded undocumented immigrants from both federal and state resources).

28. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [hereinafter PRWORA] § 401(a), (b)(1)(A), 8 U.S.C. § 1611(a), (b)(1)(A) (2012).

29. *See* 42 U.S.C. § 18082(d) (2012) (describing that in order to be eligible for a health plan through a marketplace offered under the Act or to claim tax credits, an individual may not be "not lawfully present in the United States"). An immigrant that gains legal permanent resident status will still be barred from Medicaid for the first five years that they are in the United States. *See* SHAWN FREMSTAD & LAURA COX, COVERING NEW AMERICANS: A REVIEW OF FEDERAL AND STATE POLICIES RELATED TO IMMIGRANTS' ELIGIBILITY AND ACCESS TO PUBLICLY FUNDED HEALTH INSURANCE 10 (2004), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/covering-new-americans-a-review-of-federal-and-state-policies-related-to-immigrants-eligibility-and-access-to-publicly-funded-health-insurance-report.pdf.

30. *See* PRWORA § 401(b)(1)(A), 8 U.S.C. § 1611(b)(1)(A). Emergency Medicaid covers the treatment of an emergency medical condition, which is defined as a medical condition manifesting itself by "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part." 42 U.S.C. § 1396b(v)(3)(A)–(C).

31. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-04-472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS' UNCOMPENSATED CARE COSTS 11 (2004), https://www.gao.gov/assets/250/242452.pdf.

and 2000.[32] Yet, relying on EMTALA to cover undocumented immigrants hurts not only overall economic health but also community health.[33] Decisions to not cover undocumented immigrants contribute to ineffective monitoring of undiagnosed infectious diseases, such as HIV, syphilis, and tuberculosis, which pose risks to the entire population.[34] Within undocumented immigrant communities, research illustrates that accessing preventative care early helps to mitigate problems associated with chronic conditions.[35] Having more access to health care services would help undocumented immigrants manage chronic conditions, thereby avoiding higher, related emergency room costs that could arise as their health conditions worsen.

To reduce inequality in health care, there exists a need to recognize the social determinants of health.[36] Social determinants of health ("SDH") capture how people "live, learn, work, and play"; SDH factors affect a variety of health risks and outcomes.[37] Social structure influences health and disease outcomes via material, psychosocial, and behavioral pathways throughout the lifespan.[38] In this manner, drug use, immigration status, and HIV status can be classified as SDH factors that affect health. A common history of criminalization helps illustrate the stigma between HIV status and drug use during pregnancy; the increasing treatment of immigration status as a potential social-criminal status demonstrates potential public health risks.

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32. Bruce Japsen, *Unpaid Bills Squeeze U.S. Hospitals' Resources*, CHI. TRIB. (Oct. 22, 2006), http://articles.chicagotribune.com/2006-10-22/business/0610220147_1_uncompensated-care-charity-care-illegal-immigrants.

33. *See* Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1780 n.10 (2011).

34. *Id.*

35. Samuel Wolbert, Note, *Universal Healthcare and Access for Undocumented Immigrants*, 5 PITT. J. ENVT'L PUB. HEALTH L. 61, 67 (2011).

36. Social determinants of health refer to systems to "prevent disease and treat illness when it occurs, and the structural drivers of those conditions, the distribution of power, money and resources shaped by social, economic and political forces." Ruth Bell et al., *Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change*, 38 J.L. MED. & ETHICS 470, 471 (2010).

37. *See id.*

38. *See, e.g.*, Michael Marmot & Eric Brunner, *Cohort Profile: The Whitehall II Study*, 34 INT'L J. EPIDEMIOLOGY 251, 251–56 (2005) (exploring biological, behavioral, psychosocial, and socioeconomic differences in the social gradient in health and disease for British civil servants).

B. *Frameworks for Change*

1. *Criminalization of HIV Status*

AIDS was first reported in the United States in June of 1981.[39] The Kaiser Family Foundation reports that more than one million people are currently living with HIV.[40] HIV has a "disproportionate impact on certain populations," such as racial minorities and men who have sex with men.[41] African Americans are most affected by HIV in the United States.[42] In 2016, almost 40,000 people living in the United States were diagnosed with HIV.[43] According to the Centers for Disease Control and Prevention ("CDC"), "The annual number of new diagnoses declined by five percent from 2011 to 2015."[44] Structural factors such as poverty, lack of employment opportunities, and limited health care access have been highlighted as both independent and interactive contributors to health care engagement in HIV-positive women.[45] While the majority of HIV treatment is concentrated in major cities, recent trends suggest an increasing impact of the disease on women, rural residents, and elderly adults.[46] "[P]overty and other structural factors" in the United States increase the risk for "sub-optimal engagement" for HIV care throughout communities.[47]

HIV status cases often provoke discussion regarding the balance between public health promotion and criminalization of certain behaviors. HIV historically has been linked with stigmatized populations and "discriminatory responses" by the public that have ranged from describing AIDS as "retribution" to promoting violence

39. KAISER FAMILY FOUND., THE HIV/AIDS EPIDEMIC IN THE UNITED STATES: THE BASICS 1 (2018), http://files.kff.org/attachment/Fact-Sheet-HIV-AIDS-in-the-United-States-The-Basics.

40. *Id.*

41. *Id.*

42. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT AREAS, 2014 7 (2015), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf.

43. *HIV in the United States: At a Glance*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 6, 2018), https://www.cdc.gov/hiv/statistics/overview/ataglance.html.

44. *Id.*

45. *See generally* Melonie Walcott et al., *Structural Community Factors and Sub-Optimal Engagement in HIV Care Among Low-Income Women in the Deep South of the USA*, 18 CULTURE HEALTH & SEXUALITY 682, 682 (2016) (describing structural factors limiting best engagement practices).

46. ESTHER M. FORTI ET AL., NAT'L RURAL HEALTH ASS'N, HIV/AIDS IN RURAL AMERICA: DISPROPORTIONATE IMPACT ON MINORITY AND MULTICULTURAL POPULATIONS 1 (2014), https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/HIVAIDSRuralAmericapolicybriefApril2014-(1).pdf.aspx?lang=en-US.

47. *See* Walcott et al., *supra* note 45, at 682–94.

and calling for quarantine.[48] Various approaches to prevent and/or criminalize HIV transmission have been used "at the national, state, and local levels," as detailed by a collaborative research initiative between researchers from the CDC, Department of Justice, and Oak Ridge Institute for Science and Education.[49] One punitive legislative approach has been to enact laws that criminalize behaviors associated with HIV exposure (HIV-specific criminal laws).[50]

Numerous states have legislation that criminalizes potential HIV exposure.[51] The majority of these laws were passed before studies showed that antiretroviral therapy ("ART") reduces HIV transmission risk; thus, most laws do not account for scientific-based treatments or measures, such as condom use, that reduce transmission.[52] States with HIV-specific laws often do not have legislation that matches the best scientific evidence regarding HIV transmission risk.[53] Furthermore, these laws may increase HIV-related stigma and discrimination, thus making persons at risk for HIV less willing to be tested.[54]

2. *Prosecution of Pregnant Women Using Drugs*

In the United States, research estimates that women encompass forty percent of people living with a lifetime drug use disorder.[55] Because women are at the highest risk for developing a substance use disorder during their reproductive years, they are especially

48. Thomas R. Frieden et al., *Applying Public Health Principles to the HIV Epidemic*, 353 NEW ENG. J. MED. 2397, 2397 (2005).

49. J. Stan Lehman et al., *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States*, 18 AIDS & BEHAV. 997, 998 (2014).

50. *Id.*

51. *Id.* at 1002–05.

52. *See* Leslie E. Wolf & Richard Vezina, *Crime and Punishment: Is There a Role for Criminal Law in HIV Prevention Policy?*, 25 WHITTIER L. REV. 821, 859 (2004).

53. *Id.*

54. *See generally* Scott Burris & Edwin Cameron, Commentary, *The Case Against Criminalization of HIV Transmission*, 300 JAMA 578 (2008) (discussing where to draw the line in the criminalization of HIV exposure between those who know they are infected, those who do not know, and those who avoid testing to maintain innocence); Carol L. Galletly & Steven D. Pinkerton, *Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV*, 10 AIDS & BEHAV. 451 (2006) (arguing that HIV laws undermine public health efforts by criminalizing exposure to HIV rather than criminalizing the failure to use precautionary measures and safe sex techniques); Dini Harsono et al., *Criminalization of HIV Exposure: A Review of Empirical Studies in the United States*, 21 AIDS & BEHAV. 27 (2017) (analyzing the effect of HIV exposure laws on disclosure, testing, safe sex practices, and stigmas).

55. *See* Frederick S. Stinson et al., *Comorbidity Between DSM-IV Alcohol and Specific Drug Use Disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions*, 80 DRUG & ALCOHOL DEPENDENCE 105, 110 (2005).

susceptible from ages eighteen to twenty-nine.[56] Consequently, women who are pregnant or are soon to become pregnant are at increased risk for substance abuse.[57] While drug use in the country is not a recent phenomenon, "sensationalistic coverage" of the "crack epidemic" in the mid-1980s channeled national attention to understand the relationship between drug use and socioeconomic risk factors within the United States.[58] The issue of drug use during pregnancy received considerable attention. Throughout the 1970s, research primarily assessing withdrawal effects in infants documented child outcomes associated with opiate addiction in pregnant women.[59] When the price of cocaine dropped in the 1980s, "crack" became widely available and soon followed heightened attention on "crack babies" throughout the country.[60]

The effects of drug use during pregnancy have been overstated at times, but it is important to note that parental prenatal substance abuse can lead to several adverse effects.[61] Smoking during pregnancy may affect umbilical cord structure, increase risk for ectopic pregnancy, or increase risks for preterm birth.[62] Cocaine use during pregnancy may cause effects such as placental abruption, premature rupture of membranes, preterm birth, and low birthweight.[63] Heavy alcohol use throughout pregnancy is associated with increased risk of miscarriage, congenital anomalies, stillbirth, and preterm delivery.[64] Other drug use, such as methamphetamine,

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56. *See* Wilson M. Compton et al., *Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Drug Abuse and Dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions*, 64 ARCHIVES GEN. PSYCHIATRY 566, 569 (2007).

57. Ariadna Forray, *Substance Use During Pregnancy*, F1000RESEARCH 1, 3 (May 13, 2016), https://f1000research.com/articles/5-887/v1/pdf?article_uuid=472361b2-6bc9-4de5-aee6-34a49c77c067.

58. Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch Up with Research*, 1 HARM REDUCTION J. 5, 6 (2004), https://harmreductionjournal.biomedcentral.com/track/pdf/10.1186/1477-7517-1-5.

59. *See, e.g.*, Stephen R. Kandall et al., *The Narcotic-Dependent Mother: Fetal and Neonatal Consequences*, 1 EARLY HUM. DEV. 159, 159 (1977).

60. *See* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 150–55 (2d ed. 2017).

61. *Compare* ROBERTS, *supra* note 60, at 155–58, *with infra* notes 62–67 and accompanying text (describing contemporary research on the effects of parental prenatal substance abuse and demonstrating how prior research overstated consequences).

62. U.S. DEP'T OF HEALTH & HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING: A REPORT OF THE SURGEON GENERAL 553–54, 564 (2004), https://www.ncbi.nlm.nih.gov/books/NBK44695/pdf/Bookshelf_NBK44695.pdf.

63. Forray, *supra* note 57.

64. *See generally* Beth A. Bailey & Robert J. Sokol, *Prenatal Alcohol Exposure and Miscarriage, Stillbirth, Preterm Delivery, and Sudden Infant Death Syndrome*, 34 ALCOHOL RES. & HEALTH 86 (2011) (discussing the correlation between alcohol consumption during pregnancy and increased health risks).

opioids, and tobacco, shares similar risks.[65] Prenatal substance abuse is linked to several fetal health consequences.[66]

Yet, coexisting maternal health characteristics emphasize the critical need for public health intervention. Women with substance use disorders frequently experience chronic medical problems; they also must confront conditions such as inadequate prenatal care and poverty.[67] Consistent interaction with health care providers increases the possibility that women will seek treatment for their drug abuse.[68] Consequently, overcoming drug addiction not only benefits the mother but also the newborn.[69] Developing a positive relationship with health care providers makes it more likely that women can be brought into treatment later.[70] When women fear seeking prenatal care on the basis of criminal penalties for drug use, they are less likely to form this patient-physician bond.[71]

III. RECENT INCONSISTENCIES IN IMMIGRATION ENFORCEMENT DISRUPTING PUBLIC HEALTH

Inconsistencies in immigration enforcement have stirred anxiety. The shifting trend towards the criminalization of immigration law, or "crimmigration law,"[72] has generated intense interest from legislators, scholars, and the media.[73] Although official Immigration and Customs Enforcement ("ICE") policy has not changed, state variations in enforcement have injected new concerns. This Part details official ICE policy and describes instances where immigrant populations have expressed fear for using health care services.

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65. Forray, *supra* note 57, at 4.

66. *Id.*

67. *See* Jennifer R. Havens et al., *Factors Associated with Substance Use During Pregnancy: Results from a National Sample*, 99 DRUG & ALCOHOL DEPENDENCE 89, 89–92 (2009).

68. *See* American College of Obstetricians and Gynecologists, Committee Opinion 321, *Maternal Decision Making, Ethics and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127, 1135 (2005) ("[P]unitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses").

69. Forray, *supra* note 57, at 4–5.

70. *See generally* Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST. 1, 14 (2015) (discussing the benefits of comprehensive health care services that build relationships with at-risk women and the positive spillover effects for the community as a whole).

71. *Id.* at 3.

72. This term was coined by Juliet Stumpf in 2006. Juliet Stumpf, *The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power*, 56 AM. U. L. REV. 367, 376 (2006). Crimmigration scholarship addresses important intersections between criminal and immigration law. For a recent example exploring intersections between crimmigration, reproductive justice, and health policy, see Hailey Cleek, *Borders Across Bodies: Assessing the Balance of Expanding SCHIP Coverage at the Expense of Advancing Fetal Personhood*, 34 BERKELEY J. GENDER L. & JUST. (forthcoming 2019).

73. *See, e.g.*, Stumpf, *supra* note 72.

Officers deviating from official policy undermine both legal and undocumented immigrants' accessibility to care.

A. *"Crimmigration" and Politicization*

Scholarship on crimmigration suggests that much of the basis for criminalizing immigration law stems from perceiving deportation as punishment.[74] Criminal law, historically, has sought "to prevent and address harm to individuals and society" resulting from perceived violence or evil.[75] Immigration law, traditionally, has been fashioned as a foreign policy tool: it determines who may cross the border, who may reside, and who must leave.[76] Thus, crimmigration law both "combines and heightens the exclusionary power of criminal and immigration law."[77] Immigration reforms since the late 1980s have expanded the category of the "criminal alien."[78] These reforms have been accomplished primarily in two ways: (1) by increasing criminal convictions and linking these offenses to removal proceedings; and (2) by decreasing relief remedies following criminal conviction.[79] Due to the merging interests, critics have described crimmigration tools as ones that can be used in an "ad hoc" and "instrumental" fashion that are susceptible to discriminatory application with little public accountability.[80] In this light, immigration enforcement in the United States is tied to the criminal justice system.[81]

Critics have raised important considerations for the proliferation of crimmigration. Although some state and local governments have aggressively pursued integration of immigration enforcement through local policing, others have distanced themselves from such synthesized efforts.[82] Critics have described negative effects of immigration enforcement, for example, on people who are transgender.[83] Others have noted how the increased participation of

74. *Id.* at 378–79.
75. *Id.* at 379.
76. *Id.*
77. Juliet P. Stumpf, *Doing Time: Crimmigration Law and the Perils of Haste*, 58 UCLA L. REV. 1705, 1709 (2011).
78. Yolanda Vázquez, *Perpetuating the Marginalization of Latinos: A Collateral Consequence of the Incorporation of Immigration Law into the Criminal Justice System*, 54 HOW. L.J. 639, 654 (2011).
79. *Id.* at 655.
80. David Alan Sklansky, *Crime, Immigration, and Ad Hoc Instrumentalism*, 15 NEW CRIM. L. REV. 157, 197 (2012).
81. Ingrid V. Eagly, *Criminal Justice in an Era of Mass Deportation: Reforms from California*, 20 NEW CRIM. L. REV. 12, 13 (2017).
82. Rachel E. Rosenbloom, *Policing Sex, Policing Immigrants: What Crimmigration's Past Can Tell Us About Its Present and Its Future*, 104 CALIF. L. REV. 149, 151 (2016) (describing how some states have avoided attempted adoption of Arizona's infamous "show me your papers" legislation).
83. *See, e.g.*, Pooja Gehi, *Gendered (In)security: Migration and Criminalization in the Security State*, 35 HARV. J.L. & GENDER 357, 385–88 (2012).

state and local police in federal immigration enforcement leads to a selective racial profiling scheme.[84] Although immigration laws and policies tend to be facially race-neutral, studies have demonstrated that the removal rate of immigrants of color is disproportionately higher than that of whites.[85] Latinos, facing detention, prosecution, or removal proceedings, are disproportionally impacted by United States immigration laws; Latinos comprise over ninety percent of those impacted by immigration policies.[86]

Crimmigration centralizes the theme of punishment. Consequently, people may be unwilling to address reform in this area due to a belief that those who are found to have violated immigration laws only now find themselves in trouble due to their "personal choices and behavior."[87] Individuals may also believe that immigrants pose a threat to national security and community safety. Debates on immigration have increasingly focused on threats to national security and community safety, suggesting that the "harms" against the public safety can be linked to "criminal aliens."[88] In this context, immigration status has been threaded as a link between criminal, security, and community concerns. The perception of immigrants exercising "personal choices" that have inflicted "harm" against society has transformed enforcement priorities.

More immigrants than ever before are held in prisons, jails, and federal detention facilities.[89] Noncitizens with criminal convictions have the highest priority for deportation, and a record number of immigrants were deported throughout the Obama Administration.[90] Immigration arrests are up by more than forty percent since President Trump took office compared with the same period last year.[91] The Trump Administration took office with a pledge to "round

84. *See, e.g.*, Michael J. Wishnie, *State and Local Police Enforcement of Immigration Laws*, 6 U. PA. J. CONST. L. 1084, 1084 (2004).

85. Yolanda Vázquez, *Constructing Crimmigration: Latino Subordination in a "Post-Racial" World*, 76 OHIO ST. L.J. 599, 603–04 n.11–13 (2015).

86. *Id.* at 604.

87. *Id.*

88. *See* Jennifer M. Chacón, *Unsecured Borders: Immigration Restrictions, Crime Control and National Security*, 39 CONN. L. REV. 1827, 1856–75 (2007).

89. JOHN F. SIMANSKI, U.S. DEP'T HOMELAND SEC., OFF. IMMIGR. STAT., IMMIGRATION ENFORCEMENT ACTIONS: 2013 5 (2014), https://www.dhs.gov/sites/default/files/publications/ois_enforcement_ar_2013.pdf (reporting a total of 440,557 immigrants held in immigration detention during fiscal year 2013).

90. *See* Muzaffar Chishti & Michelle Mittelstadt, *Unauthorized Immigrants with Criminal Convictions: Who Might Be a Priority for Removal?*, MIGRATION POL'Y INST. (Nov. 2016), https://www.migrationpolicy.org/news/unauthorized-immigrants-criminal-convictions-who-might-be-priority-removal.

91. Nick Miroff, *Deportations Slow Under Trump Despite Increase in Arrests by ICE*, WASH. POST (Sept. 28, 2017), https://www.washingtonpost.com/world/national-security/deportations-fall-under-trump-despite-increase-in-arrests-by-ice/2017/09/28/1648d4ee-a3ba-11e7-8c37-e1d99ad6aa22_story.html?utm_term=.8281f06f538d; U.S. DEP'T HOMELAND SEC., ICE ERO IMMIGRATION ARRESTS

up" as many as three million drug dealers, gang members, and other criminals residing illegally in the United States.[92] However, ICE data indicates that the Administration may be taking a different approach than promised.[93] Since President Trump's inauguration, the "fastest-growing category of arrests" is undocumented immigrants facing no criminal charges; arrests have skyrocketed.[94] Nick Miroff for *The Washington Post* reports that ICE arrested "more than 28,000 'non-criminal immigration violators' between Jan. 22 and Sept. 2," nearly tripling arrest statistics over the same period in 2016.[95]

B. Sensitive Locations? The Changing "Sensitivities" for Protected Locations

The Sensitive Locations Policy outlines how and to what extent ICE can engage in enforcement actions in designated "sensitive locations."[96] Sensitive locations, under ICE policy, include, but are not limited to: schools, such as daycare centers and early-learning care facilities, primary, secondary, and post-secondary educational facilities; medical treatment and health care facilities where people receive critical services, such as hospitals, doctors' offices, accredited health clinics, and urgent care facilities; and places of worship.[97] Enforcement actions "may occur at sensitive locations in limited circumstances" but generally are avoided.[98] ICE explicitly states on its website that sensitive location policies are still in effect.[99]

Nationwide, immigrants are experiencing negative health consequences and avoiding health care centers due to politicization and uncertainty regarding immigration enforcement policies. Researchers using data from the New York Department of Health and

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CLIMB NEARLY 40%, https://www.ice.gov/features/100-days (last updated Nov. 2, 2017).

92. *Id.*; *see also* Emily Schultheis, *President-Elect Trump Says How Many Immigrants He'll Deport*, CBS NEWS (Nov. 13, 2016, 10:32 AM), https://www.cbsnews.com/news/president-elect-trump-says-how-many-immigrants-hell-deport/.

93. *Id.*

94. *Id.*

95. *Id.*

96. U.S. DEP'T HOMELAND SEC., FAQ ON SENSITIVE LOCATIONS AND COURTHOUSE ARRESTS, https://www.ice.gov/ero/enforcement/sensitive-loc#wcm-survey-target-id (last updated Sept. 25, 2018).

97. *See* Memorandum from John Morton, Dir., U.S. Immigr. & Customs Enforcement, to Field Office Directors, Special Agents in Charge, Chief Counsel (Oct. 24, 2011), https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf. This memorandum was created during the Bush Administration and reaffirmed later in the Obama Administration. *See* Memorandum from David Aguilar, Deputy Comm'r, U.S. Customs & Border, on U.S. Customs and Border Protection Enforcement Actions at or Near Certain Community Locations (Jan. 18, 2013), https://foiarr.cbp.gov/streamingWord.asp?i=1251.

98. U.S. DEP'T HOMELAND SEC., *supra* note 96.

99. *Id.*

Mental Hygiene illustrated health disparities for pregnant immigrant women.[100] In a study comparing preterm birth rates among immigrant, Hispanic, and Muslim women in New York City before the 2016 election and post-inauguration period, researchers found that some demographic populations experienced significant changes in preterm births, where gestation occurs before 37 weeks.[101] Foreign-born Hispanic women with Mexican or Central American ancestry had a significant increase in preterm birth rates following the election, suggesting that sociopolitical stressors may negatively impact the health of pregnant women.[102] Some undocumented patients are avoiding hospitals in Houston, describing ICE agents as "more terrifying than an illness."[103] Following an immigration raid in Bellingham, Washington, school officials described how affected students were frightened to come to school or seek health care.[104] While ICE policy may be clear, uncertainty persists throughout communities.

IV. THE PATIENT-PHYSICIAN RELATIONSHIP AS AN AGENT FOR PUBLIC HEALTH

This Part details the rules of professionalism overseeing the practice of medicine. It argues that physicians serve not only as physical caregivers but also as agents for community well-being. By analogizing to the prosecution of pregnant women using drugs and the criminalization of HIV status, this Part demonstrates the modern trend of physicians shaping patient views of political debate. Finally, this Part shows how the patient-physician relationship may be used to create sanctuary clinics.

A. Physicians Work as More than Caregivers: The Role of Physicians in Shaping Patient Views

Although confidence in physicians has fluctuated, Americans view their doctors as honest and generally trust doctors.[105] A 2008

100 Nancy Krieger et al., *Severe Sociopolitical Stressors and Preterm Births in New York City: 1 September 2015 to 31 August 2017*, 72 J. EPIDEMIOLOGY & COMMUN. HEALTH 1147, 1147, 1151 (2018).

101. *Id.* at 1147.

102. *Id.* at 1151.

103. Ileana Najarro & Jenny Deam, *Fearing Deportation, Undocumented Immigrants in Houston Are Avoiding Hospitals and Clinics*, HOUSTON CHRON. (Dec. 28, 2017, 11:00 AM), https://www.houstonchronicle.com/news/houston-texas/houston/article/Fearing-deportation-undocumented-immigrants-are-12450772.php.

104. Kie Relyea, *After a Raid in Whatcom County, Here's How the Community Is Helping Undocumented Workers*, BELLINGHAM HERALD (Nov. 5, 2018, 11:30 AM), https://www.bellinghamherald.com/news/local/article220956480.html.

105. *See* Tami Buhr & Robert J. Blendon, *Trust in Government and Health Care Institutions*, *in* AMERICAN PUBLIC OPINION AND HEALTH CARE 15–38 (R.J. Blendon et al. eds., 2001).

Gallup survey found that sixty-four percent of Americans said doctors had very high or high ethical standards, up from fifty-six percent in 1976.[106] People see their doctors not only as experts who are well-situated to offer emotional support but also as trustworthy and motivated to protect patient well-being.[107] Simply, patients trust physicians when discussing intimate details that encompass the entirety of their well-being. Physicians as professionals have concerned themselves not only with physical well-being but also community health with respect to these two potential models.

1. HIV Status

The challenge of HIV/AIDS policy is balancing individual privacy rights with the need for understanding a government's duty in protecting public health. For the government to effectively protect public health, it needs accurate, comprehensive, and current information.[108] At times, this need can compete with the interests of private individuals with respect to patient privacy and autonomy. The United States uses criminal prosecution to influence risk behavior by people who have HIV/AIDS.[109]

General criminological theory promotes three mechanisms through which criminal law influences perceptions of HIV status.[110] Criminalizing HIV status may deter unsafe behavior by the threat of punishment.[111] By promoting social norms against a behavior, criminalizing HIV may communicate that risky behavior which might lead to HIV transmission is wrong.[112] Furthermore, imprisoning those with HIV status may incapacitate individuals who are more inclined to engage in risky behavior. In this context, society has attempted to match criminal punishment with public health goals.

These criminal prosecutions for HIV status center primarily on whether the individual knew of his or her HIV status.[113] The difficulty in criminalizing HIV status is distinguishing between criminal and noncriminal behavior.[114] Criminal liability and punishment traditionally stem from a blameworthy state of mind.[115]

106. *Id.* at 22.

107. Alan S. Gerber et al., *Doctor Knows Best: Physician Endorsements, Public Opinion, and the Politics of Comparative Effectiveness Research*, 39 J. HEALTH POL. POL'Y & L. 171, 179 (2014).

108. Edmund C. Tramont & Shant S. Boyajian, *Learning from History: What the Public Health Response to Syphilis Teaches Us About HIV/AIDS*, 26 J. CONTEMP. HEALTH L. & POL'Y 253, 265 (2010).

109. Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J.L. MED. & ETHICS 239, 239 (2002).

110. *Id.*

111. *Id.*

112. *Id.*

113. *See id.* at 250.

114. Burris & Cameron, *supra* note 54, at 579.

115. *See* H.L.A. Hart, *Punishment and the Elimination of Responsibility*, *in* PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 159, 178 (2d

While most individuals may agree that an individual intentionally trying to infect another individual with HIV is blameworthy, this same conception of blameworthiness is difficult to extend to all patients with HIV. Not every person knows that he or she is a HIV carrier. In order for a person to discover his or her HIV status, he or she must be willing to get tested. Public health interventions for HIV include expansion for voluntary testing, outreach, and training of peer leaders in the pursuit of safer sex among communities.[116] If public health agencies or physicians are forced to disclose their patients' confidential HIV testing status, individuals may be less likely to seek testing.[117] While prosecutions for HIV transmission are rare, the criminal stigma surrounding the condition may lead to individuals avoiding testing or discussing their status with their sexual partners. If the ultimate goal of HIV criminalization is to curtail HIV transmission, the policy ultimately fails because of its subliminal encouragement to avoid testing.

Within the realm of public health, HIV status disclosure demonstrates the tension between disclosure and confidentiality. An individual may fear to disclose his or her status to a third party due to possible fears of discrimination or adverse conditions. Physicians must be in a position to exercise discretion to make determinations about disclosure and notification of an individual's HIV status in the interest of public health.[118] While state-mandated reporting laws often already promote this action, patients are best served when broader public policy initiatives incentivize individuals coming into a clinic for testing. Consequently, destigmatizing HIV remains central in both disclosure and confidentiality efforts.[119] Public policy efforts that inspire stigmatization, shame, and uncertainty decrease an

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ed. 2008). *See generally* Henry M. Heart, *The Aims of the Criminal Law*, 23 L. & CONTEMP. PROBS. 401 (1958) (analyzing the reasons for and the complications behind the theories, principles, and methods of criminal law).

116. *See, e.g.*, N.Y. DEP'T HEALTH, ENDING THE EPIDEMIC TASK FORCE COMMITTEE RECOMMENDATIONS 1, 12, 17 (2015), https://www.health.ny.gov/diseases/aids/ending_the_epidemic/committee_recommendations/index.htm.

117. *See* Laura Lin & Bryan A. Liang, *HIV and Health Law: Striking the Balance Between Legal Mandates and Medical Ethics*, 7 ETHICS J. AM. MED. ASS'N 687, 687–89 (2005), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-07/hlaw1-0510.pdf.

118. *See* Bruce A. McDonald, *Ethical Problems for Physicians Raised by AIDS and HIV Infection: Conflicting Legal Obligations of Confidentiality and Disclosure*, 22 U.C. DAVIS L. REV. 557, 592 (1989) ("In a health-care system founded primarily on the relationship between doctor and patient, the physician's discretion to make reasonable determinations about disclosure and notification in the interest of public health must not unnecessarily be impeded.").

119. *See* Roger Doughty, Comment, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CALIF. L. REV. 111, 123 (1994) ("Because aggressive public health strategies depended on the identification and vigorous pursuit of affected persons, they directly conflicted with the confidentiality concerns of those persons.").

individual's willingness to seek appropriate health care interventions. Stigmatization hurts not only private individuals in need of health care but also the larger public community.

2. Prosecution of Pregnant Women Using Drugs

Concerns about mixing health and criminal goals were highlighted by the Supreme Court in *Ferguson v. City of Charleston*.[120] In 1988, staff members at the Charleston public hospital operated by the Medical University of South Carolina ("MUSC") became concerned about the increase in the use of cocaine by patients who were receiving prenatal treatment.[121] MUSC staff offered to cooperate with the city in prosecuting mothers whose children tested positive for drugs at birth.[122] The reasoning of the *Ferguson* case, in which the Court held that the program violated the Fourth Amendment, supports the view that health status information should not be used for law enforcement purposes.[123] The Court recognized the value of the patient-physician relationship and relied on briefs from both the American Medical Association and American Public Health Association in constructing its opinion.[124]

Disrupting voluntary drug use disclosures to physicians by pregnant women using drugs frustrates public health goals. By eroding the confidential patient-physician relationship, patients are not incentivized to be truthful with their physician. Additionally, such forced reporting may cause women to avoid any prenatal care. This avoidance, in effect, increases potential harm to a fetus.[125] For example, low birth weight, a primary cause of infant mortality and higher health care costs, is commonly associated with prenatal drug exposure.[126] Through prenatal care and counseling, women can come to understand the risk factors associated with drug use and be encouraged to reduce or avoid them. Women who avoid treatment for substance abuse during pregnancy not only decrease their likelihood of overcoming addiction after pregnancy but also potentially expose their unborn children to other dangerous behaviors that accompany

120. 532 U.S. 67 (2001).

121. *Id.* at 70.

122. *Id.* at 70–71.

123. *See id.* at 78 (describing 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").

124. *Id.* at 84–85 ("While state 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, when they undertake to obtain such evidence from their patients *for the specific purpose of incriminating those patients*, they have a special obligation to make sure that the patients are fully informed about their constitutional rights, as standards of knowing waiver require.").

125. *See* Forray, *supra* note 57, at 3.

126. *See id.*

drug exposure *in utero*.[127] Criminalizing health behavior status, like in *Ferguson*, hurts not only immediate care for women and children with exposure to cocaine, or other drugs but also long-term care outcomes for both mother and fetus.

In 2014, Tennessee notably became the first state to pass a law that criminalized the acts of women whose pregnancy outcome involved substance abuse. Public Chapter 820, which amended the Tennessee Code, permitted the criminal prosecution of a woman for assault for the "illegal use of a narcotic drug . . . while pregnant, if her child is born addicted to or harmed by the narcotic drug."[128] Twenty-four-year-old East Tennessee native Brittany Hudson had been abusing prescription drugs for years and knew that if her baby was born showing signs of her drug use, Hudson could be sent to jail.[129] She had forgone prenatal care for most of her pregnancy.[130] Yet, Hudson was reported to law enforcement after her newborn went into withdrawal.[131] Almost a week later, while her newborn Braylee was still in intensive care, Hudson was arrested, charged with assault, and jailed.[132] The state charged Hudson under its fetal-assault statute for illegally using narcotics while pregnant.[133] Doctors quickly condemned the law in Tennessee.[134] Doctors who treat addicts within Tennessee claimed that the experiment had backfired, as it had encouraged women to avoid prenatal care while also exposing their babies to more risks.[135] Although the fetal-assault law has now expired in Tennessee, its effects endure.[136] The number of Tennessee babies affected by drugs who have received no prenatal care has skyrocketed.[137]

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127. *See* CTR. REPROD. RTS., PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN'S HEALTH AND CHILDREN'S INTERESTS 1–7 (2000), https://www.reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf.

128. TENN. CODE ANN. § 39-13-107 (2015) (repealed 2016).

129. Nina Liss-Schultz, *Tennessee's War on Women Is Sending New Mothers to Jail*, MOTHER JONES (Mar. 14, 2016, 10:00 AM), https://www.motherjones.com/politics/2016/03/tennessee-drug-use-pregnancy-fetal-assault-murder-jail-prison-prosecution/.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. Sydney Lupkin, *Why Some Doctors Object to Tennessee Law that Criminalizes Drug Use During Pregnancy*, ABC NEWS (July 14, 2014, 5:40 PM), https://abcnews.go.com/Health/doctors-object-tennessee-law-criminalizes-drug-pregnancy/story?id=24557525.

135. Sheila Burke, *Doctors are Applauding the End of a Unique Tennessee Law Threatening Addicted Mothers with Jail for Assault if They Gave Birth to Babies with Drug Dependence*, U.S. NEWS (Apr. 1, 2016, 5:49 PM), https://www.usnews.com/news/us/articles/2016-04-01/doctors-applaud-the-end-of-tennessees-fetal-assault-law.

136. *See* Liss-Schultz, *supra* note 129.

137. *Id.*

When physicians and patients can work together in the context of drug addiction, with a shared goal of achieving the best possible outcome for mother and child, results are improved for both women and children. Detecting high-risk behaviors requires both frequent contact and uninhibited communication with medical providers, as physicians cannot detect potential problems and provide counseling if women are unwilling or unable to be completely honest about their lifestyles. In this context, criminalizing a mother's drug use during pregnancy not only punishes the mother but also the fetus. Although the adverse effects for drug use while pregnant are clear, criminalization in this context undermines health goals for both the mother and the fetus. Public health policy stands to reason that, in the pursuit of the best possible outcome for the fetus or newborn, physicians must be able to maximize potential care opportunities with the mother. Even when prioritizing the newborn's care, criminalization of drug use while pregnant leads to additional adverse consequences.

B. Using the Patient-Physician Relationship to Shape Immigration Policy

In a piece describing the relational themes of health law and ethics, Mark Hall writes about how medical care is delivered to patients "within a web of critical relationships"; both patients and family members alike must navigate these relationships within health care institutions and providers.[138] This "web" affects the way patients act as consumers.[139] Yet, patients are not isolated from the realities of criminal scrutiny outside clinic doors. Patients need a "thoroughgoing, relationship-centered approach" from their health care providers that uses a holistic experience for care.[140] Meaningful medical care depends on a successful patient-physician relationship. People seek medical care with the understanding that information disclosed to their physician will not be revealed to outsiders. Without faith in the sanctity of the patient-physician relationship, patients will be reluctant to disclose potentially incriminating information.

Fear in immigrant communities impacts the patient-physician relationship. Dr. Julie Linton, a spokeswoman for the American Academy of Pediatrics, treats Latino families in Winston-Salem, North Carolina.[141] In a profile with NPR, Dr. Linton described her recent difficulties in assuring undocumented patients seeking

138. Mark A. Hall, Forward, *Toward Relationship-Centered Health Law*, 50 WAKE FOREST L. REV. 233, 235 (2015).

139. *Id.*

140. *Id.*

141. Christina Jewett et al., *Under a Trump Proposal, Lawful Immigrants Might Shun Medical Care*, NPR (May 10, 2018, 5:00 AM), https://www.npr.org/sections/health-shots/2018/05/10/609758169/under-a-trump-proposal-lawful-immigrants-might-shun-medical-care.

answers.[142] When asked by an undocumented patient if it was safe to use the nutrition program for Women, Infants, and Children ("WIC"), Dr. Linton mused, "It feels very frightening to have a family in front of me, and have a child with so much potential . . . and be uncertain how to advise them."[143] While WIC has repeatedly been shown to lead to better health outcomes for children, patient populations fear that using such programs runs the risk of splitting families apart.[144]

Public health approaches cannot replace criminal reform, but they help to illustrate that interventions are needed to support stigmatized individuals. Together, the historical criminal treatment of individuals with HIV/AIDS, prosecution of women who use drugs during pregnancy, and deprivation of pathways to health care for undocumented immigrants demonstrate the "inevitable tensions" that exist between public health and criminal law.[145] Public health approaches to policy problems often emphasize the need for preventative care, education, and confidentiality for patients.[146] In contrast, criminal law emphasizes punishment and deterrence.[147] While some may believe that these two initiatives complement each other, experts believe that the criminalization of certain behavior ultimately undermines public health goals.[148] For example, HIV criminalization reinforces stigma, prevents individuals from seeking care, and compromises demographic health-collection of information.[149] Criminalizing maternal drug use specifically while pregnant deters women from seeking care, causing adverse outcomes not only for them but also their newborns.[150] In order to best promote public health policies, people must be willing to see their physician.

Contenders who argue that individuals are responsible for their own health may find such inclusive health policy principles implausible. Incorporating themes of blameworthiness into personal

142. *Id.*
143. *Id.*
144. *Id.*
145. Sarah J. Newman, Comment, *Prevention, Not Prejudice: The Role of Federal Guidelines in HIV-Criminalization Reform*, 107 NW. U. L. REV. 1403, 1417 (2013).
146. *Id.* at 1417–18.
147. *Id.* at 1418.
148. *See, e.g.*, Linda C. Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal Substance Abuse is Not the Answer – A Comparative Legal Analysis*, 15 MICH. J. GENDER & L. 389, 391–93 (2009); JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS), CRIMINAL LAW, PUBLIC HEALTH AND HIV TRANSMISSION: A POLICY OPTIONS PAPER 6 (2002), http://data.unaids.org/publications/irc-pub02/jc733-criminallaw_en.pdf ("[I]t is unclear whether criminal sanctions will, in practice, act as a significant deterrent to behaviour that may result in HIV transmission.").
149. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS), *supra* note 148, at 9.
150. Fentiman, *supra* note 148, at 401 (citing State v. Deborah J.Z., 596 N.W.2d 490, 494–95 (Wis. Ct. App. 1999)).

responsibility for care potentially illustrates society's willingness to extend punishment from beyond the criminal sphere into social welfare policies. In an especially valuable article detailing the themes of personal responsibility within policies for health promotion, Gerald Dworkin distinguishes several distinct spheres of "personal responsibility" within health care.[151] These spheres illustrate the tension between paternalism, communitarianism, and fairness in allocating resources for public health policy efforts.[152] In accordance with the communitarian approach, the public's health and safety is one of a special kind; health service efforts promote not only individual well-being but also surrounding communities.[153] Assigning blame in harmony with personal responsibility detracts from critical health policy initiatives: accessing health care at reasonable cost, efficiency of distributing resources, and reduction of hazards both in the environment and workplace.[154] When individuals are assigned "liability for lifestyle," we ignore the social determinants of health which shape behavior and lifestyle alike.[155] In order to best maximize available health resources, public health policy must avoid assigning blame in personal responsibility for health. Policies must promote accessibility to care while curtailing stigmatization in order to best serve vulnerable populations and society as a whole.

Beyond education campaigns to improve the public's understanding about the risks of associations decreasing clinical interactions with undocumented patient populations, the medical community can help advocate for public policy initiatives that encourage clinical interactions with sensitive patient populations. Previously, hospital administrators and doctors alike have been successful in defeating proposed private immigration enforcement laws.[156] Introduced by Rep. Dana Rohrabacher in 2004 in effort to address health care spending for undocumented immigrations, House Resolution 3722[157] would have required hospitals seeking federal reimbursement for care to screen whether patients were US citizens

151. *See generally* Gerald Dworkin, *Taking Risks, Assessing Responsibility*, 11 HASTINGS CTR. REP. 26 (1981) (examining various frameworks for individual responsibility with respect to the voluntary assumption of health risks). A person may be responsible for his body because he is "role-responsible" as a biological organism. Secondly, one may be responsible for his health through "causal" responsibility; health status is determined by one's behaviors. Yet, some extend responsibility to "liable-responsible" individuals; here, one is assigned liability for the costs and other undesirable consequences for being ill.

152. Daniel Wikler, *Who Should Be Blamed for Being Sick?*, 14 HEALTH EDUC. Q. 11 (1987), *reprinted in* PUBLIC HEALTH ETHICS: THEORY, POLICY, AND PRACTICE 89, 90–93 (Ronald Bayer et al. eds., 2007).

153. *Id.* at 91.

154. *Id.* at 95.

155. *Id.* at 93.

156. Huyen Pham, *The Private Enforcement of Immigration Laws*, 96 GEO. L.J. 777, 798 (2008).

157. H.R. 3722, 108th Cong. (2004); Pham, *supra* note 156, at 789–90.

before providing care.[158] The American Hospital Association and medical centers successfully lobbied against the bill.[159] They argued that doctors, nurses, and workers should not be turned into border agents.[160] Consistently, the unique nature of the patient-physician relationship is emphasized as safeguarding individual and community health alike.

The medical community holds a unique position in addressing patient access to clinics and securing private information. Three key considerations may help secure undocumented immigrants' access to medical care.

1. Health Insurance Portability and Accountability Act ("HIPAA") Protections

The privacy of personal health information pertains to the collection, storage, and use of personal information and addresses the question of who has access to personal information and under what conditions.[161] The HIPAA "Privacy Rule"[162] applies to "covered entities;" these organizations or groups must follow privacy standards when electronically transmitting health information.[163] Covered entities include health care providers, health plans, and health care clearinghouses.[164] When covered entities are creating or receiving personally identifiable health information ("PHI"), the Privacy Rule protects patient information.[165] PHI is defined as information, including demographic information, that "relates to past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care for the individual."[166] Covered entities may not disclose or release PHI unless authorized or as permitted or required by the Privacy Rule.[167]

HIPAA is clear in discussing how and when physicians may disclose personal health information of patients. For example, Section 164.512(j) of HIPAA permits such disclosures where disclosure is necessary "to prevent or lessen a serious and imminent threat to the health or safety of a person or the public" or disclosure

158. *See supra* note 157.
159. Pham, *supra* note 156, at 799.
160. *Id.* at 798.
161. BEYOND THE HIPAA PRIVACY RULE: ENHANCING PRIVACY, IMPROVING HEALTH THROUGH RESEARCH 153–83 (Sharyl J. Nass et al. eds., 2009) [hereinafter COMM., PRIVACY RULE].
162. 45 C.F.R. § 160.103 (2018); COMM., PRIVACY RULE, *supra* note 161.
163. COMM., PRIVACY RULE, *supra* note 161, at 157–58.
164. *Id.* at 158.
165. *Id.*
166. 45 C.F.R. § 160.103.
167. *Summary of the HIPAA Privacy Rule,* U.S. DEP'T OF HEALTH & HUM. SERV. 4, https://www.hhs.gov/sites/default/files/privacysummary.pdf (last updated May 2003).

is related to a "person or persons reasonably able to prevent or lessen the threat, including the target of the threat."[168] Disclosure is furthermore permitted where it is necessary for law enforcement authorities to "identify or apprehend an individual" in certain circumstances.[169] If a physician believes, for example, that a patient has participated in a violent crime and physically harmed another person, then disclosure may be permitted.[170] Additionally, if the physician believes that the individual may have escaped from a correctional institution or from lawful custody, the physician is again permitted to disclose.[171]

Release of patient information to Department of Homeland Security ("DHS") or ICE may have implications for doctor-patient confidentiality rights under HIPAA.[172] There are no provisions stating that the HIPAA privacy rules do not apply to undocumented immigrants. In particular, if a doctor or hospital discloses any patient's personal health information to an unauthorized non-health related agency, such as DHS, this disclosure likely violates HIPAA. Medical centers are not enforcers of immigration policy. Medical centers should affirm that they will not disclose personal health information to law enforcement agencies, particularly when there is no indication of violent crime or serious threats to health or safety.

2. Private Area Designations

It is essential for clinic administrators and health care providers to understand the differences between public and private area designations. Under the plain view doctrine, if an officer is in a location where he is lawfully present and the item's incriminating nature is readily apparent, the officer may seize the item.[173] Consequently, an immigration official may visually inspect anything, including files, that is clearly visible from the visitors' side of the reception desk.[174] Health care providers must remain diligent in protecting PHI for patients. Patient charts with PHI should face a wall or remain covered in hallway spaces. Maintaining patient files and records in only private areas will help ensure that PHI is not used in immigration enforcement in some manner.

Clinic administrators and health care providers should be mindful of their building design. It would be helpful to establish a

168. 45 C.F.R. § 164.512(j) (2018).
169. *Id.* § 164.512(f).
170. *Id.* § 164.512(j).
171. *Id.*
172. *See id.* § 164.500.
173. *See generally* Arizona v. Hicks, 480 U.S. 321 (1987) (holding that the Fourth Amendment requires the police to have probable cause to seize items in plain view).
174. *Health Care Providers and Immigration Enforcement,* NAT'L IMMIGR. L. CTR. 2 (Apr. 2017), https://www.nilc.org/wp-content/uploads/2017/04/Protecting-Access-to-Health-Care-2017-04-17.pdf.

written policy identifying which areas of the clinic are closed to the public.[175] In following the National Immigration Law Center's recommendations, "[A]ccess to private areas intended for patients and their family members should be restricted to essential medical personnel."[176] Unauthorized Individuals should not be invited to enter areas that may contain PHI such as medical examining rooms or areas containing patient records.[177] The building or office space should ensure that the public boundary is distinct from private health designations. Furthermore, in order to best protect patient security, health care providers should consider asking questions about immigration status in the private exam room to best maximize private area designations.

3. Driver's Licenses Requirements

Since 2007, thousands of undocumented immigrants within North Carolina have been unable to renew or obtain their driver's licenses, as they are not able to use their Individual Taxpayer Identification Number.[178] This has left many immigrants without reliable transportation. Consequently, this reduces the likelihood that they will be able to drive to access preventive care. Furthermore, this increases the chances that, in order to get emergency help, they will have to drive to the emergency room without a license. If someone is driving during an emergency without a license, they may be unfamiliar with the rules of the road, potentially increasing hazards for other drivers.[179] Barriers to driver's licenses not only bar access to care but also lead to potentially more dangerous driving conditions.

An unwillingness to extend driver's licenses to undocumented immigrants has numerous identification downfalls. Driver's licenses help first responders identify an individual at the scene.[180] Driver's licenses are used as one of the most common and accepted forms of identification for accessing basic private and public services. Many clinics and health care settings ask for driver's licenses for patient registration.[181] Consequently, health care providers and administrators must be aware of state barriers to accessing driver's licenses for undocumented immigrants. Clinics should permit additional forms of identification for patient registration purposes.

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175. *Id.* at 3.
176. *Id.*
177. *Id.*
178. Florence M. Simán, *Cross-Cultural Issues and Health Care Advocacy for Immigrants in North Carolina*, 70 N.C. MED. J. 149, 151 (2009).
179. *See* Alexandra Forter Sirota, *Licensing All Drivers in North Carolina: A Policy that Supports Public Safety and Boosts the Economy*, N.C. JUSTICE CTR. 2 (Apr. 2014), http://www.ncjustice.org/sites/default/files/BTC%20Brief%20-%202014%20Licensing%20All%20Drivers_0.pdf.
180. *Id.*
181. *See* Rhodes et al., *supra* note 25, at 334–35.

Individuals should encourage the adoption of legislation that would allow all residents to obtain driver's licenses. By granting driver's licenses to all residents, public safety improves on the roads. Licensed drivers are more likely to have accident insurance, reducing costs of accidents involving automobiles.[182] Individuals with driver's licenses are less likely to flee the scene of an accident.[183] Adopting this policy would produce safer roads, encourage accountability, and protect surrounding drivers on the roads.

V. CONCLUSION

Policymakers addressing both health care and immigration reform should affirm access to health care for undocumented immigrants.[184] Ethical and practical uncertainties alike arise for professionals when greater policy implications undermine patient access. Although federal policy shaping health access is unlikely to change at this time, local solutions in coordinating between hospitals, clinics, and nonprofit community health centers may help improve community health outcomes. Furthermore, state solutions, including the use of Medicaid to block funding mechanisms to provide coverage for needed services, may assist vulnerable populations.[185] Health policy analysts should study and share findings on local-level innovations aimed at improving the health, welfare, and safety of undocumented immigrants and their integration into mainstream society.[186]

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182. *See* Sirota, *supra* note 179.

183. *See* Hans Lueders et al., *Providing Driver's Licenses to Unauthorized Immigrants in California Improves Traffic Safety*, 114 PROC. NAT'L ACAD. SCI. U.S. 4111, 4115 (2017).

184. Altogether, this population will include undocumented immigrants, guest workers, permanent legal residents, refugees, and newly naturalized citizens. Berlinger & Gusmano, *supra* note 24, at 3.

185. *Id.*

186. *Id.* However, such proposals must take care to not create conflict between undocumented immigrant parents and potentially citizen children. For more on this discussion, see, e.g., Cleek, *supra* note 72.

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