Medical Repatriation in the United States: An Ethical Appraisal

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Medical Repatriation in the United States: *An Ethical Appraisal*

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ABSTRACT:

Title: Medical Repatriation in the United States: *An Ethical Appraisal*

Purpose: To examine the historical dimensions and ethical boundaries of medical repatriation, particularly as they relate to patients, health care providers, and hospitals.

Methods: The methods employed in this analysis are rooted in the traditions and techniques of modern philosophy, medical ethics and applied ethical theory.

Results: After exploration and critical evaluation of the history and motivations behind medical repatriation, considerations against the practice are advanced. Drawing on the ethical dimensions of informed consent, equality, distributive justice, transparency, and trust, the tension between medical repatriation and the ethical duties of health care providers is assessed.

Conclusions: At this time of great change in health care and immigration policy, clarity about our ethical obligations to undocumented immigrants is crucial if we are to create systems that are not only efficient, coordinated, and technologically sophisticated but also equitable for those who are vulnerable.

Reference: Young, Michael J., and Lisa S. Lehmann. "Undocumented injustice? Medical repatriation and the ends of health care." *The New England Journal of Medicine* 370.7 (2014): 669-673.)

Medical Repatriation in the United States: An Ethical Appraisal
Scholars in Medicine Project
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The focus of this scholarly project is on the ethical and philosophical dimensions of forced or encouraged medical repatriation within the United States, a practice involving the transfer of undocumented patients in need of continued medical care to their countries of origin. The attached published manuscript constitutes the product of my scholarly project work. This brief preface is intended to briefly place the work in context and delineate my role. A recent report by the New York Lawyers for Public Interest indicates that there have been at least 800 cases of medical repatriation in the United States. Despite its relative ubiquity, this practice has received relatively little attention among wider audiences of clinicians and bioethicists; this is striking, given that the difficulties displayed by this practice seem to run contrary to many of the principles and aims that have shaped and upheld medicine as a moral and meaningful enterprise. With the objective of exploring these issues, this project begins by exploring the history of medical repatriation and healthcare for undocumented immigrants in the United States; it next examines the institutional, political and financial motivations behind medical repatriation; and finally analytically appraises key ethical questions and challenges raised by the practice while offering some guidance on novel political and institutional strategies to handle the complex issues raised in these challenging settings.

The qualitative methods employed by the present analysis are rooted deeply in the traditions and techniques of modern philosophy and applied ethical theory. It takes as a conceptual starting point that certain rudimentary ethical obligations devolve upon clinicians by virtue of their membership in the medical profession and, more basically, as members of a moral community. Further analysis of the deontic status and extent of these obligations can be found in my recent

paper, *Young, Michael J. "Bioenhancements and the telos of medicine." Medicine, Health Care and Philosophy (2015).* It further recognizes that what enables our institutions to function optimally are not merely market forces but are also values and ideals that foster cooperation, build trust, and promote integrity. Distributive justice, which John Rawls deems "the first virtue of all social institutions," lies at the core of this ethical architecture.

In an influential essay on the state of contemporary philosophy in the academy, Cambridge philosopher Jane Heal identifies a perpetual risk for investigative, scientific or truth-directed enterprises to lose touch with the "nourishing roots" for human wellbeing that got the enterprise going in the first place.[1] The modern practice of medicine is no small exception to this tendency, and clinicians' involvement in medical repatriation recapitulates this tragic reality. Often, in hurried pursuit of meeting institutional benchmarks, submitting to hospital hierarchies, or mastering the latest biomedical science or techniques, clinicians experience an erosion of empathic concerns for human dignity and justice that have sustained and nourished medical practice throughout the ages. Considering this state of affairs, one may be reminded of that enigmatic remark of philosopher Ludwig Wittgenstein in one of his few remaining Notebooks (1914-1916) - "*Die Ethik handelt nicht von der Welt. Die Ethik muss eine Bedingung der Welt sein, wie die Logik.* [(Ethics does not treat of the world. Ethics must be a condition of the world, like logic[2])] (24.7.16). The meaning of Wittgenstein's statement here is not immediately clear; while logic is a condition of the world in the sense that it governs what may be the case and what may not be the case - defines, as it were, the boundaries of the totality of facts that may obtain - the same cannot, it seems, be said of ethics. Indeed, the world *does* contain things - attitudes, policies, actions, reactions, plans and projects - which are *prima facie* not ethical, in a way that the world does not contain things that are logically

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[1] Heal J. Philosophy and Its Pitfalls. Metaphilosophy 2012;43:38-45.

[2] The English translation is G.E.M. Anscombe's (Blackwell 1961).

impossible. A comment in Wittgenstein's *Tractatus* throws some light on this issue. In §6.13 he argues "[l]ogic is not a theory but a *reflexion* of the world." Perhaps what Wittgenstein is thus suggesting is that just as logic does not emerge as an ontologically distinct set of propositions about the world but instead constitutes a reflexion of the structure of the world itself and in that manner illuminates the forms of what is possible and what is not possible, ethics constitutes as a reflexion of the ideal function of the world and in this capacity illuminates the forms of what is desirable and what is not desirable. (It is in this sense a condition of the world: as logic is a reflexion of the boundaries of the possible, ethics is a reflexion of the boundaries of the good.) Both are, in a word, '*conditions of the world*' in that they are constitutive of distinctive scaffolding through which the world's potential is recognized and actualized. The relevance Wittgenstein's ideas on ethics for the medical profession cannot be understated. Far from a discipline that is ontologically distinct from the enterprise of medicine itself, medical ethics it is an articulation of the very scaffolding that enables healthcare systems to function and flourish, and in this sense is as rudimentary to the enterprise as pathophysiology is to disease, as logic is to the world.

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Appendix

Young, Michael J., Lehmann L.S., "Undocumented injustice? Medical repatriation and the ends of health care." *New England Journal of Medicine* 370.7 (2014), attached.

HEALTH LAW, ETHICS, AND HUMAN RIGHTS

Mary Beth Hamel, M.D., M.P.H., *Editor*

Undocumented Injustice? Medical Repatriation and the Ends of Health Care

Michael J. Young, M.Phil., and Lisa Soleymani Lehmann, M.D., Ph.D.

Quelino Jimenez came to the United States at 18 years of age, seeking work to provide financial support to his family of 11 in Mexico. Jimenez found a construction job in Chicago, where he worked without a legal work or residence permit for more than a year until he sustained injuries after a 20-ft fall on the job, which resulted in quadriplegia. He was admitted to a Chicago hospital, where he remained for months. No long-term care facility was willing to accept Jimenez as a patient. One day, he recounted, "They told me, 'Today you are going to your home.' . . . I wanted to say something, but I couldn't talk. I wanted to ask why."[1]

Jimenez was subsequently discharged, by means of air ambulance, to a hospital in Oaxaca, Mexico. In the Oaxaca hospital, Jimenez had bedsores, two cardiac arrests, pneumonia, and sepsis. "I didn't want to come back [to Mexico]," he told family and reporters, "because here there's no medicine. . . . I need therapy, I need a lot of things they don't have." On January 3, 2012, Jimenez died at 21 years of age.[1]

Jimenez's case offers a poignant glimpse into medical repatriation, the transfer of undocumented patients in need of subacute care to their country of origin.[2] Although data on the prevalence and circumstances surrounding medical repatriation are limited, owing to insufficient documentation and reporting requirements, a recent report based on observational data indicates that there have been at least 800 cases of attempted or successful involuntary medical repatriation of undocumented immigrants in the United States alone.[3] The relatively scant attention that this practice has received among medical professionals is striking, given that medical repatriation impinges on the core values that have shaped medicine as a moral enterprise.

We examine the ethical boundaries of medical repatriation, particularly as they relate to patients, health care providers, and hospitals, while recognizing the need for increased comprehensive reporting and data to uncover the nature and scope of this practice. After exploration and critical evaluation of the history and motivations behind medical repatriation, considerations against the practice are advanced. Drawing on the ethical dimensions of informed consent, equality, distributive justice, transparency, and trust, we assess the tension between medical repatriation and the ethical duties of health care providers. At this time of great change in health care and immigration policy, clarity about our ethical obligations to undocumented immigrants is crucial if we are to create systems that are not only efficient, coordinated, and technologically sophisticated but also equitable for those who are vulnerable.

UNDOCUMENTED IMMIGRANTS IN THE UNITED STATES

Approximately 11.7 million undocumented immigrants reside in the United States,[4] a majority of whom are unlikely to have health insurance.[5] It is estimated that 3 in every 5 undocumented immigrants are uninsured, and this rate is not expected to change substantially under the Affordable Care Act (ACA).[6] Current U.S. law prevents undocumented persons from procuring health care coverage through public exchanges, Medicaid, or Medicare; however, some undocumented immigrants receive health insurance through employers or private insurance plans.[6,7]

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), enacted by Congress in 1996, formally disqualifies undocumented immigrants from receiving most federal benefits and restricts immigrants who have been

granted lawful-residence status from receiving federal benefits during the first 5 years of lawful residence.[8] Although undocumented immigrants may receive care from community-based Federally Qualified Health Centers (FQHCs) regardless of their immigration status or ability to pay, many undocumented immigrants living in areas underserved by FQHCs rely on charity care or out-of-pocket payment for nonemergency medical services.[9]

Despite these obstacles, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital that receives Medicare funding to provide emergency care to persons in need (section 1395dd). The EMTALA statute was enacted in 1986 after members of the medical community brought the issue of "patient dumping" to light by means of a series of landmark articles. These reports exposed the practice of "denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere" and brought clarity to the ethical and social issues raised by this practice.[10-12] EMTALA restricts the transfer of patients until they are stabilized. Since EMTALA does not apply outside the emergency department, once patients are admitted to the hospital and stabilized, there is no clear legal obligation to continue delivering care.

The costs of providing stabilizing treatment to uninsured patients are substantial. According to a 2003 report from the American Medical Association, the average U.S. emergency physician provided an annual average of $138,000 in EMTALA-related uncompensated care.[13] To help offset these costs, section 1011 of the Medicare Modernization Act (Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) was implemented in 2005, followed by Medicaid Disproportionate Share Hospital (DSH) programs. These programs enabled eligible providers and hospitals to apply for federal reimbursement for care furnished to undocumented immigrants and specified low-income populations.[14] Although the ACA increases funding to FQHCs, it decreases funding for DSH programs, and as of May 2013, a total of 28 states had exhausted their section 1011 funds.[9,14]

These issues amplify the substantial financial burdens and uncertainties many medical institutions face when uninsured patients require expensive long-term care.[14] Under these circumstances, undocumented, uninsured patients in need of long-term care may end up with prolonged stays in acute care settings owing to the refusal by long-term care facilities in the United States to accept the transfer of patients for whom care is not expected to be reimbursed. This leaves hospitals with the difficult choice of whether to assume costly care for such patients indefinitely or to transfer patients to a health care facility in the patients' countries of origin. It is against this backdrop of law and policy that medical repatriation has emerged.

Historical precedent for medical repatriation is well documented in refugee and prisoner-of-war populations. The Third Geneva Convention specifies that parties to a conflict "are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick prisoners of war, after having cared for them until they are fit to travel" (article 109) and "the conditions of transfer shall in no case be prejudicial to their health" (article 46). Article 109 is qualified by the provision that "no sick or injured prisoner of war who is eligible for repatriation . . . may be repatriated against his will during hostilities."

In contrast, the transfer of stabilized, undocumented civilians is unregulated, and there is no statute in U.S. law that explicitly limits the repatriation of patients. This reality raises challenging ethical questions about the obligations of clinicians, hospitals, and the ends of health care.[15]

MOTIVATING FACTORS — THE NEXUS OF CARE, COSTS, AND POLITICS

Decisions to repatriate patients are multifaceted and might be broadly considered to be a product of three overlapping domains: financial pressures, resource strains, and sociopolitical circumstances. Financial interests may motivate the repatriation of patients for whom costly, long-term care is expected to go uncompensated. These felt motivations are accentuated in settings in which financial pressures exist to prematurely discharge patients or to avoid advocating for uninsured patients, especially in the face of perceived threats to employment, workplace relationships, or profits.[16]

Hospital administrators may argue that repatriation is an unfortunate yet inevitable consequence of the economic realities facing hospitals, is necessary to secure the financial integrity of hospitals, and enables patient care in the long term. Repatriation can be further motivated by concerns for responsible stewardship of limited resources. In such cases, decisions to repatriate patients might be considered justified, all things considered, if they promote efficient resource distributions.[17]

Medical repatriation may be influenced by sociopolitical views. Animated by beliefs that repudiate the rights of undocumented persons to receive medical care by virtue of their inability to pay or their immigration status, policymakers, hospital administrators, or clinicians may find the practice of repatriation justified.[18] Such views may be rooted in nationalistic doctrines or social-contract theories that conceptualize rights to publicly funded medical treatment as dependent on legal membership in that society, in market-based ideologies that conceive of health care not as a right but rather a service commodity to be distributed through free-market exchange, or in worries that caring for undocumented immigrants may subvert the value of citizenship or alienate politically motivated stakeholders. The practice of forced or encouraged medical repatriation can thus be understood as a product of a complex interplay of financial, resource, and sociopolitical interests — coupled with a relatively permissive legal architecture — that bear on hospital administrators and clinicians.

INFORMED CONSENT

Although decisions to repatriate undocumented patients are often straightforwardly executed, they are complicated by ethical concerns that call into question the moral integrity of the practice. Among the most conspicuous features of repatriation cases such as Jimenez's is an apparent failure to secure informed consent from patients or surrogates. Informed consent is both preventive and constructive. It serves not only to protect patients from harm but also to affirm and reinforce their autonomy, to build reasonable expectations, to protect the integrity of the medical profession, to foster trust, and to forestall abuses of power that might emerge in otherwise paternalistic settings.

Proponents of repatriation may argue that consent in such cases is not required because the patient has no legal right to reside in the United States or, alternatively, that repatriation — albeit unjustified if forced — can be justified if it is encouraged. If patients have a favorable response to physician encouragement and ultimately consent, repatriation might be considered appropriate.

However, it is questionable whether consent can be voluntary in the face of physician pressure to comply with an intervention that may not be in a patient's best interest. Although obtaining consent may alleviate some of the visible problems with repatriation, consent alone cannot vindicate the practice. At stake in this debate are not merely issues of consent but, more importantly, concerns for human equality and justice.

EQUALITY AND THE ENDS OF MEDICINE

Health care providers have an ethical duty to promote the health of persons without discrimination on the basis of ethnic group, socioeconomic status, or citizenship. This duty reminds clinicians of patients' rights and delineates the ends to which medicine should be directed. Health care providers uphold their commitment to the equality of patients by using their knowledge and skills equitably to alleviate suffering and restore health. Medical repatriation to substandard health care settings opposes this commitment.

The repatriation of undocumented immigrants constitutes an affront to the equal worth of all patients. It neglects the reality that undocumented persons commonly arrive in the United States to escape unfavorable socioeconomic conditions, ethnic discrimination, sexual exploitation, child labor, or conflict.[19] Although some immigrants escaping unsafe conditions may qualify for asylum or Temporary Protected Status in the United States, disparities in court decisions and other procedural obstacles prevent many from establishing lawful residence.[20,21] Even if "equivalent" treatment plans are arranged, repatriation will often entail a return to

unfavorable societal conditions and the severance of established social and familial ties in the United States.

Studies of repatriation for nonmedical reasons in other contexts indicate that repatriation itself might constitute harm to patients.[22-24] Medical repatriation conveys a message to repatriated patients that they are undeserving of sustained care simply by virtue of their origin or affluence. Such actions indicate that the lives worth tending to ought to be determined not according to a shared sense of humanity but rather on the basis of the ability to pay. These premises underlying medical repatriation are at odds with the ethical demands deriving from human equality that clinicians assume by virtue of their role in society and their membership in the medical profession.

JUSTICE

Can medical repatriation be squared with concerns for distributive justice? Some might argue that obligations to distribute health care justly extend only to members of our society, and because undocumented immigrants are not citizens, repatriation does not conflict with distributive justice. A premise of this argument is that undocumented immigrants are, by dint of their legal status, not members of our society. Although true in a strict legal sense, many undocumented immigrants are heavily embedded in society, through work, family, and friends.[19] This situation renders many immigrants de facto members of society, with no ethically distinguishing features from documented compatriots save legal recognition as such — a feature that is in no obvious sense morally relevant.

This premise denigrates the contributions and strivings of many immigrants in society and overlooks the reciprocity owed to undocumented immigrants by virtue of the public benefits that their contributions help sustain.[25] Insofar as the duties of justice issue from a universal recognition of the equality of all persons and take as their aim the optimization of opportunity for the least privileged, the repatriation of vulnerable patients to places where opportunities for health and social mobility are less guaranteed represents a powerful injustice.

Some may alternatively justify medical repatriation on grounds that the patient has broken the law by entering the country, and such persons correspondingly contend that repatriation is in a sense a justified reversal of that crime. However, it is not the role of medical professionals to arbitrate or interfere in legal matters, regardless of one's interpretation of immigration law.[26] Even when faced with patients charged with crimes more heinous than unauthorized entry into the United States, clinicians are expected to treat the patient in front of them and to allow the court system to formally adjudicate legal issues.

TRUST AND TRANSPARENCY

Medical repatriation may have unintended consequences for public trust in the medical profession. Reports of medical repatriation in the media cast the medical profession as an enterprise in which financial and political concerns might come at the expense of patient well-being. The imprudence of repatriation is buttressed by the fact that it is often carried out without any oversight, transparency, or reporting. Systems of concealed rules and actions enable discriminatory practices.[17,27] These realities indicate the great need for transparency and required reporting of medical repatriation.

Requiring hospitals to be transparent about repatriation events, the reasons behind them, and the outcomes of repatriation can unmask the full scope of the practice, reveal areas of exceptional inequity, and enable the development of a fairer process, even if the practice is not discontinued.[27,28] Because decisions to repatriate patients are often made on a case-by-case basis, the exposure of hospital practices can provide accountability and may increase the likelihood of providing just health care.

OBSTACLES AND OPPORTUNITIES

Some may view as radical the proposal that hospitals or long-term care facilities should provide nonemergency care to patients who could otherwise be repatriated. Critics might insist that the financial burden would be too great for hospitals or society to bear justifiably. However, the veracity of this claim hinges on a cost–benefit analysis. Data suggesting that noncitizens have

generated a surplus in Medicare funds further confound assumptions that the repatriation of undocumented immigrants portends fiscal relief.[29]

Nonetheless, such concerns rightly emphasize that any expectation for hospitals and long-term care facilities to care for patients who would otherwise be repatriated ought to be coupled with broad social or governmental programs that can relieve undue financial burdens on medical centers. Moreover, policies governing medical repatriation should ideally be developed in tandem with immigration and insurance reforms that establish streamlined paths to citizenship and insurance coverage for vulnerable immigrants.

A comprehensive solution to the problem of medical repatriation will be multilayered, involving not only clinicians but also administrators, policymakers, and public health officials who are empowered to revise policy, align incentives, and impose sound mechanisms of oversight and enforcement. Yet, by virtue of the special position they inhabit at the critical junction of policy and practice, clinicians are uniquely equipped to display the moral courage necessary to advocate effectively for patients by calling attention to the profound ethical issues raised by repatriation and to set us on a path toward a more equitable approach to the treatment of vulnerable persons in our communities and around the world.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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