Privacy and Dignity for Undocumented People? Clinicians' Duties and Responses to Patient Immigration Status Inquiries

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INTRODUCTION

Ethically-grounded care of patients with undocumented legal status is complicated by the rapidly shifting regulatory environment. Particularly when law enforcement is present "at the bedside," clinicians face questions about violations of patient privacy and protecting the clinical space from incursions by law enforcement. While law enforcement enjoys a measure of moral and legal authority, conflating the two in healthcare settings can lead to inappropriate disclosure of protected health information (PHI) or otherwise influence patient care. The actual - or perceived - authority of law enforcement in clinical settings can create legal and ethical dilemmas around maintaining patients' autonomy, privacy, and dignity. This tension is accentuated by recent state and federal policies that contravene long-standing mores and legal protections separating patients' medical needs from other aspects of their existence as members of society.

In 2025, after protections of healthcare spaces were rescinded by Department of Homeland Security (DHS), Immigration and Customs Enforcement (ICE) or Customs and Border Protection (CBP) began to carry out enforcement in hospitals. As a result, clinicians have become increasingly concerned not only about socially marginalized patients foregoing medical care,(1) but also about clinicians' own roles and responsibilities during interactions with ICE/CBP enforcement officials.(2, 3) Anxiety about those roles and responsibilities raises several key questions:

- Do undocumented persons in the U.S. have a right to Health Insurance Portability and Accountability Act (HIPAA) protections?
- When are clinicians required to respond to warrants or subpoenas produced by ICE/CBP agents?

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- How can clinicians ensure privacy of their patients with ICE officials at the bedside?

The throughline in these questions is whether the clinical team has become a *de facto* extension of the ICE/CBP enforcement team. Resolving these uncertainties requires an understanding of the targeted population, a basic legal understanding of recent policy changes and their place in the historic landscape of US immigration law, and a clear ethical approach to navigating conflicting obligations.

Immigrant Populations in the United States

Clinicians faced with ICE inquiries may recognize parallels from caring for patients involved in and detained by the criminal legal system. Unlike those patients, undocumented immigrant patients may be encountered both in and out of law enforcement custody and the overwhelming majority (approximately 70%) of all migrants arrested since January 1, 2025 have no criminal record.(4) In fact, immigrants are less likely to commit any criminal offense than U.S. citizens.(5) Many of those targeted for enforcement had temporary protected status that was only recently rescinded or were otherwise not subject to deportation orders. However, both groups of patients are decidedly vulnerable to privacy violations and other deviations from the standard of care.

A seismic shift targeting undocumented people

On January 20, 2025,(6) the DHS issued a memorandum rescinding guidelines that limited enforcement actions by ICE or CBP in or near “protected areas”; which included places of worship, schools, and medical facilities.(6, 7) These guidelines, in place since 2011 and revised in 2021, explicitly protected medical and mental healthcare facility spaces. The goal was to prevent “significant disruptions of the normal operation” of protected spaces, and avoid action “that would restrain people’s access to essential services or engagement in essential

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activities."(7, 8) This guidance emphasized that the government could "accomplish [its] enforcement mission without denying or limiting individuals' access to needed medical care," sensibly balancing priorities to promote community well-being overall. In its spirit, it reflected longstanding principles protecting healthcare facilities, articulated as early as the first Geneva convention on the rules of warfare, and sanctuary within such facilities, dating back to the time of the Reformation in English law.(2, 9, 10) In contrast, the 2025 memorandum abolished the concept of "protected areas" entirely, leaving whether an enforcement action should occur up to individual officers' "discretion along with a healthy dose of common sense."

BACK TO PRIVACY BASICS: LEGAL & ETHICAL CONSIDERATIONS

HIPAA & Immigration

Under federal law, clinicians are obligated to maintain the privacy of immigration status. Why? The controlling fact is that a patient's immigration status is considered individually identifiable and therefore PHI under the Health Insurance Portability and Accountability Act (HIPAA).(11) The statutory language of HIPAA outlines the responsibilities covered entities like providers. These responsibilities exist independent of the patient in question. As such, even where individual states have mandated additional reporting duties for physicians—a scenario largely beyond our scope—they have done so largely by categorizing immigrants within one of HIPAA's defined exceptions or being constrained by its statutes. A strong understanding of this law is therefore essential.

When immigration status is present in a patient's health record, a clinician may incorrectly believe that it *must* be disclosed to a DHS official under federal law. In fact, setting specific state laws and order aside, HIPAA itself only *legally requires* the disclosure of PHI *to the patient* upon the patient's (or their personal representative's) request, or to the U.S.

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Department of Health and Human Services upon a HIPAA compliance-related investigation, review, or enforcement action (45 CFR §164.502(a)(2)). Outside these two well-circumscribed conditions, PHI disclosures are merely *permitted* as a choice for the patient. If a clinician is compelled to disclose PHI without the patient's consent as a matter of state or federal policy, the clinician is bound to only disclose the minimum amount of information necessary to respond to the specific request (45 CFR §164.514(d)(2)).

Ethical Concerns & Privacy Best Practices

Privacy is a Constitutional right and widely acknowledged as a core responsibility to patients. This is diminished when clinicians voluntarily disclose PHI to ICE/CBP agents. Fear of disclosure may deter care-seeking. Therefore, apart from any legal mandate, our ethical imperative is to maintain patients' privacy as a key prerequisite to maintaining trust and dignity.

Whether compelled by legal or ethical concerns, one of the fundamental methods of maintaining privacy regarding immigration status is to avoid routinely collecting and recording this information in the first place.(12) Clinicians should only collect and document information that is directly pertinent to the medical care of their patients, which would not typically include their immigration status. For example, while immigration status may be a clear upstream cause of housing and food insecurity, any necessary treatment modifications can be amply justified in progress notes by referencing only these downstream factors, without specific reference to immigration status.

There are some contexts where immigration may nonetheless appear in the health record. Healthcare facilities and systems could collect patients' immigration status routinely in support of payment or care program participation. In states where undocumented immigrants may participate in Medicaid, a Medicaid participant's immigration status may therefore be collected

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and potentially subject to interagency data sharing between the Department of Health and Human Services and DHS.(13) In Texas and Florida, hospitals receiving state funds must inquire about immigration status. Critically, none of these scenarios create a responsibility for an individual clinician to document immigration status for a patient in their care. As with a wide variety of other information of interest to healthcare systems but outside the scope of clinical care, we recommend against amplifying this information in clinical notes.

Assessing Warrants

Judicial warrants (*not* administrative warrants) mandate a response as a matter of federal law. While HIPAA offers robust privacy protections, we have already noted there are exceptions. One of the most important in this context is responding to a request for information mandated by law, such as a subpoena or a judicial warrant, signed by a judge from a federal or state court (45 CFR §164.512(f)(1)(ii)). Importantly, in contrast to judicial warrants, administrative warrants are issued by agencies such as DHS-ICE, without being validated as necessary by a court. Indeed, administrative warrants may require such validation by a court in order to become enforceable over the objections of a clinician or other healthcare entity. For this reason, administrative warrants do not carry the same immediate obligation for clinician compliance as judicial warrants do, nor the same repercussions for choosing not to comply. Though the facility's risk management team should be involved in either case, the key distinction for physicians is whether the warrant was signed by a judge/magistrate, or only by an agency official.

Under HIPAA regulations, clinicians may choose to comply with an administrative warrant, just as they would with a judicial warrant (5 CFR §164.512(f)(1)(ii)(C)). However, this compliance is governed by similar rules. Notably, administrative warrants must be as specific and limited in scope as possible (45 CFR §164.512(f)(1)(ii)(C)(2)). Clinicians should therefore

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only disclose the specific information relevant to the warrant as written (45 CFR §164.512(a)(1)). Even if an ICE/CBP agent brings an individual in custody for medical care, sharing medical information, testing or results absent a legal mandate is not permissible. Notably, even if law enforcement's purpose is to identify a suspect or fugitive, under HIPAA regulations the PHI disclosed for that purpose may not include the patient's immigration status, since that status does not appear on a limited list of information that healthcare entities are allowed to disclose in such circumstances (45 CFR §164.512(f)(2)(i)).

Outside a legal framework, because our position is that a clinician's primary obligation is to their patient, not to the authorities, we advise against voluntary compliance with warrants that have not been signed by a judge or magistrate.

CONCLUSION

Clinicians are never agents of immigration enforcement, nor extensions of their will. Where the two groups' duties intersect, it is in narrow and legally prescribed contexts. We should operate accordingly. To protect patient privacy when ICE/CBP are at the bedside, focus on maintaining a trusting patient-physician relationship and limiting officers' interventions to the least intrusive measures possible. As we advise in interactions with other correctional or law enforcement officials, this can usually be established through respectful, informed dialogue between the clinician and any agency representative.

We acknowledge that the clinician's position can be fraught, and even legally permissible non-compliance may expose a clinician to risk. Clinicians facing arrest and detention while protecting patient privacy serve as cautionary tales against resisting such requests of law enforcement entities.(14) Our group, Scopes and Shields, LLC (www.scopesandshields.org), began its work in 2021 in response to similar challenges faced by physicians while caring for

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incarcerated patients when law enforcement was at the bedside.(15) Though we have heard many stories of adversity endured from the choice to uphold moral responsibilities to our patients, we have heard as profoundly of clinicians' moral injury when they cannot or do not do so. Like them, we are determined to be part of a humane future, even in a climate of growing hostility to historically marginalized populations, including undocumented persons.

As citizens and healthcare workers, we are witnessing an erosion of longstanding norms that displayed deference to the vulnerability of physical illness by tempering the operation of some law enforcement mechanisms. A major vulnerability of this assault is *our own ignorance*. To uphold patients' trust and dignity, we must reaffirm our own professional roles and responsibilities; relearn our ethical obligations to protect our patients while familiarizing ourselves with legal requirements during interactions with ICE/CBP authorities requesting patient information. We reject retaliatory actions against clinicians caring for their patients as an attack on basic human rights.

Acrimony and division seem to define the current era, but we cannot allow our own lack of knowledge about evolving legal processes be weaponized against patients in our outpatient clinics, inpatient wards, and ICUs. We can, and must, uphold our oath to do no harm. After all, we risk losing ourselves when we surrender our ethical, moral and legal obligations to our patients out of fear, ignorance or mistrust. Perhaps, via the practices outlined above, we can come one step closer to fulfilling Maimonides' "lofty aim of doing good to [God's] children."(16)

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