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A safe haven for the injured? Urban trauma care at the intersection of healthcare, law enforcement, and race

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ABSTRACT

Patients with traumatic injuries often interact with police before and during hospitalization, particularly when their injuries are due to violence. People of color are at highest risk for violent injuries and have the poorest outcomes after injury. The purpose of this study was to describe how injured, Black patients perceived their interactions with police and what these perceptions reveal about police involvement within trauma care systems. We combined data from two qualitative studies to achieve this aim. The first was ethnographic fieldwork that followed Black trauma patients in the hospital through the physical and emotional aftermath of their injuries. The second was a qualitative, descriptive study of how patients experienced trauma resuscitation in the emergency department (ED). Both studies were conducted between 2012 and 2015 at the Trauma Center at Penn, an academic medical center in Philadelphia, Pennsylvania, United States. The present study includes data from 24 adult, Black participants undergoing treatment for injury. We reanalyzed all interview data related to law enforcement encounters from the scene of injury through inpatient hospitalization and coded data using a constant comparative technique from grounded theory. Participants described law enforcement encounters at the scene of injury and during transport to the hospital, in the ED, and over the course of inpatient care. Injured participants valued police officers' involvement when they perceived that officers provided safety at the scene, speed of transport to the hospital, or support and information after injury. Injured participants also found police questioning to be stressful and, at times, disrespectful or conflicting with clinical care. Communities, trauma centers, and professional societies have the opportunity to enact policies that standardize law enforcement access in trauma centers and balance patients' health, privacy, and legal rights with public safety needs.

1. Introduction

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

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with direct health implications. Those with limited access to employment are also more likely to be uninsured and have fewer resources and choices when seeking healthcare services (Alexander, 2010; Gates et al., 2014).

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

Rich's *Wrong Place, Wrong Time* (2008) explores trauma and violence in the lived experience of young, gunshot injured, Black men in Boston. This work laid the foundation for in-depth study of the social etiologies of racial outcome disparities following a traumatic injury. Rich illustrated numerous ways that the men he followed were disenfranchised from the healthcare resources they needed to support their physical and psychological healing. He also reflected on how healthcare providers stereotyped these injured men as perpetrators rather than victims of violence. Though there is very limited research in this area, negative stereotypes have the potential to alter how trauma care is delivered, even when biases are unconscious (Haider et al., 2015). The presence of police within healthcare space may reinforce deviant and criminal stereotypes of injured patients and interfere with their ability to occupy what Parsons (1951) describes as the "sick role." These patients may find the safe haven of the hospital to be compromised (Conrad and Schneider, 1992), when rightfully or not, they are held accountable for the cause of their injuries.

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

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

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

2. Methods

2.1. Setting

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

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

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