CONTRA COSTA
MENTAL HEALTH
COMMISSION
1340 Arnold Drive, Suite 200
Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

CONTRA COSTA
MENTAL HEALTH COMMISSION

Mental Health Commission
Justice Systems Committee Meeting
Tuesday, July 27, 2021, 1:30-3:00 PM
Via: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195

Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from the May 25, 2021 Justice Systems Committee meeting**

VI. **DISCUSS The need for Detention Facility statistics for those who are Incompetent to Stand Trial to determine how many incarcerated persons currently from Contra Costa County are "waitlisted" for a State Hospital IST bed.**

VII. **DISCUSS Law Enforcement physical restraint alternatives during a mental health crisis call**

VIII. **Adjourn**

Mental Health Commission
Justice Systems Committee Meeting
Tuesday July 27, 2021
Agenda Item VI - State Hospital Bed Discussion Points

Agenda Item VI: DISCUSS State Hospital Bed Contracts

- How is the 20 State Hospital beds contract currently utilized by Contra Costa Behavioral Health Services for CC residents?
- How could negotiations over ICT State hospital beds affect their future utilization?
- With which State Hospital does CCBHS have contracts (Currently Napa State Hospital) (14) and Metropolitan State Hospital (6) and what is the current dollar amount if each of these contracts?
- What is the Current classification of State Hospital Beds used by CC residents and what is the number of persons by self-identified gender and ethnicity occupying those beds?
  1. LPS Conservatorship (Civil only)
  2. Misdemeanor Incompetent to Stand Trial (MIST)
  3. Felony IST
  4. LPS Murphy Conservatorship (combined civil / criminal justice system)
  5. An offender with a Mental health Disorder
  6. Not guilty by reason of insanity
  7. Sexually violent Predator

Questions from the Mental Health Commission's
Justice Committee for David Seidner
Via Commissioner Douglas Dunn

In his fairly recent MHC meeting presentation regarding the legal settlement agreement with the Prison Law Office, he listed 4 Tracks of persons incarcerated, primarily at the Martinez Detention Facility (MDF).

Out of approx. 350 inmates (of 703) with moderate to severe mental and behavioral health issues, this was the approximate breakdown by track (as I remember it):

Track 1 (most severe): At least 140-150 persons
Track 2 (severe-moderate): At least 70-85 persons
Track 3 (moderate-making progress): 70-80 persons
Track 4 (moderate to mild-the most progress: 35-45 persons

It would be most helpful to get the self-identified ethnicity, "primary language," and gender of these individuals.

Among these tracks, I'm sure those who are considered Incompetent to Stand Trial (IST) come from track 1 & 2 which could be upwards of 225 persons.

As much as possible, we really need to get the most accurate "point-in-time" number of MDF and West County Detention Facility (WCDF) inmates who are current classified/diagnosed as either Misdemeanor Incompetent to Stand Trial (MIST) or Felony Incompetent to Stand Trial (FIST).
We really need both "counts."

This will give us a good idea, from the "county jail "side," how many incarcerated persons currently from Contra Costa County are "waitlisted" for a State Hospital IST bed."

Medical Professionals, Excessive Force, and the Fourth Amendment

Osagie K. Obasogie* & Anna Zaret**

Police use of force is a persistent problem in American cities, and the number of people killed at the hands of law enforcement has not decreased even as social movements raise greater awareness. This context has led to reform conversations on use of force that seek less violent ways for police to engage the public. One example of how this might occur is through partnerships between police and medical professionals to use chemical restraints—drugs traditionally used in hospital settings to calm agitated or aggressive patients—to sedate people who refuse or are unable to comply with law enforcement. The injury and, at times, death that can result gives rise to a key yet unexplored constitutional issue: does the Fourth Amendment allow medical professionals to collaborate with police and use chemical restraints during routine arrests? When, if at all, does the use of powerful sedatives by paramedics to facilitate an arrest become an unreasonable use of force? Federal courts have been inconsistent on these issues and overly deferential to medical professionals and law enforcement. In this Article, we provide the first scholarly analysis of how Fourth Amendment rules concerning use of force apply to medical practitioners who partner with law enforcement to chemically subdue arrestees—not for their medical benefit, but to assist police. After analyzing the legal, medical, and ethical contours of this novel constitutional issue, we argue that Fourth Amendment limits on chemical restraints in policing should mirror existing federal regulations on using such drugs in healthcare settings found in Title 42 of the Code of Federal Regulations. In this way, medical necessity, individual autonomy, and the person's wellbeing would be prioritized over convenience to law enforcement. This approach might also clarify medical practitioners' role during police stops and arrests and provide guidance on how they may participate in a way that conforms with both Fourth Amendment norms and their professional commitment to promoting patient health and safety.

DOI: https://doi.org/10.15779/Z38NK3658H.

INTRODUCTION

John Powell had just finished visiting his cousin at North Memorial Hospital near Minneapolis, Minnesota.[1] As he entered the hospital parking

* Haas Distinguished Chair and Professor of Bioethics, University of California, Berkeley, Joint Medical Program and School of Public Health. B.A. Yale University; J.D. Columbia Law School; Ph.D. University of California, Berkeley. We are grateful to Catherine Albiston, Eric Biber, and Calvin Morrill for providing comments on early drafts of this Article. A special thank you to the editorial staff at *California Law Review* for their excellent support.

** Ph.D. student, University of California, Berkeley, School of Law, Jurisprudence and Social Policy. B.A. University of California, Santa Cruz; J.D. University of California, Hastings College of the Law.

1. John Croman, *Man Files Lawsuit Over Ketamine Injection*, KARE11 (July 14, 2018, 1:35 PM), https://www.kare11.com/article/news/man-files-lawsuit-over-ketamine-injection/89-573408858 [https://perma.cc/N4XV-C3H2].

garage, he saw a group of police officers near his car.[2] Earlier that day, the police responded to a 9-1-1 call placed by a hospital employee about a "very light skinned or Hispanic male" in the parking lot with a gun who appeared to be suicidal.[3] Powell—a Black man with a dark complexion—did not match this description.[4] Nevertheless, the officers drew their weapons when they saw Powell, ordered him to the ground, and handcuffed him.[5] Later, the police claimed that Powell approached them with what they thought was a firearm,[6] but was then determined to be his car keys.[7] The police held him on the ground in the rain for about an hour.[8]

The employee who made the 9-1-1 call confirmed that Powell was not the person she saw earlier.[9] Yet, the officers still refused to release Powell and kept him detained in a squad car.[10] Frustrated, Powell began kicking and screaming.[11] From the back of the car, Powell could see a North Memorial Hospital ambulance arrive.[12] Paramedics stepped out and huddled with officers.[13] A paramedic then approached Powell, still handcuffed in the back of the car, and stuck the needle of a syringe that contained a drug called ketamine in his arm.[14] All Powell remembers after that is falling over.[15] Powell's breathing stopped due to an adverse reaction to the drug, which required immediate medical attention to save his life.[16] Powell was intubated and hospitalized.[17]

* * *

Excessive use of force by law enforcement has been a critical issue for many years,[18] but public discussion has substantially increased as a result of social movements protesting police shootings of unarmed people.[19] Some have

2. Andy Mannix, *Lawsuit Says Police Detained Innocent Man at North Memorial, Urged Paramedics to Use Ketamine to Sedate Him*, STAR TRIB. (July 12, 2018, 11:14 AM), https://www.startribune.com/lawsuit-says-police-detained-innocent-man-at-north-memorial-urged-paramedics-to-use-ketamine-to-sedate-him/487951331 [https://perma.cc/3LVJ-AB45].

3. Amended Complaint at 3–4, Powell v. Staycoff, No. 17-cv-3018 PAM/SER, 2019 WL 2524771 (D. Minn. June 19, 2019).

4. *Id.* at 4–5.

5. *Id.* at 5.

6. *Id.* at 6–7.

7. *Id.* at 7–8.

8. Croman, *supra* note 1.

9. *Id.*

10. *Id.*

11. Mannix, *supra* note 2.

12. Croman, *supra* note 1.

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. Complaint and Jury Demand, *supra* note 3, at 7.

18. *See, e.g.*, FRANKLIN E. ZIMRING, WHEN POLICE KILL (2017); PAUL BUTLER, CHOKEHOLD: POLICING BLACK MEN (2017).

19. *See* Osagie K. Obasogie & Zachary Newman, *Black Lives Matter and Respectability Politics in Local News Accounts of Officer-Involved Civilian Deaths: An Early Empirical Assessment*, 2016 WIS. L. REV. 541, 542.

responded to this concern by calling on law enforcement to deploy tactics that de-escalate tense situations and use non-lethal approaches more frequently for detaining individuals.[20] In light of these efforts to shift police practices away from deadly use of force, partnerships between law enforcement and paramedics[21] that rely on chemical restraints—drugs commonly used by medical professionals to sedate agitated patients—could become an attractive option for subduing police detainees. This might limit death, injury, and other adverse health outcomes connected to police use of force.

These developments raise new and unanswered questions about use-of-force tactics that involve medical providers collaborating with law enforcement. In *Graham v. Connor*, the U.S. Supreme Court held that the Fourth Amendment provides the sole constitutional guidance for when and how police and other state actors can use force against members of the public.[22] These limits prohibit police and other state officials from deploying unreasonable levels of force.[23] Yet, how should courts think about the Fourth Amendment reasonableness standard in relation to medical providers working with police and using drugs like ketamine

20. In a 2000 report on the use of chemical restraint in law enforcement, the authors note, "There is a need for non-lethal techniques with a high degree of specificity, selectivity, safety, and reversibility to avoid producing a lasting impairment to the subject(s) or individual(s) activating the technique. Consideration of the use of calmatives as non-lethal techniques is both timely and warranted." JOAN M. LAKOSKI, W. BOSSEAU MURRAY & JOHN M. KENNY, THE ADVANTAGES AND LIMITATIONS OF CALMATIVES FOR USE AS A NON-LETHAL TECHNIQUE 6 (2000), https://erowid.org/psychoactives/war/war_article1.pdf [https://perma.cc/K9PN-ASU6].

21. There are technical differences between paramedics, emergency medical technicians (EMTs), and other first responders who may render medical assistance in pre-hospital settings. *See generally What's the Difference Between an EMT and a Paramedic?*, UCLA CTR. FOR PREHOSPITAL CARE, https://www.cpc.mednet.ucla.edu/node/27 [https://perma.cc/AW8R-BGHE]. For the sake of brevity, we will use the term "paramedic" throughout this Article to capture the range of professionals who may act in this capacity.

22. The *Graham* court noted:

> Today we make explicit what was implicit in *Garner*'s analysis, and hold that *all* claims that law enforcement officers have used excessive force—deadly or not—in the course of an arrest, investigatory stop, or other "seizure" of a free citizen should be analyzed under the Fourth Amendment and its 'reasonableness' standard, rather than under a "substantive due process" approach. Because the Fourth Amendment provides an explicit textual source of constitutional protection against this sort of physically intrusive governmental conduct, that Amendment, not the more generalized notion of "substantive due process," must be the guide for analyzing these claims.

Graham v. Connor, 490 U.S. 386, 395 (1989) (referencing Tennessee v. Garner, 471 U.S. 1 (1985)).

23. In the majority opinion for *Graham*, Justice Rehnquist did not provide an exact definition of what "reasonable" means in the excessive force context. Rehnquist noted:

> Because "[t]he test of reasonableness under the Fourth Amendment is not capable of precise definition or mechanical application," Bell v. Wolfish, 441 U.S. 520, 559 (1979), however, its proper application requires careful attention to the facts and circumstances of each particular case, including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he is actively resisting arrest or attempting to evade arrest by flight.

Id. at 396 (alteration in original).

to chemically restrain people—not for medical purposes, but to assist in their arrest or detention?

At least two novel Fourth Amendment concerns emerge. The first issue deals with *who* is using force. How do constitutional rules governing use of force apply to medical providers, as opposed to police, when these providers collaborate with law enforcement to detain citizens in public or pre-hospital settings? Although police often work with paramedics to respond to calls for service, legal scholars have not closely examined the constitutional limits that apply when professionals other than the police use force to detain citizens.[24] The second issue deals with the *type of force* used. If a paramedic uses drugs to sedate and detain a citizen in a manner that causes harm, does this chemical restraint count as "force" for constitutional purposes? The Supreme Court has not yet considered this issue, though several lower courts have, albeit inconsistently.[25] As law enforcement seeks to respond to public demands for police to use less lethal tactics during arrests and investigations, these questions situate the legal framework for evolving forms of force that may be used.

This Article explores how the Fourth Amendment might limit medical providers' use of chemical restraints in detaining members of the public. Unlike scholarship concerning the ways that law restricts medical providers in their interactions with people in *clinical environments*, this Article focuses on paramedics interacting with people in public or *pre-clinical* settings, where their professional expertise is used for law enforcement rather than medical purposes. While collaboration between paramedics and police is a common aspect of first-

24. Scholars have explored the growing apparatus of private policing (security guards, institutional police forces, etc.) and how the law should treat private police forces; however, most of that work centers on issues other than excessive force. *See, e.g.*, Heidi Boghosian, *Applying Restraints to Private Police*, 70 MO. L. REV. 177, 177 (2005); David A. Sklansky, *The Private Police*, 46 UCLA L. REV. 1165, 1169–70 (1999); Leigh J. Jahnig, *Under School Colors: Private University Police As State Actors Under § 1983*, 110 NW. U. L. REV. 249, 251 (2015). In addition, scholars have focused on the state-action doctrine—the principle that certain constitutional protections, including the Fourth and Fourteenth Amendments, apply only to state and local governments and not to private parties—and discussed the implications of expanding Section 1983 claims for excessive force to private actors. John L. Watts, *Tyranny by Proxy: State Action and the Private Use of Deadly Force*, 89 NOTRE DAME L. REV. 1237, 1238–39 (2014).

25. *Compare* Est. of Barnwell v. Grigsby, 801 F. App'x 354, 370–71 (6th Cir. 2020) (granting judgment as a matter of law to paramedic facing excessive-force claim because the paramedic did not act in a law-enforcement capacity), Thompson v. Cope, 900 F.3d 414, 422–23 (7th Cir. 2018) (granting qualified immunity to paramedic and dismissing excessive-force claim because paramedic would not have known that Fourth Amendment rules apply to paramedics), *and* Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 221 (6th Cir. 2007) (holding that qualified immunity shields paramedics from Fourth Amendment claims when they act to render aid rather than to enforce the law), *with* Green v. City of New York, 465 F.3d 65, 83 (2d Cir. 2006) (allowing excessive-force claim against paramedic to proceed past summary judgement because the law clearly established at the time of the incident that "a competent adult could not be seized and transported for treatment unless she presented a danger to herself or others"), *and* Haas v. County of El Dorado, No. 2:12-cv-00265-MCE-KJN, 2012 WL 1414115, at *9–10 (E.D. Cal. Apr. 23, 2012) (denying paramedic's motion to dismiss excessive-force claim on the grounds that paramedic acted in a law-enforcement capacity when he injected the plaintiff with a tranquilizer).

responders' work, Fourth Amendment use-of-force literature has often overlooked the implications of these partnerships. This Article makes an important contribution by identifying and discussing whether unnecessary and often dangerous chemical restraints used by paramedics for the purpose of an arrest or detainment might constitute excessive use of force under the Fourth Amendment. It also engages the ethics of chemical restraints to provide three proposals aimed at preventing situations akin to what happened to John Powell in Minneapolis. These proposals attempt to guard against the possibility of a troublesome future where police and paramedics jointly engage in life-threatening uses of chemical restraints for convenience rather than for arrestees' health.

Part I introduces the constitutional limits to the use of force as it typically occurs in the context of an encounter between the police and private citizens. We provide a brief history of the Fourth Amendment to highlight the purpose of constitutional restrictions on police force, outline the current legal standards courts use in evaluating excessive-force claims, and discuss how the Fourth Amendment framework developed by courts has limitations in addressing police violence. This Section also briefly reviews the existing scholarly literature on the use of force and the Fourth Amendment. In doing so, we draw attention to the fact that despite this voluminous literature, scholars have not examined how existing constitutional limits on the use of force during an arrest or investigatory stop might apply to medical professionals. Part II discusses the law surrounding medical professionals' use of chemical restraints in both clinical and pre-clinical settings. To add context to this discussion, we analyze two medical research studies on ketamine that were conducted by a Minneapolis-area hospital system and often led to partnerships between paramedics and police officers in public, pre-hospital settings. This study and the resulting informal collaborations between police and paramedics to administer ketamine, exposed by the *Minneapolis Star Tribune* in the summer of 2018,[26] demonstrates that John Powell's life-threatening encounter with chemical restraints was not an isolated incident. While there are not many official figures on the number of police departments that partner with local paramedics to administer ketamine, nor on how often chemical restraints are used during police activity across the country,[27]

26. Andy Mannix, *At Urging of Minneapolis Police, Hennepin EMS Workers Subdued Dozens with a Powerful Sedative*, STAR TRIB. (June 15, 2018), https://www.startribune.com/at-urging-of-police-hennepin-emts-subdued-dozens-with-powerful-sedative/485607381 [https://perma.cc/3RKF-E98A].

27. An investigation by KUNC found that paramedics and emergency medical technicians in Colorado used ketamine 902 times over thirty months to treat individuals thought to be experiencing excited delirium. *See* Michael de Yoanna & Rae Solomon, *Medics in Colorado Dosed 902 People with Ketamine for 'Excited Delirium' in 2.5 Years*, KUNC (July 21, 2020), https://www.kunc.org/post/medics-colorado-dosed-902-people-ketamine-excited-delirium-25-years#stream/0 [https://perma.cc/BH55-AGGX]. This is an important context for understanding the police/EMT collaboration that led to the ketamine injection and subsequent death of Elijah McClain in Aurora, CO in 2019. This incident is discussed in more detail in the conclusion.

it is clear that Minneapolis is not alone.[28] Accordingly, our review of practices in Minneapolis serves as a reasonable description of how this might occur elsewhere.

Part III draws upon current legal frameworks, as well as observations from the ketamine episodes in Minneapolis, to offer three recommendations that can prevent medical providers from using excessive force and keep police from supplanting medical providers' professional and ethical duties. We argue that first, medical providers should develop use-of-force guidelines that provide clear rules regarding when and what type of force is appropriate for healthcare professionals to use. Second, first-responder policies are needed at the state and local level to create a firewall between police and medical professionals so that the former do not unduly influence the decision-making of the latter. Third, when plaintiffs bring Section 1983 excessive-force claims against paramedics who use chemical restraints, courts should use existing federal regulations governing medical professionals' use of these drugs in hospital settings (e.g., 42 C.F.R. § 482.13) to inform their considerations of whether particular uses of chemical restraints in public or pre-hospital settings meet Fourth Amendment standards concerning reasonableness.

We then conclude with a discussion of the theoretical contributions this Article makes in expanding our understanding of what Osagie Obasogie and Zachary Newman have called in previous work an "[e]ndogenous Fourth Amendment."[29] This notion of legal endogeneity[30] characterizes federal courts' tendency to defer to police departments' internal policy preferences in defining the constitutional reasonableness of force incidents rather than developing

28. *See, e.g.*, Elise Schmelzer, *Death of Unarmed 23-Year-Old in Police Custody Prompts Questions About Increasingly Common Use of Ketamine As Sedative For Agitated Patients*, DENVER POST (Oct. 14, 2019, 6:00 AM), https://www.denverpost.com/2019/10/14/ketamine-sedative-law-enforcement-elijah-mcclain [https://perma.cc/525B-VHTJ]; Nick Blizzard, *Suspect Sedated with Drugs After Fighting 4 Police Officers, Tasers*, DAYTON DAILY NEWS (Jan. 23, 2020), https://www.daytondailynews.com/news/local/new-details-suspect-sedated-with-drugs-after-fighting-police-officers-tasers/FcwwN0L4As6cJRjAFBYQUL [https://perma.cc/J623-2XZA].

29. Osagie K. Obasogie & Zachary Newman, *The Endogenous Fourth Amendment: An Empirical Assessment of How Police Understandings of Excessive Force Become Constitutional Law*, 104 CORNELL L. REV. 1281, 1281 (2019).

30. Legal endogeneity theory was first developed by Lauren Edelman in the context of organizational studies and employment law to offer an empirical explanation for why race and gender discrimination persists in workplaces after major statutory developments in anti-discrimination law. *See* LAUREN B. EDELMAN, WORKING LAW: COURTS, CORPORATIONS, AND SYMBOLIC CIVIL RIGHTS (2016). Edelman finds, in short, that in response to these statutory changes, work organizations created anti-discrimination policies that are largely symbolic and do not address the structural nature of discrimination. *Id.* at 38. When litigation arises, federal courts tend to reference, refer, or defer to these workplace administrative policies as an appropriate interpretation and implementation of antidiscrimination statutes like Title VII. *Id.* at 173. This allows these laws to be defined by the managerial preferences of employers rather than by independent judicial assessments that could be more favorable to employees. *Id.* at 228. Therefore, the legal meaning of these anti-discrimination reforms is created by endogenous or internal dynamics within the workplace that reflect managerial preferences and not by external determinants or sources of law. *Id.*

independent standards. Courts often use the administrative rules regarding use of force created by police in response to *Graham v. Connor* as the standard for what the Fourth Amendment requires. This dynamic allows police perspectives to *become* constitutional law, often to the detriment of victims pursuing legal remedies. The authors argue that federal courts' deferential posture can be disrupted in favor of more impartial ways to understand which types of force should be seen as "reasonable" and lawful under the Fourth Amendment. By using democratic sources of constitutional interpretation that include broader community sensibilities, diverse constituents' perspectives, and other expert opinions, federal courts can apply standards regarding the appropriate use of force that balance the needs and expectations of community members with those of law enforcement. This can be understood as *anti-endogeneity*, or resisting determinations of Fourth Amendment reasonableness that are tied to the organizational preferences of the group meant to be regulated and seeking more equitable standpoints for constitutional interpretation. In the context of medical professionals and chemical restraints, existing federal regulations on the appropriate use of these drugs in hospital settings should inform federal courts' understanding of paramedics' obligations and detainees' rights in *pre-hospital* environments. This provides an important theoretical framework that prioritizes patient health and safety over convenience to law enforcement and medical professionals. Moreover, as a method of interpreting Fourth Amendment reasonableness, first discussed by Obasogie and Newman[31] and further developed in this Article, *anti-endogeneity* could offer new ways to think about broader efforts encouraging use-of-force reform that can serve the public good.

I.
EXCESSIVE FORCE AND THE FOURTH AMENDMENT: DOCTRINAL AND SCHOLARLY PERSPECTIVES

The Fourth Amendment provides constitutional protection against unreasonable uses of force by the government.[32] Most excessive force claims are in response to violence perpetuated by law enforcement. As such, it is important to understand how the Fourth Amendment operates in these cases before examining how it might work in situations involving medical providers. This Section provides that context. It starts with a brief history of the Fourth Amendment and its intended purpose of shielding individuals from state power. It then discusses the expansion of the Fourth Amendment through two key Supreme Court decisions—*Tennessee v. Garner* (1985) and *Graham v. Connor* (1989)—and outlines the doctrinal standards that govern Fourth Amendment excessive-force cases. After explaining the current state of Fourth Amendment

31. *See generally* Osagie K. Obasogie & Zachary Newman, *Constitutional Interpretation Without Judges: Police Violence, Excessive Force, and Remaking the Fourth Amendment*, 105 VA. L. REV. 425 (2019).

32. *See* U.S. CONST. amend. IV.

use-of-force doctrine, this Section briefly explores scholars' perspectives on Fourth Amendment use-of-force jurisprudence to highlight common themes and to draw attention to the absence of research regarding constitutional limitations on medical practitioners' use of chemical restraints for law enforcement purposes.

A. Fourth Amendment Limitations on Use of Force

The Fourth Amendment is part of the Bill of Rights, which reflects a constitutional commitment to the idea that individuals are entitled to protection from abuses of state power.[33] The framers of the Constitution crafted the Bill of Rights based on British attempts to "prescribe the individual rights of the citizenry,"[34] reflecting a concern with the proper relationship between individuals and the federal government. While the Bill of Rights deals specifically with the boundaries of federal power, the Fourteenth Amendment's Due Process Clause incorporated most of these amendments so that they also apply to state governments.[35] The rights contained in these amendments are primarily a set of negative freedoms intended to give all citizens the right to be free from specific types of state conduct. Consistent with this framing, the language of the Fourth Amendment provides:

> The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.[36]

Thus, the Fourth Amendment, in theory, protects individual liberty and privacy by guaranteeing protection from unreasonable searches and seizures. The U.S. Supreme Court has come to understand police use of force as a "seizure" within the meaning of the Fourth Amendment.

Modern criminal procedure originated between 1920 and 1940 through Supreme Court cases involving Black defendants who suffered lynching or egregious injustices in criminal trials in southern states under "Jim Crow justice."[37] The development of case law invalidating convictions under the

---

33. *See* 1 JAMES BRYCE, THE AMERICAN COMMONWEALTH 483–84 (1888) ("[The] ten amendments made immediately after the adoption of the Constitution . . . constitute what the Americans, following the English precedent, call a Bill of Rights, securing the individual citizen and the states against the encroachments of federal power.").

34. Joyce A. McCray Pearson, *The Federal and State Bills of Rights: A Historical Look at the Relationship Between America's Documents of Individual Freedom*, 36 HOW. L.J. 43, 45 (1993).

35. *See* Donald A. Dripps, *The Fourteenth Amendment, the Bill of Rights, and the (First) Criminal Procedure Revolution*, 18 J. CONTEMP. LEGAL ISSUES 469, 470 (2009) ("The theory that the Fourteenth Amendment incorporates the Bill of Rights established the foundation for the Warren Court's 'criminal procedure revolution.'").

36. U.S. CONST. amend. IV.

37. Michael J. Klarman, *The Racial Origins of Modern Criminal Procedure*, 99 MICH. L. REV. 48, 49 (2000).

Fourteenth Amendment on the basis of the right to counsel, biased judges, knowingly-perjured testimony, and coerced confessions "required a departure from a century and a half of tradition and legal precedent, both grounded in federalism concerns"[38] that customarily left these issues to state and local governments. These departures, however, were not necessarily instances of judicial protection of minorities from majoritarian misbehavior but a reflection of a growing national consensus that Jim Crow laws were no longer defensible.[39] This paved the way for criminal procedure decisions in later cases involving the limits of state power in the context of police use-of-force doctrine.

The Court continued to expand constitutional rights in the criminal procedure realm during the mid-century Warren Court era. During this time, the Court began to "use the Constitution as the primary means of regulating the police."[40] This new constitutional discourse on police activity focused on expanding rights and remedies in the context of searches and seizures. These developments limited the power of the state, via the police, to infringe upon citizens' personal property or restrict bodily autonomy.

The current constitutional standard for "what counts" as excessive force is a relatively recent development. Much of this conversation centers around 42 U.S.C. § 1983, which creates a private cause of action against state officials who deprive individuals of constitutional rights. This federal statute codifies the Civil Rights Act of 1871, which was created during Reconstruction in response to racist violence against persons who were formerly enslaved. It largely laid dormant until the Supreme Court's 1961 decision in *Monroe v. Pape*, which rejuvenated such federal civil rights claims.[41] From this period until the late 1980s, federal courts used a variety of legal doctrines to assess claims that a police use-of-force incident violated an individual's constitutional rights.[42] Following a 1973 Second Circuit decision in *Johnson v. Glick*, substantive due

38. *Id.* at 48.

39. *See id.* at 93. Klarman notes that these

> early cases almost certainly were consonant with dominant national opinion at the time. Even within the South, significant support existed for the results in these cases. As noted earlier, these rulings only bound the southern states to abstract norms of behavior that they generally had embraced on their own. In the North, meanwhile, although blacks suffered oppressive discrimination in housing, employment, and public accommodations, the criminal justice system approached somewhat nearer to the ideal of colorblindness. Thus, it is erroneous to conceive of these landmark criminal procedure cases as instances of judicial protection of minority rights from majoritarian oppression. Rather, they better exemplify the paradigm of judicial imposition of a national consensus on resistant state outliers (with the qualification that even the southern states generally accepted these norms in the abstract).

Id.

40. Rachel A. Harmon, *The Problem of Policing*, 110 MICH. L. REV. 761, 765 (2012).

41. 365 U.S. 167 (1961) (holding that 42 U.S.C. § 1983 provided a cause of action for Mr. Monroe to sue Chicago police officers for an unreasonable search and seizure), *overruled in part by* Monell v. Dep't of Soc. Servs., 436 U.S. 658 (1978).

42. Osagie K. Obasogie & Zachary Newman, *The Futile Fourth Amendment: Understanding Police Excessive Force Doctrine Through an Empirical Assessment of* Graham v. Connor, 112 NW. U. L. REV. 1465 (2018).

process under the Fourteenth Amendment emerged as a dominant (though not exclusive) framework from which federal courts examined whether certain applications of police force violated the constitution. *Johnson v. Glick* focused heavily on the subjective intent of police officers, noting that courts should examine whether police used force in "good faith" or "maliciously and sadistically for the very purpose of causing harm."[43]

Two Supreme Court decisions during the 1980s changed use-of-force jurisprudence. The first case was *Tennessee v. Garner* (1985), which involved the death of Edward Garner, a Black fifteen-year-old.[44] Garner was unarmed and fleeing the scene of a suspected burglary.[45] While Garner climbed over a fence attempting to escape arrest, a Memphis police officer shot him in the back of the head and killed him.[46] Garner's father sued both the officer who shot his son and the Memphis police department.[47] The Court noted that apprehension by use of deadly force constitutes a seizure under the Fourth Amendment.[48] As to when deadly force is reasonable to use, the Court held:

> [I]f the suspect threatens the officer with a weapon or there is probable cause to believe that he has committed a crime involving the infliction or threatened infliction of serious physical harm, deadly force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.[49]

The Court held that using deadly force on a fleeing person who did not pose any of these threats is unconstitutional, leading to a determination that the Tennessee state statute (as well as similar laws in several other states) that permitted such force could no longer stand.[50] *Garner* has been celebrated for creating a bright-line rule that prohibits deadly force in these circumstances.

This decision largely spoke to the unlawfulness of state statutes that allowed deadly force against unarmed persons fleeing from the police. Although influential, *Garner* did not directly address which constitutional standard federal courts should use to determine when police use of force becomes excessive. In *Graham v. Connor* (1989), the Court made a definitive statement that put all

43. Johnson v. Glick, 481 F.2d 1028, 1033 (2d Cir. 1973), *abrogated by* Graham v. Connor, 490 U.S. 386 (1989).

44. 471 U.S. 1 (1985).

45. *Id.* at 3–4.

46. *Id.*

47. *Id.* at 5.

48. *Id.* at 7.

49. *Id.* at 11–12.

50. *Id.* at 11 ("The use of deadly force to prevent the escape of all felony suspects, whatever the circumstances, is constitutionally unreasonable. It is not better that all felony suspects die than that they escape. Where the suspect poses no immediate threat to the officer and no threat to others, the harm resulting from failing to apprehend him does not justify the use of deadly force to do so. It is no doubt unfortunate when a suspect who is in sight escapes, but the fact that the police arrive a little late or are a little slower afoot does not always justify killing the suspect. A police officer may not seize an unarmed, nondangerous suspect by shooting him dead. The Tennessee statute is unconstitutional insofar as it authorizes the use of deadly force against such fleeing suspects.").

excessive-force claims into the terrain of the Fourth Amendment.[51] The case involved a situation where DeThorne Graham, a diabetic, experienced an insulin reaction that was misinterpreted by the police as him being an unruly and uncooperative "drunk."[52] The police treated Graham harshly as they pinned him down on the sidewalk, handcuffed him, and threw him into a patrol car.[53] As a result of this encounter, Graham sustained a broken foot, several lacerations, and a persistent ringing in his ear.[54] Graham brought a Section 1983 suit in federal district court, claiming that the excessive use of force by the officers violated his Fourteenth Amendment substantive due process rights.[55] The trial and appellate courts sided with the police officers.[56] Yet, when the case reached the Supreme Court, the justices rejected the argument that excessive-force claims fall under the Fourteenth Amendment.[57] Instead, they held that excessive force claims "are properly analyzed under the Fourth Amendment's 'objective reasonableness' standard, rather than under a substantive due process standard."[58]

The *Graham* court explained this shift by noting that "[d]etermining whether the force used to effect a particular seizure is reasonable under the Fourth Amendment requires a careful balancing of the nature and quality of the intrusion on the individual's Fourth Amendment interests against the

51. 490 U.S. 386, 388 (1989) ("This case requires us to decide what constitutional standard governs a free citizen's claim that law enforcement officials used excessive force in the course of making an arrest, investigatory stop, or other 'seizure' of his person. We hold that such claims are properly analyzed under the Fourth Amendment's 'objective reasonableness' standard, rather than under a substantive due process standard.").

52. *Id.* at 389.

53. *Id.*

54. *Id.* at 390.

55. *Id.*

56. *Id.* at 391.

57. *Id.* at 393–94.

58. *Id.* at 388. While the Court framed excessive-force claims as violations of the Fourth Amendment, this does not preclude individuals from bringing claims involving excessive force under the Fourteenth Amendment. The standard that a plaintiff must meet to establish a due-process violation under the Fourteenth Amendment is higher than the standard for an unlawful seizure or excessive force claim under the Fourth Amendment. Whereas an alleged Fourth Amendment violation is evaluated under a reasonableness standard, *Ohio v. Robinette*, 519 U.S. 33, 34 (1996), "the Due Process Clause is violated by executive action only when it 'can properly be characterized as arbitrary, or conscience shocking, in a constitutional sense.'" Cnty. of Sacramento v. Lewis, 523 U.S. 833, 847 (1998) (quoting Collins v. City of Harker Heights, 503 U.S. 115, 128 (1992)); *accord* Porter v. Osborn, 546 F.3d 1131, 1137 (9th Cir. 2008) ("[O]nly official conduct that 'shocks the conscience' is cognizable as a due process violation.") (citing *Lewis*, 523 U.S. at 846).

> Where actual deliberation is practical, then an officer's 'deliberate indifference' may suffice to shock the conscience. On the other hand, where a law enforcement officer makes a snap judgment because of an escalating situation, his conduct may be found to shock the conscience only if he acts with a purpose to harm unrelated to legitimate law enforcement objectives.

Hayes v. Cnty of San Diego, 736 F.3d 1223, 1230 (9th Cir. 2013) (citing Wilkinson v. Torres, 610 F.3d 546, 554 (9th Cir. 2010)).

countervailing governmental interests at stake."[59] To do so, a court must evaluate the facts and circumstances of each particular case. Three factors courts must consider are "[(1)] the severity of the crime at issue, [(2)] whether the suspect poses an immediate threat to the safety of the officers or others, and [(3)] whether he is actively resisting arrest or attempting to evade arrest by flight."[60] Some federal courts have found, however, that these factors are not exhaustive.[61] Since "there are no per se rules in the Fourth Amendment excessive force context,"[62] courts must "examine the totality of the circumstances and consider 'whatever specific factors may be appropriate in a particular case, whether or not listed in *Graham*.'"[63]

In addition, the Court has explained that "[t]he 'reasonableness' of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight."[64] This is because "[t]he calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation."[65]

Since *Graham*, federal courts have largely used Fourth Amendment standards to determine the lawfulness of police use of force. The Supreme Court reaffirmed this approach to excessive-force claims in 2007 in *Scott v. Harris*.[66] In this case, a police officer used the bumper of his patrol car to stop a fleeing suspect in a vehicle, leading the car to roll down an embankment and overturn.[67] The suspect in the car was severely injured and brought a Section 1983 excessive-force claim against the officer.[68] Citing *Graham*, the Court noted, "[i]t is . . . conceded, by both sides, that a claim of excessive force in the course of making [a] . . . seizure of [the] person . . . [is] properly analyzed under the Fourth Amendment's objective reasonableness standard. The question we need to answer is whether Scott's actions were objectively reasonable."[69]

In light of these doctrinal developments, the next Section describes scholars' interpretations of the Fourth Amendment's limits on police use of force.

---

59. *Graham*, 490 U.S. at 396 (quoting Tennessee v. Garner, 471 U.S. 1, 8 (1985) (internal quotation marks omitted).

60. *Id.*

61. *See, e.g.*, George v. Morris, 736 F.3d 829, 837–38 (9th Cir. 2013).

62. Mattos v. Agarano, 661 F.3d 433, 441 (9th Cir. 2011) (en banc).

63. Bryan v. MacPherson, 630 F.3d 805, 826 (9th Cir. 2010).

64. *Graham*, 490 U.S. at 396 (citing Terry v. Ohio, 392 U.S. 1, 20–22 (1968)); *see id.* ("'Not every push or shove, even if it may later seem unnecessary in the peace of a judge's chambers,' violates the Fourth Amendment." (citation omitted)).

65. *Id.* at 396–97.

66. 550 U.S. 372 (2007).

67. *Id.* at 375.

68. *Id.* at 375–76.

69. *Id.* at 381 (quoting *Graham*, 490 U.S. at 386) (citation and internal quotation marks omitted).

B. Scholarly Perspectives on the Fourth Amendment and Police Use of Force

Legal scholarship discussing police use of force and constitutional law provides important evaluations of how courts have interpreted the Fourth Amendment. Scholars have emphasized the limitations and flaws of the Fourth Amendment as a mechanism for addressing police use of force. For example, Rachel Harmon has written that Fourth Amendment use-of-force jurisprudence is "indeterminate and undertheorized, particularly as applied to nondeadly force."[70] Harmon argues that this indeterminacy on when and how police can use force is in stark contrast with basic criminal law, which has justification defenses that serve as a "well-established conceptual structure for deciding when, how, and why one person may justifiably use force against another."[71] This effort at bringing the rules regarding police use of force in line with existing criminal law is important and insightful as it draws attention to the wide latitude and deference given to police through a Fourth Amendment reasonableness standard that leaves most excessive-force claims without remedy. Harmon's call for importing a justification standard into Fourth Amendment excessive-force inquiries highlights the extent to which this area of law is largely underdeveloped, which can allow questionable practices—such as the use of chemical restraints—to emerge without broader consideration of their constitutionality.

Brandon Garrett and Seth Stoughton also explore the lack of clarity provided by the Fourth Amendment and federal courts' interpretations of it in their article *A Tactical Fourth Amendment*.[72] Garrett and Stoughton observe that most police departments do not have specific policies that describe when officers can use force on community members and instead reference a force continuum that embraces relativism rather than clear standards.[73] They argue that this lack

---

70. Rachel A. Harmon, *When is Police Violence Justified?*, 102 NW. U. L. REV. 1119, 1119 (2008).

71. *Id.* at 1120. Harmon notes that:

> Specifically, the law of justification defenses permits individuals to use force to serve particular well-defined interests, such as to protect themselves or others, under specific, carefully delineated conditions, i.e., when that force is necessary to protect against an imminent threat to one of those interests and is proportional to that threat. Analogously, I contend that the Fourth Amendment permits police uses of force only to serve directly the state's distinct interests in (1) facilitating its institutions of criminal law, most commonly by enabling a lawful arrest; (2) protecting public order; and (3) protecting the officer from physical harm. Moreover, even if one of these interests is at stake, a use of force should be considered unreasonable—and therefore unconstitutional under the Fourth Amendment—unless it is a response to an imminent threat to one of these interests, the force reasonably appears necessary in both degree and kind to protect the interest, and the harm the force threatens is not substantially disproportionate to the interest it protects. In this way, the substructure of justification defenses can be used to analyze whether a police use of force is constitutional.

Id. (footnote omitted).

72. Brandon Garrett & Seth Stoughton, *A Tactical Fourth Amendment*, 103 VA. L. REV. 211 (2017).

73. *Id.* at 213, 278–80.

of tactical guidance produces unlawful uses of force, leading the authors to harken back to earlier periods in the 1970s and 1980s that emphasized tactical training to minimize force.[74] While this approach initially found some support by the Supreme Court in *Tennessee v. Garner* (where the court created a bright-line tactical rule against shooting fleeing unarmed persons), this emphasis on court-imposed tactical limits dissipated after *Graham v. Connor*.[75] Garrett and Stoughton argue that this post-*Graham* case law has hindered sound police tactics and training and "confound[ed] efforts to draft clear use-of-force policies."[76]

Other scholars, like Nancy Marcus, have also tried to reclaim *Tennessee v. Garner* as an important constitutional limitation on police use of force that is still relevant after *Graham v. Connor* and that should be central to police training.[77] Marcus argues that *Tennessee v. Garner* should be revived in the Fourth Amendment context to further move use-of-force case law toward defining firm rules that establish when police are precluded from using specific levels of force.[78]

Scholars have also placed issues of race and racism at the heart of the Fourth Amendment's failure to protect victims of police violence who are largely

---

74. *Id.* at 216–17.

75. *Id.* at 217 ("The impediments [to tactical policing] are the result of the flexible, 'totality of the circumstances' analysis that the Supreme Court adopted to govern use of force under the Fourth Amendment. That flexible standard grows out of a mantra first articulated by the Court in the 1989 decision in *Graham*: that officers make 'split-second' decisions in use-of-force situations. That description, originating in Justice Sandra Day O'Conner's dissent in *Garner*, has animated the Court's excessive-force case law ever since.").

76. *Id.*

77. Marcus states that:

> What the police who killed Eric Harris, Walter Scott, and Samuel DuBose failed to grasp, with terrible repercussions, is that the Supreme Court in *Garner*, while acknowledging the need of law enforcement to restrain fleeing felons, emphatically held that lethal force is *not* a constitutional means of accomplishing that end, declaring: "It is not better that all felony suspects die than that they escape." *Garner*'s holding necessarily extends to prohibit lethal force against fleeing unarmed suspects of mere misdemeanors, not just felons, and to individuals who are not suspected of any particular crime at all (such as Eric Garner, Eric Harris, and Walter Scott).
>
> Although *Tennessee v. Garner*'s limitations were clearly not at the forefront of the officers' minds in those cases, to this day, *Garner* remains the seminal Supreme Court case limiting the use of deadly force by law enforcement officers. This is true even if *Garner* is not sufficiently emphasized in use-of-force trainings or universally understood by both law enforcement and civilian populations. To fully appreciate the necessary role that *Garner* must play in use-of-force training and analyses of cases involving police killings, it is important to recognize that *Garner* is as much good law today as the day it was decided. This is the case even after the subsequent *Graham v. Connor* decision that articulated a broader objective reasonableness standard for analyses of use-of-force generally (i.e., not just in those cases specifically involving lethal force against fleeing suspects).

Nancy C. Marcus, *From Edward to Eric Garner and Beyond: The Importance of Constitutional Limitations on Lethal Use of Force in Police Reform*, 12 DUKE J. CONST. L. & PUB. POL'Y 53, 80 (2016) (footnotes omitted).

78. *Id.* at 82.

Black and Brown. A foundational article from this perspective is Michael Klarman's *The Racial Origins of Modern Criminal Procedure*, which argues that "the linkage between the birth of modern criminal procedure and southern black defendants is no fortuity."[79] While not specifically about excessive force, Klarman's article draws attention to the role of race and racism in shaping the development of criminal procedure in the mid to late twentieth century. Klarman points to the egregiousness of southern injustice that led appellate courts to articulate basic rules for how people are to be treated when accused or suspected of a crime.[80] Other scholars, such as Tracey Maclin[81] and Devon Carbado,[82] have also explored the impact of race in Fourth Amendment cases. While the cases Maclin and Carbado study concern stops and pretextual seizures and do not pertain directly to use of force, their scholarship nonetheless offers insight and doctrinal context that can inform our understanding of how race factors into excessive force claims. These authors demonstrate that by framing Fourth

---

79. Klarman, *supra* note 37, at 48.

80. Klarman makes three points about southern injustice giving rise to modern criminal procedure:

> First, the southern state appellate courts and the United States Supreme Court were operating on the basis of different paradigms when they evaluated the fairness of these criminal trials. For the southern courts, the simple fact that these defendants enjoyed the formalities of a criminal trial, rather than being lynched, represented a significant advance over what likely would have transpired in the pre-World War I era. For the United States Supreme Court, on the other hand, criminal trials were supposed to be about adjudicating guilt or innocence, not simply avoiding a lynching. Second, because these southern criminal trials were so egregiously unfair, public opinion in the nation generally supported the Supreme Court's interventions. Thus, these early criminal procedure cases hardly represent the sort of countermajoritarian judicial decision-making one often associates with landmark criminal procedure decisions such as *Mapp* or *Miranda*. Third and finally, it is possible that the southern state courts themselves would have intervened to rectify the obvious injustices involved in these cases had the circumstances been a little different. Southern courts in the post-World War I period were becoming more committed to norms of procedural fairness, even in cases involving black defendants charged with serious interracial crimes. Yet, in cases that aroused outside criticism of the South or that posed broader challenges to the system of white supremacy, the southern state courts regressed. Cases that might never have reached the United States Supreme Court a decade or two earlier slipped through the state system uncorrected, thus providing the occasion for landmark criminal procedure rulings.

Id. at 49 (footnote omitted).

81. *See, e.g.*, Tracey Maclin, *Race and the Fourth Amendment*, 51 VAND. L. REV. 333 (1998) (criticizing the Supreme Court's decision in *Whren v. United States*, 517 U.S. 806 (1996), which held that an officer's subjective motivation for effecting an otherwise-authorized traffic stop does not bear on the Fourth Amendment's "reasonableness" inquiry, as enabling pretextual, racially-motivated traffic stops, which disproportionately burden Black motorists).

82. Carbado notes:

> [V]irtually none of this literature links the Supreme Court's racial insensitivity in the Fourth Amendment context to racial ideology—that is, commitments about and conceptions of race. Put another way, the race and Fourth Amendment scholarship fails to examine the nexus between the development of Fourth Amendment doctrine on the one hand, and ideological notions about what race is and should be on the other.

Devon W. Carbado, *(E)racing the Fourth Amendment*, 100 MICH. L. REV. 946, 965 (2002) (footnote omitted).

Amendment matters in abstract doctrinal terms that are inattentive to the racial backdrop that shapes many police interactions, the Court and many Fourth Amendment scholars have failed to develop a doctrine that might actually limit police excessive force.

Scholars have also voiced concern about the individualism embedded in Fourth Amendment case law that "frame[s] excessive force as a problem that derives from rogue police officers who harbor racial animus against African Americans" and ignores the structural dimensions of police violence.[83] Obasogie and Newman argue that the history, text, and jurisprudence of the Fourth Amendment suggest that it was developed to address individual grievances, which raises questions regarding whether it is capable of speaking to group phenomena such as racialized police violence.[84] Other scholars have similarly argued that the Fourth Amendment precipitates disproportionate police contact with racial minorities, in that it codifies rather than limits the ability of police to harass and inappropriately use force on people of color.[85]

These arguments regarding the role of race in Fourth Amendment jurisprudence give rise to more particular claims concerning the nature of excessive-force jurisprudence. For example, Paul Butler does not mince words in his book *Chokehold: Policing Black Men* when he states, "The problem is the criminal process itself. Cops routinely hurt and humiliate black people because that is what they are paid to do. Virtually every objective investigation of a U.S. law enforcement agency finds that the police, *as policy*, treat African Americans with contempt."[86] Butler argues that excessive use of force is police department policy that reflects explicit racism in policing and is essentially sanctioned by federal courts.[87] Similarly, Alice Ristroph resists claims that the rules pertaining to police use of force suffer from constitutional ambiguity and argues that the seizure authority given to police under the Fourth Amendment predictably leads to excessive and deadly uses of force.[88] This constitutive approach—that is, that law constitutes or produces these outcomes[89]—aligns with concerns of explicit

83. Devon W. Carbado & Patrick Rock, *What Exposes African Americans to Police Violence?*, 51 HARV. C.R.-C.L. L. REV. 159, 161 (2016).

84. Obasogie & Newman, *supra* note 42, at 1470–75.

85. *See, e.g.*, Maclin, *supra* note 81, at 337–40; Jordan Blair Woods, *Decriminalization, Police Authority, and Routine Traffic Stops*, 62 UCLA L. REV. 672, 683–84 (2015).

86. BUTLER, *supra* note 18, at 2.

87. *Id.* at 187–89.

88. Alice Ristroph, *The Constitution of Police Violence*, 64 UCLA L. REV. 1182 (2017).

89. Ristroph notes that:

> [T]he usual critiques of police shootings operate on the underlying assumption that the officer who chose to shoot made a bad choice against a backdrop of reasonable, if somewhat indeterminate, legal guidelines. Responsibility for the killings is placed with the officers (or, in the view of the officers' defenders, with the noncompliant suspects) and not with the constitutional doctrine that structures police authority, nor with the people who have crafted that doctrine, nor with The People on whose behalf the doctrine is said to be crafted.
>
> This focus on the officer overlooks what it [*sic*] is sometimes called the constitutive function of constitutional law.

racism articulated by Butler and others in that it suggests that excessive use of force by the police is a feature of modern policing, not an aberration.

Butler, Ristroph, and others make these claims about the persistent role of explicit racial bias in policing against what has become an increasingly popular explanation for the racially disproportionate nature of police excessive force: implicit bias. Social psychologists have developed experimental exercises suggesting that much of the decision-making concerning policing, including use of force, is driven by unconscious bias rather than a singular conscious disdain for minority groups.[90] For example, L. Song Richardson writes that "unconscious racial biases and implicit white favoritism can result in racial disparities in police violence."[91] This research has led to the emergence and growth of implicit bias training for police officers that attempts to reduce force incidents and their disproportionate impact on communities of color.[92] From this standpoint, reducing police use of force is not simply a matter of changing tactics or refining judicial interpretations of which behaviors are reasonable under the Fourth Amendment. It also involves broader institutional and structural shifts that can change the cognitive biases of officers.

It is clear that the legacy of explicit racial bias in criminal procedure continues to shape interpretations and applications of the Fourth Amendment,[93] while implicit bias has been shown to impact the decision-making of many professionals, including those working in law and medicine.[94] Yet this Article takes a more constitutive[95] approach to understanding the relationship between

---

Id. at 1187 (footnote omitted).

90. *See, e.g.*, Jennifer L. Eberhardt, Phillip Atiba Goff, Valerie J. Purdie & Paul G. Davies, *Seeing Black: Race, Crime, and Visual Processing*, 87 J. PERSONALITY & SOC. PSYCH. 876 (2004); LORIE A. FRIDELL, PRODUCING BIAS-FREE POLICING 7–29 (2017).

91. L. Song Richardson, *Police Racial Violence: Lessons from Social Psychology*, 83 FORDHAM L. REV. 2961, 2962 (2015).

92. *See, e.g.*, Al Baker, *Confronting Implicit Bias in the New York Police Department*, N.Y. TIMES (July 15, 2018), https://www.nytimes.com/2018/07/15/nyregion/bias-training-police.html [https://perma.cc/2B92-WHLT]; Tom James, *Can Cops Unlearn Their Unconscious Biases?*, ATLANTIC (Dec. 23, 2017), https://www.theatlantic.com/politics/archive/2017/12/implicit-bias-training-salt-lake/548996 [https://perma.cc/CWV8-QFST].

93. *See, e.g.*, Carbado, *supra* note 82; BUTLER, *supra* note 18.

94. *See, e.g.*, IMPLICIT RACIAL BIAS ACROSS THE LAW (Justin D. Levinson & Robert J. Smith eds., 2012); DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015).

95. Constitutive approaches to understanding race and racism focus on the social and legal practices that make certain ideas about human difference thinkable and coherent. Our understanding of human groups does not stem from isolated observations that impress social meaning upon us. Rather, an entire network of social practices creates the conditions for us to see the world and interpret differences in specific ways. Understanding this conditioning process that constitutes people's worldview on race and other matters can help us understand how race (and practices that we create around the idea of human difference) are created, maintained, and justified. For an extended conversation, see OSAGIE K. OBASOGIE, BLINDED BY SIGHT: SEEING RACE THROUGH THE EYES OF THE BLIND (2014). This constitutive approach to race aligns strongly with the constitutive approaches to law as described by Ristroph, *supra* note 88. Race and law are mutually constitutive, meaning that the existing configuration of one is not possible without the other. Both inform the legitimation of

the Fourth Amendment, chemical restraints, and minority communities. This approach is attentive to the set of social and legal conditions that make it possible for law enforcement and medical professionals to think that injecting arrestees with powerful drugs comports with their professional, legal, and ethical obligations.

In light of the broad literature on the Fourth Amendment and use of force, it is curious that there is little research that explores the constitutional implications of use of force by medical professionals who partner with law enforcement. Excessive force is largely conceptualized in legal scholarship in one way: bad cops who violently attack community members. Given the shifting social and political climate where people are demanding that police officers use less violent tools when engaging the community, it is important to take a close look at medical professionals' use of chemical restraints in public settings as a way to understand how force and its implications may be changing. The ketamine incidents in Minneapolis provide a helpful case study for examining these issues. The next Section discusses the situation in Minneapolis to explore the Fourth Amendment implications that may arise when medical providers use chemical restraints to induce compliance with law enforcement and whether this practice might constitute a form of excessive force.

II.
MEDICAL PROFESSIONALS AND CHEMICAL RESTRAINTS

John Powell's detainment by Minneapolis police and nearly fatal chemical restraint by paramedics[96] demonstrates how alternative forms of force thought to be less lethal may raise many of the same concerns as traditional uses of force. In this Section, we begin by investigating the use of chemical restraints in healthcare settings to understand and compare their use in pre-clinical settings for law enforcement purposes. Through our analysis of a Minneapolis-area study designed to test ketamine's efficacy when used by paramedics in the field, we examine how ketamine as a chemical restraint shifted from a medical to a criminal justice tool in Minneapolis and how blurred lines between healthcare and law enforcement can lead to Fourth Amendment issues that have gone largely unexplored.

A. Chemical Restraints in Healthcare Settings

Chemical restraints are used in healthcare settings to control people who exhibit agitation or other behavioral problems that might lead them to harm themselves or others. Medical professionals often prefer sedating patients instead of using physical restraints that can make it more difficult to treat patients in

practices and roles that shape police use of force. *See generally* Laura E. Gómez, *Understanding Law and Race as Mutually Constitutive: An Invitation to Explore an Emerging Field*, 6 ANN. REV. L. & SOC. SCI. 487 (2010).

96. Mannix, *supra* note 2.

need.[97] Much of the conversation surrounding the use of chemical restraints has occurred in nursing homes, although they are not uncommon in other areas such as psychiatric care facilities and emergency medicine.[98] These drugs can be taken orally or through injection (intramuscular and intravenous), depending on the cooperation of the patient.[99]

There are three different types of drugs that medical providers typically use to chemically restrain agitated patients. The first set of drugs are known as *benzodiazepines*, which are primarily used to treat anxiety by impacting brain neurotransmitters.[100] Lorazepam is a favorite of this class of medication among providers when used as a chemical restraint "because of its rapid onset, lack of active metabolites, effectiveness in patients intoxicated with a sympathomimetic agent such as cocaine, and availability in oral, IM, and IV formulations."[101] Midazolam is another *benzodiazepine* used to subdue agitated or confused patients. The second type of drug used for chemical restraint are *typical antipsychotics*. They are helpful when treating agitated patients suffering from a preexisting psychiatric problem. While these drugs can be used in conjunction with *benzodiazepines*, some typical antipsychotics like Haloperidol are known to cause significant side effects, including severe muscle spasms and contractions known as extrapyramidal syndrome that, in limited instances, have emerged in patients days after a single dose.[102] Lastly, a new generation of *atypical antipsychotics* are also used for chemical restraint. This includes drugs such as Olanzapine, Risperidone, and Ziprasidone. Atypical antipsychotic drugs are generally seen as an improvement over the previous generation, in that they "provide more tranquilization and less sedation . . . [while also having a] lower incidence of [extrapyramidal syndrome] from the serotonergic activity."[103]

---

97. Coburn and Mycyk note that:

> Physical restraints can be counterproductive because struggling against restraints may prevent obtaining a history or completing a thorough physical examination. Chemical restraints can help gain better control of the agitated patient and allow evaluation and treatment. Complications associated with struggling against physical restraints, such as hyperthermia, dehydration, rhabdomyolysis, or lactic acidosis, can all be minimized with the early use of chemical sedation.

Victoria A. Coburn & Mark B. Mycyk, *Physical and Chemical Restraints*, 27 EMERGENCY MED. CLINICS N. AM. 655, 660 (2009) (footnote omitted).

98. *See generally Chemical Restraint in the ED*, ACEP NOW (Dec. 1, 2012), https://www.acepnow.com/article/chemical-restraint-ed/?singlepage=1 [https://perma.cc/PVL6-TWYZ].

99. "[I]f no immediate threat is displayed and the patient is cooperative, oral medications should be considered as first-line therapy, followed by either IM or IV administration, depending on the medication choice and ease of access." Benjamin B. Mattingly & Andrew D. Small, *Chemical Restraint*, MEDSCAPE (Nov. 21, 2016), https://emedicine.medscape.com/article/109717-overview#a2 [https://perma.cc/CZK7-YS8T].

100. Richard I. Shader & David J. Greenblatt, *Use of Benzodiazepines in Anxiety Disorders*, 328 NEW ENGLAND J. MED. 1398 (1993).

101. Coburn & Mycyk, *supra* note 97, at 662.

102. *Id.* at 660.

103. *Id.* at 661.

It is important to note that the Food and Drug Administration has not approved any of the drugs used as chemical restraints in healthcare settings. These drugs are developed and approved for patients suffering from specific psychiatric and behavioral disorders, yet are used off-label as chemical restraints on patients largely without regard to whether they have been diagnosed with these indicated health concerns.[104] Indeed, using these drugs for their calmative effect rather than indicated purpose is a key aspect of chemical restraint, in that they are not necessarily *prescribed* to a patient, but used singularly, intermittently, or as needed to change patients' mood or behavior. In a 2007 hearing before a House subcommittee on Oversight and Investigations, Associate Director Dr. David Graham of the FDA Office of Surveillance and Epidemiology warned of the dangers of this approach:

> I would pay careful attention to antipsychotic medications. . . . The trend is the atypicals because they reputedly have a better safety profile, a lower side effect profile. . . . The problem with these drugs are [*sic*] that we know that they are being used extensively off label in nursing homes to sedate elderly patients with dementia and other types of plot [*sic*] disorders. It is known that the drugs don't work in those settings. And it is off label, they just do what they want. But the fact is, is that it increases mortality perhaps by 100 percents [*sic*]. It doubles mortality. So I did a back-of-the-envelope calculation on this and you have probably got 15,000 elderly people in nursing homes dying each year from the off-label use of antipsychotic medications for an indication that FDA knows the drug doesn't work. This problem has been known to FDA for years and years and years . . . .[105]

As Dr. Graham noted, even in controlled environments such as hospitals and nursing homes, the use of powerful drugs to sedate rather than treat a diagnosed illness can lead to patient harm and premature death.

B. Federal Regulations on Chemical Restraints in Healthcare

Developments in nursing home standards played an important role in establishing the current legal and regulatory framework governing the use of chemical restraints in healthcare settings. When Medicare and Medicaid were established in 1965, nursing home standards "were weak and all but a few nursing facilities were able to meet the standards, despite reports of poor quality care."[106] Subsequent federal legislation in 1967 and 1972 also missed the mark,

---

104. Krista Maier, *Chemical Restraints and Off-Label Drug Use in Nursing Homes*, 16 MICH. ST. U. J. MED. & L. 243, 255–56 (2012).

105. *The Adequacy of FDA to Assure the Safety of the Nation's Drug Supply: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Com.*, 110th Cong. 66 (2007) (statement of David J. Graham, Associate Director, Science and Medicine, FDA Office of Surveillance and Epidemiology).

106. JOSHUA M. WIENER, MARC P. FREIMAN & DAVID BROWN, NURSING HOME CARE QUALITY 3 (2007),

as it "focused on nursing homes' ability to provide care rather than the quality of care received by residents—in other words, structure rather than process and outcome."[107] The Reagan Administration's attempt to loosen government oversight of nursing homes was strongly opposed by consumer advocates who worked closely with Congress, which twice passed legislation to thwart the Administration's efforts.[108] This impasse was resolved by requesting an independent assessment from the Institute of Medicine (IOM) in 1986 to study the condition of nursing homes in the United States so as "to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care."[109] The report produced by the IOM committee, titled *Improving the Quality of Care in Nursing Homes*, "proposed sweeping reforms, most of which became law in 1987 with the passage of the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987."[110]

Title 42 of the Code of Federal Regulations contains implementing regulations for this Act. For example, 42 C.F.R. § 483 clearly states that residents at nursing facilities have "[t]he right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."[111] After the Nursing Home Reform Act was passed, nursing home oversight was split between the federal government and states, with the Centers for Medicare and Medicaid Services (CMS) enacting regulations that states had to implement to ensure compliance by individual nursing homes.[112] The CMS manual defines chemical restraints as "any drug that

---

https://pdfs.semanticscholar.org/41fc/9bfef13d1a3591cf84ba37ebd48b729c4e7e.pdf?_ga=2.143089269.1592105359.1579408484-1604635965.1578888055 [https://perma.cc/2UEN-EGFQ].

107. *Id.*

108. *Id.* at 5.

109. COMM. ON NURSING HOME REGUL., INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 1 (1986).

110. Martin Klauber & Bernadette Wright, *The 1987 Nursing Home Reform Act*, AARP, https://www.aarp.org/home-garden/livable-communities/info-2001/the_1987_nursing_home_reform_act.html [https://perma.cc/48RT-V9BW].

111. 42 C.F.R. § 483.10(e)(1) (2019); *see also* 42 U.S.C. § 1396r(c)(1)(A)(ii) (2018) ("[Patients have t]he right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed (I) to ensure the physical safety of the resident or other residents, and (II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).").

112.

> The federal Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring that all healthcare providers that participate in the Medicare and/or Medicaid programs are in compliance with federal health and safety standards. To ensure that nursing homes that participate in one or both of these programs (the vast majority of U.S. nursing homes) meet these standards, CMS delegates responsibility to state governments, which oversee quality assurance in the nursing homes within their states. This delegation is carried out through a written contract with each state, usually a state's department of health (DOH), to conduct surveys (inspections) of individual nursing homes as well as to provide other

is used for discipline or convenience and not required to treat medical symptoms"[113] and prioritizes patient autonomy as stated in Section 483.[114] Similarly, 42 C.F.R § 482.13, promulgated in 1986, conditions hospital participation in Medicare and Medicaid on whether "[a]ll patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff."[115] To be sure, chemical restraints are still used in hospitals and nursing home settings.[116] But legal and professional trends since these regulations were enacted in the 1980s have moved away from using chemical restraints to ease the work of staff members and to only using them to ensure patient and staff safety.[117] Many states have

---

> quality assurance functions, such as responding to consumer complaints about a facility's care. Because these contractual activities are the principle means by which providers are held accountable for meeting federal standards, they are critical to ensuring both quality of care for nursing home residents across the country as well as appropriate use of the government funding that pays for a substantial portion of nursing home care. Thus, the efficacy of CMS's oversight of each state agency's performance in its surveying and oversight activities, as dictated by these contracts, is crucial.

CYNTHIA RUDDER, RICHARD J. MOLLOT, MAGGIE BAUMER & IAN DRISCOLL, GOVERNMENT MONITORING & OVERSIGHT OF NURSING HOME CARE: THE RELATIONSHIP BETWEEN FEDERAL AND STATE AGENCIES 9 (2010) (footnotes omitted), https://theconsumervoice.org/uploads/files/issues/LTCCC-Report.pdf [https://perma.cc/PQ2X-QZDT].

113. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUM. SERVS., CMS MANUAL SYSTEM: PUB. 100-07 STATE OPERATIONS PROVIDER CERTIFICATION 3 (2016), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R157SOMA.pdf [https://perma.cc/TRA9-99ZX].

114. CMS regulations also state:

> Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. In this situation, the use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode. The facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.

Id. at 4.

115. 42 C.F.R. § 482.13(e) (2019).

116. *See* Maier, *supra* note 104, at 257. Maier notes that:

> Despite the regulations, nursing homes still use medications as a way to control residents. In 2001 over 27% of Medicare beneficiaries in nursing homes received an antipsychotic prescription—the highest level in over a decade. Yet, according to a 1999 study, only 8% of nursing home residents had been diagnosed with "other mental disorders." Further, a study of 2004 nursing home data revealed that over 86.3% of nursing home patients receiving an antipsychotic drug received it for an off-label use. Most of those patients had been diagnosed with dementia, and 63% of them were residents in a for-profit facility. Finally, over 75% of those beneficiaries were enrollees in either Medicare or Medicaid. While over time the percentage of residents receiving antipsychotic medications for off-label uses has decreased, in 2008, CMS reported that almost 20% of nursing home residents receiving antipsychotic medications did not have a psychotic or related diagnosis.

Id. at 256–57 (footnotes omitted).

117. Michael Silverman notes in *Emergency Physicians Monthly* that:

> More and more hospitals are changing their restraint policies or trying to go restraint free.

reaffirmed these values in their laws and regulations governing healthcare settings.[118]

While the Nursing Home Reform Act demonstrates a commitment to curtailing the use of chemical restraints in nursing facilities, it remains unclear whether the Act provided residents with an affirmative right to sue nursing homes that violate the rules regarding chemical restraints. Indeed, circuit courts have been inconsistent on whether the Nursing Home Reform Act authorizes a private cause of action for residents against nursing homes or if it creates rights that can be enforced by 42 U.S.C § 1983. The Ninth Circuit most recently addressed this issue in 2019, holding that the Act is sufficiently rights-creating such that it could be enforced via Section 1983.[119] In reaching that conclusion, it joined the Third Circuit, which has allowed Section 1983 claims as a vehicle to enforce rights under the Act since 2009.[120] Meanwhile, the Second Circuit, as well as several district courts, have held that the Act provides no cause of action for private plaintiffs or enforceable rights under Section 1983.[121] Perhaps because of this, as well as many nursing home residents' limited resources, there are few cases that interpret the regulations governing chemical restraints in nursing homes.[122] In the next Section, we move from discussing chemical

---

> The patient population in the ED often times has patients who will continue to require some sort of restraint to protect the patient and/or the staff. The goals of the provider are to diagnose and treat the patient's underlying medical problem which may require effectively using medications to help control the patient's symptoms so that they can be more participatory in their plan of care. Accurate and thorough documentation on these patients is critical.

Michael Silverman, *Restraints: All Holds Barred?*, EMERGENCY PHYSICIANS MONTHLY (Oct. 10, 2016), https://epmonthly.com/article/all-holds-barred [https://perma.cc/23HM-FQVM].

118. For example, the California Code of Regulations states that patients in healthcare facilities have the right:

> To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint . . . except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

CAL. CODE REGS. tit. 22, § 72527(a)(24) (2020). Similarly, state law in New York states that health care facilities must ensure that "the resident is free . . . from any psychotropic drug administered for purposes of discipline or convenience, and not required to treat the resident's medical conditions or symptoms . . . ." N.Y. COMP. CODES R. & REGS. tit. 10, § 415.4(a)(1) (2020).

119. Anderson v. Ghaly, 930 F.3d 1066, 1070 (9th Cir. 2019).

120. Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520 (3d Cir. 2009).

121. *See* Prince v. Dicker, 29 F. App'x 52, at *54 (2d Cir. 2002); Duncan v. Johnson–Mathers Health Care, Inc., No. 5:09-CV-00417-KKC, 2010 WL 3000718, at *10 (E.D. Ky. July 28, 2010); Baum v. N. Dutchess Hosp., 764 F. Supp. 2d 410, 425 (N.D.N.Y. 2011).

122. A search conducted in January 2020 of all cases citing the parts of the regulations that deal with chemical and physical restraints resulted in only 186 total cases, and of that set, only 5 cases mentioned "chemical" or "chemical restraint." None described clearly relevant fact patterns. In some cases, it is unclear from the fact pattern whether the issue pertained to physical or chemical restraint. *See, e.g.*, Lakeridge Villa Health Care Ctr. v. Leavitt, 202 F. App'x 903 (6th Cir. 2006). There is also evidence that concerns regarding chemical restraints in nursing homes are often brought under state law.

restraints in clinical settings to cases involving chemical restraints and their use in pre-hospital or public settings. As an example of how chemical restraints operate in public settings, we examine a Minneapolis clinical trial involving the use of ketamine as a chemical restraint and describe how chemical restraints can shift from a healthcare tool to a law enforcement tactic.

C. Chemical Restraints as Law Enforcement Tactic: Minneapolis Case Study

As Brandon Garrett and Seth Stoughton note in their article "A Tactical Fourth Amendment," there is growing concern that police officers do not have enough tactical guidance on how to properly diffuse tense situations without resorting to deadly force or other avoidable forms of violence.[123] While Garrett and Stoughton advocate reconstructing the existing constitutional test regarding "what counts" as excessive force,[124] others address tactical ambiguity in use-of-force law and policy by arguing for expanding the tools that are available to law enforcement. This has led to a growing number of researchers and law enforcement practitioners who are interested in exploring the use of chemical restraints as part of policing practice.[125] John Powell's detainment and chemical restraint in Minneapolis exemplifies how evolving norms regarding the use of force are creating Fourth Amendment challenges that have gone largely unaddressed. There are no official statistics on how often police officers partner with medical professionals to administer chemical restraints in pre-hospital settings. Thus, the Powell incident in Minnesota, where ketamine was used as a chemical restraint, provides unusual insight into how this practice may develop in different parts of the country.[126]

See, e.g., Fiala v. Bickford Senior Living Grp., LLC, 43 N.E.3d 1234 (Ill. App. Ct. 2015) (bringing a claim under the Illinois Nursing Home Care Act, 210 ILL. COMP. STAT. 45/1-101 et seq. (West 2014)); Robicheaux v. Adly, 827 So. 2d 429 (La. Ct. App. 2002) (bringing a claim that, in part, concerns chemical restraints under Louisiana's Patient's Bill of Rights, LA. STAT. ANN. § 40:2010.8(A)(9) (2020)).

123. Garrett and Stoughton note:

> As ongoing public controversy over high-profile police killings drives home, the rules governing police use of force remain deeply contested. Members of the public may assume that police rules and procedures provide detailed direction about when officers can use deadly force. However, many agencies train officers to respond to threats according to a force "continuum" that does not provide hard-edged rules for when police can use deadly force. Nor, as recent cases have illustrated, does a criminal prosecution under state law readily lend itself to defining when police uses of force are appropriate.

Garrett & Stoughton, *supra* note 72, at 213.

124. *Id.* at 275 n.282.

125. *See, e.g.*, Danielle M. Weiss, *Calming Down: Could Sedative Drugs Be a Less-Lethal Option?*, NAT'L INST. JUST. (October 2008), https://nij.ojp.gov/topics/articles/calming-down-could-sedative-drugs-be-less-lethal-option [https://perma.cc/YJ6L-8C8S]; LAKOSKI ET AL., *supra* note 20.

126. For other examples of ketamine being used as a chemical restraint by law enforcement, see Schmelzer, *supra* note 28; Blizzard, *supra* note 28.

1. Ketamine's Accepted Medical Uses

Law enforcement researchers and policymakers currently favor a wider range of drugs for use as chemical restraints than what is typically used in healthcare settings.[127] While it is common for healthcare professionals to use benzodiazepines, typical antipsychotics, and atypical antipsychotics, researchers examining the use of chemical restraints in law enforcement have looked beyond these three drug classes to identify over a hundred different compounds that could be administered.[128] Ketamine has become a popular choice.

Developed in 1962 and approved for human use in 1970, ketamine quickly became a widely used battlefield anesthetic during the Vietnam War.[129] Its properties made it possible for physicians to perform painful surgeries in remote locations. As a dissociative anesthetic, ketamine distorts perception of sight and sounds, produces feelings of detachment from the environment and one's self, and induces insensitivity to pain.[130] The drug "exerts its effect by 'disconnecting' the thalamocortical and limbic systems [of the brain], effectively dissociating the central nervous system from outside stimuli (eg [*sic*], pain, sight, sound)."[131] Its effects put one in a "trancelike cataleptic state of 'sensory isolation' . . . characterized by potent analgesia, sedation, and amnesia while maintaining cardiovascular stability and preserving spontaneous respirations and protective airway reflexes."[132]

Today, ketamine continues to be used to facilitate sedation during surgery.[133] It is the most popular drug for painful surgical procedures in children.[134] It is sold under the brand name Ketalar and in generic versions as an injection.[135] According to its FDA-approved product labeling, the drug can be used for the following purposes: (1) "as the sole anesthetic agent for diagnostic and surgical procedures that do not require skeletal muscle relaxation;" (2) "for the induction of anesthesia prior to the administration of other general anesthetic agents;" and (3) "to supplement low-potency agents, such as nitrous oxide."[136] When used for these approved purposes, ketamine has several potential side-

127. *See generally* LAKOSKI ET AL., *supra* note 20; Weiss, *supra* note 125.

128. *See* LAKOSKI ET AL., *supra* note 20, at 15–16.

129. *Ketamine*, CTR. FOR SUBSTANCE ABUSE RSCH. (Oct. 29, 2013), http://www.cesar.umd.edu/cesar/drugs/ketamine.asp [https://perma.cc/D84Y-GFY5].

130. *Id.*

131. Steven M. Green, Mark G. Roback, Robert M. Kennedy & Baruch Krauss, *Clinical Practice Guideline for Emergency Department Ketamine Dissociative Sedation: 2011 Update*, 57 ANNALS EMERGENCY MED. 449, 449 (2011).

132. *Id.* (footnote omitted).

133. *Ketamine*, JOHNS HOPKINS ALL CHILDREN'S HOSP., https://www.hopkinsallchildrens.org/patients-families/health-library/healthdocnew/ketamine [https://perma.cc/B8BY-2PG3]; Green et al., *supra* note 131, at 449.

134. Green et al., *supra* note 131, at 449.

135. PAR PHARM., KETALAR (KETAMINE HYDROCHLORIDE) INJECTION 3, https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/016812s043lbl.pdf [https://perma.cc/6Z43-LXWM].

136. *Id.* at 3.

effects, including "severe depression of respiration or apnea," "airway obstruction," and psychological "emergence reactions" involving "dream-like states, vivid imagery, hallucinations, and emergence delirium."[137]

In addition to its legitimate medical purposes, ketamine is illegally used for recreational purposes.[138] People use it to experience hallucinations and to feel separated from their bodies.[139] Ketamine can, however, cause "a terrifying sense of almost complete detachment that may feel like a near-death experience" and is similar to having a "bad trip on LSD."[140] Ketamine is also one of the three most commonly used drugs for sexual assault.[141] It is favored by perpetrators because it comes in a clear liquid form that cannot easily be detected when added to drinks and very quickly renders a victim unconscious.[142]

Ketamine has been tested experimentally in public settings as a drug to relax and calm people experiencing different levels of agitation. Paramedics responding to emergency 9-1-1 calls conducted these experiments. In these studies, if the paramedic determined that a person is sufficiently agitated to qualify for inclusion in the research, the paramedic gave the subject an experimental dose of ketamine before transporting them to the hospital. Researchers in one such study found that in nearly half of all cases, the patient experienced dangerous complications, including depressed breathing for a period long enough to require intubation.[143] We will now turn to a discussion of how a hospital organization in Minneapolis carried out these experiments, often in collaboration with the police.

2. Minneapolis Case Study: Experiments Using Ketamine in Emergency Medicine

Physicians at the Minneapolis-based hospital organization Hennepin Healthcare conducted two clinical trials that involved paramedics using ketamine on community members. The purpose of the experiments was to test ketamine's efficacy in sedating people experiencing "acute undifferentiated agitation."[144] In the experiments, paramedics responded to 9-1-1 calls-for-service about medical emergencies and then administered ketamine to agitated

137. *Id.* at 1, 4, 7 (capitalization altered).

138. JOHNS HOPKINS ALL CHILDREN'S HOSP., *supra* note 133.

139. *Id.*

140. *Id.*

141. *Date Rape Drugs*, OFF. ON WOMEN'S HEALTH (Apr. 26, 2019), https://www.womenshealth.gov/a-z-topics/date-rape-drugs [https://perma.cc/9PZ5-6ATP].

142. *Id.*

143. Jon B. Cole, Johanna C. Moore, Paul C. Nystrom, Benjamin S. Orozco, Samuel J. Stellpflug, Rebecca L. Kornas, Brandon J. Fryza, Lila W. Steinberg, Alex O'Brien-Lambert, Peter Bache-Wiig, Kristin M. Engebretsen & Jeffrey D. Ho, *A Prospective Study of Ketamine Versus Haloperidol for Severe Prehospital Agitation*, 54 CLINICAL TOXICOLOGY 556, 556 (2016) (finding, in a clinical trial of ketamine versus haloperidol in prehospital settings, that complications occurred in 49 percent of patients that received ketamine and that 39 percent of subjects had to be intubated).

144. *Id.*

patients before transporting them to the hospital.[145] Many, though not all, of these incidents involved law enforcement encouraging or directing paramedics to inject agitated individuals with ketamine after they were arrested or detained. Nevertheless, this set of experiments provides a context for understanding how law enforcement often became active participants in the decision to administer ketamine. As we discuss in more detail below, Hennepin Healthcare did not require paramedics to obtain patients' informed consent before enrolling them in the experiments and giving them trial doses of ketamine.[146] Researchers designed the studies to compare ketamine with the two most commonly used drugs for treating "agitation"—haloperidol and midazolam.

When used in medical terminology, "agitation" refers to "a temporary disruption of typical physician–patient collaboration . . . [which] interfere[s] with assessment and treatment during a period when immediate treatment is necessitated."[147] An agitated individual might exhibit "motor restlessness, heightened responsivity to internal and external stimuli, irritability, [or] inappropriate or purposeless verbal or motor activity . . . ."[148] More severe forms of agitation might involve "explosive and/or unpredictable anger; intimidating behavior; restlessness, pacing, or excessive movement; physical and/or verbal self-abusiveness; demeaning or hostile verbal behavior; uncooperative or demanding behavior or resistance to care; and impulsive or impatient behavior or low tolerance for pain or frustration."[149]

The first Minneapolis-based study on the use of ketamine to treat agitation began in October 2014. The study was designed to compare the effects of ketamine to haloperidol.[150] Throughout the one-year study, paramedics responding to emergency calls-for-service determined if patients qualified and, if so, enrolled the patients as subjects. For the first three months of the study, paramedics treated enrolled subjects with haloperidol. For the next six months, haloperidol was removed from all ambulances, and paramedics treated subjects with ketamine. Then for the final three months, paramedics went back to treating subjects with haloperidol.[151] To measure the efficacy of ketamine and haloperidol, paramedics used stopwatches to record how long it took patients to

145. *Id.*

146. *Id.*

147. Michael H. Allen, *Managing the Agitated Psychotic Patient: A Reappraisal of the Evidence*, 61 J. CLINICAL PSYCHIATRY (SUPP. 14) 11, 12 (2000).

148. Bruno Pacciardi, Mauro Mauri, Claudio Cargioli, Simone Belli, Biagio Cotugno, Luca Di Paolo & Stefano Pini, *Issues in the Management of Acute Agitation: How Much Current Guidelines Consider Safety?*, 4 FRONTIERS PSYCHIATRY, May 2013, at 1, 1.

149. Michael H. Allen, Glenn W. Currier, Daniel Carpenter, Ruth W. Ross & John P. Docherty, *Introduction: Methods, Commentary, and Summary*, 11 J. PSYCHIATRIC PRAC. (SUPP. 1) 5, 9 (2005).

150. Cole et al., *supra* note 143, at 557.

151. *Id.*

reach sedation after administering either drug.[152] Paramedics also recorded complications and whether individuals had to be intubated.[153]

Patient consent was not required before enrolling in the study because Hennepin Healthcare's institutional review board (IRB)—the organization tasked with reviewing human subjects research—decided that the study was eligible for a waiver.[154] 45 C.F.R. § 46.116 allows such a waiver when: (1) the research "involves no more than minimal risk to the subjects"; (2) "[t]he research could not practicably be carried out without the requested waiver or alteration"; (3) the waiver "will not adversely affect the rights and welfare of the subjects"; and (4) subjects are provided, when available, with additional information and details after they participate in the trial.[155] Hennepin Healthcare did perform a "community consultation" with "caregivers affected by [the] study as well as a select group of patients at a local homeless shelter's inpatient chemical dependency program," "given the particularly vulnerable nature of this patient population."[156]

To determine who qualified for the study, paramedics used the Altered Mental Status Scale (AMSS). The AMSS assesses levels of alertness or sedation, agitation, or intoxication.[157] The scale allows medical providers to assign scores

---

152. *Id.*

153. *Id.*

154. *Id.*

155. *See* 45 C.F.R. § 46.116(f)(3)(i)–(v) (2020). "[M]inimal risk" means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations. 45 CFR §§ 46.102(i); 46.116(f)(3)(i)–(v) (2020). There is an additional regulation allowing informed consent requirements to be waived in emergency-medicine research. 21 C.F.R. § 50.24 (2020). This regulation does not require an IRB to find that the research involves no more than minimum risks. *See id.*; U.S. DEP'T OF HEALTH & HUM. SERVS. ET AL., GUIDANCE FOR INSTITUTIONAL REVIEW BOARDS, CLINICAL INVESTIGATORS, AND SPONSORS: EXCEPTION FROM INFORMED CONSENT REQUIREMENTS FOR EMERGENCY RESEARCH (2013). Instead, the regulation allows a waiver where:

> 1) the research involves human subjects who cannot give consent because of life-threatening medical conditions; 2) the condition requires immediate intervention; 3) available treatments are unproven or unsatisfactory and further research is needed to determine which therapy is best; 4) the research might provide benefit to the study subject; 5) clinical equipoise exists between the study and standard treatment; 6) the research cannot occur without the exception; 7) intervention must start before consent from a legally authorized representative is feasible and there is no way to identify likely subjects prospectively; 8) the primary investigator attempts to contact, within the therapeutic widow [sic], the legally authorized representative or a family member who might object; and 9) the primary investigator has provided an informed consent document to use if and when feasible.

Terri A. Schmidt et al., *Confronting the Ethical Challenges to Informed Consent in Emergency Medicine Research*, 11 ACAD. EMERGENCY MED. 1082, 1087 (2004). It is important to also note that the researchers in the Minneapolis trial relied upon the pre-2018 version of 45 C.F.R § 46.116. After the revision to the Common Rule in 2018, this part of the statute was amended to include an additional grounds for waiver regarding the use of "identifiable private information or identifiable biospecimens," provided that "the research could not practicably be carried out without using such information or biospecimens in an identifiable format." 45 C.F.R § 46.116(f)(3)(iii) (2020).

156. Cole et al., *supra* note 143, at 557.

157. *Id.*

to an individual based off the medical providers' observations of the individual's responsiveness, speech, facial expressions, and eyes.[158] Qualified patients presented with "severe acute undifferentiated agitation,"[159] which the study defined as an AMSS score of 2 or 3. A score of 2 corresponds to "[a]nxious, agitated" responsiveness, "[l]oud outbursts" in speech, and "[n]ormal" facial expressions and eyes, while a score of 3 corresponds to "[v]ery anxious, agitated" responsiveness with a "mild physical element of violence," "[l]oud outbursts" in speech, "[a]gitated" facial expressions, and "[n]ormal" eyes.[160] The trial excluded patients with profound agitation, which was defined as an AMSS score of 4 ("[c]ombative, very violent, or out of control").[161] These patients were excluded because the researchers' institution "deemed it unethical and unwise to withhold ketamine from the most profoundly agitated patients at any time for both patient and caregiver safety."[162]

The results of the study showed that ketamine worked faster than the previous treatment but also caused significant problems. The median time to sedation using ketamine was only five minutes, whereas the median time using haloperidol was seventeen minutes.[163] However, 49 percent of patients receiving ketamine experienced complications, compared to just 5 percent of those receiving haloperidol.[164] Subjects receiving ketamine were almost ten times more likely to have breathing problems that required intubation.[165] In total, 39 percent of patients receiving ketamine had to be intubated due to some form of airway obstruction, whereas only 4 percent of patients receiving haloperidol required intubation.[166]

It is likely that these results were not surprising, as many of the researchers knew prior to the study that ketamine posed great risks. Indeed, approximately two years before this trial, many of the same investigators published a paper in *Prehospital Emergency Care* that presented two case reports on the use of prehospital ketamine for the management of what is thought to be the most profound type of agitation, known as excited delirium syndrome.[167] In that paper, they explicitly warned that ketamine should only be considered as a treatment

158. *Id.*
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.*
163. *Id.* at 560.
164. *Id.* at 560–61.
165. *Id.* at 556.
166. *Id.* at 560.
167. Jeffrey D. Ho, Stephen W. Smith, Paul C. Nystrom, Donald M. Dawes, Benjamin S. Orozco, Jon B. Cole & William G. Heegaard, *Successful Management of Excited Delirium Syndrome with Prehospital Ketamine: Two Case Examples*, 17 PREHOSPITAL EMERGENCY CARE 274, 274 (2013). For a critical discussion of excited delirium syndrome, see Michael Barajas, *Excited. Delirious. Dead.*, TEX. OBSERVER (Oct. 16, 2017), https://www.texasobserver.org/excited-delirious-dead/ [https://perma.cc/P7WZ-2TBN].

for extreme instances of agitation and that it should not be used in patients with lesser degrees of agitation (including severe agitation and acute agitation) because of the drug's known toxicities. They warned:

> We would caution against using ketamine sedation in situations that do not warrant the immediate need for interruption of the severe, life-threatening, metabolic acidosis/catecholamine surge crisis seen in late-stage [excited delirium syndrome]. . . . We would advocate that ketamine not be the chemical solution for every unruly or belligerent subjects [*sic*], as this would lead to overuse with unnecessary risk.[168]

Despite these recommendations, the researchers decided to proceed with the 2014 study. And then, after finding that ketamine posed a significantly higher rate of complications, many of the same researchers decided to conduct yet another study in August 2017.

This second trial was also done under the auspices of Hennepin Healthcare and compared the efficacy of ketamine to midazolam.[169] This study largely mirrored the first in terms of research design. Qualifying participants were given ketamine for the first six months of the study and midazolam in the second six months.[170] Paramedics recorded the time it took each drug to sedate individuals and whether individuals suffered from complications and needed intubation.[171] This time, however, the study had more prospective participants because it included both severely agitated and profoundly agitated patients.[172] Hennepin Healthcare again waived informed consent requirements based on its assessment that the study involved no more than minimum risks.[173] The trial was suspended on June 25, 2018, after details about the study were exposed by the *Minneapolis Star Tribune*.[174]

The public was eventually made fully aware of Hennepin Healthcare's experimental use of ketamine after the Minneapolis Office of Police Conduct Review (OPCR), a neutral agency that investigates police misbehavior, issued a report revealing the use of the drug in situations involving paramedics and police officers.[175] The OPCR investigation started after a Fall 2017 audit of police body camera footage of use-of-force incidents revealed multiple episodes where paramedics injected detained or arrested individuals with an unknown substance that made them fall unconscious.[176] Several police reports identified the drug

168. *Id.* at 277.

169. HENNEPIN HEALTHCARE RSCH. INST., *Ketamine Versus Midazolam for Prehospital Agitation*, CLINICALTRIALS.GOV (Apr. 5, 2019), https://clinicaltrials.gov/ct2/show/NCT03554915 [https://perma.cc/UA9D-JJZ2].

170. *Id.*

171. *Id.*

172. *Id.*

173. *Id.*

174. MINNEAPOLIS, MPD INVOLVEMENT IN PRE-HOSPITAL SEDATION 4 (2018) [hereinafter OPCR REPORT].

175. *See generally id.*

176. *Id.* at 3.

administered as ketamine.[177] The OPCR reported its findings to the Minneapolis director of civil rights, who instructed the OPCR to begin a thorough investigation of the use of ketamine in calls-for-service involving the Minneapolis Police Department (MPD).[178] In the course of that investigation, an anonymous source released a draft version of the report to the media.[179]

The final report was released in July 2018 and concluded that the number of police reports mentioning ketamine increased from two in 2010 to sixty-two in 2017.[180] In one case, ketamine had been administered four separate times to the same person.[181] The report includes demographic information about the people involved in the incidents from 2016 to 2017. Black community members were disproportionately represented,[182] comprising 40 percent of the people injected with ketamine yet only constituting 19.4 percent of the Minneapolis population.[183] These figures should be understood in the context of other racial disparities regarding policing in Minneapolis, which includes using force against Black people seven times more often than against white people.[184] Moreover, Minneapolis's racial inequalities in policing are compounded by racial disparities in other areas, including income, unemployment, poverty, homeownership, incarceration, and education.[185] These concurrent and overlapping inequalities create a social context where the overall devaluation of the Black community can lead to the increased, and often unnecessary, use of dangerous chemical restraints by paramedics.

OPCR analysts found and reviewed body-camera footage of eight instances that took place between 2016 and 2018. In these incidents, the footage showed Minneapolis Police Department officers participating in the decision to administer ketamine.[186] This participation ranged from officers telling medics to

177. *Id.*

178. *Id.*

179. *Id.* at 6.

180. *Id.* at 10.

181. *Id.*

182. *Id.* app. 5. Race was reported by the officers. The racial demographics of the citizens involved in the incidents were as follows: 40 percent Black, 39 percent White, 10 percent American Indian/Alaskan Native, 9 percent Other/Mixed Race, 2 percent Unknown/Unreported. *Id.*

183. *QuickFacts: Minneapolis City, Minnesota*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/minneapoliscityminnesota [https://perma.cc/LA6P-KA72].

184. Richard A. Oppel Jr. & Lazaro Gamio, *Minneapolis Police Use Force Against Black People at 7 Times the Rate of Whites*, N.Y. TIMES (June 3, 2020), https://www.nytimes.com/interactive/2020/06/03/us/minneapolis-police-use-of-force.html [https://perma.cc/5WB6-PZ3B].

185. Greg Rosalsky, *Minneapolis Ranks Near the Bottom for Racial Equality*, NPR (June 2, 2020, 6:30 AM), https://www.npr.org/sections/money/2020/06/02/867195676/minneapolis-ranks-near-the-bottom-for-racial-equality [https://perma.cc/A2MR-2WVE]; *see also* Christopher Ingraham, *Racial Inequality in Minneapolis is Among the Worst in the Nation*, WASH. POST (May 30, 2020), https://www.washingtonpost.com/business/2020/05/30/minneapolis-racial-inequality [https://web.archive.org/web/20200603053057/https://www.washingtonpost.com/business/2020/05/30/minneapolis-racial-inequality/].

186. OPCR REPORT, *supra* note 174, at 10.

bring ketamine ("When EMS gets here, just tell them to bring the ketamine in") to instances where medics asked the officers whether the individual should be sedated ("You guys want us to give him something?").[187] Though officers did not inject anyone, they often assisted by holding down or restraining individuals while paramedics administered the drug.[188] Individuals who were given ketamine as a chemical restraint were also physically restrained with handcuffs in 88 percent of cases, restrained by EMS devices (typically stretchers with straps) in 43 percent of cases, had spit hoods[189] placed on them in 33 percent of cases, and were secured with hobbles or leg restraints in 15 percent of cases.[190] At the time of the audit, MPD did not have a policy addressing interactions between paramedics and police or the use of chemical restraints such as ketamine.

The OPCR report contained alarming details regarding multiple—and seemingly routine—incidents where police officers pressured paramedics to use ketamine as a chemical restraint.[191] The body-camera footage of several incidents reviewed by OPCR revealed that in some cases, the police requested ketamine even though an individual had already been subdued.[192] In one case, an officer spoke with paramedics about giving an individual a shot of ketamine.[193] When the individual saw the needle, he said he did not want the shot, adding, "[W]hoa, whoa, that's not cool!" He pleaded, "I don't need that!"[194] He was then injected with the drug twice and secured to a chair.[195] Shortly after, he became nonverbal and his vocalizations unintelligible, prompting one officer to remark, "he just hit the K-hole," a slang term for the intense delirium brought on by ketamine.[196]

In another incident, police responded to a call involving an "emotionally disturbed" person contemplating suicide.[197] The police found the person in his residence sleeping face down on a couch, and they double-handcuffed him without resistance.[198] When the paramedics arrived, one of the officers made an

187. *Id.*
188. *Id.* at 11.
189. Spit masks–or spit hoods–have been used by law enforcement officers for years, often in jails and prisons. Most are made from nylon mesh that loosely cover a person's head with an elastic band to keep it affixed around their neck. Some have plastic that covers the mouth and nose portion. Scott Morris, *Justified by Myth, Spit Hoods Can Kill*, OAKLAND REP. (Aug. 12, 2019), https://www.oaklandreporter.org/2019/08/justified-by-myth-spit-hoods-can-kill.html [https://perma.cc/9HJ3-LS2W].
190. OPCR REPORT, *supra* note 174, at 11.
191. *Id.* at 12–15.
192. *Id.*
193. *Id.* at 15.
194. *Id.*
195. *Id.*
196. *Id.*
197. *Id.* at 12.
198. *Id.*

"injection" motion toward the individual and laughed.[199] The officer then radioed, "[T]ell [the paramedics] they're going to have to bring a shot in."[200] Shortly before being taken to the ambulance, the individual yelled, "[L]et me go!"[201] The officer replied, "[I]n about two seconds when they shove a needle in your ass. They'll give you a little ketamine."[202] At the hospital, once the individual was taken to a room, an officer stated, "[He] needs a locker [*sic*] room unless you're going to give [him] a shot, because [he] needs a shot . . . ."[203]

The report also suggests that paramedics may have administered ketamine to people because it would benefit Hennepin Healthcare's research experiment and not because it was medically necessary. Body-camera footage from one case showed a woman, after being maced by police, asking for an asthma pump. Instead, a paramedic gave her an injection of ketamine. "If [she] was having an asthma attack, giving ketamine actually helps patients and we're doing a study for agitation anyway so I had to give [her] ketamine,"[204] the unnamed paramedic told a police officer. After receiving ketamine, the woman's breathing stopped, and medical staff resuscitated her, according to the report.[205] The authors of the OPCR report said that it was "troubling that the dictate of the 'study' mentioned by the paramedics appears to have played a significant role in the decision to administer ketamine."[206]

There is also evidence that police instructed the paramedics about how much ketamine to administer. During one incident, an individual—who had been given ketamine on at least four separate occasions in one year—was confronted by the police after an alleged jaywalking incident and began taunting the officers.[207] The officers told the individual to stop using profanity, and when the individual continued to use inappropriate language, the officers attempted to detain him. The individual actively resisted arrest and scratched an officer. Then the officers handcuffed and hobbled him, fitted him with a spit hood, and strapped him to a stretcher. Once inside an ambulance, the individual loudly objected to arrest and the officers' force. A paramedic said, "[A]re you gonna draw it [ketamine] up[?]"[208] The person was given the ketamine injection despite his objection as the officer restraining him referred to the drug as "the good

199. *Id.*
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.*
204. *Id.* at 13.
205. *Id.*
206. Andy Mannix, *Ketamine study at Hennepin Healthcare Suspended After Criticism from Politicians*, STAR TRIB. (June 26, 2018, 11:38 AM), https://www.startribune.com/ketamine-study-at-hennepin-healthcare-suspended-after-criticism-from-politicians-minneapolis-police-sedate/486507021 [https://perma.cc/Y7DV-RRZV].
207. OPCR REPORT, *supra* note 174, at 14.
208. *Id.*

stuff."[209] The injection did not cause the individual to fall unconscious, and the group discussed giving him more ketamine, to which he replied, "[D]on't give me anything."[210] The officer then suggested to the paramedic that "[l]ast time" it took "two doses."[211] The officer told the paramedic that he had seen the person a few nights earlier.[212]

Another key concern raised was whether the studies actually involved only minimal risks—a concept used in clinical trials to, in part, determine whether waivers of consent requirements are appropriate.[213] Public Citizen's Health Research Group—a consumer-protection organization—and dozens of doctors, lawyers, and bioethicists submitted a letter to the U.S. Department of Health and Human Services requesting a formal compliance oversight investigation. With respect to the waiver of consent, the letter stated:

> A prospective clinical trial in which human subjects were assigned by a research protocol to receive the general anesthetic ketamine or a different powerful sedative drug for agitation, rather than according to the clinical judgment of the health care professionals caring for the subjects, clearly exceeded minimal risk and therefore was **not** eligible for waiver of informed consent under HHS regulations at 45 C.F.R. § 46.116(d).[214]

The conclusion of the OPCR report included policy recommendations for the Minneapolis Police Department, such as creating a policy governing appropriate interactions between MPD officers and emergency medical responders; providing MPD officers with training about interactions with emergency medical responders; exploring the addition of rules regarding "emotionally disturbed persons" to the MPD policies and procedures; establishing a protocol for medical research involving police detainees; and exploring options for notifications of medical research involving detainees.[215] The report also called for training paramedics about interactions with police officers who may try to participate in decision-making about giving pharmaceuticals to patients.

But such policy recommendations, which regulate partnerships between police and paramedics using ketamine in pre-hospital settings, raise significant legal issues that have yet to be resolved. The collaboration between police and medical professionals to use chemical restraints for subduing detained individuals raises at least two novel constitutional questions. First, do Fourth

209. *Id.*
210. *Id.*
211. *Id.*
212. *Id.*
213. Letter from Michael A. Carome, Dir., Pub. Citizen Health Rsch. Grp. et al., to Scott Gottlieb, Comm'r, Food and Drug Admin. & Jerry Menikoff, Dir., HHS Off. for Hum. Rsch. Prots., at 2 (July 25, 2018) (on file with author).
214. *Id.* at 7.
215. OPCR REPORT, *supra* note 174, at 16.

Amendment restraints on police use of force also apply to medical providers who are jointly responding to emergency calls-for-service with the police? Second, are chemical restraints administered by medical professionals in pre-hospital settings a form of "force" regulated by the Fourth Amendment? We address these questions in the next Section, which examines how Fourth Amendment rules governing use of force might apply to medical providers who use chemical restraints in public settings.

III.
LAW, MEDICAL PROFESSIONALS, AND USE OF FORCE

Legal scholars have published a considerable amount of literature on the Fourth Amendment and use of force, but there is little material on how the Fourth Amendment might address use of force by people other than police officers. As the ketamine incidents in Minneapolis demonstrate, paramedics and other medical providers work closely with police when responding to emergency calls-for-service, and sometimes these incidents involve forcibly subduing people. This close relationship between police and paramedics, in conjunction with new demands for police officers to use less violence,[216] might lead medical providers and police to explore using chemical restraints in routine law enforcement matters as a seemingly less lethal form of force. Given this potential, it is critical to understand how existing constitutional rules might apply to medical providers when they use chemical restraints for this purpose. This Section explores these issues.[217]

---

216. *See, e.g.*, Emily Bazelon, Alicia Garza, Phillip Atiba Goff, Vanita Gupta, Sam Sinyangwe & J. Scott Thomson, *A Discussion About How to Reform Policing*, N.Y. TIMES MAG. (June 13, 2020), https://www.nytimes.com/interactive/2020/06/13/magazine/police-reform.html [https://perma.cc/2WCD-G7MZ]; #8CANTWAIT, https://8cantwait.org [https://perma.cc/6ETT-EEQU?type=image]; #8TOABOLITION, https://www.8toabolition.com [https://perma.cc/KJU7-PYEC].

217. A separate constitutional issue worth flagging is the Fourteenth Amendment right to refuse medical treatment and the corollary liberty interest in being free from unwanted medical interventions. The Supreme Court has held that under the Due Process Clause of the Fourteenth Amendment, individuals have "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." Washington v. Harper, 494 U.S. 210, 221–22 (1990). There have been several cases involving Fourteenth Amendment claims against paramedics and other health-care workers for the forcible administration of chemical restraints. Courts generally find due process violations in chemical restraints beyond the extent necessary to ensure patient health or safety. *See* Olafson v. Schulz, No. 3:14-cv-90, 2017 WL 4172154, at *7 (D.N.D. Aug. 22, 2017) (concluding that a chemical restraint does not violate a patient's due process rights if the patient is a danger to himself or others), *report and recommendation adopted*, 2017 WL 4170349 (D.N.D. Sept. 19, 2017); Morgan v. Rabun, 128 F.3d 694, 696–97 (8th Cir. 1997) (recognizing the liberty interest in being free from forcible administration of psychotropic drugs and requiring a showing of dangerousness in order for involuntary chemical restraint to be permissible); Thomas S. *ex rel* Brooks v. Flaherty, 699 F. Supp. 1178, 1188 (W.D.N.C. 1988) (concluding that chemical restraints were used beyond the extent necessary to secure safety and therefore violated substantive due process rights), *aff'd*, 902 F.2d 250 (4th Cir. 1990); Rennie v. Klein, 720 F.2d 266, 269 (3d Cir. 1983) (holding that chemical restraints that substantively depart from accepted medical judgment, practice, or standards violate the constitutional right to refuse medical treatment).

While there are not any Supreme Court decisions that directly deal with medical providers using force, a few federal district and circuit courts have examined this topic. In this Section, we examine these lower court cases to reveal several insights about how the Fourth Amendment operates in the context of medical providers using chemical restraints in public settings. We first examine the broad issue of state action as it relates to medical providers and explain when public and privately employed professionals fall under the purview of the Fourth Amendment. Next, we discuss cases that specifically engage the question of whether chemical restraints constitute excessive force. These cases suggest that chemical restraints are a constitutionally recognized form of force and may amount to excessive force when used for a non-medical purpose that causes harm. An excessive force claim against a medical provider in this context likely hinges on what the court believes the medical provider's purpose to be in using a chemical restraint. Courts finding that providers used chemical restraints as part of ongoing medical treatment generally dismissed excessive-force claims, whereas courts finding that providers used chemical restraints to aid law enforcement allowed them to proceed.

At the end of this Section, we tie the existing precedent on medical providers' use of force back to the critical issues raised by the ketamine incidents in Minneapolis. This allows us to better understand the relationship between chemical restraints, law, and medicine in Fourth Amendment contexts.

A. Constitutional Torts and Medical Providers as State Actors

Most excessive-force cases involve police officers, while harms that implicate medical professionals typically fall under tort law.[218] This might lead some to assume that Fourth Amendment rules on use of force do not apply to medical providers. Fourth Amendment standards, however, do not apply to police officers alone.[219] Indeed, courts have held that a variety of individuals—including firefighters, social workers, and healthcare providers—have used unreasonable or excessive force in violation of Fourth Amendment standards.[220] The rules determining which categories of people may be regulated by the Fourth Amendment do not emerge clearly from the Constitution itself. These categories

218. *See* Gwen Seabourne, *The Role of the Tort of Battery in Medical Law*, 24 ANGLO-AM. L. REV. 265 (1995).

219. *See* 42 U.S.C. § 1983 (2018) (imposing liability on every person who, under the color of a state statute, ordinance, or regulation, causes the deprivation of another's federally protected right); *supra* Part I.A.

220. *See, e.g.*, Michigan v. Tyler, 436 U.S. 499, 506 (1978) (holding that the Fourth Amendment applied to firefighters investigating the cause of a fire); Doe v. Heck, 327 F.3d 492, 510 (7th Cir. 2003) (applying the Fourth Amendment to a child welfare caseworker who, accompanied by a police officer, removed a child from class to question him about circumstances in his home); Cole v. City of Chicago, No. 06 C 4704, 2008 WL 68687, at *6 (N.D. Ill. Jan. 4, 2008) (allowing excessive-force claim against paramedic to proceed).

materialize instead from the statutory mechanism for enforcing constitutional rights: 42 U.S.C. § 1983.

Section 1983 allows people deprived of their federal constitutional rights to sue in federal court and receive monetary damages or an injunction to prevent further constitutional violations.[221] However, Section 1983 only applies when the person who committed the constitutional violation acted "under color of state law."[222] To meet this requirement, generally, the constitutional violator must be a state or local actor[223] rather than a private individual. These actors include government entities as well as individual public officials, officers, and employees.[224] In addition, the government actor must have committed the violation while either performing or purporting to perform her official government duties.[225]

The "under color of state law" requirement is key to understanding how Fourth Amendment standards might apply to healthcare providers. In the healthcare context, some providers, such as public hospital employees, are public officials. In cases involving public employees, therefore, there is no dispute that the Fourth Amendment standards concerning use of force apply. But many healthcare providers work for privately-owned health care companies. Does the Fourth Amendment apply in this context?

Courts apply Section 1983 to private actors under a few circumstances, two of which are most relevant to healthcare.[226] The first circumstance, known as the *traditional public function test*, occurs when a private actor is contracted to perform activities that are typically handled by the government.[227] Examples include firefighting, police activity, and prison services, including the provision of healthcare to incarcerated persons.[228] In *West v. Atkins*, the Supreme Court found that a doctor under a contract with the state to provide medical care to incarcerated persons acted under the color of law for the purposes of Section 1983.[229] Other cases have also indicated that providing medical services can

221. 42 U.S.C. § 1983 (2018).

222. *See* West v. Atkins, 487 U.S. 42, 48 (1988).

223. The U.S. Supreme Court held that federal actors who violate constitutional rights are held to a similar standard. *See* Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics, 403 U.S. 388 (1971).

224. *West*, 487 U.S. at 48; Filarsky v. Delia, 566 U.S. 377 (2012).

225. *West*, 487 U.S. at 48.

226. For a description of the various state action tests used by federal courts, see Julie K. Brown, Note, *Less is More: Decluttering the State Action Doctrine*, 73 MO. L. REV. 561 (2008). For example, another approach to understanding state action involves private actors performing exclusively public functions. *See* Jack M. Beermann, *Why do Plaintiffs Sue Private Parties Under Section 1983?*, 26 CARDOZO L. REV. 1, 26 (2004). This only arises in the context of elections and private property, and thus has no application to health-care providers. *Id.*

227. *See* Richard Frankel, *Regulating Privatized Government though § 1983*, 76 U. CHI. L. REV. 1449, 1453 (2009).

228. Flagg Bros. v. Brooks, 436 U.S. 149, 163–64 (1978).

229. 487 U.S. at 52–54; *see also* Hicks v. Frey, 992 F.2d 1450, 1458 (6th Cir. 1993) ("It is clear that a private entity which contracts with the state to perform a traditional state function such as

constitute a public function. For example, the Tenth Circuit noted that performing "necessary municipal functions," including running nursing facilities, constitutes state action.[230] A district court in Arizona concluded that a private entity that contracted with the state to provide state-mandated health services through a government program was a state actor.[231] As such, many privately-employed medical providers will fall under the purview of Section 1983, either because they contract with government entities to provide services or because the services they offer constitute public functions.

The second circumstance that may give rise to Section 1983 liability for a private medical provider, known as *joint action* or *joint participation theory*, applies when a private actor works alongside and in conjunction with government actors. This theory is the most relevant to incidents that involve paramedics using chemical restraints to aid law enforcement, such as the ketamine incidents in Minneapolis. Under the joint action theory, a private party can be said to have acted "under color of state law" for the purposes of Section 1983 when the private party is a "willful participant in joint activity with the State or its agents."[232] There is no firm rule for determining what constitutes being a "willful participant" in "joint activity" with the state,[233] but courts generally look to the actual interactions between state and private actors in a given situation, as opposed to the general relationship between the two. [234]

The key Supreme Court case on the right to bring claims under Section 1983 against private actors via joint action theory is *Adickes v. SH Kress & Co.*[235] In *Adickes*, private department-store employees allegedly worked jointly with the police to maintain racial segregation at the store's lunch counter.[236] The Court said that the petitioner could bring a claim against the restaurant workers if she could prove that the store employee and the police "reached an understanding to deny [the petitioner] service in [the store], or to cause her subsequent arrest because she was a white person in the company of Negroes."[237] The Court explained:

> [A] private party involved in such a conspiracy, even though not an official of the State, can be liable under § 1983. "Private persons, jointly engaged with state officials in the prohibited action, are acting 'under color' of law for purposes of the statute. To act 'under color' of law does

providing medical services to prison inmates may be sued under § 1983 as one acting 'under color of state law.'" (citing *West*, 487 U.S. at 54)), *abrogated in part by* Farmer v. Brennan, 511 U.S. 825 (1994).

230. Tool Box v. Ogden City Corp., 316 F.3d 1167, 1176 (10th Cir. 2003), *vacated on reh'g en banc*, 355 F.3d 1236 (10th Cir. 2004) (en banc).

231. J.K. *ex rel.* R.K. v. Dillenberg, 836 F. Supp. 694, 699 (D. Ariz. 1993).

232. Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 294, 296 (2001).

233. *See* Frankel, *supra* note 227, at 1453 n.26.

234. *See, e.g.*, Adickes v. S. H. Kress & Co., 398 U.S. 144 (1970); Youngblood v. Hy-Vee Food Stores, Inc., 266 F.3d 851, 855 (8th Cir. 2001).

235. 398 U.S. at 144.

236. *Id.* at 153–57.

237. *Id.* at 152.

> not require that the accused be an officer of the State. It is enough that he is a willful participant in joint activity with the State or its agents."[238]

The department-store employees argued that there was no evidence that they conspired with the police and that they therefore could not be sued under Section 1983. The Court, however, concluded that the petitioner only needed to show that police were present in the store when the managers enforced the racial segregation policy in order for a jury to reasonably conclude that the store owners and police worked together to deny the petitioner service.[239] The Court's analysis in *Adickes* leads to a broad conception of joint action that includes not only explicit agreements to act together, but also any mutual "meeting of the minds."[240]

In the context of medical providers using chemical restraints, these two legal doctrines—the traditional public function test and joint action theory—demonstrate that there are many ways in which privately-employed medical providers might be treated as state actors acting under color of state law. Under the traditional public function test, if private paramedics work under a contract to provide state-mandated health services, the paramedics would likely qualify as state actors. But more to the point, the joint action theory provides a clear path to liability for medical providers who use chemical restraints in public settings to induce legal compliance. If a medical provider uses chemical restraints to make someone comply to an officer's commands, she is working in a law enforcement capacity. The joint action theory applies because paramedics in this context are acting with police as arms of the state. Regardless of whether the paramedics are employed by public or private entities, medical providers working with police in such situations are acting "under color of law" for the purposes of Section 1983.

The main takeaway from these doctrines is that medical providers are likely subject to Fourth Amendment rules governing use of force if they use chemical restraints to assist police in making a detention or arrest. With this in mind, we now turn to a discussion of the cases examining whether paramedics' use of chemical restraints in pre-hospital contexts raise Fourth Amendment concerns.

B. Federal Court Decisions on Medical Providers and Chemical Restraints

There are a few notable federal cases where individuals sued paramedics for using chemical restraints in public settings. These cases, like the ketamine incidents in Minneapolis, involve paramedics responding to 9-1-1 calls and then injecting individuals with chemical restraints before transporting them to the hospital. An analysis of these cases fills an existing gap in the use-of-force

238. *Id.* (quoting United States v. Price, 383 U.S. 787, 794 (1966)).
239. *Id.* at 158.
240. *Id.* at 158.

literature and can improve our understanding of the use of chemical restraints in non-clinical settings.

The cases involving medical providers and chemical restraints bring clarity to the following two critical Fourth Amendment issues: The first relates to chemical restraints as a form of force used in interactions with the public. When used to induce legal compliance, a review of existing federal court decisions suggests that giving an individual a drug such as ketamine is deemed a type of "force" for Fourth Amendment constitutional purposes. The second relates to how courts analyze the substantive question of what type of medical force qualifies as "excessive." Courts are prone to dismiss excessive-force claims against paramedics if they were pursuing a medical purpose rather than a law enforcement purpose when administering the chemical restraint.[241] As we discuss in more detail through the cases below, the issue of a paramedic's purpose emerges in excessive-force cases during the court's analysis of whether paramedics are entitled to qualified immunity. To demonstrate how this analysis operates, we examine a series of cases from federal courts that have had an opportunity to review this issue, which includes the Sixth Circuit, Seventh Circuit, Second Circuit, and Eastern District of California.

1. The Sixth Circuit: Medical Treatment vs. Law Enforcement

In *Peete v. Nashville*, a young man's grandmother called 9-1-1 because he was having a seizure.[242] The five defendants—paramedics, emergency medical technicians, and firefighters employed by the city—arrived and pinned the man down, applied pressure to his head and neck, and failed to make sure that he had clear airways, which led to the man's death.[243] His estate brought a Section 1983 excessive force claim against the paramedics.[244] The issue in the case centered on whether the paramedics were entitled to qualified immunity.[245]

Paramedics like the one in *Peete* often raise qualified immunity defenses in excessive-force cases because it potentially shields them from liability. Qualified immunity extends to public officials performing their official duties in circumstances where the law governing the constitutional right at issue is not deemed to be "clearly established" at the time of the events in question.[246] The

241. *See* Est. of Barnwell v. Grigsby, 801 F. App'x 354, 370–71 (6th Cir. 2020); Thompson v. Cope, 900 F.3d 414, 417 (7th Cir. 2018); McKenna v. Edgell, 617 F.3d 432, 435 (6th Cir. 2010); Peete v. Nashville, 486 F.3d 217, 222 (6th Cir. 2007); Frank v. Cascade Healthcare Cmty., Inc., No. 6:11-cv-06402-AA, 2014 WL 793073, at *6 (D. Or. Feb. 23, 2014), *aff'd*, 688 F. App'x 461 (9th Cir. 2017) (mem.).

242. 486 F.3d at 219–20.

243. *Id.*

244. *Id.* at 219.

245. *Id.* at 219–21.

246. The Supreme Court has said that it "'do[es] not require a case directly on point' for a right to be clearly established," but that "existing precedent must have placed the statutory or constitutional question beyond debate." White v. Pauly, 137 S. Ct. 548, 551 (2017) (per curiam) (quoting Mullenix v. Luna, 577 U.S. 7, 12 (2015)). It has also emphasized that "clearly established law must be

issue of whether there is "clearly established" law governing medical providers' use of force in the Fourth Amendment context is often the key dispute in excessive-force cases involving medical professionals. For many courts, the answer to this question depends upon the purpose pursued by the medic, or what role they were playing when they made the decision to use a chemical restraint.

The district court in *Peete* initially denied qualified immunity to the defendants, who then appealed to the Sixth Circuit.[247] In its decision, the Sixth Circuit held that qualified immunity is more readily available to medical professionals when they are providing aid as opposed to enforcing the law.[248] Addressing the "clearly established law" prong of the qualified immunity test, the court stated that there were "no cases applying the Fourth Amendment to paramedics coming to the aid of an unconscious individual as a result of a 911 call by a family member."[249] The court further concluded that "where the purpose is to render solicited aid in an emergency rather than to enforce the law . . . there is no federal case authority creating a constitutional liability for the [conduct] alleged in the instant case."[250] Therefore, even though the paramedics "badly botched the job,"[251] they were entitled to qualified immunity.

The Sixth Circuit reaffirmed the importance of distinguishing between actions intended for medical purposes and actions in support of law-enforcement aims in *McKenna v. Edgell*.[252] *McKenna*, like *Peete*, did not involve chemical restraints, but the case is nevertheless a useful illustration of the way the Sixth Circuit conceptualizes actions intended to serve a law enforcement purpose. In *McKenna*, a daughter called 9-1-1 when her father was having a seizure.[253] The parties disputed the specifics about what happened after the officers arrived, but they agreed that the officers handcuffed the father.[254] They also searched his dresser drawer and medicine cabinet, allegedly looking for drugs, and ran his license plates.[255] The father brought a Section 1983 excessive-force claim based on the officers' decision to handcuff and restrain him immediately following his seizure.[256] The key question in the case was whether the officers acted with a medical purpose or a law enforcement purpose in their interactions with the

'particularized' to the facts of the case" and "not be defined 'at a high level of generality.'" *Id.* at 552 (quoting Anderson v. Creighton, 483 U.S. 635, 6340 (1987)); Ashcroft v. al-Kidd, 563 U.S. 731, 742 (2011).

247. 486 F.3d at 219.
248. *Id.* at 221.
249. *Id.* at 220.
250. *Id.* at 221.
251. *Id.* at 222.
252. 617 F.3d 432 (6th Cir. 2010).
253. *Id.* at 435.
254. *Id.*
255. *Id.* at 436.
256. *Id.*

father.[257] At the district court, the judge rejected the officers' argument that they were acting with a medical purpose and therefore were entitled to qualified immunity, and the case went to trial.[258] The jury found that the officers were not entitled to qualified immunity and awarded damages to the father.[259] On appeal, the Sixth Circuit affirmed the jury's finding that the officers acted in a law-enforcement rather than a medical-provider capacity because the officers conducted a search of the father's home and ran a background check on license plates during the incident.[260] The question of the officers' role in the incident was not based simply on their official positions as law enforcement officers.[261] Rather, their role was determined through an analysis of the specific actions they took in the case.[262] The case thus demonstrates that for a Fourth Amendment and qualified immunity analysis, police and medical providers alike can potentially act in either a law-enforcement or an emergency-medical-response capacity. Specific factual questions about the defendant's role in the incident, such as whether the defendant assisted in a search or performed other law-enforcement tasks, is what ultimately determines whether the defendant can face Section 1983 liability for excessive force.

The Sixth Circuit recently revisited this issue in an unpublished opinion, *Estate of Barnwell v. Grigsby*.[263] This case concerned a Tennessee resident named Dustin Barnwell who died after a paramedic injected him with a chemical restraint.[264] Barnwell's fiancée had called 9-1-1 because she believed he was overdosing on prescription drugs.[265] Officers arrived at Barnwell's home and woke him up.[266] Barnwell became combative, and the officers handcuffed him.[267] Several paramedics then arrived and administered a drug called succinylcholine—a muscle relaxant that causes paralysis—which inhibited his ability to breathe on his own.[268] Barnwell began to suffer from cardiac issues and had to be intubated.[269] He died shortly afterwards at the hospital.[270] Barnwell's estate sued the officers and paramedics for damages under 42 U.S.C. § 1983.

257. *Id.* at 439–40 ("We conclude that whether the officers were entitled to qualified immunity depends on whether they acted in a law-enforcement capacity or in an emergency-medical-response capacity when engaging in the conduct that McKenna claimed violated the Fourth Amendment.").
258. *Id.* at 436–37.
259. *Id.* at 437.
260. *Id.* at 443.
261. *Id.* at 440–41.
262. *Id.*
263. Est. of Barnwell v. Grigsby, 801 F. App'x 354, 370–71 (6th Cir. 2020).
264. *Id.* at 359
265. *Id.* at 358.
266. *Id.*
267. *Id.*
268. *Id.* at 359.
269. *Id.*
270. *Id.*

The district court in *Barnwell* rejected the paramedics' argument for summary judgment based on qualified immunity.[271] The court reasoned that summary judgement was improper because genuine issues of material fact remained regarding both the medical necessity of using the drug and the paramedics' intent in administering it.[272] The district court emphasized that the plaintiff's expert opined there was no medical reason to paralyze decedent's lungs.[273] On appeal, the Sixth Circuit affirmed the district court ruling and concluded that there was a genuine factual dispute about whether or not it was medically necessary to administer the paralytic drug.[274] The case eventually went to trial, but on the third day of trial, the court granted the defendants' motion for judgement as a matter of law and disposed of the excessive force claims against the paramedics.[275] The court reasoned that the plaintiffs did not provide sufficient proof that the paramedics who administered the paralytic drug acted in a law enforcement capacity.[276]

Based on this precedent, future cases in the Sixth Circuit regarding medical professionals' use of chemical restraints in public settings will likely depend upon whether the medical professionals intended to render medical care or to induce compliance with law enforcement. As we discuss in more detail in the conclusion of this section, the only medical purpose for using a chemical restraint is to protect a patient's health and safety. Accordingly, when chemical restraints are used for any other purpose, courts should conclude that the person administering them is not acting with a medical purpose. Under Sixth Circuit law, such a provider would not be entitled to qualified immunity.

2. The Seventh Circuit: Deference to Medical Professionals

The Sixth Circuit's distinction between interventions intended as medical aid and actions done with a law enforcement purpose in *Peete* and *McKenna* had the potential to set a standard for other circuits to follow in use-of-force cases against medical providers. However, when the Seventh Circuit cited to these cases, it produced inconsistent rules and outcomes. One Seventh Circuit case, *Thompson v. City of Indianapolis*, serves as an example.

In *Thompson v. City of Indianapolis*, the family of Dusty Heishman sued an Indianapolis-area hospital system and a paramedic after Heishman died

271. Est. of Barnwell v. Roane Cnty., No.: 3:13-CV-124-PLR-HBG, 2016 WL 5937821, at *7 (E.D. Tenn. June 16, 2016) *aff'd* Est. of Barnwell v. Grigsby, 801 F. App'x 354 (6th Cir. 2020). The court also denied the police officer defendants' motion for summary judgment on qualified immunity grounds. *Id.*

272. *Id.* at *7.

273. *Id.*

274. Est. of Barnwell by S.C.B. v. Grigsby, 681 F. App'x 435, 442 (6th Cir. 2017).

275. Est. of Barnwell v. Grigsby, 801 F. App'x 354, 370–71 (6th Cir. 2020).

276. *Id.*

following an arrest.[277] Police officers initially responded to a 9-1-1 call reporting that Heishman was acting erratically.[278] When the officers arrived, they found Heishman naked and alone in the middle of a road.[279] They put him in leg shackles and handcuffs and held him on the ground face down "with approximately four officers staying in physical contact with him."[280] Paramedics were not called to the scene. They only happened to be in the area because they were responding to an unrelated call about a dog bite and the officers asked the paramedic crew to take a look at Heishman.[281] When the paramedics approached Heishman, he "was lying prone in the middle of the street, was handcuffed behind his back with leg shackles on, and had been tased."[282] It appeared to the paramedics that Heishman was under the influence of drugs.[283] Despite the fact that he was already restrained, one of the paramedics gave Heishman an injection of a sedative drug known as Versed.[284] No one monitored his vital signs after the chemical restraint was administered.[285] As they transported him to an ambulance, the paramedics and officers realized that Heishman had stopped breathing.[286] Heishman had gone into cardiac and respiratory arrest.[287] Though he was temporarily revived, he had lost all brain functioning and died several days later.[288]

Heishman's family brought a Section 1983 excessive force claim against the paramedic who administered the chemical restraint. The paramedic—relying on the *Peete* decision from the Sixth Circuit—argued that he believed it was necessary to administer the chemical restraint in the course of providing medical treatment.[289] According to the defendant, he did not violate Fourth Amendment standards, or at the very least was entitled to qualified immunity, because he had intended to provide medical care.[290] The plaintiffs argued that because the police had already handcuffed and shackled Heishman, and left him lying in a prone position on the ground and not actively resisting, there was no medical need to use a chemical restraint for his own or others' safety.[291] The plaintiffs also

277. No. 1:15-cv-01712-TWP-DML, 2017 WL 4248006, at *1 (S.D. Ind. Sept. 25, 2017), *rev'd and remanded sub nom.* Thompson v. Cope, 900 F.3d 414 (7th Cir. 2018).
278. *Id.* at *2.
279. *Id.*
280. *Id.*
281. *Id.*
282. *Id.*
283. *Id.*
284. *Id.* at *3.
285. *Id.*
286. *Id.*
287. *Id.*
288. *Id.*
289. *Id.* at *5 (citing Peete v. Nashville, 486 F.3d 217, 221 (6th Cir. 2007)).
290. *Id.*
291. *Id.*

emphasized the fact that the paramedic administered the chemical restraint after discussing the situation with law enforcement officers.[292]

The district court concluded that the paramedic administered a chemical restraint to Heishman to assist law enforcement officers in effectuating an arrest.[293] The court said that although Heishman was under the influence of drugs and in what the paramedic described as a state of "excited delirium," the chemical restraint used by the paramedic to assist in the arrest was an unreasonable use of force because Heishman was already restrained on the ground, handcuffed, and leg-shackled when the chemical restraint was administered.[294] The court further held that because there was a clearly established right to be free from excessive force in the course of an arrest, and because the paramedic had used unreasonable force, the paramedic was not entitled to qualified immunity.[295]

On appeal, the Seventh Circuit reversed the district court decision.[296] The court reframed the factual situation as one involving the "administ[ration of] a therapeutic drug in response to a medical emergency."[297] The court's view was that:

> [T]he question for qualified immunity is whether it was clearly established in 2014 that a paramedic "seizes" an arrestee and is subject to Fourth Amendment limits on excessive force by sedating the arrestee—who appears to the paramedic to be suffering from a medical emergency—before taking the arrestee by ambulance to the hospital.[298]

The court stated that a paramedic or lawyer reasonably familiar with Fourth Amendment law would not have known that Fourth Amendment rules apply to "treatment in the field during a medical emergency."[299] The court also said that the plaintiffs identified no cases where a court found a medical provider violated Fourth Amendment standards for "using a therapeutic drug to sedate an arrestee to be taken safely to the hospital."[300] The court did cite two cases holding that paramedics can be liable for transgressions of Fourth Amendment standards related to chemical restraints: a California district court case, *Haas v. County of El Dorado* (which we discuss in more detail below), and the district court decision in *Estate of Barnwell* (from our discussion of the Sixth Circuit's approach to this issue).[301] The court distinguished these cases in just one line, stating: "we doubt that the reasoning of those cases applies."[302] The court

292. *Id.* at *6.
293. *Id.*
294. *Id.* at *5.
295. *Id.* at *6.
296. Thompson v. Cope, 900 F.3d 414 (7th Cir. 2018).
297. *Id.* at 423.
298. *Id.* at 422.
299. *Id.* at 422–23.
300. *Id.*
301. *Id.* at 420.
302. *Id.* at 421.

deferred the issue of whether the paramedic violated Heishman's constitutional rights because it found the qualified immunity issue dispositive.[303]

The Seventh Circuit's decision to reframe the issue as one about medical providers rendering therapeutic treatment is puzzling because the court did not overturn the district court's finding that the paramedic acted in a law-enforcement capacity. Indeed, the defendants argued that the evidence at the district court was insufficient to support the conclusion that the paramedic acted in a law-enforcement capacity and the Seventh Circuit declined the invitation to revisit those factual issues.[304] Nonetheless, the court—citing the Sixth Circuit decision in *Peete*—went on to describe the paramedic as acting in a medical capacity through its entire qualified immunity analysis.[305]

Although the Seventh Circuit did not refer to the medical-treatment-versus-law-enforcement capacity test explicitly, the reasoning in its qualified immunity analysis essentially follows the same rule. The Seventh Circuit's decision provides that any individual who is acting in the course of rendering medical aid is shielded from the requirements of the Fourth Amendment because there is no clearly established Fourth Amendment caselaw stating that badly-botched medical treatment can constitute excessive force.[306] This leaves enormous room for courts to determine whether a chemical restraint used in a given context was administered for law-enforcement purposes or for medical purposes. Indeed, that is exactly what happened in this case: the district court relied on the fact that Heishman was already incapacitated to determine that the alleged medical justification for the chemical restraint was unpersuasive, whereas the circuit court interpreted the same facts as an instance of paramedics rendering a "therapeutic drug" in a medical emergency.[307] As we discuss in Part IV, guidelines from in-patient healthcare contexts can help better inform courts' decisions about whether chemical restraints are used for medical purposes or law-enforcement purposes in a given circumstance.

3. Different Paths Taken By The Second Circuit and Eastern District of California

The medical-versus-law-enforcement rule adopted by the Sixth and Seventh circuits is not indicative of how all courts decide cases involving paramedics and the Fourth Amendment. At least two courts—the Second Circuit and a district court in California—have departed from the Sixth and Seventh Circuits' determination that acting with a medical purpose entitles one to

303. *Id.* at 420–21.
304. *Id.* at 420.
305. *Id.* (citing Peete v. Nashville, 486 F.3d 217, 221 (6th Cir. 2007)).
306. *Id.* at 423.
307. *Id.*; Thompson v. City of Indianapolis, No. 1:15-cv-01712-TWP-DML, 2017 WL 4248006, at *6–7 (S.D. Ind. Sept. 25, 2017), *rev'd and remanded sub nom.* Thompson v. Cope, 900 F.3d at 414.

qualified immunity from use-of-force claims.[308] In the Second Circuit case *Green v. City of New York*, a plaintiff with the neuro-muscular disease ALS sued emergency medical responders and police officers after they seized him from his home and forced his transfer to a hospital despite his and his family's insistence that he did not require medical assistance.[309] The plaintiff's daughter initially called 9-1-1 because the plaintiff was having trouble breathing.[310] Before the emergency responders arrived, the plaintiff's family was able to help him regain his ability to breathe.[311] The plaintiff communicated to the emergency medical responders that he did not wish to be transported to the hospital.[312] Several police officers arrived, announced that they were in command, and demanded that the medical providers take him to the hospital.[313] The officers knocked the plaintiff's wife to the floor while they began to move the plaintiff,[314] and threatened to handcuff her.[315] The plaintiff brought a Section 1983 suit, alleging that the paramedics and police unreasonably seized him in violation of the Fourth Amendment.[316] The Second Circuit allowed the claim to survive summary judgment and denied the defendants' qualified immunity defense.[317] The court concluded that "it was clearly established at the time of the incident under review that a competent adult could not be seized and transported for treatment unless she presented a danger to herself or others."[318] The fact that the medical providers may have intended to provide treatment did not shield them from liability for rendering medical aid using unreasonable force under the circumstances.[319]

Although the Second Circuit's decision conflicts with the Sixth Circuit's view, a California district court in 2012 decided a case about chemical restraints by combining the two circuits' standards. This case, *Haas v. County of El Dorado*,[320] highlights how paramedics who use chemical restraints to help police officers are necessarily acting in a law-enforcement, rather than a medical-provider, capacity.

---

308. *See* Green v. City of New York, 465 F.3d 65, 84 (2d Cir. 2006); Haas v. County of El Dorado, No. 2:12-cv-00265-MCE-KJN, 2012 WL 1414115, at *4–10 (E.D. Cal. Apr. 23, 2012). Some courts have, however, adopted the distinction between a medical purpose and a law-enforcement purpose when adjudicating claims against police officers that claimed to have rendered medical assistance. *See* Frank v. Cascade Healthcare Cmty., Inc., No. 6:11-cv-06402-AA, 2014 WL 793073, at *5–6 (D. Or. Feb. 23, 2014) (relying on the distinction between officers acting in a law enforcement capacity and in an emergency responder capacity to conclude that restraints to render medical assistance are not Fourth Amendment violations), *aff'd*, 688 F. App'x 461 (9th Cir. 2017) (mem.).

309. 465 F.3d at 72–73.

310. *Id.* at 70.

311. *Id.*

312. *Id.*

313. *Id.* at 71.

314. *Id.* at 72.

315. *Id.* at 73.

316. *Id.*

317. *Id.* at 83.

318. *Id.*

319. *Id.* at 83–84.

320. No. 2:12-cv-00265-MCE-KJN, 2012 WL 1414115, at *4–10 (E.D. Cal. Apr. 23, 2012).

In *Haas*, a preschool teacher began to feel lightheaded and fainted as he walked out of his classroom.[321] His coworkers thought he may have had a seizure and called 9-1-1.[322] Haas quickly recovered, was able to stand on his own, and said that he was feeling better.[323] When the paramedics arrived, they insisted on taking the teacher to the hospital, but Haas said he did not want or need to go to the hospital.[324] The paramedics called the police for assistance and continued to insist that the teacher go to the hospital when the officers arrived.[325] When Haas refused, the officers tackled him and the paramedics injected him with midazolam—a drug that, like ketamine, is often used to facilitate sedation before surgery.[326]

Haas sued the paramedics and police officers under Section 1983 for use of excessive force.[327] The court first discussed the Second Circuit's standard as stated in *Green* that it is unreasonable to seize a person for medical treatment unless the person is a danger to herself or others.[328] The court then looked to the Sixth Circuit cases holding that the issue of whether a medical provider or police officer is entitled to qualified immunity depends on whether they acted in a law-enforcement or in an emergency-medical-response capacity.[329] The court then synthesized the law on medical providers using force as follows:

> [D]efendants . . . who "seize" an individual while responding to a 911 call requesting medical assistance are entitled to qualified immunity when: 1) the plaintiff was unconscious, incompetent to refuse medical treatment, or dangerous; 2) defendants acted as medical emergency responders, as opposed to law enforcement officer [*sic*]; *and* 3) the plaintiff was in actual or apparent need of medical assistance.[330]

The most interesting part is the court's brief analysis of the second element: whether the paramedics acted in a law-enforcement or an emergency-medical responder capacity when using a chemical restraint. On that issue, the court found that the paramedics were acting as law enforcement officers rather than emergency medical responders because they "injected a tranquilizer into [Haas] not for the purpose of rendering medical aid but for the purpose of assisting law enforcement officers in restraining [him]."[331] This, along with the fact that Haas competently refused medical treatment and did not need medical assistance, led the court to reject the defendants' argument that the paramedics

321. *Id.* at *1.
322. *Id.*
323. *Id.*
324. *Id.*
325. *Id.* at *1–2.
326. *Id.* at *2.
327. *Id.* at *4.
328. *Id.* at *7 (citing Green v. City of New York, 465 F.3d 65, 83 (2d Cir. 2006)).
329. *Id.* at *8 (citing McKenna v. Edgell, 617 F.3d 432, 439–40 (6th Cir. 2010)).
330. *Id.* at *9.
331. *Id.*

were entitled to qualified immunity, thus allowing the Section 1983 claim to proceed.[332]

* * *

These cases demonstrate several important points about how Fourth Amendment use-of-force standards apply to medical providers who use chemical restraints on individuals outside of clinical settings. First, in each case, the court recognized that when a medical provider uses a chemical restraint to seize an individual and move them to a hospital or jail, the provider has engaged in behavior that qualifies as force. Chemical restraints might not be the type of force that comes to mind when we think about state and police violence, but the cases above and the ketamine incidents in Minneapolis demonstrate how the definition of "force" and its implications may be changing. As the courts have correctly recognized, incapacitating an individual against their will via chemical restraint is a form of force.

Second, some courts conclude that medical providers or other officials who use an unreasonable amount of force in encounters with the public can be held responsible for violating Fourth Amendment standards in Section 1983 litigation.[333] However, other courts use the doctrine of qualified immunity to shield medical providers from liability.[334] Courts that apply qualified immunity to claims against medical providers focus on the distinction between acting with a medical-responder purpose and a law-enforcement purpose. Courts have not clearly delineated the contours of this distinction, but what is clear—as the California district court in *Haas* recognized—is that a medical provider who uses a chemical restraint is only acting with a medical purpose if the restraint is necessary to protect a patient's health or safety.[335] Any other uses of chemical restraints, including using the restraint to help officers secure legal compliance, suggests that the provider is acting with a law-enforcement purpose and should be subject to Fourth Amendment standards. This idea has important implications for situations like those that occurred during the Hennepin trials in Minneapolis, where paramedics used ketamine at the direction of police to help facilitate arrests and without concern for the health of the person being arrested.[336] In cases where medical providers submit to the police officer's request for a chemical restraint despite the lack of a medical reason to do so, it should be clear to courts that the medical providers are acting in a law-enforcement capacity.

But what are we to make of the medical-purpose versus law-enforcement-purpose more generally? On the one hand, the test may be problematic insofar as it is always difficult to determine a person's intent. Courts may struggle to

332. *Id.* at *1, *10.

333. *See id.* at *4–10.

334. *See* Thompson v. Cope, 900 F.3d 414, 420–21 (7th Cir. 2018); Peete v. Nashville, 486 F.3d 217, 219–20 (6th Cir. 2007).

335. *Haas*, 2012 WL 1414115, at *9.

336. *See* OPCR REPORT, *supra* note 174, at 12–15.

find a consistent and proper way to determine the purpose of a medical provider's actions. Yet on the other hand, there are some clear lines that courts could draw. If a medical provider intervenes, using chemical restraints or otherwise, to help the police, but the intervention is unnecessary from a medical perspective, courts could treat the medic as a law-enforcement agent. One benefit of the test is that it reinforces that paramedics ought to *always* act exclusively as medical care providers. While paramedics often work alongside police, it is critical that they exercise independent judgment and preserve their roles as medical providers with duties to patients. In the Section that follows, we provide three recommendations that can ensure paramedics maintain this distinct role when responding to emergencies alongside police officers.

IV.
RECOMMENDATIONS: TOWARD THE ETHICAL USE OF MEDICINE IN POLICING

The ketamine incidents in Minneapolis highlight the risk that police officers might participate in or co-opt the medical decision-making process when they work with paramedics to respond to emergency calls for service. We may see more incidents in the future where police task paramedics with using chemical restraints to help police officers secure legal compliance. This Section provides recommendations to establish proper boundaries between medical providers and police and to clarify the relationship between the Fourth Amendment's restrictions on unreasonable force and the use of chemical restraints on community members. These recommendations focus on (1) developing state and local laws that create a firewall between medical professionals and law enforcement in pre-hospital settings that allows medical providers to focus on serving patients while maintaining independence from police; (2) creating use-of-force policies for medical providers that inform them of the constitutional limits of medical force; and (3) encouraging courts to use existing federal regulations governing chemical restraints in medical settings to determine the constitutional reasonableness of using chemical restraints in public or pre-hospital settings.

First, state and local laws should establish the autonomy of healthcare providers and healthcare institutions. Medical professionals and the police may work together in responding to emergencies. Yet, the police are oriented to public criminal justice goals while medical professionals are oriented to individual patients' well-being. Medical providers on the scene with police should not be treated as an arm of law enforcement. The relationship must be carefully managed to maintain medical providers' independence.

The public's trust in both medical providers and law enforcement officers depends on each institutions' sovereignty and ability to exercise independent judgment within their respective spheres of expertise. At a minimum, state and local laws should affirm that police may not directly or indirectly pressure medical providers to take any actions during emergency encounters. Police

should not participate in healthcare providers' discussion of a person's condition or possible treatments. To mitigate against subtle forms of police coercion or communication through body language or gestures, police and medical professionals should maintain physical distance in pre-hospital settings and document all conversations between units. Any use of chemical restraints or other pharmaceuticals should be at the sole discretion of medical professionals and police should not participate in medical providers' decisions about whether they should administer a particular drug.

Second, just as police have local use-of-force guidelines that develop in the context of the Fourth Amendment,[337] medical professionals should also have guidelines that speak to the appropriate uses of force in pre-hospital settings. The federal rules governing the use of chemical restraints in nursing homes prohibit the use of such restraints except where used to protect patient safety. Even when the law permits chemical restraints in the medical context, it protects the patient's right of refusal unless they are in imminent harm.[338] The guidance for medical professionals and statement of patients' rights found in these federal regulations should extend beyond the nursing home setting to include paramedics' interactions with the community.

Use-of-force policies for medical practitioners should further provide detailed outlines and examples of situations in which force can be used and what level of chemical or physical force is appropriate. Moreover, these guidelines should prioritize community members' health and autonomy and explain that law enforcement should have no influence on decisions regarding patient health and safety.

Given that emergency medical responders are often involved when police subdue a person, medical providers also need to be trained on how to interact with the police. Medical providers should know how to tactfully refuse to assist police in seizing an individual if the seizure does not promote the individual's health or safety; to only use chemical restraint when it is medically necessary; and to not let an officer's recommendations supplant their own medical judgment. Policies should also make medical providers aware of their right—indeed, obligation—to refuse police officers' attempts to intervene in medical decision-making. Policies should clearly state that it is lawful for medical

337. *See generally* Obasogie & Newman, *supra* note 29. One finding from this research is that all of the local use-of-force policies surveyed included a reference to *Graham v. Connor*, which shows that local municipalities create their policies with Fourth Amendment standards in mind. *Id.* at 1303.

338. *See* 42 C.F.R. § 483.12(a)(2) (2020) (noting that nursing facilities must "[e]nsure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints."); *see also* 42 C.F.R. § 483.10(e)(1) (2020) (stating that patients have "[t]he right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with § 483.12(a)(2).").

professionals to rebuff police officer's request for medically unnecessary interventions. Training on how to respond if a police officer inserts themselves into the medical decision-making process is also critical. Giving medical providers clear language they could use in response to improper requests would empower them to respond appropriately. This training could reduce the chances that medical professionals misuse or weaponize chemical restraints in pursuit of the interests of the criminal justice system.

At the same time, existing use-of-force trainings and policies for law enforcement should emphasize the need for separation between police and medical professionals. These trainings should instruct police officers that it is inappropriate to suggest how to provide care or to ask medical providers for assistance in seizing suspects. In addition, law enforcement policies should clearly state that chemical restraints can be unlawful force when used inappropriately. Police departments are responsible for establishing guidelines that outline officers' work with medical providers using chemical force. An injection of ketamine or other chemical restraints may seem innocuous, but it can lead to grave harms, if not death—not unlike other uses of force.

Lastly, it is important for federal courts to recognize that existing laws and regulations on chemical restraints in healthcare settings can inform what courts might consider a constitutionally reasonable use of chemical restraints in pre-clinical or public settings. Fourth Amendment standards for reasonableness apply in the context of Section 1983 use-of-force litigation and therefore shape how federal courts view the behavior of medical professionals who use chemical restraints. Federal statutes and regulations pertaining to nursing home care state that (1) medical professionals should never use chemical restraints merely for the sake of convenience; (2) chemical restraints should only be used when it is necessary to protect a patient's safety; and (3) that a patient has a right to refuse unless the restraint is required to prevent imminent harm to the patient or others. These standards are what federal law considers to be the reasonable use of chemical restraints in hospital settings, and it should inform their reasonable use in pre-hospital settings when paramedics collaborate with law enforcement. Chemical restraints used for the sake of convenience or to help officers secure compliance would not meet these federal guidelines and therefore should not be a reasonable use of force under *Graham*. Yet, chemical restraints used to prevent a police detainee from imminently harming herself or others would comply with existing federal regulations and would meet Fourth Amendment reasonableness standards. We see aspects of this approach in some jurisdictions. Yet in other jurisdictions, a more explicit connection between the federal standards on chemical restraints in hospital and pre-hospital settings could help fill an absent analysis on the intersection of the Fourth Amendment, medical providers, and chemical restraints and provide a framework for consistent application in federal courts. This improved understanding may help prevent future instances like those

in Minneapolis, where the unnecessary use of chemical restraints became dangerous law enforcement tools.

Paramedics who work with police to detain individuals are part of the broader social problem of racialized police violence. Institutions that regularly collaborate with law enforcement to surveil the lives and activities of vulnerable communities—social welfare agencies,[339] low-income healthcare facilities,[340] child protective services,[341] and others—often absorb carceral logics[342] when interacting with communities they are supposed to serve and support. Paramedics can also adopt these carceral frameworks when working with communities of color. This adoption can lead them to unwittingly substitute law enforcement perspectives that often see Black and Brown people as threats instead of using their own patient-centered training that instructs them to treat all people in distress with compassion. This is how institutional and structural racism operates: dominant logics link together across institutional spaces to create a network of collaborative bias that normalizes racial oppression. Adoption of carceral logics also explains how, as seen in Minneapolis, paramedics can quickly—and, at times, enthusiastically—submit to the racialized requests of law enforcement to use dangerous chemical restraints disproportionately on people of color.

Acknowledging the Fourth Amendment implications of medical professionals using chemical restraints in pre-hospital settings can have real, material consequences for everyday interactions between police, paramedics, and community members. Developing constitutional boundaries on these interactions is important because these rules establish the framework for policies, customs, and cultures that shape police use of force.

Using existing federal health regulations to inform reasonableness under the Fourth Amendment is just the beginning. More encompassing social, legal, and political engagement with the use of chemical restraints and other emerging police tactics will require interventions in many other areas. However, given that the current constitutional framing views issues of force exclusively through the Fourth Amendment, it is important to situate medical professionals' use of chemical restraints within these constitutional guarantees of individual rights and restrictions on police use of force.

---

339. Sheila P. Vakharia, *"Social Workers Belong in Police Departments" Is an Offensive Statement*, FILTER (June 10, 2020), https://filtermag.org/social-workers-police-departments [https://perma.cc/4GEJ-RJXJ].

340. *See* KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017).

341. *See* DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE (2002).

342. This term "refers to the variety of ways our bodies, minds, and actions have been shaped by the idea and practices of imprisonment—even for people who do not see themselves connected explicitly to prisons." *About Us: Frequently Asked Questions*, ROCHESTER DECARCERATION RSCH. INITIATIVE, http://www.sas.rochester.edu/rdri/about/faq.html [https://perma.cc/WV5S-MF32].

CONCLUSION

Elijah McClain had just left a local convenience store in Aurora, Colorado.[343] The twenty-three-year-old had a slight frame and regularly wore ski masks, even during the summer, as he had anemia and often became cold.[344] A passerby called 9-1-1 after seeing McClain, a masked Black man, walking down the street, saying that he looked suspicious.[345] As McClain carried his groceries, three Aurora police officers responded to the call and stopped him.[346] Police body-cam footage captured the increasingly hostile interaction, where officers initiated a struggle with McClain after he repeatedly asked to be left alone.[347] He was brought to the ground by the officers, put into a chokehold, and handcuffed face-down with his hands behind his back. While handcuffed and immobilized, Aurora Fire Rescue arrived at the scene and injected McClain with five hundred milligrams of ketamine.[348] McClain went into cardiac arrest in the ambulance on the way to the hospital. He was pronounced brain dead several days later and taken off of life support.[349]

---

343. Lucy Tompkins, *Here's What You Need to Know About Elijah McClain's Death*, N.Y. TIMES (Aug. 16, 2020), https://www.nytimes.com/article/who-was-elijah-mcclain.html [https://perma.cc/M549-F2FV].

344. Kieran Nicholson, *No Criminal Charges Against Aurora Officers in Death of Elijah McClain*, DENVER POST (Nov. 23, 2019, 9:59 AM), https://www.denverpost.com/2019/11/23/elijah-mcclain-dead-no-charges-aurora-officers [https://perma.cc/4QEX-KALK].

345. Michael Roberts, *Attorney Rips "Undetermined" Autopsy in Elijah McClain Aurora Police Death*, WESTWORD (Nov. 13, 2019, 5:15 AM), https://www.westword.com/news/elijah-mcclain-aurora-police-death-autopsy-report-ripped-by-attorney-11546039 [https://perma.cc/P5DR-NYZS].

346. Tompkins, *supra* note 343.

347. An officer got close to McClain and touched him. "Stop tensing up, dude. Stop tensing up," the officer said. McClain said:

> "I am going home. . . . Leave me alone," and "Let me go. No, let me go. I am an introvert. Please respect my boundaries that I am speaking."
>
> A struggle escalated, and three officers wrangled McClain toward a lawn, eventually taking him down.

Nicholson, *supra* note 344.

348. Reports suggest that there was some communication between police and medics regarding the use of ketamine on McClain before Aurora Fire Rescue arrived. NBC News reported, "A medic told officers that 'when the ambulance gets here, we're going to go ahead and give him some ketamine.' The officers responded, 'Sounds good,' and they told the medic that McClain appeared to be 'on' something and that he had 'incredible strength.'" Erik Ortiz, *Elijah McClain Was Injected with Ketamine While Handcuffed. Some Medical Experts Worry About its Use During Police Calls*, NBC NEWS (July 3, 2020, 5:20PM), https://www.nbcnews.com/news/us-news/elijah-mcclain-was-injected-ketamine-while-handcuffed-some-medical-experts-n1232697 [https://perma.cc/6TUW-3HTN]; *see also* Schmelzer, *supra* note 28.

349. Elise Schmelzer, *Aurora Man to Be Taken Off Life Support After Confrontation with Police Left Him Dead*, DENVER POST (June 9, 2020, 11:58 AM), https://www.denverpost.com/2019/08/30/elijah-mcclain-aurora-police-death [https://web.archive.org/web/20201003092728/https://www.denverpost.com/2019/08/30/elijah-mcclain-aurora-police-death/].

McClain's autopsy lists his cause of death as "[u]ndetermined."[350] However, the evidence suggests that ketamine may have played a significant role. Aurora Fire Rescue claimed that they injected McClain because he exhibited "excited delirium"—a condition of profound agitation that law enforcement and medical examiners often use to justify use of force.[351] Excited delirium "is not a currently recognized medical or psychiatric diagnosis according to either the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IVTR) of the American Psychiatric Association or the International Classification of Diseases (ICD-9) of the World Health Organization."[352] As the attorney representing the McClain family notes, the police body-cam video refutes the medics' claim in that "[t]he video shows the opposite of anybody showing any signs of excited delirium. . . . There's no legal or factual reason why a chemical restraint was used because [McClain] was already totally still and totally compliant."[353] The *Denver Post* reported that first responders' use of ketamine had become "increasingly common," with "[n]inety fire departments and emergency medical service agencies across Colorado – including those in Aurora, Denver and Colorado Springs – hav[ing] waivers from the Colorado Department of Public Health and Environment to use ketamine to treat excited delirium . . . ."[354] Paramedics in Colorado have administered ketamine to over nine hundred people over a two and a half year period—180 times in the first half of 2020 alone.[355] Elijah McClain's death draws attention to the dire risks of casually and indiscriminately using chemical restraints to police marginalized communities. The most vulnerable populations who disproportionately contact

350. MONICA BRONCUCIA-JORDAN, OFF. OF THE CORONER, ADAMS & BROOMFIELD CNTYS., AUTOPSY REPORT OF ELIJAH MCCLAIN (2019), https://www.scribd.com/document/434633869/Elijah-McClain-Autopsy-Report#download [https://perma.cc/D4UN-7JFG].

351.

> [N]early all reported cases of excited delirium involve people who are fighting with police. . . . [ACLU attorney Eric] Balaban charges that police officials are using the diagnosis "as a means of white-washing what may be excessive use of force and inappropriate use of control techniques by officers during an arrest."

Laura Sullivan, *Death by Excited Delirium: Diagnosis or Coverup?*, NPR (Feb. 26, 2007, 4:00PM), https://www.npr.org/templates/story/story.php?storyId=7608386 [https://perma.cc/BFR6-NWJ5].

352. Asia Takeuchi, Terence L. Ahern & Sean O. Henderson., *Excited Delirium*, 12 W.J. EMERGENCY MED. 77, 77 (2011).

353. Schmelzer, *supra* note 28.

354. *Id.* In the state of Colorado, a local fire, paramedic, or other "agency's medical director must apply for a waiver from the state health department for paramedics to use [ketamine] on patients who experience excited delirium. . . . In 2018, according to state records, the drug was administered 265 times with a total of 14 cases that involved one or more complication." Lori Jane Gliha, *Problem Solvers Investigation: Colorado Paramedics Injecting Sedative Ketamine into Agitated Patients*, FOX 31 DENVER (Nov. 21, 2019), https://kdvr.com/2019/11/21/problem-solvers-investigation-colorado-paramedics-injecting-sedative-ketamine-into-agitated-patients [https://perma.cc/WSK4-PVBW]. For an example of local guidelines in Colorado on the use of ketamine, see COLO. SPRINGS FIRE DEP'T & AM. MED. RESPONSE, PREHOSPITAL PRACTICE GUIDELINES (2019), https://coloradosprings.gov/sites/default/files/inline-images/prehospital_practice_guidelines_2.11.19.pdf [https://perma.cc/ZRZ9-522X].

355. de Yoanna & Solomon, *supra* note 27.

law enforcement—people who are unhoused, racial minorities, and those with preexisting mental health or other medical issues—are most likely to bear the consequences of chemical restraints when law enforcement uses them as a policing strategy, which exacerbates social inequalities.

There are important counterarguments that might support the use of chemical restraints during some police engagements. Some may argue that chemical restraints offer a kinder and gentler way for police to subdue individuals who may be a danger to themselves or others, which can lead to fewer instances of deadly force and therefore save lives. The idea is that the use of drugs under the supervision of a paramedic is safer than physical forms of police force, or that using different drugs might address any particular danger presented by ketamine. Another perspective is that close collaboration between first responders—particularly police and paramedics—is important to promote open communication and decision-making. Bringing in outside legal or regulatory frameworks that restrict the nature of these conversations in pre-clinical settings might ultimately lead to inefficient exchanges between professionals and patient harm. These are certainly important considerations. But these perspectives obscure a key point: patient need as determined by medical professionals should singularly determine the use of chemical restraints without influence from law enforcement or concern for any police investigation.

Law enforcement has the ability to use physical restraints while paramedics have the ability to use chemical restraints. This separation must be maintained. Police could discuss a detainee's physical condition with a paramedic, and a paramedic could use this information to independently conclude that a chemical restraint might benefit the health of a patient. For example, if a paramedic receives information that a detained person has been extremely agitated to the point that they might harm themselves, the paramedic might examine the person and conclude that a chemical restraint could be beneficial. In this hypothetical, communication between police and paramedics is needed for the paramedic to understand the detained person's health status so that she can make a decision that would protect the patient's interest. This situation is fundamentally different from the examples from Minneapolis discussed above, where police ask paramedics to administer chemical restraints not to protect detainees' health, but to simply make their jobs easier. This practice not only violates professional and ethical guidelines, but can also lead to significant patient harm.

This Article has drawn attention to the growing use of chemical restraints by medical practitioners for law enforcement purposes and argues that this practice constitutes an unreasonable use of force when done for the convenience of police rather than the health of those they detain. By putting existing practices and federal regulations concerning chemical restraints in conversation with Fourth Amendment use-of-force standards and existing case law, this Article demonstrates the significant constitutional issues that courts need to address to protect individual rights. Put simply, if using chemical restraints on an already

compliant or physically restrained person in a hospital setting conflicts with federal regulations on clinical care, then similar acts towards John Powell, Elijah McClain, or any other detained person in public or pre-clinical settings should also be an unreasonable use of force that violates the Fourth Amendment.

The doctrinal contributions of this Article are connected to the expansion of Osagie Obasogie and Zachary Newman's important theoretical argument concerning federal courts' understanding of Fourth Amendment reasonableness in relation to excessive force. In *The Endogenous Fourth Amendment*, Obasogie and Newman extend legal endogeneity theory, first developed by Lauren Edelman as a way to understand federal statutory law,[356] to the realm of constitutional law.[357]

Edelman developed legal endogeneity theory to understand the organizational dynamics that allow federal statutes like Title VII, initially designed to protect women and minorities from workplace discrimination, to become a means for organizations to reassert and rearticulate their often biased preferences, practices, and perspectives as the legal rule.[358] Characteristics of legal endogeneity are (1) ambiguous legal text intended to stimulate reform that (2) organizations respond to with symbolic gestures rather than substantive change that (3) federal courts defer to as actual compliance (instead of creating independent standards). Legal endogeneity theory shows how federal statutes meant to curb discrimination become mechanisms of oppression.[359] Applying this theory to the Fourth Amendment, Obasogie and Newman question the largely-held assumption that the Fourth Amendment has an exogenous effect on defining the lawfulness of police force. In other words, they question the assumption that Fourth Amendment text shapes what counts as reasonable or unreasonable police use of force against community members.[360] The authors engage in an empirical and doctrinal analysis of use-of-force policies from the seventy-five largest cities and find that this traditional understanding of the Fourth Amendment is often incorrect.[361] Their analysis shows that federal courts' understanding of constitutional reasonableness routinely defers to police conceptions of reasonable force as stated in their administrative use-of-force policies.[362] Federal courts often hold that a police officer does not offend the Fourth Amendment if their particular use of force is consistent with police department policy.[363] Therefore, courts often do not create the meaning of reasonableness exogenously or from judicial or textual mechanisms, but

356. EDELMAN, *supra* note 30.
357. Obasogie & Newman, *supra* note 29.
358. EDELMAN, *supra* note 30, at 3–20.
359. *Id.* at 12.
360. *See* Obasogie & Newman, *supra* note 29.
361. *Id.* at 1286.
362. *Id.* at 1288.
363. *Id.*; *see also* Christopher Logel, Comment, *Cracking* Graham*: Police Department Policy and Excessive Force*, 20 BERKELEY J. AFR.-AM. L. & POL'Y 27 (2018).

endogenously by police organizations whose internally-developed rules on when and how to use force *become* the constitutional standard.[364]

Legal endogeneity in the Fourth Amendment context usually absolves police use of force—even when such force might otherwise might be seen as excessive.[365] Judicial deference to police preferences limits accountability when force becomes unreasonable. Yet, understanding how legal endogeneity shapes the application of Fourth Amendment rules creates important opportunities for disruption and reform. Obasogie and Newman note in a separate Article titled *Constitutional Interpretation Without Judges*, "If courts are going to defer to police in defining the constitutional meaning of excessive force, then grassroots efforts to change police behavior can not only positively impact individual communities, but perhaps 'filter up' to have a more synergistic effect in reshaping the constitutional rule."[366]

This Article's discussion of chemical restraints used in pre-clinical settings exemplifies this potential. As a doctrinal matter, chemical restraints should be understood as a form of force, and Fourth Amendment restrictions ought to apply to medical professionals who administer these drugs for law enforcement purposes. However, Obasogie and Newman's commitment to *anti-endogeneity* in Fourth Amendment jurisprudence informs our argument that federal courts ought to seek guidance from other health law regulations to understand what "reasonable" means in the context of paramedics use of chemical restraints. As a normative claim, anti-endogeneity discourages uncritical judicial deference to police norms, practices, and preferences[367] in defining constitutional standards. Instead, anti-endogeneity moves toward democratic sources to interpret ambiguous constitutional text about use of force on community members. Obasogie and Newman sketch the possibilities of this approach:

> If police largely control the administrative site where use of force policies are developed and ultimately impact how federal courts think about the constitutional boundaries of excessive force, then citizens, stakeholders, and the public can work with police to intervene at this point. Disrupting the very mechanism that police use to limit accountability can create the conditions for reimagining the Fourth

364. Obasogie & Newman, *supra* note 29, at 1287–88.

365. For example, in a 2008 case from a federal district court in Texas, the court found that an officer's knee strike to the plaintiff that caused significant damage was not unreasonable because "[u]nder the Fort Worth Police Department's guidelines, a knee strike is considered an intermediate use of force" and thus, by definition, "not the deadly use of force or a technique that could cause serious injury." Peterson v. City of Fort Worth, No. 4:06-CV-332-Y, 2008 WL 440301, at *10 (N.D. Tex. Feb. 19, 2008), *aff'd*, 588 F.3d 838 (5th Cir. 2009). From the court's perspective, the plaintiff's ruptured femoral artery did not matter. What became dispositive was how the police use of force policy characterized the particular action.

366. Obasogie & Newman, *supra* note 31, at 427–28.

367. Judicial deference to police preferences and perspectives occurs in many aspects of criminal procedure. *See* Anna Lvovsky, *The Judicial Presumption of Police Expertise*, 130 HARV. L. REV. 1995, 1997–98 (2017); Aziz Z. Huq, *Fourth Amendment Gloss*, 113 NW. U. L. REV. 701, 703 (2019).

> Amendment from the "bottom up." This can play an important role in both preventing police use of force before it happens while also providing rules to point to in demonstrating liability when officers deviate from force policies and violate rights. If these policies are reframed with improved values and strategies for avoiding force, and courts continue to deem them relevant in signaling compliance, then legal endogeneity could be inverted from a process police use to protect themselves to one where the public could intervene for reform.[368]

These "bottom up" sources for interpreting the Fourth Amendment could include federal statutes and regulations created by a representative arm of government that describe when chemical restraints can be used in hospital settings. This would exemplify a broader community and professional sensibility regarding what is reasonable and appropriate.

The democratic processes tied to developing federal statutes or administrative regulations often reflect a series of conversations among stakeholders on what works best for various constituencies and how government should engage a particular issue. As discussed in Part III.B of this Article, the Nursing Home Reform Act that was codified in Title 42 of the Code of Federal Regulations articulates a strong aversion to non-medical uses of chemical restraints. This standpoint is the result of extended discussions between medical providers, advocates for nursing home residents, and legislators. It is further informed by an independent report from policy experts at the Institute of Medicine (now called the National Academy of Medicine). The deliberative process tied to developing federal statutes or administrative laws and policies creates a wealth of knowledge on stakeholders' experiences, concerns, and needs. Where there is textual ambiguity in the Fourth Amendment on the meaning of "reasonableness," *anti-endogeneity* suggests that federal courts should define terms in ways that support the interest of the broadest constituency, not the narrow policy preferences of the police or paramedics—the very government actors that the Fourth Amendment is designed to regulate. By drawing upon parallel interpretations found in other democratic and deliberative spaces, federal courts can enforce otherwise ambiguous constitutional text in ways that best serve the community.

Developing mechanisms to disrupt legal endogeneity in Fourth Amendment jurisprudence is an important opportunity for reforming how police and paramedics use force in communities. Although professional expertise is important, deferring to the interests of law enforcement entities to define what counts as appropriate use of force leaves community members vulnerable and excluded from the process of determining how the law should treat them.[369]

---

368. Obasogie & Newman, *supra* note 31, at 444–45.

369. Aspects of this argument align with an important literature in administrative law on selecting which agencies make particular decisions and considering the tradeoffs in choosing between agencies to achieve regulatory goals. For a discussion, see, for example, Eric Biber, *Too Many Things to Do: How to Deal with the Dysfunctions of Multiple-Goal Agencies*, 33 HARV. ENV'T L. REV. 1 (2009); Eric

Applying standards on chemical restraints developed in other branches of government to interpret Fourth Amendment "reasonableness" is a key mechanism to ensure that community standards inform government officials' treatment of people. This mechanism is an important sensibility in Fourth Amendment jurisprudence that courts have undervalued, and its enforcement in the context of chemical restraints might be a critical first step to rethinking many aspects of use-of-force inquiries.

Biber, *Which Science? Whose Science? How Scientific Disciplines Can Shape Environmental Law*, 79 U. CHI. L. REV. 471 (2012).