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A Safe Haven for the Injured? Urban trauma care at the intersection of healthcare, law enforcement and race

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Abstract

Patients with traumatic injuries often interact with police before and during hospitalization, particularly when their injuries are due to violence. People of color are at highest risk for violent injuries and have the poorest outcomes after injury. The purpose of this study was to describe how injured, Black patients perceived their interactions with police and what these perceptions reveal about police involvement within trauma care systems. We combined data from two qualitative studies to achieve this aim. The first was ethnographic fieldwork that followed Black trauma patients in the hospital through the physical and emotional aftermath of their injuries. The second was a qualitative, descriptive study of how patients experienced trauma resuscitation in the emergency department (ED). We reanalyzed all interview data related to law enforcement encounters from the scene of injury through inpatient hospitalization and coded data using a constant comparative technique from grounded theory. Participants described law enforcement encounters at the scene of injury and during transport to the hospital, in the ED, and over the course of inpatient care. Injured participants valued police officers' involvement when they perceived that officers provided safety at the scene, speed of transport to the hospital, or support and information after injury. Injured participants also found police questioning to be stressful and, at times, disrespectful or conflicting with clinical care. Communities, trauma centers, and professional societies have the opportunity to enact policies that standardize law enforcement access in trauma centers and balance patients' health, privacy, and legal rights with public safety needs.

Keywords

United States; trauma; injury; racism; health disparities; law enforcement; police

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Introduction

Law enforcement personnel have pervasive power in the lives and deaths of the people with whom they interact (Lipsky 2010). Krieger and others have called for the explicit study of the racialized health consequences of law enforcement in the United States (US) (Krieger et al., 2015, Miller et al., 2016, Barber et al., 2016, DeGue, Fowler and Calkins, 2016). Recent research has demonstrated how police-involved injuries (Goff et al., 2016) and the mental stress of intensive policing practices like “stop and frisk” disproportionately impact communities of color (Geller et al., 2014, Golembeski and Fullilove, 2005, Lacoe and Sharkey, 2016, Goff et al., 2016, Carr, Napolitano and Keating, 2007, Lersch, Bazley and Mieczkowski, 2008). There are also downstream health consequences that result from inequalities in the broader criminal justice system. Black people are more likely to be suspected of crimes, arrested for crimes, and receive the harshest sentences (Bobo and Thompson 2010, Gibran Muhammad, 2010, Alexander, 2010). As Alexander (2010) and Wacquant (2001, 2008) have theorized, this continuum of systemic bias has perpetuated intergenerational poverty and health risks by limiting access to political, social and economic opportunity. A criminal record, for example, can lead to unemployment and disqualification from a range of social services, like food and housing assistance with direct health implications. Those with limited access to employment are also more likely to be uninsured and have fewer resources and choices when seeking healthcare services (Alexander 2010, Gates, Artiga and Rudowitz 2014).

Emergency medical treatment for traumatic injury should be an exception to racialized limitations to health and healthcare. US law requires hospitals to provide emergency care to all, regardless of ability to pay for services (Centers for Medicare and Medicaid Services, 2012). In cities across the US, Black men are at highest risk of violent, life-threatening injuries (Smith, Richardson and BeLue, 2009; Logan, Smith and Stevens 2011). Care for these injuries may be guaranteed by law, but can be challenging even in urban centers with multiple high-acuity hospitals. “Trauma deserts” have been identified in cities like Chicago, where the highest-need areas are at furthest proximity to specialized trauma services (Crandall et al., 2013). Even with full and equal access to trauma care, all patients may not benefit equally. US trauma systems are highly successful in saving the lives of severely injured people (MacKenzie et al., 2006), but studies have demonstrated worse outcomes for Black patients when compared to white patients (Haider et al., 2008, Arthur et al., 2008, Hicks et al., 2014).

Rich’s *Wrong Place, Wrong Time* (2008) explores trauma and violence in the lived experience of young, gunshot injured, Black men in Boston. This work laid the foundation for in-depth study of the social etiologies of racial outcome disparities following a traumatic injury. Rich illustrated numerous ways that the men he followed were disenfranchised from the healthcare resources they needed to support their physical and psychological healing. He also reflected on how healthcare providers stereotyped these injured men as perpetrators rather than victims of violence. Though there is very limited research in this area, negative stereotypes have the potential to alter how trauma care is delivered, even when biases are unconscious (Haider et al., 2015). The presence of police within healthcare space may reinforce deviant and criminal stereotypes of injured patients and interfere with their ability

to occupy what Parsons (1951) describes as the “sick role.” These patients may find the safe haven of the hospital to be compromised (Conrad and Schneider, 1992), when rightfully or not, they are held accountable for the cause of their injuries.

From a patient-centered perspective, law enforcement that occurs in trauma care space may be distressing for patients who don’t trust the police or to have had negative experiences with them in the past. Following Rich, a handful of studies have explored trauma care from the perceptive of gunshot injured Black patients. These studies suggest that patients may interpret police interactions before and during hospitalization as inappropriate and dehumanizing (Patton et al., 2016, Leibschultz et al., 2010). The presence of police during trauma care activities can also blur the line between healthcare and law enforcement practitioners. When Black patients in a Boston trauma center observed that police were permitted to question them inside ambulances or in the hospital, for example, it diminished their trust in their healthcare providers and created suspicion of collusion between law enforcement and healthcare (Leibschultz, 2010). Together, these findings call for “critical reflection on how to improve the inpatient experiences” (Patton et al., 2016 p. 17) so that hospitalization itself does not discourage the rehabilitative and post-injury care that injured people may need.

The purpose of this study was to delve into the intersection between trauma care and law enforcement from the perspective of Black patients, and to explore the implications of this intersection on their interpretation of injury, hospitalization, and recovery. As investigators, we approached this phenomenon based in our direct experiences as healthcare providers caring for injured people and as researchers studying trauma care outcomes. We have often witnessed police interacting with patients before and during their care. These interactions are not limited to patients with gunshot wounds or other violent injuries, but may occur after car crashes, falls, or other kinds of injuries. We interpret that the goal of these police interactions is to secure public safety and investigate crime. Nonetheless, we are concerned about patients’ ability to protect their rights during police questioning when they are medically unstable, in distress, or receiving medications like narcotics that may reduce their ability to think and communicate clearly.

This study centers on the point of view of Black patients in Philadelphia who are at disproportionate risk for violent injury (Beard et al., 2017), negative perceptions of police (Carr et al., 2007), and exposure to racism in their everyday lives (Ford and Airhihenbuwa, 2010). Black people may mistrust healthcare providers for a multitude of reasons that range from perceived discrimination to the reverberations of racist exploitation in US medical research (Lee, Ayers & Kronenfeld, 2009, Halbert et al., 2006, Nicolaidis et al., 2010). If patients have the perception that law enforcement and healthcare systems are institutionally aligned, their distrust may be magnified. This in turn may make them reluctant to seek care or disclose key personal information (Liebschultz et al., 2010, Musa et al., 2009, Dovido et al., 2008). Disengagement and distrust may also contribute to long-term racial disparities after injury including increased risk of reinjury (Kaufman et al., 2016), higher rates of mental health disorders (Richmond et al., 2014), and the use of risky strategies, like substance abuse, to cope with the physical and mental aftermath of injury (Rich, 2005, Lee, 2013).

Methods

Setting

For this study, we incorporated data from two qualitative studies that were carried out in the same Philadelphia trauma system between 2012 and 2015. As the largest city in Pennsylvania, Philadelphia has a population of 1.5 million. Forty-four percent of residents are Black and 32% of Black Philadelphians live below the poverty line (United States Census, 2017). Both studies focused trauma patients' perceptions of their injuries and medical care at an urban, Level I trauma center in West Philadelphia, a majority Black region of the city. Level 1 trauma centers are officially designated to provide advanced care for injured patients including "total care for every aspect of injury" (American Trauma Society, 2017). Injured patients enter the trauma center through an area of the ED known as the trauma bay. Here, a team of clinicians perform a rapid, protocol-driven series of assessments and treatments known as "trauma resuscitation." The goal of trauma resuscitation is to identify and control life threatening injuries using a consistent and practiced approach. After initial evaluation and treatment, patients may be able to go home, or require further treatment in the operating room or inpatient hospital ward.

Philadelphia has enacted an unusual protocol which permits non-medical police personnel to transport people with penetrating injuries like gunshot or stab wounds to the hospital without waiting for emergency medical services (Philadelphia Police Department, 2012). The aim of this protocol is to reduce the time between injury and treatment in order to save more lives. Police transport confers equal, if not superior, survival (Branas, Sing and Davidson, 1995, Band et al., 2014), but exposes injured patients to be exposed to police interactions immediately after injury. Because Black people across socioeconomic strata in Philadelphia live with a higher risk for violent injuries (Beard et al., 2017) it is a policy that disproportionately impacts these city residents.

Study Design

Given the paucity of research on the intersection between trauma care and law enforcement, we used a mixed source qualitative descriptive study design (Sandelowski, 2000) to provide an exploratory description (Hays and Singh, 2011) of how patients perceive law enforcement interactions in the course of their injury care. We combined data from two studies. The first study (Study 1) is an ethnography conducted by a researcher and trauma nurse (SFJ). The purpose of this work, theoretically informed by critical race theory (CRT), was to describe how Black individuals with traumatic injury interpreted interactions with healthcare providers, the meaning of clinical space, and the consequence of injury in patients' lived experience (Cook, 2005; Soyini, 2011). In keeping with the core tenets of CRT, this study centered on injured Black patients. Their experiences and voices were the central axis of research, rather than a point of comparison to white patients who represented the dominant racial group in the health system we studied (Ford and Airhihenbuwa, 2010). Ethnographic fieldwork included immersive observation and interviews that were used to interpret how participants experienced their injury and trauma care (Jorgensen, 1989: Cook, 2005). The second source is a qualitative descriptive study (Study 2) led by a researcher and physician (EJK). The purpose of this interview-based study was to describe patient perceptions of

acute trauma resuscitation and provide patient-centered insight into this phase of emergency injury care. Study 1 and 2 were both approved by the Institutional Review Board (IRB) of the University of Pennsylvania. As the researchers leading these two studies, we identified similar thematic content related to law enforcement interactions in our data, and sought to paint a fuller picture of this phenomenon by combining our two sources of data.

Participant Selection

Study 1 recruited 12 English-speaking Black patients (10 men and 2 women) after they were medically stable and admitted as inpatients in the hospital's trauma intensive care or surgical care wards. Participants were recruited based on a Black racial assignment by hospital registrars. All participants self-identified as Black or African American in concordance with recorded demographic characteristics. Patients were not eligible if they had self-inflicted injuries, a diagnosis of a major psychotic disorder, inability to communicate, and/or were in police or corrections custody. There were no incentives provided for participation.

Study 2 recruited 30 English-speaking patients (25 men and 5 women) who had undergone trauma resuscitation. The study team conducted interviews within 2 days of injury. Because this study focused on acute care in the trauma bay, we excluded patients with altered consciousness during resuscitation or at the time of interview eligibility. In order to collect data on the wide range of patients and types of injuries treated in the trauma bay, we recruited patients across demographic categories and in approximately equal numbers of violently and non-violently injured patients. IRB approval was granted to include patient under arrest or in police custody. However, for the two such patients we approached, police guards were unwilling to grant the privacy required for an interview, and to protect participant privacy we excluded these patients. Participants received a $25 cash incentive for interview completion.

This current analysis includes data from a combined 24 participants from Study 1 and Study 2 who self-identified as Black or African American and whose interviews included description of police interactions. Of the 12 patients in Study 1, seven (all men) described interactions with police before and during hospitalization. These participants had all been injured by violence. Seventeen participants in Study 2 described interactions with the police before and during hospitalization, this included 13 of the 14 violently injured participants recruited for Study 2. Table 1 shows participant and injury characteristics of the participants included in analysis.

Procedures

In Study 1, following written informed consent, SFJ observed care and interviewed participants in their hospital rooms and other clinical and administrative areas of the hospital. Observations of care practices, as well as subjective and clinical reflections, were described in detailed field notes (Jacoby, 2016). Interviews were embedded in fieldwork to allow participants to voice their own interpretation of their injury care experience. These interviews were typically audio-recorded and structured through broad open-ended questions that focused on participants' perceptions of their injury, recovery process, hospitalization and interaction with healthcare providers. Interview content related to police interactions

emerged naturally in the interviews; there were no questions designed to elicit descriptions of this phenomenon. Participants were followed until hospital discharge.

In Study 2, EJK and a trained research assistant conducted private, audio-recorded interviews after receiving verbal informed consent. A semi-structured interview guide focused interview content on participants' trauma resuscitation as well as their experiences before arriving to the hospital and immediately after hospital admission. We refined this interview guide during the course of the study in order to delve more deeply into the early findings that emerged in the first 5 interviews. Some interview content related to interactions with police and law enforcement emerged spontaneously as participants described the events of their injury and trauma resuscitation. If not, we probed specifically using questions like, "Were the police or security there?" and "What do you remember about them?"

Analysis

Data from Study 1 and 2 were coded using NVIVO (v. 11 QSR International, Doncaster, Australia, 2015) to describe events, locations, and participants' perceptions of trauma care. For the secondary analysis, reported in the current paper, we combined data and the descriptions of each participant who indicated interactions with police. Although both studies included observation of trauma care processes, we only analyzed interview data in order to emphasize patients' own perspectives of their interactions with police after injury. We (SFJ and EK) inductively open coded the combined data and then collaboratively worked to refine codes until we reached consensus on an initial coding schema. We organized these codes into categories using a constant comparative technique adapted from grounded theory (Strauss and Corbin 1990) for the perceptions (participants' descriptions of events and people), and interpretations (the meaning participants' attributed to these events) that participants described about police interactions after injury and their influence on clinical care. We noticed that participants' perceptions of police interactions were strongly associated with the timing and setting in their injury care trajectory. A final thematic description (Cohen 2008) was developed to reflect how participants understood the intersections of trauma care and law enforcement at temporal points ranging from the moments immediately after injury to several weeks later in the inpatient setting.

Results

This analysis describes the ways in which a group of Black patients who were predominately male and violently injured interpreted the presence and impact of law enforcement personnel in their trauma care experience. Participants described their view of the intersections between law enforcement and healthcare at three distinct points in their injury care trajectory: at the scene of injury and pre-hospital transport, during emergency care in the trauma bay (trauma resuscitation), and during inpatient hospital care and rehabilitation.

Police were the first responders at the scene of injury for many participants. Most expected police to respond to their needs and these expectations ranged from immediate hospital transport to securing personal property. Participants valued these services but also

interpreted that police priorities at the scene of injury were not consistently aligned with their need for immediate medical attention.

Interpretations of police questioning at the scene of an injury: "And they ask you so many questions at the time"

For participants with violent injuries, being questioned about the events that led up to an injury felt dehumanizing when they believed that their life was in danger. A young participant who was waiting in his house for help to arrive after being shot and calling 911, recalled the confusion and fear he experienced when he couldn't distinguish if the police had arrived to take him to the hospital or arrest him; "I just remember the cop kicking in my door with his gun out asking who all lived here. I still don't understand the purpose… Scary… Yeah. I'm thinking I was gonna get arrested. At the same time, I'm getting transferred to the hospital." A 32-year-old man who injured himself with a knife in a dispute with his girlfriend was reluctant to call for help as he tried to minimize his injury in front of his children, but said he had to, because there was just "too much blood." He recalled police questioning him and stated that he believed that their primary interest was information: "The police was there. They wrote some information down, but then – so, I seen as though I was bleeding too much, they couldn't really talk to me the way they wanted to talk to me."

In some cases, on-scene questioning was perceived as a form of unjust profiling. After dropping off his son at daycare, a 46-year-old participant was walking to a corner store when he was approached by a group of teenagers. In what he believed was an attempted robbery, they shot him several times in his chest and abdomen. When the police arrived, officers began questioning him about the shooting. He interpreted this questioning as an unnecessary delay in medical care: "All I see is a police car coming to get me. And they ask you so many questions at the time. And it could have been my life because I'm trying to let him know that I couldn't talk. I'm getting ready to die… Let me get to the hospital." He reasoned that the police chose to question him first because they believed that he may have been involved in criminal activity: "When something happens to someone on the streets, they always seem like they categorize you as a bad person regardless of what the situation is. I don't have a record, none of that," when for him, the priority should have been to: "Get me to a hospital. Get me there."

The experience of police transport: "They came before the ambulance came"

Many participants were transported to the hospital in police vehicles. Some felt that the speed of transport and the reassurances that police officers provided was evidence that the police were acting in their service. A 31-year-old man was walking home from a bar when he was assaulted by a man who attempted to rob him. The assailant had a gun, and they struggled over it, which left the participant shot in the groin and buttock. He walked the rest of the way home where someone notified the police, who then took him to the hospital. He described this form of transport as "scary" but ultimately "okay." He figured that it was a departure from the norm: "I mean as far as – I never did no time in jail, but just as far as like the police actually helping you for a change."

A 19-year-old man reported that he was smoking cigarettes and "chilling" with his friends when three men approached. He saw "sparks from a gun" and realized he was shot. He perceived police officers as a source of support, recalling how they stayed with him through the initial phase of his care in the hospital "They shook my hand, said, 'all right, man. We was by your side the whole time,' and all that." He also valued the speed of transport: "Because without them, I probably would have been still sitting on the step bleeding to death. And they came before the ambulance came, so I just say thank them, like I thank them." This participant described transport by police care as quick, as "They (police) came in no time, got me here to the rescue," but also insecure and physically dangerous: "I wasn't like strapped in or nothing. So all the fresh bullet wounds that I just got, I was sliding all over the place. When they're making wide turns, I was hitting my arm and hitting my buttocks where I got shot at right here." A 44-year-old man injured who was walking through a park when someone started "shooting up the playground" also felt police transport might have worsened his injuries: "I fell on the floor in back. They never strapped me down, so I fell on the – you know that divider there? I was laying back there while he was rushing rolling over and over, so then – that might have had something to say why the bullet went around like it went."

For other participants, police transport felt slow and dehumanizing. A 48-year-old man who was shot in his knees while walking to his mother's house believed police delayed departure to the hospital in order to search the scene for a weapon. He then perceived the route that the police drove on the way to the trauma center as circuitous: "I was looking like, what, they trying to let me die or something? … Blood just was gushing out of both legs. I'm like, I'm ready to bleed to death because they messed it up right here." He also felt degraded by the physical experience of police transport:

> "The way they handled my body, like when a person gets shot – you know how they just handle them – handle a person? It was real disrespectful, even though they're there to save lives or whatever. The way they just toss you like you're a piece of trash."

A 38-year-old participant's cousin had died while being transported to the hospital in a police vehicle several years before. This participant was at his front door when a young man on a bicycle fired several shots across the porches on his block. After being shot in his leg and groin, he recalled telling his younger brother and girlfriend to "Call the paramedics. So I can get out of this." But when the police arrived first and tried to transport him, he refused. He had recently been released from a 10-year period of incarceration and was very distrustful of police. Even though the police officer urged him to get him into the back of his car, and physically pulled him toward the car's open door, he resisted insisting: "I'm not going in the back of no cop car, man."

Expectations for the role of police: "things you know living in the city"

Even among participants who were injured in non-violent events, early police interactions reflected ambiguous role expectations for police and emergency medical first responders at the scene of an injury. A 29-year-old man who was injured in a motorcycle crash while out riding with friends recalled that bystanders called 911 and reported the incident as a

shooting: “That’s the only way you get them to come fast. Someone has been shot, somebody out here shooting…So that’s things you know living in the city – certain parts in the inner city.” Though Philadelphia has eight well-distributed trauma centers, in some communities and neighborhoods emergency transport systems may be perceived as dangerously slow. In this example, bystanders reported firearm activity as a strategy to expedite medical care, knowing that police may prioritize their response to a shooting over a car accident. Although the police did arrive quickly after the 911 call, when they found that there had not been a shooting, it appeared that they were planning to leave. The participant recalled the pressure of bystanders that kept the police from leaving: “but he couldn’t, because it’s a hundred people out there watching him. And he had to just make sure the scene was okay.”

A 21-year-old woman described a sense of betrayal after not being offered emergency care by the police who were the first to respond. Police arrived from two jurisdictions and told her, “because you’re in between districts there’s nothing we can do about it,” and then left. She and bystanders were “upset” as they waited for other help to arrive.

Interactions with police in the ED: “Everything was just all happening at one time.”

Once at the trauma center, participants described how police officers observed their clinical exams or asked questions during the course of their emergency treatment. For many, this added to the confusion of the resuscitation experience and intensified a belief that police prioritized their own need for information over participants’ health. The participant who was shot on the way home from a bar remembered that in the ED, police “was just asking me millions of questions and just trying to figure out who did it and everything. Everything was just all happening at one time.” The participant shot near the playground had similar thoughts, recalling “the nurses and doctors and there was a lot of cops there. People kept coming and asking me was I okay…Every time I blinked my eyes, here come two detectives. There go two cops. Ward detective and a little social worker from this hospital.” He interpreted an intensive sequence of questioning by police in the trauma bay as evidence that the police did not believe the story he told them about the events of his shooting:

> “The more I told them no, it was more. They kept trying to switch the questions around and ask me the same question over again but in a different way…I didn’t see nothing. I just heard a gunshot. And that’s all I know. I looked down and I was bleeding…Many times, All the cops kept putting it in different words, but still what was being said was the same thing.”

Another 23-year-old participant with a gunshot wound in his chest felt that being questioned during trauma resuscitation was evidence that the police did not care about his health: “They don’t care if you’re asleep, about to go into surgery. They want to get questions from you.” He elaborated on what it felt like to be questioned while a team of trauma surgeons and nurses were preparing to insert a chest tube that would help him to re-expand his lung and breathe:

> “Doctor sitting there trying to operate on me and the detective is coming around them. ‘Do you know who did this to you? Know his name? Where he live at?’ …I

> could hardly breathe…You want to sit here and ask me questions while I'm getting ready to die.

For him, 'that just showed me you don't care nothing about nobody's health. None of that. You just care about your paycheck and meeting your quotas."

Only one participant recalled that healthcare providers limited police access in the ED. After being assaulted while waiting for a trolley, a 56-year-old man recalled that ED staff "wouldn't even let the police talk to me. The police that wanted to talk to me. They told him they couldn't talk to me. They had it, so he gave me his card and told me to call when I got out."

Interactions with police after hospital admission: "getting information out of me"

Participants admitted to the hospital for continued treatment and evaluation perceived their interactions with police outside of the emergency setting as ranging from helpful to confrontational. A 26-year-old participant was distressed by the hours he could not remember after being shot and was thankful that the police could help explain what happened after he lost consciousness. The police who followed up with him described how they were parked up the street when he was shot, and were able to pick him up and take him directly to the hospital. He in turn was able to help the police identify his shooter, who was arrested soon after.

The participant who injured himself with a knife during an argument with his girlfriend recalled the police following up:

> "When they came up here, the only thing they really wanted to know is 'who did it? Are you going to press charges,' or, you know, something like that? …He told me to sign a piece of paper stating that I did not need any police assistance or anything related to that nature. So I signed the paper. We talked a little bit for about two minutes, and then he left."

A 54-year-old man who was shot by his friend's ex-boyfriend while at a restaurant with her described his interaction with police on the inpatient floor as "fine." He recalled that "they came the next day…They asked me a couple questions. In fact, they're supposed to come back sometime today – detective… It was only one guy."

Interactions with law enforcement during inpatient hospitalization felt disrespectful to other participants. One participant interpreted that the detective who questioned him believed that he was lying, in part, because of the block on which he was shot:

> Detective come up here asking me – talking about 'don't feed him a line of bullshit.' I said, 'a line of bullshit? I got shot'… I'm trying to tell the detective and shit. He's like, 'you know, I know what goes on that block and this, that and the other, and a bunch of bullshit'… And he talk – come up here telling me 'don't bullshit you and shit. You know what I mean? What happened?' And he knows that block, and he knows that that block is known for weed and this, this and the other. I'm like, what?"

Another participant was infuriated that a detective interfered with his medical care in order question him. He reported that a nurse “was about to hang my pain medication and the detective was like, ‘please leave, I’m about to interview him.’” The participant recalled thinking “I’m sitting here like, I need that. That’s my pain medication. I’m in pain right now. I got shot. I need that pain medication.” He interpreted the detective’s attitude as “nonchalant” and that “he ain’t even care.” For this participant, “The only thing the detective cared about was getting information out of me.”

Discussion

Our descriptive study demonstrated that interactions with police were common during the early phases of trauma care for a group of injured, Black patients in Philadelphia and that patients’ interpreted these interactions in very different ways. Some participants felt that law enforcement officers performed a useful and appropriate service, expediting transport to the hospital, safety at the scene, or information and reassurance after injury. Others, who expected such service, were disappointed in police performance. For some participants, police interactions were a source of distress that made them feel that police were more interested in obtaining information than in participants’ wellbeing. Others were simply overwhelmed by the combination of intensive medical care and intensive police questioning in the moments and days after injury. These findings reinforce those of Patton et al. (2016), who found that Black, gunshot injured patients in Chicago described a conflict between police assistance at the scene of injury and officers’ aggressive pursuit of information.

There is opportunity for intervention and improvement at each point of the injury care continuum where participants identified conflicted interpretations of the intersection between healthcare and law enforcement. Systemic factors in Philadelphia undoubtedly contribute to a zone of overlap between the health and law enforcement, particularly for violently injured patients. Approximately half of all victims of gunshot and stab wounds in Philadelphia are transported to the hospital in a police vehicle rather than an ambulance (Band et al., 2014). This codified practice (Philadelphia Police Department, 2012) creates a conduit for police into clinical space. This overlap disproportionately impacts Black city residents who live with the highest exposure to gun violence (Beard et al., 2017). As participants reflected, police transport has the potential to provide access to care and can introduce an opportunity for positive interactions between police and city residents who may skeptical or afraid of police. However, some participants experienced police transport as dangerous or painful, and one participant’s distrust of police led him to refuse this form of transport entirely. Although police transport is rare in the U.S., and nearly 90% of cases occur in just three cities (Philadelphia, Sacramento, and Detroit), this strategy may appeal to policymakers striving to improve trauma care (Wandling et al., 2016). Cities with similar policies and those considering adopting police transport to improve trauma outcomes should evaluate the racialized and psychological dimensions of these policies.

In settings without police transport, interaction between patients and law enforcement may still occur in the hospital. Participants in this study shared varied interpretations of their interactions with police in the ED and during inpatient hospitalization, often feeling confused or overwhelmed. These interactions contributed to many participants’ sense that

police investigation conflicted with or even superceded the participants' own medical care and wellbeing.

With reflection on the experiences of the patients in this study, we recommend that healthcare institutions formulate policies for where, when, and how police interact with patients in trauma centers and emphasize the patient's health and well-being. To our knowledge there are no explicit professional guidelines that standardize law enforcement access to patients in this zone of overlap between law enforcement and medical care. (Jones, Appelbaum and Siegel 2006, Tahouni, Liscord and Mowafi, 2015). The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires healthcare providers and institutions to keep information about patients confidential. However, mandatory reporting laws are a common exception, and in most US states, healthcare providers are required to report a suite of infections and injuries to local law enforcement. In the absence of definitive institutional or professional norms to guide these interactions, patients, clinicians and police must improvise. It is unlikely that ad hoc negotiations over police access within healthcare institutions optimally balance the needs of patients with the societal mandates of law enforcement. Police officers' agenda to investigate a crime may be in tension with the immediate goals of patient care, as study participants noted when, for example, a police officer delayed a patient's pain medication to proceed with questioning.

Police interviews should wait until patients are medically stabilized and able to understand their rights and responsibilities and respond to police questions. Patients should also have routine access to counsel and support during police questioning. Patients, providers, and law enforcement officers should be educated on patients' rights and needs in this setting. Educational efforts should explicitly incorporate an exploration and understanding of the role of race and structural racism in healthcare and law enforcement, and the roles of police and healthcare providers in perpetuating these structures (Ansell & McDonald, 2015). Such policies would be aligned with contemporary ethical principles that guide the delivery of healthcare (Reiser 1994). These include keeping "responsibility to the patient paramount" (American Medical Association Principles of Medical Ethics, 2016), and practicing healthcare "with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (American Nurses Association Code of Ethics, 2015). The American College of Emergency Physicians' Ethics Committee issued a statement on police involvement during emergency care that acknowledges that even in the cases that a 'victim' is associated criminal activity, physicians "should treat (these patients) with the same respect and attention they afford other patients." The Committee also notes that healthcare providers "should attempt to accommodate law enforcement personnel in a professional manner (Tahouni, Liscord and Mowafi, 2015)." However, using PubMed, Google, and the organizational websites of relevant professional societies, we were not able to identify any more specific guidelines which leaves the practical details of enacting these recommendations to individual healthcare providers (American College of Emergency Physicians 2017, American College of Surgeons 2017, American Association for the Surgery of Trauma 2017, Society of Trauma Nurses 2017, American Medical Association 2017).

In addition to protecting patients from delays in trauma care and upholding ethical standards, clear policies for law enforcement activity within healthcare institutions may serve to interrogate under-recognized processes of institutional racism and challenge racial inequities in injury outcomes. Black Philadelphians have lowest rates of employment and health insurance in the city (Urban League of Philadelphia, 2012). Injured Black patients may lack the perceived social and economic capital of more affluent and resourced patients. In turn, healthcare institutions may be blind to or less motivated to enact policy that specifically protects the privacy, autonomy and confidentiality of these patients. As Bassett (2015) warns, “if we fail to explicitly examine our policies and fail to engage our staff in discussions of racism and health… we may unintentionally bolster the status quo.” Clear policy may also lessen the impact of clinicians’ biases in patient care by standardizing procedures (Dovido, 2008, Feagin and Bennefield, 2014) which may reduce disparities (Lau, 2015, Zeidan et al., 2013). If such policies are implemented, future research should study their impact on patient trust, perceptions of discrimination, healthcare engagement (Feagin and Bennefield, 2014), and known outcome disparities.

The intent of this mixed-source study was to lay the groundwork for discourse on an important aspect of patient experience. Our study was inspired by our individual experiences as trauma clinicians as well as the work of the Black Lives Matter movement and others who have brought renewed public attention to the disproportionate impact of police actions on individuals and communities of color (Garcia and Sharif, 2015, Garza, 2016). As trauma clinicians, we were motivated to understand the impact of policing on our own patients, and to seek opportunities to improve patient health and safety in this larger context. Nonetheless, we acknowledge several limitations to this research. We combined two studies with different designs and incentivization structures. Police interactions and patient perceptions of law enforcement during trauma care processes were not the primary areas of focus in either study. We organized the content thematically according to phases of trauma care, but we recognize that other organizations may be possible. We hope that this structure can help to identify opportunities for intervention and improvement. Future research focused specifically on the experience of patients interacting with police may reveal more nuanced and theoretically-informed interpretations of racialized intersections between law enforcement and trauma care. However, since we used our own data, we had the advantage of having “been there” (Heaton, 2008), allowing us to analyze the data in context. We believe that combining similar studies conducted in the same institutions with similar populations within a short time frame allows us to build initial insight into an important phenomenon. In future research we hope to include a broader understanding of participants’ past personal or community exposures to law enforcement, as well as the perspectives of healthcare providers and law enforcement officers. Likewise, our study focused on patients’ short term impressions. A fuller examination of the impact of police involvement during trauma care on patients’ longer term recovery and healthcare engagement could reveal additional opportunities for intervention. Lastly, as secondary study, we did not review our findings with participants. Engaging these stakeholders in future research and in guideline development is crucial.

Conclusions

Healthcare providers and police officers have overlapping mandates after injury: to protect and treat injured patients, on the one hand, and to protect public safety on the other. Injured participants valued police officers' involvement when they perceived that officers provided safety at the scene, speed of transport to the hospital, or support and information after injury. Injured participants also found police questioning to be stressful and, at times, disrespectful or conflicting with clinical care. The overlap of clinical and law enforcement activities during trauma care may decrease patient trust in the health care system and compromise the safe haven that all patients deserve. It may also limit physical and psychological healing and perpetuate racial disparities in injury risk and recovery. Explicit policy and protocols can build equity in trauma care and may reduce outcome disparities. We encourage all stakeholders from trauma physicians and nurses to hospital administrators to local communities and law enforcement agencies to collaborate on clear policies for police interactions with injured patients.

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Table 1

Participant Characteristics

	Interview and Ethnography Participants N=24
Age (Median [IQR])	30 [20.5, 55]
	N (%)
Gender	
Male	23 (95.8)
Female	1 (4.2)
Injury intent	
Unintentional	5 (25.8)
Intentional	19 (74.2)
Mechanism of injury	
Traffic	5 (25.8)
Blunt assault	2 (8.3)
Stab	5 (25.8)
Gunshot	12 (50.0)