Qualified Immunity and the Prehospital Medical Provider

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Abstract. The murder of George Floyd at the hands of Minneapolis police officers resulted in nationwide calls for police reform. Graphic video footage of Floyd's death quickly reached every corner of the internet. For months, his death dominated the news cycle, made international headlines, and sparked protest throughout the nation. To those seeking justice, the doctrine of qualified immunity was quickly identified as a potential barrier to police accountability. It was decried as a form of legal invulnerability for police—a shield used to evade civil liability for acts of abuse and misconduct. For that reason, criticism of qualified immunity has largely focused on its protection of police officers. Yet qualified immunity also protects other discretionary state actors.

Framing qualified immunity through the narrow lens of law enforcement ignores entire swaths of discretionary state actors who rely on its protection yet remain largely innocent in the debate over police misconduct. To fully appreciate the implications of eliminating qualified immunity, the consequences of reform must encompass all whom it would impact. This Comment will focus on prehospital medical providers.

While eliminating qualified immunity may curb some police misconduct, it will also impact prehospital medical providers and the crucial services they provide to their communities. To these providers, qualified immunity is an essential protection that allows them to put the patient first. Its absence would be felt by individual providers, entire communities, and the national 9-1-1 system in general.

This Comment will highlight some of the unintended consequences of eliminating qualified immunity. It proposes measured solutions

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that address calls for police reform while preserving qualified immunity's protection for prehospital medical providers rendering aid.

Introduction

In recent years, qualified immunity has gone from being an obscure legal doctrine—scrutinized primarily within academic circles—to a central topic of debate on the national political stage. In May 2020, video footage depicting the death of George Floyd at the hands of Minneapolis police officers resulted in national cries for police reform.[1] Qualified immunity became a source of intense controversy—a potential barrier to justice and a roadblock on the path to police reform. Since then, calls to eliminate qualified immunity have continued to gain public support.

Debates over qualified immunity have largely focused on protections for police officers.[2] Videos depicting police use-of-force, particularly against members of minority communities, have flooded news cycles and social media sites, bringing a previously underreported issue to center stage.[3] The George Floyd Justice in Policing Act of 2021, passed by the House of Representatives in March 2021, sought to eliminate qualified immunity for law enforcement, thus affording the victims of police misconduct a chance to pursue civil damages.[4] The bill represented a larger commitment by many to end a legal protection that has been criticized as racist and an obstacle to justice.

While it is true that early notions of qualified immunity emphasized law enforcement protections, its reach extends far beyond the thin blue line.[5] Qualified immunity protects all state actors whose work requires discretionary action, often under little supervision and in high-stress conditions.[6] Eliminating qualified immunity would impact not only law enforcement but emergency medical services ("EMS") responders as well.[7]

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[1] David Schultz, *The $2 Billion-Plus Price of Injustice: A Methodological Map for Police Reform in the George Floyd Era*, 47 MITCHELL HAMLINE L. REV. 203, 203 (2021).

[2] *See, e.g.*, Lawrence Rosenthal, *Defending Qualified Immunity*, 72 S.C. L. REV. 547, 548 n.1, 572 nn.109–10, 577, 586 (2020); Alexander J. Lindvall, *Qualified Immunity and Obvious Constitutional Violations*, 28 GEO. MASON L. REV. 1047 (2021).

[3] *See, e.g.,* David G. Maxted, *The Qualified Immunity Litigation Machine: Eviscerating the Anti-Racist Heart of § 1983, Weaponizing Interlocutory Appeal, and the Routine of Police Violence Against Black Lives*, 98 DENVER L. REV. 629, 639–43 (2021).

[4] George Floyd Justice in Policing Act of 2021, H.R. 1280, 117th Cong. (2021).

[5] *See* Pierson v. Ray, 386 U.S. 547, 556–57 (1967).

[6] *See* Harlow v. Fitzgerald, 457 U.S. 800, 816, 818 (1982).

[7] Qualified immunity applies only to state actors. EMS agencies contracted with a state or municipal government to respond to 9-1-1 calls may not be covered under the doctrine. Making that determination requires a fact-intensive inquiry. *Compare* Filarsky v. Delia, 566 U.S. 377, 389–90 (2012) ("[I]mmunity under § 1983 should not vary depending on whether an individual working for the government does so as a full-time employee, or on some other basis."), *with* Tanner v. McMurray, 989 F.3d 860 (10th Cir. 2021) (rejecting *Filarsky* as applied to a for-profit government contractor rendering medical services inside the Bernalillo County Metropolitan Detention Center). *See infra* Part I.B.1.

Unlike police work, which exercises authority as a means to enforce the law, EMS providers use authority to render medical aid to those in need.[8]

The prehospital medical setting is often characterized by its chaos and lack of predictability.[9] As Secretary of Defense Donald Rumsfeld famously noted, "there are known knowns; there are things we know we know. We also know there are known unknowns . . . we know there are some things we do not know. But there are also unknown unknowns—the ones we don't know we don't know."[10] Rumsfeld's statement has been frequently cited in the EMS community to refer to the challenges responders regularly encounter on the job.[11] EMS responders are required to exercise judgment and discretion in the field; at times this can result in less than desirable outcomes for the patient or provider. Presently, the doctrine of qualified immunity serves as a protection against civil liability for responders who make reasonable but mistaken judgments about open legal questions during the performance of their duties.[12] Removing this protection may have significant unintended consequences. Qualified immunity grants state EMS providers necessary insulation from civil damages liability and should be preserved amid calls to eliminate the protection for law enforcement.

This Comment analyzes qualified immunity as applied to EMS and discusses the potential ramifications of eliminating qualified immunity to medical providers in the prehospital setting. Part I provides background on the doctrine of qualified immunity as well as the role of EMS providers in the prehospital setting. Part II differentiates the public health role of EMS providers from the enforcement role traditionally reserved for police. It also analyzes some of the common arguments for and against qualified immunity. Part III closes by making a number of recommendations that preserve EMS protections under qualified immunity while reforming the doctrine in a way that addresses the present calls for change.

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[8] *See* Amanda C. DeDiego, Evan Burns, Kristina M. Faimon, Elyssa B. Smith & Lauren Moret, "*The Butler of Healthcare": Exploring Trauma Narratives of Emergency Medical Services Personnel*, 7 J. MIL. GOV'T COUNSELING 72, 72 (2019); *see generally* Eric Levy, *Indianapolis Police Officers Starting to be Cross-Trained as EMTs*, FOX 59 NEWS (Aug. 8, 2004), https://perma.cc/VDH4-XNHR.

[9] *See generally* DeDiego et al., *supra* note 8.

[10] Donald Rumsfeld, Sec'y of Def., Dept. of Def., U.S. Department of Defense News Briefing (Feb. 12, 2002), https://perma.cc/T5CU-L752.

[11] *See, e.g.*, *Thoughtful Decision-Making for EMS Managers*, JEMS (Sept. 9, 2010), https://perma.cc/V9V7-G9VF.

[12] *See* Pierson v. Ray, 386 U.S. 547, 557 (1967).

I. Qualified Immunity and the State Actor

Civil damages suits against public officials have long been recognized as an effective means of challenging the constitutionality of government conduct.[13] Under 42 U.S.C. § 1983, legal action may be brought against those acting under color of law who deprive another of "any rights, privileges, or immunities secured by the Constitution and laws."[14] The doctrine of qualified immunity serves as a direct barrier to any such remedy by protecting state actors from damages liability so long as they have not violated "clearly established" rights.[15] Qualified immunity was intended to protect law enforcement officers acting in good faith from frivolous lawsuits and damages liability that result from the discretionary function of their duties.[16] But its reach is not limited to protecting police; the doctrine shields other discretionary state actors, including EMS providers acting on behalf of a state or municipality.[17] While calls to eliminate qualified immunity have largely targeted law enforcement, other actors who rely on its protections would find themselves equally vulnerable in its absence.[18] Placing this added burden on state actors who perform lifesaving services may have a significant negative impact on the quality of service offered to society.[19] Despite a wealth of literature discussing the elimination of qualified immunity, little has been authored about the considerable negative repercussions associated with eliminating the protection for emergency medical responders.

A. *The Doctrine of Qualified Immunity*

For an individual named in a § 1983 suit, the doctrine of qualified immunity serves as a potential protection from civil damages liability.[20] Initially, the "good faith" inquiry that qualified immunity called for placed unique burdens on the individual state actor while interfering with the effectiveness of government operation.[21] As such, the Supreme Court

13 *See* Rosenthal, *supra* note 2, at 547.

14 42 U.S.C. § 1983.

15 Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982).

16 *Pierson*, 386 U.S. at 556–57 ("Part of the background of tort liability, in the case of police officers making an arrest, is the defense of good faith and probable cause.").

17 *See Harlow*, 457 U.S. at 818.

18 *See* Joanna C. Schwartz, *After Qualified Immunity*, 120 COLUM. L. REV. 309, 313–315 (2020).

19 *See id.*

20 *See Harlow*, 457 U.S. at 818.

21 *See id.* at 807, 817 ("Judicial inquiry into subjective motivation therefore may entail broad-ranging discovery and the deposing of numerous persons, including an official's professional colleagues. Inquiries of this kind can be peculiarly disruptive of effective government.").

broadly expanded qualified immunity, holding that "government officials performing discretionary functions generally are shielded from liability for civil damages insofar as their conduct does not violate *clearly established statutory or constitutional rights* of which a reasonable person would have known."[22] For a right to be clearly established, it must be sufficiently clear that a reasonable official would understand his conduct to be violating that right.[23] It is enough that existing precedent render the statutory or constitutional question "beyond debate."[24] The Court's ongoing development of qualified immunity has sought to strike a balance between two important interests: "the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction, and liability when they perform their duties reasonably."[25]

For the government to function efficiently, those acting on its behalf must not be in constant fear of civil litigation.[26] As the Supreme Court has recognized, fear of reprisal can alter the course of one's conduct and have a detrimental impact on government efficiency.

> [E]ven where personal liability does not ultimately materialize, the mere 'specter of liability' may inhibit public officials in the discharge of their duties for even those officers with airtight qualified immunity defenses are forced to incur 'the expenses of litigation' and to endure the 'diversion of their official energy from pressing public issues.'[27]

Though overcoming qualified immunity imposes a substantial burden on a prospective claimant, the government must still ensure state actors are adequately trained to recognize the clearly established rights that, if violated, may subject them to civil liability.[28] In practice, however, the Supreme Court has acknowledged that qualified immunity protects "all but the plainly incompetent or those who knowingly violate the law."[29]

Determining whether or not a government actor should receive the protection of qualified immunity implicates a two-part test first established in *Saucier v. Katz*.[30] The test requires courts to first answer the following question: "Taken in the light most favorable to the party

22 *Id.* at 818 (emphasis added).

23 Anderson v. Creighton, 483 U.S. 635, 640 (1987).

24 Ashcroft v. al-Kidd, 563 U.S. 731, 741 (2011).

25 Pearson v. Callahan, 555 U.S. 223, 231 (2009).

26 Atwater v. Lago Vista, 532 U.S. 318, 351 n.22 (2001).

27 *Id.* (quoting Harlow v. Fitzgerald, 457 U.S. 800, 814 (1982)).

28 Rosenthal, *supra* note 2, at 585–86.

29 *Ashcroft*, 563 U.S. at 743 (quoting Malley v. Briggs, 475 U.S. 335, 341 (1986)); *see Pearson*, 555 U.S. at 231 ("The protection of qualified immunity applies regardless of whether the government official's error is 'a mistake of law, a mistake of fact, or a mistake based on mixed questions of law and fact.'" (quoting Groh v. Ramirez, 540 U.S. 551, 567 (2004))).

30 533 U.S. 194 (2001).

asserting the injury, do the facts alleged show the [government actor's] conduct violated a constitutional right?"[31] If the court determines no constitutional right has been violated, the inquiry ends, and there is no need for qualified immunity.[32] If the court determines that a constitutional right has been violated, the court then asks whether or not the right was clearly established at the time of the incident.[33] The answer to that question requires the court to consider "whether it would be clear to a reasonable [government actor] that his conduct was unlawful in the situation he confronted."[34] If the answer is "no," the state actor receives qualified immunity.[35]

The suggestion that police regularly use qualified immunity to escape charges of abuse and misconduct has recently made the doctrine a major social and political issue.[36] The murder of George Floyd at the hands of Officer Derek Chauvin triggered what some have called a movement to defund the police.[37] Outspoken celebrities and activist groups like Black Lives Matter quickly took to social media to demand justice for Floyd and the prior victims of police violence.[38] Hashtags like #EndQualifiedImmunity were soon trending online, prompting a national discussion on the state of policing in America.[39] Some lawmakers were quick to target qualified immunity as the source of the problem and call for the doctrine's end.[40] Several state legislatures introduced bills to eliminate qualified immunity at the state level by permitting civil action under state constitutions, rather than through federal § 1983 suits.[41] While many of these bills have stalled or fallen short of eliminating qualified immunity, motivated advocates continue to petition the courts and their

31 *Id.* at 201. While this case pertained to the actions of a military police officer, the principle established is equally applicable to all government actors seeking protection under qualified immunity.

32 *Id.*

33 *Id.*

34 *Saucier*, 533 U.S. at 202. The Court also noted that a circuit split on the relevant issue would indicate that no clearly established right existed: "If judges thus disagree on a constitutional question, it is unfair to subject [government officials] to money damages for picking the losing side of the controversy." Wilson v. Layne, 526 U.S. 603, 618 (1999).

35 *Saucier*, 533 U.S. at 202.

36 *See* Schultz, *supra* note 1, at 208–10.

37 *Id.* at 203–04.

38 Tyler McCarthy, *Celebrities Who Have Joined George Floyd Protests Against Police Brutality*, FOX NEWS (June 3, 2020), https://perma.cc/Z9FW-5RN6.

39 *See* Maxted, *supra* note 3, at 636–38.

40 *See* Ending Qualified Immunity Act, H.R. 1470, 117th Cong. (2021).

41 *See, e.g.*, New Mexico Civil Rights Act, H.B. 4, 55th Leg., 1st Sess. (N.M. 2021); S.B. 20-217, 72nd Gen. Assemb., Reg. Sess. (Colo. 2020); S.B. 1991, 2021–2022 Leg., Reg. Sess. (N.Y. 2021).

elected officials to abolish the protection.[42] Whether change should come from the courts, Congress, or state legislatures, responding to calls for change should not be done in haste. Understanding how qualified immunity impacts other state actors should play a vital role in how a remedy is sought.

B. *The Role of Emergency Medical Services Providers*

Qualified immunity protects a class of state actors who are often referred to jointly as first responders. The term "first responder" applies broadly to "[a] member of a police force, fire department, or medical-services unit with special training to be the initial person to help in an emergency."[43] As one might imagine, the services rendered by first responders vary greatly depending on the type of agency they work for and the role of the individual provider.[44] Despite considerably different primary objectives, almost all first responders are trained to render emergency medical aid.[45] In most jurisdictions, this duty is primarily the responsibility of emergency medical technicians ("EMTs") and paramedics.[46] In many states, career firefighters are required to possess

[42] *See* Kimberly Kindy, *Dozens of States have Tried to End Qualified Immunity. Police Officers and Unions Helped Beat Nearly Every Bill*, WASH. POST (Oct. 7, 2021), https://perma.cc/SGQ3-XNR4.

[43] *First Responder*, BLACK'S LAW DICTIONARY (11th ed. 2019).

[44] Broadly dividing first responders into the categories of police, fire, and EMS is insufficient to identify the duties of the individual. In fact, there is tremendous crossover with regard to the training and capability of those in each service. For example, many police departments now have "police medics" who are sworn law enforcement officers yet primarily function in a medical capacity. Similarly, many metropolitan fire departments require their career firefighters to be trained on both fire suppression and emergency medical services. The integration of 9-1-1 services has also seen an increase in the use of dual dispatching—a practice in which police or firefighters respond to medical emergencies, in addition to EMS, to provide basic medical services such as CPR and first aid. The more mobile nature of "patrol work" often results in police being the first to arrive and render aid at a medical scene. *See, e.g.*, Robert J. Myerburg, Jeffrey Fenster, Mauricio Velez, Donald Rosenberg, Shenghan Lai, Paul Kurlansky, Starbuck Newton, Melenda Knox & Agustin Castellanos, *Impact of Community-Wide Police Car Deployment of Automated External Defibrillators on Survival from Out-of-Hospital Cardiac Arrest*, 106 CIRCULATION 1058, 1059, 1063 (2002); *see also infra* notes 45–49 and accompanying text.

[45] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1797.183 (West 2007) (requiring all California peace officers except those who serve in a primarily clerical capacity to be trained to administer first aid and CPR); TEX. OCC. CODE ANN. § 1701.2551 (West 2012) (requiring all Texas peace officers to provide first aid or treatment to injured parties encountered while discharging the officer's official duties).

[46] Although EMTs and paramedics are both tasked with responding to and rendering aid at emergency medical incidents, their scope of practice differs greatly and varies by state. In general, an EMT is responsible for rendering basic first aid and conducting minimally invasive diagnostic tests, and may be permitted to administer oxygen and a very limited number of other pharmacological agents. Initial training time varies by state but typically calls for around 170 hours of combined

medical training to at least the EMT-level.[47] In addition, several police agencies are moving towards a policing model that includes designated law enforcement officers cross-trained as EMTs or paramedics.[48] Regardless of the first responder's primary occupation or title, the term "EMS provider" in this Comment applies to all first responders *rendering aid* while acting as an agent of the state.

1. Determining State Actors

An estimated sixty percent of EMS agencies operate within some form of governmental structure, the most common being fire-department-based EMS and independent non-fire-based EMS.[49] As direct government actors—regardless of whether the EMS providers are paid or volunteer—those working at one of these agencies are inherently acting "under color of law" during the course of their service. The remaining forty percent of agencies are private and thus not automatically subject to § 1983's reach.[50] While various tests for determining the applicability of § 1983 liability to private entities have been used, the public function test and entwinement test are perhaps best suited to the first responder context.[51]

Under the public function test, "[s]tate action may be found in situations where an activity that traditionally has been the exclusive, or near exclusive, function of the State has been contracted out to a private entity."[52] The delegated activity must be one "traditionally under the

academic coursework and clinical shadowing. A paramedic provides more advanced prehospital treatment, which includes intravenous administration of pharmacological agents (including controlled substances), advanced airway management, and EKG interpretation. Paramedic candidates typically complete between 1,200 and 1,800 hours of advanced training above that which is required to become an EMT. In addition to these two medical responders, some states also have Emergency Medical Responders, with less training than EMTs, and Advanced EMTs, whose training falls between that of the EMT and the paramedic. *See generally* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., DOT-HS-812-666, NATIONAL EMS SCOPE OF PRACTICE MODEL (2019) [hereinafter EMS SCOPE OF PRACTICE].

47 Steve Przborowski, *Becoming a Firefighter: 10 Must-Do Things*, FIRERESCUE1 (Mar. 14, 2020), https://perma.cc/DC2Q-HHMM.

48 *See, e.g.*, Levy, *supra* note 8; Greg Jordan, *Va. Pilot Program to Train Police Deputies as EMTs*, POLICE1 (Jul. 20, 2021), https://perma.cc/BV9Y-GSMR.

49 NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., DOT-HS-812-041, EMS SYSTEM DEMOGRAPHICS (2014) [hereinafter EMS SYSTEM DEMOGRAPHICS].

50 *Id.*

51 *See, e.g.*, Grogan v. Blooming Grove Volunteer Ambulance Corps., 768 F.3d 259, 264–65, 268 (2d Cir. 2014); *See also* Brentwood Acad. v. Tenn. Secondary Sch. Athletics Ass'n, 531 U.S. 288, 295, 297, 302–03 (2001) (explaining a number of tests including the nexus test, coercion test, joint action test, public function test, and entwinement test).

52 Horvath v. Westport Library Ass'n, 362 F.3d 147, 151 (2d Cir. 2004).

exclusive authority of the state" and not merely a task regularly performed by government.[53] In *Grogan v. Blooming Grove Volunteer Ambulance Corps*,[54] the Second Circuit held that "the provision of emergency medical care and general ambulance services" were not an exclusive public function and cited a number of instances in which private agencies regularly carried out these functions.[55] A number of district courts in other circuits have made similar determinations, holding that EMS does not constitute state action under the public function test.[56] Despite this view towards private EMS organizations, the Courts of Appeals for the Second and Fourth Circuits have held that private non-profit fire services—including those that perform EMS functions—can qualify as state actors under the public function test.[57] Similarly, the Supreme Court has held fire protection to be a state and municipal function "administered with a greater degree of exclusivity."[58] Given today's overlap and cross-training of these two professions, is such a distinction warranted? If a firetruck loaded with firefighter-EMTs is dispatched to a fire and those onboard render medical aid to a patient with smoke inhalation, would they suddenly cease being state actors under the public function test?

The entwinement theory offers a different approach to determining state action. Under this test, state action may occur when a private entity is "entwined with governmental policies, or when government is entwined in its management or control."[59] In *Grogan*, the appellee alleged that sanctions imposed against her by a private volunteer ambulance corps constituted state action because the state of New York "imposes a variety of regulatory requirements on volunteer ambulance and emergency services organizations."[60] The Second Circuit rejected this argument, noting that while the state may have a substantial role in licensing and regulating EMS agencies, it does not participate in the sort of in-house

53 *See* Sybalski v. Indep. Grp. Home Living Program, Inc. 546 F.3d 255, 259 (2d Cir. 2008); *Grogan*, 768 F.3d at 264 (quoting Blum v. Yaretsky, 457 U.S. 991, 1005 (1982)).

54 768 F.3d 259 (2d Cir. 2014).

55 *Id.* at 265.

56 *See* Chassey v. Humphreys, No. CV-07-189, 2009 WL 3334912 (D. Or. Oct. 13, 2009) (holding private medical transport EMTs were not state actors under § 1983); Donnelly v. Kutztown Area Transp. Serv., 198 F. Supp. 3d 499, 508–09 (E.D. Pa. 2016) (holding private EMS providers contracted with a public college were not state actors under § 1983).

57 *See* Janusaitis v. Middlebury Volunteer Fire Dept., 607 F.2d 17, 23–24 (2d Cir. 1979); Goldstein v. Chestnut Ridge Fire Co., 218 F.3d 337, 343–45 (4th Cir. 2000).

58 Flagg Bros., Inc. v. Brooks, 436 U.S. 149, 163 (1978).

59 Brentwood Acad. v. Tenn. Secondary Sch. Athletics Ass'n, 531 U.S. 288, 296 (2001) (quoting Evans v. Newton, 332 U.S. 296, 301 (1966)).

60 Grogan v. Blooming Grove Volunteer Ambulance Corps., 768 F.3d 259, 268 (2d Cir. 2014).

disciplinary action at issue in *Grogan*.[61] Notably, the court stopped short of finding that EMS could never qualify as state action under the entwinement theory; it simply rejected the state action argument given the facts of the case.[62]

The Supreme Court has held, however, that the various tests used to determine state action are simply different methods of characterizing a "necessarily fact-bound inquiry,"[63] and that "[o]nly by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance."[64] That being said, a fact-bound inquiry that relies on the holding of *Grogan* presents a rather compelling argument that state action exists in the performance of at least some private EMS functions.

The 9-1-1 system is overseen by the Federal Communications Commission and operated by state and local governments; therefore, the interaction between EMS and patient is necessarily facilitated by the state.[65] In addition, the state establishes the protocols and standing orders that EMS providers must adhere to.[66] EMS agencies and their providers are not permitted to adopt their own methodology for assessing or treating various conditions.[67] Failing to follow state guidelines may be grounds for administrative sanction and license revocation.[68] Furthermore, in almost every state, EMS providers are required by law to document all patient care interactions and submit or retain a patient care report for the state to review.[69]

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61 *See id.* at 259; *see also* United States v. Int'l Brotherhood of Teamsters, 941 F.2d 1292, 1296 (2d Cir. 1991) ("The question is not whether the decision to *establish* the [private organization] was state action, but rather whether the [private organization's] decision to *sanction* [the plaintiffs] may be 'fairly attributable' to the Government.").

62 *Grogan*, 768 F.3d at 267–69.

63 Lugar v. Edmondson Oil Co., 457 U.S. 922, 939 (1982).

64 Burton v. Wilmington Parking Auth., 365 U.S. 715, 722 (1961).

65 *See* 47 U.S.C. § 615 ("The Federal Communications Commission shall encourage and support efforts by States to deploy comprehensive end-to-end emergency communications infrastructure and programs . . . [and] in encouraging and supporting that deployment . . . shall consult and cooperate with State and local officials responsible for emergency services and public safety . . . ."). States heavily regulate use of the 9-1-1 system and the public safety answering points ("PSAPs") responsible for dispatching resources to 9-1-1 callers. *See, e.g.*, N.Y. COUNTY § 325(9)–(10) (McKinney 2017) (defining public safety answering points as being operated by either the state police or a local government).

66 *See, e.g.*, 16 DEL. ADMIN. CODE §§ 9701–9706 (2023). While a state may determine its own EMS scope of practice, the National Highway Traffic Safety Administration publishes a national model that states are strongly encouraged to meet or exceed. *See generally* EMS SCOPE OF PRACTICE, *supra* note 46.

67 *See generally* EMS SCOPE OF PRACTICE, *supra* note 46.

68 *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1798.200(c) (West 2007).

69 *See, e.g.*, N.Y. PUB. HEALTH § 3053 (McKinney 2023).

With respect to those operating in an emergency 9-1-1 environment, EMS personnel (1) are dispatched to an incident by the state; (2) render aid in compliance with state regulations; (3) submit a mandatory report to the state; and (4) are subject to state discipline for failing to adhere to state regulations.[70] The Second Circuit in *Grogan* held that "the provision of emergency medical care and general ambulance services" is not an exclusive public function, dismissing the claim that under the public function test a private EMS provider was a state actor for purposes of § 1983 liability.[71]

However, a fact-based entwinement analysis, which focuses more on the government's "management or control" of a private actor, may trigger a different result.[72] Considering the extensive state involvement highlighted above, one could argue that private EMS providers rendering aid as a 9-1-1 dispatched service provider should be state actors under § 1983. Should the courts agree, such a determination may create two distinct categories of private EMS providers: the provider operating within the state 9-1-1 system—the quasi-public state actor—and the provider who operates outside the 9-1-1 system to whom § 1983 liability does not apply.[73] Under this framework, § 1983 liability could be applicable to over eighty percent of EMS personnel and all of those responding to 9-1-1 calls for help.[74] That same eighty percent can also, at least in theory, benefit from the protections of qualified immunity.

2. Discretionary Actors

EMS is not dissimilar from policing in that it requires an actor to make quick decisions in a high-stress environment—the very rationale for qualified immunity.[75] While police are authorized to use force for purposes of compliance or to effect an arrest, EMS providers generally have no such authority. Whether or not an EMS provider has the authority to force compliance or take action against the wishes of a patient often depends on the patient's capacity—a determination that can be made significantly more difficult when, for example, the patient is impaired by drugs or

70 *See supra* notes 52–58.

71 *See* Grogan v. Blooming Grove Volunteer Ambulance Corps, 768 F.3d 259, 265 (2d Cir. 2014).

72 Brentwood Acad. v. Tenn. Secondary Sch. Athletics Ass'n, 531 U.S. 288, 296–97 (2001).

73 There are many EMS services that operate outside of the emergency 9-1-1 system. Medical transport services, on-site standby services, and hospital-based EMS providers are just a few of the non-9-1-1 EMS services that exist.

74 *See* EMS SYSTEM DEMOGRAPHICS, *supra* note 49.

75 *See* Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982).

alcohol.[76] Capacity determinations, while common, are just one way that EMS providers are expected to exercise discretionary judgement in the field.[77] Yet a clinical error in determining capacity can have profound medical and legal implications for patient and provider alike. Understanding the consequences of this provider-patient interaction requires one to understand the discretionary nature of the provider's role, the prehospital setting in which he or she operates, and the current impact of qualified immunity on the decisions being made in the prehospital setting.

a. *The Importance of Capacity Determinations*

Despite playing a crucial role in one's daily life, the concept of capacity is seldom a topic of discussion. Capacity serves as a prerequisite for most legal decision-making. It indicates one's ability to self-advocate and, in its absence, may authorize others to act on one's behalf.[78] Despite capacity being necessary to maintain any sense of legitimate autonomy, this vital cognitive marker is frequently impaired or intentionally diminished through the consumption of alcohol.[79] In the United States alone, it is estimated that nearly fifteen million people ages twelve and older have suffered from alcohol use disorder at one point in their life.[80] When EMS comes into contact with someone who is impaired by alcohol, determining his or her capacity can become a far greater challenge and further reinforces the need for EMS to be able to exercise discretion in the field.[81]

In the legal sense, capacity refers to the individual's "mental ability to understand the nature and effect of [his or her] acts."[82] Capacity speaks to

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[76] *See* Rod Brougard, *Alcohol-Related Issues in an Emergency*, VERYWELL (Aug. 16, 2021), https://perma.cc/8A9S-VRTQ.

[77] *See* Ellison v. Hobbs, 786 F. App'x 861, 871–72 (11th Cir. 2019) (per curiam) (noting that an EMS provider's authority includes the ability to determine whether or not a patient has "adequate medical decision-making capacity to refuse transport to a hospital for emergency medical care").

[78] *See generally* Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 OR. L. REV. 353, 397–98 (2008).

[79] It can also be impaired through disease, trauma, and intoxication by other substances. The often intentional nature of alcohol impairment and the frequent interactions between intoxicated individuals and EMS make alcohol impairment an ideal case for demonstrating the importance and difficulty of assessing capacity in the field.

[80] *See* NAT'L INSTS. OF HEALTH, NAT'L INST. ON ALCOHOL ABUSE AND ALCOHOLISM, ALCOHOL FACTS AND STATISTICS (2021) (defining alcohol use disorder as "[a] chronic brain disorder marked by compulsive drinking, loss of control over alcohol use, and negative emotions when not drinking").

[81] *See* Vars, *supra* note 78.

[82] *Capacity*, BLACK'S LAW DICTIONARY (11th ed. 2019).

the individual's ability to reason, process information, and make decisions based on information and potential outcomes.[83] In the medical context, it pertains to the individual's ability to understand the risks and benefits of treatment, as well as the alternatives to treatment.[84] During a prehospital encounter with EMS, a patient's capacity establishes his or her ability to refuse medical treatment.[85] Capacity, being a transitory state, may exist one moment and be absent the next.[86] An individual must demonstrate capacity at the time a decision is being made for that decision to be legally effective.[87] For example, some patients experience a brief self-limiting postictal state after an epileptic seizure and may have altered mental status or even appear combative.[88] A decision rendered during this period of impairment would be ineffective. The subsequent return of normal function restores the patient's capacity and once again renders him or her capable of decision-making. EMS providers exercise discretion when determining the point at which a patient's baseline functioning has sufficiently returned.

Though frequently used interchangeably, capacity in this context is not synonymous with competency.[89] Competency is a legal finding—a status that a court assigns to an individual after finding that the individual either possesses or lacks the mental ability to understand problems and

[83] *See* Laura L. Sessums, Hannah Zembrzuska & Jeffrey L. Jackson, *Does This Patient Have Medical Decision-Making Capacity?*, 306 JAMA 420, 421 (2011); Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1835 (2007).

[84] *See* Appelbaum, *supra* note 83; s*ee also Informed Consent*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("A patient's knowing choice about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure.").

[85] In the absence of capacity and decision-making ability, a patient is unable to assert his or her right to refuse medical treatment and the provider may treat under the doctrine of implied consent. *See Implied Consent*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Consent inferred from one's conduct rather than from one's direct expression.").

[86] While some conditions may render an individual permanently incapacitated, others may result in episodic impairment. For example, an individual diagnosed with dementia may experience periods where they lack capacity, yet capacity may exist at other times. Similarly, intoxication may render someone incapacitated, yet the body's natural metabolic process functions to breakdown and remove alcohol from the bloodstream resulting in a return of capacity as blood-alcohol concentration decreases. *See* Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 FORDHAM L. REV. 1177, 1182 (1994).

[87] *See generally* Soumya Hegde & Ratnavalli Ellajosyula, *Capacity Issues and Decision-Making in Dementia*, 19 ANNALS INDIAN ACAD. NEUROLOGY 34, 36 (2016).

[88] *See, e.g.*, Everson v. Leis, 556 F.3d 484, 489 (6th Cir. 2009).

[89] *See* Hegde & Ellajosyula, *supra* note 87, at 34–35.

make decisions.[90] An individual with diminished capacity is not necessarily incompetent unless adjudicated as such.[91] He or she may still be able to effectively self-advocate and make legal decisions. Conversely, an individual ruled to be incompetent may not be able to make legal decisions even if he or she possesses the capacity to otherwise do so.[92] In other words, capacity is usually a clinical determination whereas competency is a legal finding.[93] In the prehospital setting, a legal determination as to competency is not practicable, and therefore reliance falls on a clinical determination of capacity.[94]

Capacity does, however, exist outside of the clinical setting and has a prominent role in the law.[95] In addressing capacity to contract, the Restatement (Second) of Contracts section 16 notes that

> [a] person incurs only voidable contractual duties by entering into a transaction if the other party has reason to know that by reason of intoxication (a) he is unable to understand in a reasonable manner the nature and consequences of the transaction, or (b) he is unable to act in a reasonable manner in relation to the transaction.[96]

Further clarity appears in the Restatement's comments, which assert that "a contract made by an intoxicated person is enforceable by the other party even though entirely executory, unless the other person has reason to know that the intoxicated person lacks capacity."[97] In accordance with the Restatement, capacity lies at the very root of contract formation, and an intoxicated individual may still contract up to the point that intoxication is "*so extreme* as to prevent any manifestation of assent."[98]

Unlike many other means of impaired capacity, intoxication is unique for a number of reasons. First, intoxication is typically a temporary self-

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90 *See* Christopher Libby, Amanda Wojahn, Joseph R. Nicolini & Gary Gillette, *Competency and Capacity*, NIH (June 5, 2022), https://perma.cc/G6J3-8YUV.

91 *Id.*

92 *Id.*

93 *Id.*

94 *See* Ellison v. Hobbs, 786 F. App'x 861, 872 (11th Cir. 2019) (holding that a paramedic may properly exercise "discretion and clinical judgment, based on his experience and knowledge as a trained paramedic" to determine whether or not a patient possesses adequate medical decisionmaking capacity).

95 *See* Laura J. Whipple, *Navigating Mental Capacity Assessment*, 29 TEMP. J. SCI. TECH. ENV'T L. 369, 373 (2010) (identifying different legal standards of mental capacity such as testamentary capacity, donative capacity, contractual capacity, decisional capacity, informed consent capacity, and trust capacity).

96 RESTATEMENT (SECOND) OF CONTRACTS § 16 (AM. L. INST. 1981).

97 *Id.* cmt. a.

98 *Id.* cmt. b (emphasis added).

limiting impairment.[99] In many instances, capacity is incrementally restored through the body's natural process of breaking down and filtering intoxicants from the bloodstream.[100] Second, intoxication is typically a self-inflicted condition—a conscious decision made by the individual with the awareness, if not the intent, that impairment would result. Third, the impairing effects of intoxication are broad and can range from minimal impairment to incapacitation.[101] This wide-ranging patient presentation helps to explain why determining the exact point at which capacity is absent can be so challenging for EMS.

Intoxication in and of itself does not negate one's capacity.[102] Instead, intoxication should be viewed as a spectrum of impairment. The first responder need hardly deliberate over those who appear at either end of this spectrum. A minimally intoxicated individual demonstrates capacity through his or her language, speech, coordination, and exhibited cognition; he or she may not appear to have any impairment.[103] Determining capacity is similarly obvious when intoxication renders the individual unconscious. An unconscious individual is incapacitated and is therefore unable to appropriately seek help or refuse medical treatment.[104] A first responder presented with this type of patient relies on the doctrine of implied consent and relevant state statutes to ensure the individual

99 *See, e.g.*, Missouri v. McNeely, 569 U.S. 141, 152 (2013) ("It is true that as a result of the human body's natural metabolic processes, the alcohol level in a person's blood begins to dissipate once the alcohol is fully absorbed and continues to decline until the alcohol is eliminated."); State v. Strong, 493 N.W.2d 834, 837 (Iowa 1992) ("[I]t is common knowledge that cocaine, once ingested orally, is absorbed into the blood and, like alcohol, is eliminated by the body.").

100 *See McNeely*, 569 U.S. at 153 ("BAC evidence from a drunk-driving suspect naturally dissipates over time in a gradual and relatively predictable manner.").

101 This point is rather self-evident. An intoxicating substance's ability to impair coincides with a number of factors, such as the concentration or strength of the dose, the quantity consumed, the weight of the user, the user's experience with the substance, and the time period in which the substance is consumed. The wide range of variables helps to explain why the same substance or dose may impair two people differently.

102 *See* Whipple, *supra* note 95, at 370.

103 *See* Craig Barstow, Brian Shahan & Melissa Roberts, *Evaluating Medical Decision-Making Capacity in Practice*, 98 AM. FAM. PHYSICIAN 40, 40 (2018). *See also* Lucy v. Zehmer, 84 S.E.2d 516, 520 (Va. 1954) ("The record is convincing that Zehmer *was not intoxicated to the extent of being unable to comprehend* the nature and consequences of the instrument he executed, and hence that instrument is not to be invalidated on that ground." (emphasis added)).

104 *Incapacitated Person*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Someone who is impaired by an intoxicant, by mental illness or deficiency, or by physical illness or disability to the extent that personal decision-making is impossible.").

receives needed care.[105] Questions of capacity are generally aroused when the patient presents somewhere between these opposing ends of the spectrum.[106] In addition to the challenges induced by the impairment itself, determining capacity can also be more challenging when the patient is uncooperative—a common occurrence among intoxicated individuals.

To demonstrate capacity, the patient must exhibit the ability to (1) effectively communicate a choice; (2) understand relevant information as it is communicated; (3) appreciate the significance of the information they are being told; and (4) use reasoning to arrive at a specific decision regarding his or her care.[107] Throughout the process of assessing a patient's capacity, responders must be mindful of two competing interests: (1) the right of the individual to make his or her own decisions; and (2) the need to protect and care for those whose lack of capacity renders them incapable of self-advocacy. Making an error in this determination in the absence of qualified immunity may not only interfere with the patient's rights but may also subject the EMS provider to civil and criminal liability.[108] Given the profound implications of such a determination, one might assume that first responders receive extensive training and statutory guidance to aid in this assessment. In reality, these clinical determinations often come down to the provider's subjective assessment of the patient—a seemingly unreliable standard considering the consequence may be the unlawful deprivation of a patient's constitutionally protected rights.[109] In a world without qualified immunity for EMS providers, even a good faith effort to ensure patient safety could result in civil liability.

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105 *See* United States v. Booker, 728 F.3d 535, 542–43 (6th Cir. 2013) ("There is of course a privilege generally recognized in tort law for doctors to deliver medically indicated emergency care when the patient cannot make the choice pro or con, often because the patient is unconscious.").

106 *See* Roca, *supra* note 86, at 1195 (noting that "[t]he physician does not always arrive at conclusions about capacity with complete confidence"); Marc L. Martel, Lauren R. Klein, James R. Miner, Jon B. Cole, Paul C. Nystrom, Kayla M. Holm & Michelle H. Biros, *A Brief Assessment of Capacity to Consent Instrument in Acutely Intoxicated Emergency Department Patients*, 36 AM. J. EMERGENCY MED. 18, 22 (2018) (noting a correlation between mean blood alcohol concentration and demonstrated capacity).

107 *See* Sessums et al., *supra* note 83, at 421.

108 *See, e.g.*, Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."); Howard v. Univ. of Med. and Dentistry of N.J., 800 A.2d 73, 77 (N.J. 2002) ("[a] patient has several avenues of relief against a doctor: (1) deviation from the standard of care (medical malpractice); (2) lack of informed consent; and (3) battery.").

109 *See* Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 131, 134 (1999).

b. *Patients' Rights Impacted by Capacity*

Under normal circumstances, seizing people against their will, subjecting them to medical treatment, and transporting them to another location would, at the very least, expose an individual to civil liability.[110] Violations of one's Fourth Amendment protection against unreasonable seizure and the right to refuse medical treatment under the Fourteenth Amendment are traditionally remedied through monetary damages or injunctive relief under § 1983.[111] For this statute to be applicable, the violation must be committed by an individual while acting "under color of state law."[112] Ironically, determining that a state actor is subject to § 1983 liability may also serve to protect the individual under the doctrine of qualified immunity.

i. Excessive Force and Unreasonable Seizures

The Fourth Amendment protects "[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures."[113] The seizure of a person, which can take the form of physical force or a show of authority that in some way restrains the liberty of a person, may include that individual's detention for purposes of medical assessment and care.[114] A brief initial detention to determine the individual's capacity is likely to pass the Fourth Amendment's reasonableness standard, but what happens when the detention

110 *See, e.g.*, Green v. City of New York, 465 F.3d 65, 83–84 (2d Cir. 2006) (noting that it is clearly established that a competent adult cannot be seized and transported for treatment unless the patient represents a danger to himself or others).

111 Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

42 U.S.C. § 1983.

112 *See* West v. Atkins, 487 U.S. 42, 48 (1988) ("To state a claim under § 1983, a plaintiff must allege the violation of a right secured by the Constitution and laws of the United States, and must show that the alleged deprivation was committed by a person acting under color of state law.").

113 U.S. CONST. amend. IV.

114 Torres v. Madrid, 141 S. Ct. 989, 995 (2021) (quoting Terry v. Ohio, 392 U.S. 1, 19 n.16 (1968)).

continues?[115] While there is ample Fourth Amendment case law discussing law enforcement seizures and excessive use of force, there are notably fewer cases directly discussing Fourth Amendment claims against EMS providers.[116] As a result, it is less likely that first responders will be on notice that their conduct could violate a clearly established right.[117] In the circuits where it has been addressed, qualified immunity has served as an instrumental barrier to insulate EMS providers from § 1983 liability.[118]

In *Peete v. Nashville*,[119] EMS was dispatched—via the 9-1-1 system—to assist a patient experiencing an epileptic seizure.[120] While the patient was seizing, EMS providers attempted to restrain him using their bodyweight and by tying his hands and ankles behind his back, all while failing to maintain a patent airway.[121] The patient died as a result of the providers' actions, and his estate brought a § 1983 suit alleging excessive use of force.[122] The Sixth Circuit held that the providers were entitled to qualified immunity, noting that "where the purpose is to render solicited aid in an emergency rather than to enforce the law . . . there is no federal case authority" that may otherwise serve to clearly establish the existence of such liability.[123]

In *Thompson v. Cope*,[124] the Seventh Circuit reached a similar conclusion in differentiating law enforcement's use of force with that of a paramedic rendering aid.[125] Upon EMS arrival, the decedent was lying naked and prone in the middle of the street with his hands cuffed behind his back and his ankles shackled together.[126] The patient had previously been tased by police and had been punched and choked in a physical altercation.[127] The paramedic on scene noted that the patient was sweating profusely, appeared to be on drugs, and was likely in a state of excited

115 *See* U.S. CONST. amend. IV; *see also* Birchfield v. North Dakota, 579 U.S. 438, 477 (2016) (noting that "reasonableness is always the touchstone of Fourth Amendment analysis").

116 *See, e.g.*, Michigan v. Tyler, 436 U.S. 499 (1978) (holding Fourth Amendment seizures applicable to firefighters); Green v. City of New York, 465 F.3d 65 (2d Cir. 2006) (holding the Fourth Amendment applicable to paramedics transporting a patient against his will).

117 *See* Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 221 (6th Cir. 2007).

118 *See, e.g.*, *id.*; Thompson v. Cope, 900 F.3d 414, 423–24 (7th Cir. 2018).

119 486 F.3d 217 (6th Cir. 2007).

120 *Id.* at 219–20.

121 *Id.* at 220.

122 *Id.* at 219.

123 *Id.* at 221.

124 900 F.3d 414 (7th Cir. 2018).

125 *See* Thompson v. Cope, 900 F.3d 414, 422–23 (7th Cir. 2018).

126 *Id.* at 418.

127 *Id.*

delirium.[128] Despite already being restrained, the paramedic administered a sedative, which caused the patient to go into cardiac arrest and die at the hospital a few days later.[129] The patient's estate brought a § 1983 suit against the paramedic for excessive use of force.[130] In its opinion granting the paramedic qualified immunity, the court noted that neither a paramedic nor a lawyer "reasonably familiar with circuit and Supreme Court precedent would have understood that the Fourth Amendment . . . applies to treatment in the field during a medical emergency."[131]

This medical distinction for Fourth Amendment claims has not been adopted in all circuits. In *Green v. City of New York*,[132] 9-1-1 was called for a ventilator-dependent patient with amyotrophic lateral sclerosis ("ALS") after his ventilator malfunctioned and family members were forced to manually ventilate him with a bag valve mask.[133] In addition to relying on a ventilator, ALS had rendered the patient only able to communicate through blinking and use of a computerized system he could control with a press of his finger.[134] By the time EMS had arrived, the patient was conscious and had regained his baseline functioning.[135] Both the patient—through his computer—and his wife repeatedly reiterated to EMS that they were no longer needed and that everything was under control.[136] Despite adamant protest and stable vital signs, the patient was picked up and carried out to the ambulance for transport.[137] The family sued the EMS command supervisor under § 1983, alleging an unlawful seizure.[138] The Second Circuit denied the supervisor's qualified immunity defense, having 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 [he] presented a danger to [him]self or others."[139]

While the Second Circuit did not apply the Sixth and Seventh Circuit's medical treatment standard, a key distinction can be made between the facts of the cases. In both *Peete* and *Thompson*, EMS

128 *Id.* at 420.

129 *Id.* at 418.

130 *Id.*

131 *Id.* at 422–23.

132 465 F.3d 65 (2d Cir. 2006).

133 Green v. City of New York, 465 F.3d 65, 69–70 (2d Cir. 2006).

134 *Id.*

135 *Id.*

136 *Id.*

137 *Id.* at 73.

138 *Id.* at 79–80.

139 *Id.* at 83–84.

encountered patients with impaired capacity.[140] In *Peete*, the patient was experiencing a seizure and was effectively incapacitated.[141] In *Thompson*, the patient was under the influence of drugs and in a state of excited delirium, both of which impair capacity.[142] By contrast, the patient in *Green* had stable vitals and demonstrated unencumbered decisional capacity through means his physical limitations would allow.[143] His barrier to communication did not negate his capacity, it merely required a nuanced approach to assessing it. As these cases suggest, capacity is a significant determination made by EMS during a patient assessment, and it may even directly impact the provider's later claim of qualified immunity.

ii. The Right to Refuse Medical Treatment

In addition to Fourth Amendment seizure and use of force, medical treatment or an invasive assessment despite the individual's express refusal of treatment implicates his or her Fourteenth Amendment *liberty interest*.[144] Whether an individual's "constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests."[145] The courts have generally shied away from upholding state interests above the individual's liberty interest and right to bodily autonomy.[146]

The right of a patient to refuse medical treatment is "embodied in the common-law doctrine of informed consent."[147] Informed consent in the medical context is a type of express consent that requires that a patient be made fully aware of the risks of a given treatment or procedure, be made fully aware of any alternatives that may exist, and have an opportunity to

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140 *See* Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 221 (6th Cir. 2007); Thompson v. Cope, 900 F.3d 414, 418 (7th Cir. 2018).

141 *Peete*, 486 F.3d at 220.

142 *See Thompson*, 900 F.3d at 418.

143 Green v. City of New York, 465 F.3d 65, 71–72 (2d Cir. 2006). The New York City fire department's policy required EMS to evaluate "decision-making capacity" prior to granting a refusal of service. *Id.* at 72. The policy in question required the patient have the ability to communicate—"verbally or non-verbally"—and stipulated that EMS "must accept a competent person's refusal to accept medical treatment." *Id.*

144 *See* Parham v. J.R., 442 U.S. 584, 600 (1979) ("[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment . . . .").

145 Youngberg v. Romeo, 457 U.S. 307, 321 (1982).

146 *Cf.* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring) ("Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.").

147 *Id.* at 268.

ask questions of the provider prior to undergoing treatment.[148] An individual who expressly consents to treatment without being informed of the risks associated has granted express consent, but not informed consent.[149] Naturally, a person who lacks capacity is therefore incapable of granting informed consent due to his or her inability to comprehend the nature of treatment.[150] If, however, an individual does possess the requisite capacity and makes an informed decision to refuse treatment, what happens if he or she is nonetheless subjected to unwanted medical treatment?[151]

In addition to alleging excessive use of force, the patient in *Green* alleged a Fourteenth Amendment claim.[152] Citing *Cruzan v. Director, Missouri Department of Health*,[153] the Second Circuit reiterated the principle "that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[154] Because the patient in *Green* had not been subjected to medical treatment, only transport, the court reasoned that the action of EMS was more reasonably classified as a Fourth Amendment seizure, rather than a liberty interest claim.[155] On that basis, it did not analyze the patient's Fourteenth Amendment claim.[156]

In *Rangel v. Forsyth County*,[157] EMS responded to a 9-1-1 call from the plaintiff's residence alleging that the plaintiff was unconscious on the kitchen floor after consuming a combination of medication and wine.[158] Upon arrival, paramedics attempted to determine the plaintiff's capacity, but she was "either unable or unwilling to answer basic orientation questions."[159] The plaintiff would not permit EMS to assess her and at one point ran across the kitchen and punched one of the paramedics.[160] EMS forcibly transported the plaintiff to a local hospital, and she subsequently brought a § 1983 suit against EMS, alleging they subjected her to medical

148 *See* Parth Shah, Imani Thornton, Danielle Turrin & John E. Hipskind, *Informed Consent*, NlH (June 11, 2022), https://perma.cc/Y9EA-B96D.

149 *See* Cecil Casterline, *Informed Consent: Malpractice*, 18 BAYLOR L. REV. 137, 137–38 (1966).

150 *See, e.g.*, Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 222 (6th Cir. 2007) (describing the plaintiff's claim as a negligence medical malpractice claim for unauthorized treatment).

151 *See, e.g.*, Green v. City of New York, 465 F.3d 65, 71–72, 77–78, 82, 85–86 (2d Cir. 2006).

152 *Id.* at 84.

153 497 U.S. 261 (1990).

154 *Green*, 465 F.3d at 84 (internal quotation marks omitted) (quoting *Cruzan*, 497 U.S. at 278).

155 *Id.* at 85.

156 *See id.*

157 No. 07–CV–0142, 2009 WL 362128 (N.D. Ga. Feb. 10, 2009).

158 *Id.* at *1.

159 *Id.* at *2.

160 *Id.*

treatment she did not want.[161] The district court acknowledged that "a *competent* adult patient has the right to refuse medical treatment in the absence of conflicting state interest."[162] However, the court also noted that the plaintiff failed to show that she was competent at the time.[163] Considering the patient had reportedly been unconscious after consuming unknown amounts of wine and unidentified medication, "it was reasonable for the emergency personnel to try to evaluate her mental status before abandoning her . . . ."[164]

Although few cases directly speak to the issue of unwanted medical treatment performed by EMS, cases after *Cruzan* have upheld the general right to refuse medical treatment.[165] Determining whether this right has been violated requires balancing "the liberty of the individual" with "the demands of organized society."[166] These demands, or state interests, may include the preservation of life or the protection of the vulnerable.[167] The Supreme Court has held that the "integrity of an individual's person is a cherished value of our society" and has distinguished "minor intrusions into an individual's body under stringently limited conditions" with "more substantial intrusions."[168] Attempting to balance these interests on the fly is another consideration EMS providers must keep in mind when rendering aid.

II. Eliminate, Reform, or Leave it Alone

For every advocate pursuing the elimination of qualified immunity, there is an equally passionate defender of the doctrine. Calls for reform have largely targeted policing while failing to consider the impact of change elsewhere.[169] Framing the discussion so narrowly ignores entire swaths of discretionary state actors who rely on qualified immunity yet

161 *Id.*

162 *Id.* at *7 (emphasis in original) (internal quotation marks omitted) (quoting *In re* L.H.R, 321 S.E.2d 716, 722 (Ga. 1984)).

163 *Rangel*, 2009 WL 362128, at *8.

164 *Id.*

165 *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702, 720 (1997).

166 Poe v. Ullman, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting).

167 *See Glucksberg*, 521 U.S. at 729.

168 Schmerber v. California, 384 U.S. 757, 772 (1966).

169 *See, e.g.,* Jennifer E. Laurin, *Reading* Taylor*'s Tea Leaves: The Future of Qualified Immunity*, 17 DUKE J. CONST. L. & PUB. POL'Y 241, 249 (2022); Bryan Castro, Comment, *Can You Please Send Someone Who Can Help? How Qualified Immunity Stops the Improvement of Police Response to Domestic Violence and Mental Health Calls*, 16 HARV. L. & POL'Y REV. 581, 581 (2022).

remain largely innocent in the debate over police misconduct.[170] To fully appreciate the implications of eliminating qualified immunity, the consequences of reform must encompass all whom it would impact.

A. *Differentiating Police and EMS*

It is true that police and EMS respond to many of the same calls and often work together in cooperative fashion.[171] After all, EMS cannot provide good patient care at a scene if it is not safe for them to work.[172] This overlap on scene has necessarily resulted in some overlap in training. Many police agencies train their officers to assist with medical emergencies.[173] In fact, several state laws require it.[174] Similarly, EMS agencies have found that their providers benefit from the same training in de-escalation tactics that police have traditionally undergone as a part of their training.[175] Despite some significant overlap, the two professions have a fundamental difference when it comes to their chief responsibility. While police serve their communities in a number of ways, enforcing the law remains a foremost objective.[176] For EMS providers, rendering aid serves as the primary responsibility.

As the enforcement arm of the government, police are tasked with ensuring public order and, if need be, using force to do so.[177] The use of force as a means of maintaining order or punishing is clearly distinguishable from the primary role of EMS—lifesaving. While neither profession is objectively more noble than the other, society tends to recognize rendering aid as an inherent good whereas the sometimes necessarily brutish tactics used by police are viewed as less endearing.[178]

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170 *Frequently Asked Questions About Ending Qualified Immunity*, INST. FOR JUST., https://perma.cc/8USG-D9R6 (Feb. 6, 2023).

171 *See supra* notes 44–48 and accompanying text.

172 *See* Taylor A. Klein & Prasanna Tadi, *EMS Scene Safety*, *in* STATPEARLS (May 8, 2022), https://perma.cc/5X8W-5CVC.

173 *See generally* Shawna Renga, *Law Enforcement Officers as Medical First Responders Can Save Lives*, EMS1 (Aug. 28, 2015), https://perma.cc/9MEX-U5ZZ.

174 *See supra* note 45.

175 *See* Harry P. Dolan & Richard R. Johnson, *Surviving Verbal Conflict: Verbal De-Escalation Needs for EMS Personnel*, JEMS (Oct. 31, 2019), https://perma.cc/L6ZK-G5KF.

176 *See* Cynthia A. Brown, *Divided Loyalties: Ethical Challenges for America's Law Enforcement in Post 9/11 America*, 43 CASE W. RSRV. J. INT'L L. 651, 670 (2011).

177 *See* INT'L ASS'N OF CHIEFS OF POLICE, NATIONAL CONSENSUS POLICY AND DISCUSSION PAPER ON USE OF FORCE 2 (rev. July 2020), https://perma.cc/Y5VQ-W9UX.

178 *See* Gabriela Schulte, *Poll: 68 Percent of Voters Approve of the Police over Politicians, Journalists*, THE HILL (July 2, 2020), https://perma.cc/DD26-RJA5 (showing "healthcare workers" with a ninety-four percent approval rating compared with police at sixty-eight percent).

Recognizing this distinction is a necessary prerequisite in talks about reforming qualified immunity. With the emotionally charged incidents that have made qualified immunity a household term, it's easy to understand why arguments are typically framed in a police context. Just as eliminating qualified immunity may have a profound impact on the culture of policing, the impact on EMS may be equally profound. The consequences of such a change will be felt not just by the individual providers, but by the communities they serve and society in general. Understanding the consequences of eliminating or reforming qualified immunity for EMS is as important as considering the impact on law enforcement.

B. *Arguing for the Elimination of Qualified Immunity*

Since the Supreme Court's decision in *Harlow v. Fitzgerald*[179] reformulated the qualified immunity test, there have been calls to eliminate or restructure it.[180] The most recent push for reform has largely focused on police misconduct towards Black and minority individuals.[181] The names of the victims of police use-of-force have been used as a call for justice, for accountability, and to reimagine policing in America more broadly.[182] While some are calling for a modest restructuring of qualified immunity, others are demanding its complete elimination; some wish to abolish policing all together.[183] Myriad arguments are offered in support of these calls for change. By reviewing these arguments critically and as applied to EMS, a more realistic understanding of potential consequences begins to emerge.

1. Remedies to Victims, Costs to the State

A common argument for eliminating qualified immunity is that it deprives individuals of the very justice that a § 1983 suit is intended to preserve.[184] During Reconstruction, the Ku Klux Klan Act of 1871 was one

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179 457 U.S. 800 (1982).

180 *See, e.g.*, Stephanie E. Balcerzak, Note, *Qualified Immunity for Government Officials: The Problem of Unconstitutional Purpose in Civil Rights Litigation*, 95 YALE L.J. 126, 127 (1985).

181 *See* Schultz, *supra* note 1, at 222–23.

182 *See George Floyd: Timeline of Black Deaths and Protests*, BBC NEWS (Apr. 22, 2021), https://perma.cc/FAS8-8D8P.

183 *See, e.g.*, West Resendes & Somil Trivedi, *We Must Abolish Qualified Immunity to Prevent Further Police Harm–Especially for People in Mental Health Crises*, ACLU (Mar. 19, 2021), https://perma.cc/C68Y-LWF4.

184 *See* Maxted, *supra* note 3, at 635–36.

of several civil rights acts passed by Congress to combat racial violence in the South and enforce the provisions of the Fourteenth Amendment.[185] Elements of the Act were later codified at 42 U.S.C. § 1983 and have remained largely unchanged to this day.[186] Many who advocate the elimination of qualified immunity point out that the doctrine of qualified immunity effectively "clip[s] § 1983's wings" by indemnifying government's primary enforcement apparatus, the police, from abusive behavior.[187] If police can fall back on the protection of qualified immunity without individual consequence, how does § 1983 offer the public any of the protection it was intended to offer?

UCLA law professor Joanna Schwartz conducted a comprehensive study on the impact of qualified immunity in constitutional litigation.[188] Reviewing some 1,183 suits filed between 2011 and 2012 against state and local law enforcement, she determined that qualified immunity could have been used as a defense in 979 of those cases.[189] It was used successfully in only 3.9% of them.[190] An earlier study found that governments, not the individual state actors, pay out 99.98% of damages recovered by victims of police misconduct.[191] This data seems to highlight two facts: (1) qualified immunity's protection is used only in a small percentage of eligible police misconduct cases; and (2) the individual state actors tend to pay little, if any, damages, regardless of qualified immunity.

It is important to remember that qualified immunity only protects the state actor from civil damages liability, not criminal wrongdoing. Individuals pursuing justice through the incarceration of state actors are not obstructed by qualified immunity. As for a victim's pursuit of monetary damages, there's an obvious reason why governments pay out nearly all settlements—deep pockets. Consider some of the most recent high-profile cases of individuals killed by police or while in police custody. In the spring of 2016, the city of Cleveland agreed to pay the family of Tamir Rice, a twelve-year-old boy shot by police, a $6 million settlement.[192] The City of New York agreed to a $5.9 million settlement with the family of Eric Garner who was killed when police placed him in an illegal

185 *See* Cathy Bissoon, Benita Y. Pearson & David A. Sanders, *From the KKK to George Floyd: Three Judges Explore Qualified Immunity*, 22 SEDONA CONF. J. 533, 537–38 (2021).

186 *See id.* at 537.

187 *See* Maxted, *supra* note 3, at 632, 635–36.

188 Joanna C. Schwartz, *How Qualified Immunity Fails*, 127 YALE L.J. 2, 2 (2017).

189 *Id.* at 28.

190 *Id.* at 26–27.

191 Joanna C. Schwartz, *Police Indemnification*, 89 N.Y.U. L. REV. 885, 890 (2014).

192 *See* Taylor Ardrey, *Here's a List of Settlements Paid to the Families of Black People Killed at the Hands of Police*, INSIDER (Mar. 17, 2021, 6:48 PM), https://perma.cc/UQ55-GMDX.

chokehold.[193] These large settlements still fall far short of the $12 million paid out over the death of Breonna Taylor, the $15 million paid out in the case of Elijah McClain, and the $27 million paid out to the family of George Floyd.[194] Even with a lifetime of garnished wages, an individual state actor would never be able to compensate victims in a way that mirrors the government.

Police funding is the second largest category of local government spending and together accounts for up to $193 billion annually.[195] Since 2014, the City of New York has spent $1.3 billion towards alleged police misconduct.[196] These payouts have become an accepted part of governance, with states and localities often budgeting large sums of money for anticipated misconduct and the settlements that follow.[197] There is no reason to expect the elimination of qualified immunity itself would change this fact. Individual state actors would still face criminal sanctions and local governments would still be expected to make the large payouts that an individual could not. However, this should not be construed to suggest that qualified immunity has no impact.

Police unions and supporters of qualified immunity have cited these statistics in defense of the doctrine.[198] If qualified immunity is so seldomly used to defend police, it must not be contributing to widespread abuses by bad actors. This misses a key point relevant not only to understanding qualified immunity's impact on policing but on prehospital EMS as well. As the Court has recognized, "the mere 'specter of liability' may inhibit public officials in the discharge of their duties," and qualified immunity serves to quell any such inhibition.[199]

This reasoning flows in both directions. Just as government actors can rest assured their actions will be indemnified, so too can the public. As a result, the very knowledge that an actor's conduct may be protected under qualified immunity may prevent a person from ever filing suit in the first place. The illusion of an impenetrable barrier to litigation can be just as effective as the barrier itself. Evidence suggests only one percent of people

193 *Id.*

194 *Id.*; *Aurora Agrees to Pay $15 Million in Elijah McClain Case; Largest Police Related Settlement in City, Colorado History*, CBS COLO. (Nov. 17, 2021, 11:59 PM), https://perma.cc/K787-HE5T.

195 *See How Much Do America's Biggest Counties Spend on Police?*, USA FACTS (Oct. 1, 2020, 2:09 PM), https://perma.cc/2HZB-4CAW.

196 *See* Christina Carrega, *Millions in Lawsuit Settlements Are Another Hidden Cost of Police Misconduct: Experts*, EYEWITNESS NEWS ABC 7 (June 14, 2020), https://perma.cc/VAU4-5XMD.

197 *See id.*

198 *See* Mike Callahan, *The Attack on the Police Officer's Qualified Immunity Defense*, POLICE1 (June 8, 2020), https://perma.cc/T83B-RNUM.

199 Atwater v. City of Lago Vista, 532 U.S. 318, 351 n.22 (2001) (quoting Harlow v. Fitzgerald, 457 U.S. 800, 814 (1982)).

who believe they have been the victim of police misconduct ever file a lawsuit.[200] This may also explain why there is so little case law regarding qualified immunity for prehospital EMS providers. In the absence of local news stories condemning EMS patient care, how many people even know qualified immunity applies to EMS?

In the absence of qualified immunity, new categories of defendants may offer profitable prospects for lawyers and litigants alike. If qualified immunity indirectly discourages § 1983 suits, 42 U.S.C. § 1988 does the opposite.[201] Civil rights cases are notoriously difficult to win and often result in lower damages awards than other types of cases.[202] Under § 1988, an attorney representing a client in a civil rights case may be awarded reasonable attorney's fees if successful.[203] Even if the awarded damages are relatively insignificant, it is not uncommon for attorney's fees to greatly exceed damages in a civil rights case.[204] As a result, state and municipal governments are often encouraged to reach settlement agreements, which avoid § 1988 awards.[205] Even still, the potential added cost to the taxpayer for covering EMS providers could be quite significant.

What happens in rural communities with a purely volunteer EMS service? Private EMS services may, in many instances, be regarded as acting under color of law for purposes of § 1983 liability.[206] That presently provides them the security of qualified immunity. In the absence of qualified immunity, the burden of damages would fall on the individual provider. Unlike state and local governments, private ambulance companies—particularly volunteer ones—would not have the same financial means to pay out large settlements.[207] Therefore, that burden would necessarily fall squarely on the individual provider.

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200 Joanna C. Schwartz, *What Police Learn from Lawsuits*, 33 CARDOZO L. REV. 841, 863 (2012) (citing MATTHEW R. DUROSE, ERICA L. SCHMITT & PATRICK A. LANGAN, U.S. DEP'T OF JUST., CONTACTS BETWEEN POLICE AND THE PUBLIC: FINDINGS FROM THE 2002 NATIONAL SURVEY, at 16–20 (2005)).

201 *See* Civil Rights Attorney's Fees Awards Act of 1976, 42 U.S.C. § 1988.

202 Michael Selmi, *Public vs. Private Enforcement of Civil Rights: The Case of Housing and Employment*, 45 UCLA L. REV. 1401, 1452 (1998).

203 42 U.S.C. § 1988.

204 *See, e.g.*, City of Riverside v. Rivera, 477 U.S. 561, 564–65 (1986) (affirming $245,456.25 in attorney's fees under § 1988 for a civil rights lawsuit that resulted in only $33,350 in compensatory and punitive damages).

205 *See* Mike Maciag, *From Police Shootings to Playground Injuries, Lawsuits Drain Cities' Budgets*, GOVERNING (Oct. 12, 2016), https://perma.cc/SZ89-LF2L.

206 *See supra* Section I.B.1.

207 *Cf.* Aaron Bolton, *Rural Ambulance Services at Risk as Volunteers Age and Expenses Mount*, NPR WAMU (July 5, 2021, 5:00 AM), https://perma.cc/R27J-KXH2 (noting the difficulties for rural EMT services, including "a growing financial crisis among rural volunteer EMT agencies: A third of them are at risk because they can't cover their operating costs").

Rural EMS is already facing a national staffing crisis.[208] By removing the protection of qualified immunity and placing potential damages liability on the backs of volunteer providers, it seems highly unlikely that rural service providers would continue to operate. For these communities, already limited in their access to healthcare resources, the loss of EMS could prove deadly.

2. Lack of Accountability and Stagnation of the Law

Another frequent complaint with qualified immunity is that it rewards police misconduct and permits it to continue indefinitely.[209] These arguments often emphasize the Supreme Court's decision in *Pearson v. Callahan*.[210] In 2009, the Court receded from its decision in *Saucier*, suggesting that its previously established two-part procedure "should not be regarded as an inflexible requirement."[211] Instead, the Court held that lower courts are best suited to determine whether or not the first step in the *Saucier* procedure is needed to "facilitate the fair and efficient disposition of each case."[212] Some have argued that skipping the first step may create a "continuous immunity loop" that prevents consensus from ever being clearly established by the lower courts.[213] This permits future actors to simply repeat the activity without consequence until the Supreme Court chooses to weigh in.

The Supreme Court's recent decision in *Rivas-Villegas v. Cortesluna*[214] has only strengthened the belief that "clearly established" law may be unlikely to develop outside of the Supreme Court.[215] In reversing the Ninth Circuit's denial of qualified immunity to a police officer, the Court ruled that "[e]ven assuming that Circuit precedent can clearly establish law for purposes of § 1983," the facts of the case were too dissimilar from past precedent.[216] On the same day, the Court reversed a Tenth Circuit ruling

208 *See* Terresa Monroe-Hamilton, *American Ambulance Association's Disturbing Warning: EMS Shortage Threatens 911 System*, BPR (Oct. 9, 2021), https://perma.cc/46EK-XXSK.

209 Shane Fowler, *How a Little-Known Law Turns Police into 'Bad Apples' and Denies Breonna Taylor Justice*, COURIER J. (Mar. 5, 2021, 8:16 AM), https://perma.cc/7BLV-3CB4.

210 555 U.S. 223 (2009).

211 *Id.* at 227.

212 *Id.* at 242.

213 *See* Matthew J. Shechtman, *Piercing* Pearson*: Is Qualified Immunity Curbing Students' Religious Speech Rights?*, 43 STETSON L. REV. 17, 20 (2013).

214 142 S. Ct. 4 (2021).

215 *See* Rivas-Villegas v. Cortesluna, 142 S. Ct. 4, 8 (2021) (stating that neither the petitioner nor the lower court had identified any Supreme Court cases that addressed facts similar to those at issue and could demonstrate clearly established law).

216 *See id.*

and held that the police officers in that case were entitled to qualified immunity because the cases presented did not clearly establish that the officers' conduct was unlawful.[217]

If the Court were to take the stance that only Supreme Court precedent is able to "clearly establish" rights for the purposes of qualified immunity, the law's development would stagnate.[218] This lack of development would likely strengthen arguments for eliminating qualified immunity across the board, and with it, endanger the protection for EMS providers who rely upon it.

C. *Understanding Qualified Immunity in the EMS Context*

Sweeping changes to qualified immunity or its complete elimination would bring with it, at least temporarily, a strong sense of uncertainty for many discretionary government actors outside of policing. The impact of such a change would likely be felt differently by different industries, and the consequences could result in significant upheaval. With its decades-long existence, state and local governments have developed a significant reliance interest in qualified immunity. When it comes to government actors exercising discretionary functions, everything from their compensation and training to institutional budgeting and risk management practices recognize that qualified immunity is baked into the cake.[219] In the absence of such protections, governments would have to reimagine how many of today's most essential institutions function. Prehospital EMS is one such service likely to see significant disruption.

The prehospital EMS system is already suffering from severe understaffing.[220] In a recent letter to congressional leadership, American Ambulance Association President Shawn Baird warned that the "nation's EMS system is facing a crippling workforce shortage . . . . [that] threatens to undermine [the] emergency 9-1-1 infrastructure . . . ."[221] Unlike policing, the nation's EMS system has always relied, in part, on service providers

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217 *See* City of Tahlequah v. Bond, 142 S. Ct. 9, 12 (2021).

218 *See* JOHN G. ROBERTS, JR., 2021 YEAR-END REPORT ON THE FEDERAL JUDICIARY 7 (2021) (reporting that of the 5,307 cases filed with the Supreme Court in the 2020 term, 72 were argued).

219 *See* Carrega, *supra* note 196.

220 *See generally* Monroe-Hamilton, *supra* note 208.

221 Letter from Shawn Baird, President, Am. Ambulance Ass'n, & Bruce Evans, President, Nat'l Ass'n of Emergency Med. Technicians, to Nancy Pelosi, Speaker, U.S. House of Representatives, Kevin McCarthy, Minority Leader, U.S. House of Representatives, Charles Schumer, Majority Leader, U.S. Senate & Mitch McConnell, Minority Leader, U.S. Senate (Oct. 1, 2021), https://perma.cc/EDC9-56GM.

that are either part-time or volunteer.[222] The National Association of State EMS Officials' 2020 National EMS Assessment reported a total of 1,031,328 licensed EMS professionals in the United States,[223] while the 2021 Current Population Survey estimated only 176,103 employed full-time in EMS.[224] Those who are employed full-time are proportionately underpaid when compared to similarly high-stress and physically demanding careers.[225] In 2021, the median nationwide pay for police was $66,020 compared to only $36,930 for EMTs and paramedics.[226] Subjecting an already strained workforce to the possibility of recurrent litigation and damages liability seems like the perfect formula for mass exodus. For an industry that provides life-saving services and is already heavily reliant on volunteerism, the effect of such a significant staffing shortage could be life-threatening, particularly in rural and economically impoverished areas.

For those who choose to remain in the EMS community despite losing the assurances of qualified immunity, the industry as a whole would likely see dramatic operational changes. An often-cited risk of eliminating qualified immunity is that it promotes timidity and an inclination for discretionary actors to minimize risk of liability in a way that causes a net societal harm.[227] EMS responders are not compensated based on call volume or patient outcomes and as such, are less likely to internalize the benefits of zealous patient advocacy.[228] Instead, these benefits are externalized to the general public and the individual patients

222 *See, e.g.*, DG PATTERSON, SM SKILLMAN & MA FORDYCE, WWAMI RURAL HEALTH RSCH. CTR., PREHOSPITAL EMERGENCY MEDICAL SERVICES PERSONNEL IN RURAL AREAS: RESULTS FROM A SURVEY IN NINE STATES 13 (final rep. 149, Aug. 2015) (noting that 14.4% of urban and 53.1% of isolated small rural EMS agencies are entirely staffed by volunteers).

223 *See* NAT'L ASS'N OF STATE EMS OFFS., 2020 NATIONAL EMERGENCY MEDICAL SERVICES ASSESSMENT 47 tbl.30 (2020), https://perma.cc/VDV6-TKAP (statistic obtained by excluding "Emergency Medical Dispatcher (EMD)" from "Grand Total").

224 *See B24124, Detailed Occupation for the Full-Time, Year-Round Civilian Employed Population 16 Years and Over*, U.S. CENSUS BUREAU (2021), https://perma.cc/XHR8-H6TN (statistic obtained by combining "emergency medical technicians" and "paramedics").

225 The high-stress environment of EMS work has long been associated with higher incidents of depression, post-traumatic stress disorder, and suicide. A seven-year study in Arizona found that the rate of death by suicide was over twice as high among EMTs as it was among the general public: 5.2% incidence and 2.2% incidence, respectively. *See* Catherine R. Counts, *Research Analysis: More than 1-in-20 EMT Deaths Are Due to Suicide*, EMS1 (Nov. 13, 2018), https://perma.cc/6H5C-WBMS.

226 *Compare* U.S. BUREAU OF LAB. STATS., OCCUPATIONAL OUTLOOK HANDBOOK: POLICE AND DETECTIVES (2021), https://perma.cc/9QEJ-SUGU, *with* U.S. BUREAU OF LAB. STATS., OCCUPATIONAL OUTLOOK HANDBOOK: EMTS AND PARAMEDICS (2021), https://perma.cc/5V2Y-RWL5.

227 *See* Rosenthal, *supra* note 2, at 587.

228 *See id.* at 571–72.

who receive better care as a result.[229] If EMS responders "are forced to internalize the costs of their activities through damages liability, when they do not internalize the benefits, the likely result would be to encourage officials to avoid conduct that exposes them to liability."[230]

D. *Illustrative Scenario*

Imagine for a moment that it's a Friday night and EMS has been dispatched by a 9-1-1 call center to the local university to assess an intoxicated eighteen-year-old student. Upon arrival, the student is unable to stand, covered in vomit, and slurring his speech. A police officer on scene informs the paramedic that a portable breath test estimated the student's BAC to be 0.318 percent, nearly four times the legal limit to operate a motor vehicle. The paramedic informs the student that they will transport him to the hospital, give him intravenous fluids, and let him "sleep it off" in the emergency room. While acknowledging his impairment, the student insists he is fine to return to his dorm room. Despite the student's protest, the paramedic insists the student be evaluated at the hospital. After a ten-minute ambulance ride—during which the student has his vital signs checked, a blood sample drawn, and intravenous fluids administered—he arrives at the hospital where he notifies the triage nurse that he does not wish to be treated. The triage nurse takes report from the transferring EMS team, then promptly discharges the patient as refusing treatment against medical advice. The student catches an Uber back to his dorm room and goes to sleep without incident.

1. Capacity and Discretion

The above student was subjected to transport and medical treatment against his will because the EMS providers believed he lacked the requisite capacity to make medical decisions for himself. As this scenario illustrates, a subjective capacity determination may be all that separates qualified medical care from an unlawful deprivation of the patient's constitutional rights. A capacity determination, like other subjective determinations made in the prehospital setting, exemplifies the discretionary role of EMS.

In the above scenario, EMS authored a patient care report citing as grounds for transport the following findings: (1) the patient's inability to stand; (2) active vomiting; (3) the patient's slurred speech; (4) a dangerously high BAC; and (5) fear the patient could aspirate vomit in his

229 *Id.* at 572.

230 *Id.*

sleep if left alone. Though noteworthy clinical findings, none of these relate to a capacity determination that implicates one's ability to exercise the right to refuse unwanted medical treatment. If qualified immunity was based on the subjective standard of good faith or reasonableness, it would be hard to argue that the EMS providers did anything other than act in the patient's best interest. However, the above scenario describes a patient who was aware of his present condition and the nature of the proposed treatment, was aware of the alternative to treatment, demonstrated an ability to effectively communicate his decision to EMS, and was shortly thereafter deemed to have decisional capacity by a higher-trained healthcare provider.[231] Despite the student's express refusal, he was still subjected to bodily seizure, medical treatment, and contractual obligations to pay for medical services. Under present-day qualified immunity doctrine—as reinforced by the Court's recent decisions—there is a decent chance that the EMS providers would be immune from damages liability.[232] In the absence of qualified immunity, the providers may have instead opted to emphasize liability over patient safety.

EMS providers have a certain scope of practice depending on their level of certification.[233] While operating within this scope, responders typically adhere to EMS standing orders that have been approved by a state EMS regulatory authority.[234] As long as providers do not deviate from these standing orders or operate outside their scope of practice, they have great discretion regarding the provider-patient interaction. Under the protection of qualified immunity, EMS providers are encouraged to place the patient's needs first. This is particularly evident when the patient is in some way impaired and the provider must exercise judgement as to whether or not decisional capacity exists. Presently, a provider who renders aid later deemed unwelcomed but reasonable is shielded from liability. In the absence of qualified immunity, that same provider could be liable for damages.

As was the case in *Rangel*, a court may find that the intoxicated student from the scenario was subjected to a reasonable bodily intrusion when EMS conducted a non-invasive assessment of vital signs for the

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231 This scenario assumes that the second capacity determination was not made due to a change in the patient's clinical presentation but was instead made due to the nurse's more extensive training and experience in making capacity determinations.

232 *See* Rivas-Villegas v. Cortesluna, 142 S. Ct. 4, 7–8 (2021); City of Tahlequah v. Bond, 142 S. Ct. 9, 11 (2021). *See also supra* Section I.B.1.

233 *See generally* EMS SCOPE OF PRACTICE, *supra* note 46.

234 *See, e.g.*, DEL. OFF. EMERGENCY MED. SERVS., DELAWARE BASIC LIFE SUPPORT PROTOCOLS, GUIDELINES AND STANDING ORDERS FOR PREHOSPITAL AND INTERFACILITY PATIENTS 11 (2022).

purposes of determining his capacity.[235] However, the Supreme Court has previously described blood draws as "significant bodily intrusions" as they require "'piercing the skin' [to] extract a part of the subject's body."[236] While this has traditionally been in the context of a Fourth Amendment search, the invasiveness of such a procedure is not diminished because of the state's reason for doing so.

2. An Untenable Choice for EMS

In a world without qualified immunity, EMS providers may be constantly forced to decide which "type" of § 1983 liability they wish to subject themselves to. EMS providers taking affirmative steps to ensure a patient is medically cared for may be opening themselves up to § 1983 liability by unlawfully seizing a person or subjecting him or her to unwanted medical treatment. EMS personnel who make the opposite choice, however, could face liability under a state-created danger theory of liability.[237]

Returning to the scenario discussed in Section II.D, imagine that instead of transporting the student, the EMS crew's concern over liability led them to permit the student to go home. Once safely home, the student's impaired balance caused him to fall and strike his head, resulting in permanent brain damage. On one hand, the crew may be subject to a § 1983 suit for transporting and treating the student against his will. On the other hand, the crew may face liability for releasing an intoxicated individual who they knew to be impaired. Under qualified immunity, the EMS personnel who treat and transport are likely shielded from liability. The actions taken by EMS constitute a good faith effort to protect the individual, and in the absence of "clearly established" guidance to the contrary, EMS providers could reasonably rely on being protected. However, qualified immunity does not protect state actors under the state-created danger doctrine.[238] Therefore, the decision not to transport may still subject EMS to liability if the patient were to be injured later.[239]

235 *See* Rangel v. Forsyth County, No. 07–CV–0142, 2009 WL 362128, at *8 (N.D. Ga. Feb. 10, 2009).

236 *See* Missouri v. McNeely, 569 U.S. 141, 174 (2013) (Roberts, C.J., concurring in part); Birchfield v. North Dakota, 579 U.S. 438, 463 (2016) (quoting Skinner v. Ry. Lab. Execs.' Ass'n, 489 U.S. 602, 625 (1989)).

237 *See* Erwin Chemerinsky, *The State-Created Danger Doctrine*, 23 TOURO L. REV. 1, 3 (2007).

238 *See* Rivas v. City of Passaic, 365 F.3d 181, 194–97 (3d Cir. 2004).

239 *See, e.g.*, Bowers v. DeVito, 686 F.2d 616, 618 (7th Cir. 1982) ("If the state puts a man in a position of danger from private persons and then fails to protect him . . . it is as much an active tortfeasor as if it had thrown him into a snake pit."); *see also* Kneipp v. Tedder, 95 F.3d 1199, 1208, 1213 (3d Cir. 1996) (permitting a state-created danger claim to proceed against police officers when an

As a result, it is reasonable to suspect that EMS providers would exercise caution and err on the side of rendering aid. This option not only benefits them from a liability standpoint, but in many cases, it benefits the patient.

In the absence of qualified immunity, EMS providers face liability regardless of their decision. Not only would providers have to be concerned with managing the patient in a high-stress environment, but they would also have to consider which route of liability they were more likely to be subjected to.[240] One can reasonably imagine EMS providers modifying patient care with these personal risks in mind. The protections of qualified immunity were devised to prevent this very type of discretionary actor hesitation and timidity.[241] Like other healthcare professions, prehospital EMS is a field dedicated to patient wellbeing and the preservation of life.[242] A system that encourages providers to balance the wellbeing of their patients with the constant threat of personal liability is a losing solution for society as a whole. Qualified immunity as applied to prehospital EMS providers ensures that lifesaving care can be administered quickly and efficiently in a way that promotes the health and safety of the patient. To introduce the "specter of liability" into exigent healthcare decisions would be a disservice to the dedicated providers and the communities that rely upon them in their darkest hour.[243]

III. The Future of Qualified Immunity Doctrine

While the Supreme Court's most recent decisions have upheld qualified immunity, a number of Justices have hinted at a willingness to review it.[244] Societal demand for change is as strong as ever, and qualified

intoxicated woman fell and suffered brain injuries after officers separated her from her husband and permitted her to walk home alone).

240 *See* Thompson v. Cope, 900 F.3d 414, 423 (7th Cir. 2018) (noting that qualified immunity exists to avoid a catch-22 in which a medical provider must "treat the arrestee or don't treat him, but face a lawsuit either way").

241 *See* Rosenthal, *supra* note 2, at 587.

242 *See* Charles B. Gillespie, *Code of Ethics for EMS Practitioners*, NAEMT (June 14, 2013), https://perma.cc/79N5-XHEH.

243 *See* Harlow v. Fitzgerald, 457 U.S. 800, 814 (1982).

244 *See, e.g.*, Baxter v. Bracey, 140 S. Ct. 1862, 1862 (2020) (order denying certiorari) (Thomas, J., dissenting) ("The text of § 1983 'ma[kes] no mention of defenses or immunities.'" (quoting Ziglar v. Abbasi, 137 S. Ct. 1843, 1870 (2017) (Thomas, J., concurring in part and concurring in judgment) (alteration in original))); Kisela v. Hughes, 138 S. Ct. 1148, 1162 (2018) (Sotomayor, J., dissenting) ("Such a one-sided approach to qualified immunity transforms the doctrine into an absolute shield for law enforcement officers . . . . It tells officers that they can shoot first and think later, and it tells the public that palpably unreasonable conduct will go unpunished.").

immunity remains a key political issue going into 2023.[245] Congress, the courts, and state legislatures should seriously consider the implications of eliminating qualified immunity before making sweeping changes to a protection relied upon by many outside of law enforcement. Rather than eliminate qualified immunity, there are a number of reforms that could effectively address the concerns of the public while still protecting the needs of discretionary actors like EMS providers.

A. *Returning to* Saucier

As some have noted, the Court's decision in *Pearson* to break away from the two-part inquiry in *Saucier* has led to a stagnation in the development of "clearly established" rights.[246] As a result, qualified immunity may be granted despite a court addressing similar circumstances in a previous case. Since the courts are able to skip the constitutional inquiry part of the *Saucier* test, no decision as to what constitutes a clearly established right is rendered and the law fails to further develop in this area.

While the Supreme Court has not expressly announced which authorities may render a right as "clearly established," prior case law suggests it need not come from the Supreme Court itself.[247] In the 2020 term, the Supreme Court disposed sixty-nine cases in fifty-five signed opinions.[248] Of those, only one case addressed qualified immunity.[249] During that same term, the courts of appeals decided over three hundred cases addressing qualified immunity, twenty-five of which directly focused on the doctrine.[250] Due to obvious restrictions on time, the Supreme Court is simply not able to adequately resolve many of the

245 *Compare* Qualified Immunity Act of 2023, H.R. 233, 118th Cong. (2023), *with* Tim Hains, *Is it Time to End Qualified Immunity for Cops?*, REALCLEAR POL. (Jan. 11, 2023), https://perma.cc/7SYR-73UK.

246 *See* Shechtman, *supra* note 213, at 23 (pointing out that the Court's decision in *Pearson* encourages lower courts to dismiss cases without constitutional discussion that could render rights clearly established for future cases); Pearson v. Callahan, 555 U.S. 223, 227 (2009).

247 *See* Elder v. Holloway, 510 U.S. 510, 516 (1994) (noting that a court should use its "full knowledge of its own and other relevant precedents" when reviewing qualified immunity).

248 *See* ROBERTS, *supra* note 218.

249 *See* Taylor v. Riojas, 141 S. Ct. 52, 53 (2020). *But cf.* Hernandez v. Mesa, 140 S. Ct. 735, 741 (2020) (referencing an earlier decision in which the Court rejected the Fifth Circuit Court of Appeals' grant of qualified immunity).

250 This conclusion was reached by conducting a case search on Westlaw for "Qualified Immunity." The search was restricted to reported decisions by the federal courts of appeals occurring between October 1, 2020 and September 30, 2021. The results were further reduced to identify cases addressing liability under § 1983. The search returned 260 cases.

constitutional inquiries that may otherwise develop qualified immunity doctrine.

Two actions can be taken to remedy this. First, the federal courts of appeals are not barred from adhering to the two-part test in *Saucier*.[251] As a matter of judicial efficiency, the appellate courts should return to answering the initial question as to whether or not a challenged action is unconstitutional. This promotes development in the law while providing guidance to state actors and the lower district courts. By defining what "clearly established" laws are and what state actors must do to comply with them, this legal development will help to reform police misconduct or, at the very least, help hold police accountable for their actions. For this reason, the Supreme Court should encourage lower courts to return to the two-part inquiry and move away from its later holding in *Pearson* that granted courts more discretion.[252]

B. *The Rendering Aid Distinction*

When reviewing complaints of excessive force, the Sixth and Seventh Circuits have differentiated force used while rendering aid from that used to enforce the law.[253] This medical distinction has been referenced by the Fifth and Eighth Circuits but is not yet binding.[254] The Second Circuit's decision in *Green* seems, at first glance, to go against this distinction.[255] The real issue in *Green*, however, was one of training.[256] The patient in *Green* did not need medical aid; both he and his wife communicated as much.[257] The paramedic defendant failed to differentiate between a person whose medical complications interfere with ordinary baseline functioning and a patient who requires medical intervention.[258] Even the Sixth and Seventh Circuits' rendering aid distinction, properly applied, would have saved the defendant in *Green*.

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251 *See* Saucier v. Katz, 533 U.S. 194, 201 (2001).

252 *See* Pearson v. Callahan, 555 U.S. 223, 227 (2009).

253 *See* Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 221 (6th Cir. 2007); Thompson v. Cope, 900 F.3d 414, 422–23 (7th Cir. 2018).

254 *See* Pena v. Givens, 637 F. App'x 775, 781 (5th Cir. 2015) (per curiam); Buckley v. Hennepin County, 9 F.4th 757, 761 (8th Cir. 2021); *see also* Ellison v. Hobbs, 786 F. App'x 861, 873 (11th Cir. 2019) (granting qualified immunity to a paramedic and EMT because the act of forcibly restraining a patient to effectuate patient care fell within their "'arsenal' of powers." (quoting Holloman v. Harland, 370 F.3d 1252, 1267 (11th Cir. 2004))).

255 *See* Green v. City of New York, 465 F.3d 65, 84 (2d Cir. 2006).

256 *See id.* at 72.

257 *See id.* at 70.

258 *See id.* at 70, 72.

While reviewing claims of qualified immunity, the courts should adopt the view that reasonable action taken by state actors to render aid is distinct from conduct relating to law enforcement. The calls demanding the elimination of qualified immunity focus largely on police abuse. Most, if not all, of the recently publicized deaths by police have occurred during an attempt to apprehend an individual or respond to a perceived threat.[259] Proponents of reform believe that the civil shield of immunity is promoting continued abusive behavior: "The beating heart of police violence is officers' belief they are 'enforcing the law' when carrying it out, and that is precisely what qualified immunity stands for . . . ."[260]

A rendering aid distinction is beneficial in that it does not interfere with calls for police accountability, yet still recognizes and protects the need for other state actors to be afforded discretion. This distinction could be implemented two ways. First, a third question could be added to the test in *Saucier*[261]: "Was the state actor reasonably attempting to provide medical assistance at the time that the violation occurred?" By framing the inquiry this way, qualified immunity is largely unchanged in the context of law enforcement. Instead, this new level of analysis simply creates an escape hatch for those providing services to society that relate to health and safety outside of criminal punishment. This distinction allows the courts to differentiate between groups like police and EMS while still relying on the same body of law used to determine "clearly established" rights.

A second approach would create a new category of "clearly established" rights rather than pose an entirely new question. In some ways, this approach more closely mirrors the holdings of the Sixth and Seventh Circuits.[262] Under this test, a new body of case law specific to rendering aid would be used to determine whether or not a right was clearly established at the time of a violation. In other words, a law would not be "clearly established" for purposes of this inquiry unless the case cited as precedent was decided in the context of rendering aid. A downside to this approach is that it creates a fictitious distinction between constitutional rights. In one instance, an otherwise unconstitutional act may be constitutional simply because the state actor was attempting to render medical aid at the time of the incident. Qualified immunity already creates an arbitrary distinction between rights; further complicating the

259 *See* Ardrey, *supra* note 192.

260 *See* Maxted, *supra* note 3, at 644.

261 *See* Saucier v. Katz, 533 U.S. 194, 201 (2001).

262 *See* Peete v. Metro. Gov't of Nashville, 486 F.3d 217, 221 (6th Cir. 2007); Thompson v. Cope, 900 F.3d 414, 422–23 (7th Cir. 2018).

doctrine may be judicially inefficient and confusing to those expected to adhere to it.

Regardless of the manner in which courts choose to differentiate, the distinction between rendering aid and enforcing the law is key. This distinction recognizes that police are not the sole recipients of qualified immunity's protection and that collective police action should not eliminate the protection for others. In many instances, state actors like EMS providers rely upon qualified immunity to serve the community and would otherwise face a catch-22 of civil liabilities.[263] This distinction recognizes that rendering aid and caring for others benefits both the individual patient and society. Barriers to those lifesaving services should be mitigated at all costs. Lastly, it recognizes that some individuals may qualify as state actors for purposes of § 1983 yet not have the backing of state or municipal tax dollars. Large cities may be able to pay sizable settlements, but private volunteer ambulance corps likely cannot. By protecting EMS providers, the rendering aid distinction may protect entire communities that would otherwise lose essential prehospital EMS services.

Conclusion

As an American institution, policing has long been a source of controversy and has long benefitted from the doctrine of qualified immunity.[264] Recent calls to defund, reimagine, or eliminate the police pose a number of important legal questions that will require action. Whether that action comes from courts or legislatures, those responsible should consider the full weight of their decisions.

Qualified immunity is an easy target for those who want quick solutions.[265] In pursuit of police reform, many have not considered the impact eliminating qualified immunity would have on other essential institutions.[266] Failing to recognize the full scope of those questions could have devastating consequences, not just for state actors, but for entire communities.

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263 *See Thompson*, 900 F.3d at 423.

264 *See* Maxted, *supra* note 3, at 635.

265 *See* Adam M. Taylor & Ayanna Alexander, *Calls to End Qualified Immunity Boosted by Chauvin's Conviction*, BLOOMBERG L. (Apr. 21, 2021, 2:37 PM), https://perma.cc/6ABU-F9VZ (discussing efforts to abolish qualified immunity in reaction to George Floyd's death). *But see* Deborah D. Douglas, *The Problems with Policing Are Vast. Ending Qualified Immunity Should Be Just the Start.*, WASH. POST (Apr. 22, 2021, 4:53 PM), https://perma.cc/PJW8-AYD5 (arguing that abolishing qualified immunity is a necessary but incremental step).

266 *See* Taylor & Alexander, *supra* note 265 (discussing only the impact on police).

Prehospital EMS providers work in high-stress, fast-paced environments where seconds matter and discretionary action is required.[267] Unlike policing, which is almost exclusively comprised of state and municipal career employees, the EMS system relies heavily on underpaid part-time workers and volunteers.[268] If police lose the protection of qualified immunity, many cities and states have the taxpayer dollars to cope with it. As it is, almost all police misconduct payouts come from government rather than individual actors.[269] EMS often does not have that luxury. Exposing prehospital EMS providers to what would become unavoidable civil liability could further exacerbate an already dire staffing crisis.

Critics of qualified immunity often highlight a fatal flaw in its recognition of only "clearly established" rights.[270] The Court's decision in *Pearson* has permitted the development of law to stagnate, arguably perpetuating a cycle of repeated police misconduct.[271] As the Court has noted, qualified immunity protects "all but the plainly incompetent."[272] This should not be the standard used to uphold an individual's constitutional rights. The lower courts can combat this issue by adhering to the guidance previously established by the Supreme Court in *Saucier*.[273] By conducting the initial inquiry into the constitutionality of an alleged violation, the lower courts could further develop the case law and ensure future bad actors are held accountable. Courts and legislatures can also recognize the obvious difference between acts aimed at enforcing the law and acts committed while rendering aid. This distinction may offer EMS the necessary protections under qualified immunity while permitting the courts and legislative bodies to reform policing to meet the twenty-first century expectations of the American public. While this distinction has already been recognized in some circuits, it should be adopted by others until the Supreme Court has a chance to do the same.

The doctrine of qualified immunity protects all discretionary state actors from civil liability, not just police. To reimagine policing, society

267 *See* Counts, *supra* note 225.

268 *See* Nate McCarthy, *EMTs: Overlooked and Underpaid During Pandemic*, NYACK NEWS & VIEWS (Aug. 15, 2020), https://perma.cc/PQ75-S4ZZ.

269 *See* Lisa Soronen, *What Would Eliminating Qualified Immunity Mean for States and Local Governments?*, NAT'L CONF. OF STATE LEGISLATURES (June 17, 2020), https://perma.cc/PC5J-3Z6Q (observing that state and municipal governments pay most damages regardless of an individual actor receiving qualified immunity).

270 *See generally* Karen M. Blum, *The Qualified Immunity Defense: What's "Clearly Established" and What's Not*, 24 TOURO L. REV. 501, 514–19 (2008).

271 *See* discussion *supra* Sections II.B.2, III.A.

272 Malley v. Briggs, 475 U.S. 335, 341 (1986).

273 *See* Saucier v. Katz, 533 U.S. 194, 201 (2001).

should not have to ignore the other essential state actors that depend upon the shield of qualified immunity. Eliminating qualified immunity may curb some police misconduct; it will most certainly result in a change to the EMS system. To the EMTs, paramedics, and other prehospital medical providers responding to 9-1-1 calls, qualified immunity is an essential protection that allows them to put the patient first. Its absence would be felt by individual providers, communities, and the 9-1-1 system in general.