

Medical Repatriation: Examining the Legal and Ethical Implications of an Emerging Practice

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INTRODUCTION

On July 10, 2003, Luis Alberto Jimenez was taken from the hospital that was treating him in Stuart, Florida, to an airport, where he was placed on a private plane and transported to Guatemala.¹ Mr. Jimenez had been hospitalized since 2000, when he sustained traumatic brain injuries as a result of a collision with an intoxicated Florida driver.² His brain injury rendered him completely incapacitated, and for three years he received twenty-four hour nursing care.³ Since arriving in Guatemala, though, Mr. Jimenez has not received medical treatment.⁴ His sole caregiver is his seventy-two year-old mother.⁵ He routinely suffers violent seizures, vomits blood, and falls into bouts of unconsciousness.⁶ United States immigration

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1. *Montejo v. Martin Mem'l Med. Ctr., Inc.* 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004); Deborah Sontag, *Deported*, by *U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1, available at <http://www.nytimes.com/2008/08/03/us/03deport.html> [hereinafter Sontag, *Deported*, by *U.S. Hospitals*].

2. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1, at A1.

3. *Montejo*, 874 So. 2d at 656. Jimenez was hospitalized at Martin Memorial from the time of the accident in February 2000 through June 2000, when he was transferred to a nursing facility. *Id.* Jimenez was readmitted to Martin Memorial in January 2001 on an emergency basis; he stayed there until July 2003. *Id.*

4. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1, at 19–20. Guatemala's National Hospital for Orthopedics and Rehabilitation took in Jimenez upon his arrival but discharged him a few weeks later. *Id.* The family members who came to the hospital to pick him up found Jimenez "lying in the hallway on a stretcher, covered in his own excrement." *Id.* at 19.

5. *Id.* at A1.

6. *Id.*

procedures played no role in Mr. Jimenez's deportation. Instead, the Florida hospital that previously treated him obtained a court order that allowed it to privately "repatriate" him.⁷ The timing of this trip was not incidental. The hospital transported Mr. Jimenez on a plane it had chartered a mere three hours before it was required to file a response to Mr. Jimenez's guardian's motion to stay the court order allowing for his repatriation.⁸ Mr. Jimenez's case is not unique. To be sure, he has received a level of media attention that few other patients in his position have attained.⁹ However, the underlying factual scenario—a United States hospital privately deporting a critically ill patient—is increasingly common.¹⁰

Medical repatriation results from myriad factors.¹¹ The incentives for hospitals to "repatriate" indigent immigrants are largely economic. Federal Medicare and Medicaid guidelines do not provide health care funding for the treatment of undocumented immigrants,

7. *Montejo*, 874 So. 2d at 656. The hospital intervened in guardianship proceedings, arguing that Jimenez's legal guardian was not acting in his best interest. *Id.* It sought and received a court order to transport Jimenez to Guatemala, where his family lived. *Id.* The court order was reversed in 2004 on the basis that: "(1) there was no competent substantial evidence to support Jimenez's discharge from the hospital, and (2) the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala." *Id.* at 658. By 2004, though, Jimenez already had been transported to Guatemala. *Id.* at 656.

8. *Montejo*, 874 So. 2d at 656; Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at 19. The order that allowed the hospital to transport Jimenez to Guatemala was entered on June 27, 2003. The guardian's motion for rehearing was denied on July 9, at which point he filed a notice of appeal and a motion for a stay pending that appeal. *Montejo*, 874 So. 2d at 656. The hospital began Jimenez's transport to Guatemala at 7:30 a.m. the next day. *Id.* The hospital leased the air ambulance used for Jimenez's return to Guatemala for \$30,000. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at A1. This type of fact pattern is common in repatriation cases where the patient's family attempted to use the legal system to prevent a forced repatriation. See Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at 39, available at <http://www.nytimes.com/2008/11/09/us/09deport.html> [hereinafter Sontag, *Deported in a Coma*] (describing a case in which a family's lawyer narrowly prevented an Arizona hospital from transporting an infant American citizen to a hospital in Mexico).

9. Deborah Sontag's piece on Mr. Jimenez's case appeared on the front page of *The New York Times*. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at A1.

10. Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at 18 (explaining that instances of medical repatriation are difficult to quantify, but estimating that the phenomenon is widespread enough in some areas to support a private company that caters to hospitals seeking to repatriate patients).

11. Medical repatriation is only one of the names used for this practice. It is more pejoratively deemed "international patient dumping" by some commentators. This Note will refer to it as medical repatriation because that is the most commonly used phrase.

except in the cases of medical emergencies, which traditionally have been narrowly defined.¹² However, hospitals are required by other federal legislation to treat patients suffering from emergent health care needs.¹³ Repatriation often occurs in cases like that of Mr. Jimenez, in which the patient is originally admitted after a medical emergency, but then stabilizes to the point that his condition is no longer deemed emergent.¹⁴ Hospitals see repatriation as a way to avoid the financial strain of treating patients who are unable to pay and are ineligible for public medical assistance.¹⁵ While exact numbers are not known, the practice likely has become more common in recent years as health care costs climb, as does the number of patients who are ineligible for state medical assistance because of their immigration status.¹⁶

Medical repatriation raises substantial legal and ethical questions. The facts of Mr. Jimenez's ordeal compel an almost universally negative reaction. Something about his situation and medical

12. The regulations limiting the availability of state-funded medical care for non-citizens were published as part of the wide-scale welfare reform legislation of 1996. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 [hereinafter PRWORA]. Courts have interpreted the emergency medical condition exception included in PRWORA inconsistently. See Michael J. McKeefery, Comment, *A Call to Move Forward: Pushing Past the Unworkable Standard that Governs undocumented Immigrants' Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL'Y 391, 409 (2007).

13. The duty to treat patients in medical emergencies was established by the passage of the Emergency Medical Treatment and Active Labor Act in 1986. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000).

14. See Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at A1. While "repatriation" typically occurs only in cases of immigrants or nationals of another state, hospitals sometimes use other extreme measures to discharge non-immigrants. For information on patients' rights in discharge situations, see Olga Cotera-Perez-Perez, *Discharge Planning in Acute Care and Long-Term Facilities*, 26 J. LEGAL MED. 85, 89-90 (2005). For an illustration of the use of legal processes to effectuate a discharge against a patient's will, see *Wyckoff Heights Med. Ctr. v. Rodriguez*, 741 N.Y.S.2d 400 (N.Y. Sup. Ct. 2002) (issuing a mandatory injunction requiring a patient to leave hospital from which he did not wish to be discharged).

15. Sontag, *Deported in a Coma*, *supra* note 8, at A1, 38.

16. Statistics suggest that there are an estimated 11.9 million undocumented immigrants living in the United States. JEFFERY PASSEL & D'VERA COHN, PEW HISPANIC CTR., TRENDS IN UNAUTHORIZED IMMIGRATION: UNDOCUMENTED INFLOW NOW TRAILS LEGAL INFLOW 1 (2008), <http://pewhispanic.org/files/reports/94.pdf>. The rise in health care costs in recent years is well-documented. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., NATIONAL HEALTH EXPENDITURE ACCOUNTS (2008), <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf> [hereinafter NAT'L HEALTH EXPENDITURE DATA].

repatriation seems fundamentally wrong. The sense that something about medical repatriation is not right is rooted in its potential violations of both legal standards for patient treatment and discharge,¹⁷ as well ethical standards governing the medical profession.¹⁸

Because medical repatriation implicates both legal and ethical questions, any proposal attempting to mitigate its problems must be similarly multifaceted and address both the legal and ethical issues involved. This Note puts forth two proposals. The first involves changing the Code of Federal Regulations to create legal standards limiting the practice of medical repatriation. Additionally, it would more broadly and clearly define the circumstances in which hospitals can receive funding for treatment of undocumented immigrants. The second proposal clarifies the American Medical Association's Principles of Medical Ethics with respect to the effect of patients' immigration status on the applicability of medical ethics standards.

This Note asserts that changes are necessary to both legal regulations on medical repatriation and medical ethics standards. Part I of the History section explains the relevance of medical repatriation and anticipates its likely future, absent new regulations. Part II.A of the History section discusses the evolution of medical repatriation, focusing on the lack of government funding available for treatment of undocumented immigrants and the concurrent mandate that hospitals treat all patients with emergent medical conditions. Part II.B reviews medical ethical standards and examines the interplay between ethical and legal standards. Next, this Note analyzes the various factors contributing to the emergence of medical repatriation and evaluates whether the practice comports with currently established legal and ethical standards. Finally, this Note proposes (1) changes to the

17. Legal requirements concerning treatment of patients with emergent health needs can be found in the Emergency Medical Treatment and Active Labor Act. 42 U.S.C. § 1395dd. Department of Health and Human Services regulations governing the procedures with which hospitals must comply when discharging patients can be found at 42 C.F.R. § 482.43 (2008).

18. The American Medical Association has published medical ethical standards. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS (2001) [hereinafter PRINCIPLES OF MEDICAL ETHICS], available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml>.

federal regulations governing hospitals and (2) clarifications to the ethical standards with which the medical profession strives to comply.

HISTORY

I. MEDICAL REPATRIATION IS IMPORTANT AS A MEDICAL PRACTICE, THE LEGALITY AND ETHICS OF WHICH REMAIN DISPUTED

Medical repatriation is a poorly understood phenomenon, and one that is likely to increase in importance as the number of undocumented immigrants living in the United States,¹⁹ as well as the cost of health care, continue to rise.²⁰ Hospitals are unlikely to find quick relief from the financial pressures that have contributed to their efforts to repatriate patients, particularly when one takes into account the current economic crisis. While both immigration and health care are priorities of the Obama administration,²¹ it is unclear whether any current proposals will address the interplay between these two policy areas. Additionally, despite President Obama's intent to affect policy changes,²² it is unclear what impact any changes will have on the ability of documented and undocumented immigrants to receive publicly funded healthcare.²³

19. There are an estimated 11.9 million undocumented immigrants living in the United States. PASSEL & COHN, *supra* note 16, at 1. Each year, approximately 500,000 new immigrants enter the United States without documentation. *Id.* at 2.

20. In 2007, United States health care expenditures totaled over \$2.2 trillion. NAT'L HEALTH EXPENDITURE ACCOUNTS, *supra* note 16, at tbl.1. This figure represented a 6.1 percent increase over the previous year and constituted 16.2 percent of the Gross Domestic Product. *Id.*

21. The White House Website: Issues, <http://www.whitehouse.gov/issues> (follow "Immigration" hyperlink) (last visited Sept. 12, 2009).

22. *See supra* note 21 and accompanying text.

23. While the Obama administration has articulated policies in the realms of both immigration and health care, there is not yet a proposal specifically linking the two. *See supra* note 21 and accompanying text. The economic crisis is another potential barrier to the effectuation of meaningful immigration and health care reform. *See note 21 and accompanying text.* In addition, anti-immigrant sentiment remains an obstacle to the creation of a comprehensive immigration policy. For an examination of the role of anti-immigrant attitudes in policy debates surrounding immigrant health care access, see Saby Ghoshray, *Race, Symmetry and False Consciousness: Piercing the Veil of America's Anti-Immigration Policy*, 16 TEMP. POL. & CIV. RTS. L. REV. 335, 364–65 (2007); Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 486–88 (2007).

There is scant information regarding the growth of medical repatriation's use by hospitals or the number of people affected by its operation.²⁴ The very factors that make medical repatriation troubling also render it difficult to study: it exists in a murky gray area between immigration law, health care law, and medical ethics.²⁵ Hospitals are unlikely to advertise their use of repatriation, and many whom it affects are unable or unwilling to draw public attention to their plight.²⁶ The specific cases that have been brought to light, like that of Mr. Jimenez, illustrate that patients who challenge hospitals' attempts to repatriate them face uphill battles that are difficult even with legal assistance and most likely impossible without it.²⁷

Despite the factors that make medical repatriation difficult to quantify, some people and organizations are attempting to collect data on its practice. In her 2008 *New York Times* article that brought Mr. Jimenez national attention, Deborah Sontag estimates that a Phoenix hospital repatriates nearly one hundred patients per year, while a Chicago hospital returned ten patients to Honduras in a recent twelve-month period.²⁸ Sontag's article also points to the existence of

24. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1, at 18.

25. For an examination of the interplay between immigration and health care regulations, see Susan Okie, *Immigrants and Health Care—At the Intersection of Two Broken Systems*, 357 *NEW ENG. J. MED.* 525 (2007). For an analysis of the interconnectedness of legal and ethical requirements, see Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 *NOTRE DAME J.L. ETHICS & PUB. POL'Y* 245, 247–53 (2000).

26. There are a variety of reasons that undocumented immigrants might be uniquely unlikely to protest the practice of repatriation. They may fear drawing attention to the immigration status of themselves or their families, or they may have been told that their only way to receive medical care is through repatriation. Sontag reports on a mother whose consent was obtained after, as she describes, “[t]hey said we had no rights, the baby neither. They said they would send the baby with or without me. When Elliott was two weeks, they told me to gather my things because the baby was leaving in 15 minutes.” *Id.* This case illustrates the gap in communication between hospital officials and patients, particularly when language barriers are present. It also illustrates that determining “consent” in medical repatriation cases is difficult. For more on the issues of informed consent and its relation to medical ethics and legal obligations, see Scott, *supra* note 25, at 263–67. For further analysis of linguistic barriers and the statutory efforts to remedy them, see Mee Moua, Fernando Guerra, Jill Moore & Ronaldo Valdiserri, *Immigrant Health: Legal Tools/Legal Barriers*, 30 *J.L. MED. & ETHICS* 189, 193 (2002). For more on barriers affecting immigrant access to healthcare generally, see Okie, *supra* note 25, at 526.

27. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1; Sontag, *Deported in a Coma*, *supra* note 8.

28. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1, at 18. This Note's focus on issues unique to immigrant access to health care and legal challenges in avoiding repatriation does not

a company, Mexcare, whose niche is the provision of repatriation services, as evidence that the practice is fairly common.²⁹

Research and anecdotal evidence suggest that undocumented immigrants are not the only patients affected by hospitals' repatriation efforts. Cases of hospitals repatriating immigrants who are lawfully living in the United States abound.³⁰ Moreover, in at least one instance, a hospital tried to repatriate a United States citizen—an infant born in its own maternity ward.³¹ The range of people affected by medical repatriation further counsels for an examination of its legality and compliance with norms of medical ethics.

Medical repatriation recently has begun to emerge as a topic of interest. The California Medical Association voiced its opposition to the forced repatriation of patients after a vote in October 2008.³² The American Medical Association's House of Delegates voted in early November 2008 to begin a study of the practice.³³ The increasing

intend to imply that non-immigrants do not face a myriad of challenges. For a vivid illustration of the use of the legal process to forcibly discharge a patient, see *Wyckoff Heights Med. Ctr. v. Rodriguez*, 741 N.Y.S.2d 400, 401 (N.Y. Sup. Ct. 2002).

29. Sontag, *Deported*, by *U.S. Hospitals*, *supra* note 1, at 18. This company, MexCare, has been operating since 2001 and bills itself as “an alternative choice for the care of the unfunded Latin American national.” MexCare Homepage, <http://mexcare.com> (last visited Apr. 17, 2010). MexCare operates with a network of over twenty hospitals and treatment centers in Latin America. MexCare Locations, http://mexcare.com/locations_MexCare.html (last visited Apr. 17, 2010).

30. Sontag, *Deported in a Coma*, *supra* note 8, at 38.

31. *Id.* The child suffered from Down syndrome, had a heart defect, and was born to undocumented immigrant parents. *Id.* The hospital sought to repatriate the child on the basis that, from a continuity of care perspective, it would be better to send him to a Mexican hospital because his parents were Mexican citizens. *Id.* The parents averted their child's repatriation only after they contacted the Mexican consulate, which provided them with an attorney. The two-week old infant was literally on his way to the airport. *Id.* His repatriation was averted only with the threat of police intervention. *Id.*

32. *Doctors Study Repatriation of Uninsured*, N.Y. TIMES, Nov. 11, 2008, at A18. The House of Delegates vote came at least in part as a response to the publicity brought to the issue by the August *New York Times* article. *Id.*

33. *Id.* While the American Medical Association (“AMA”) has declined to condemn medical repatriation outright before conducting this study, it has acknowledged concern over both the inappropriate discharge of patients and the financial solvency of hospitals. *Id.* “There are conflicting concerns here. On the one hand, patients shouldn't be dumped. On the other, hospitals need to be solvent. After all, if the care of these patients were actually paid for by some entity, these repatriations would not be happening and this would not be an issue.” *Id.* (statement by AMA trustee Dr. Joseph Annis).

media attention given to medical repatriation and its specific occurrences is beginning to mirror the media attention given to patient dumping in the 1980s.³⁴ Growing public sympathy for those suffering the effects of medical repatriation increases the chance that popular pressure will lead to new legislation.³⁵

As the number of immigrants living in the United States continues to grow and the cost of health care continues to rise,³⁶ the factors that incentivize medical repatriation will likely persist. Anti-immigrant attitudes play an important role, too, at least to the extent that hospitals arguably face much less public outrage when they repatriate Latinos and non-citizens than when they “dumped” non-Latino U.S. citizens.³⁷ Unless something changes, hospitals likely will continue to

34. See David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 32–43 (1998). Intense media scrutiny surrounding one particular case of patient dumping and the resulting public outrage at the dumping of seriously ill indigent persons were among the key factors ultimately leading to the drafting of the Emergency Medical Treatment and Active Labor Act (“EMTALA”). *Id.* Hyman correctly asserts that EMTALA’s passage was strongly affected by public outcry at specific instances of patient dumping. His argument that this reliance on public outrage is problematic because it can be manipulated by advocacy groups suggests that he would find reliance on cases like Mr. Jimenez’s similarly problematic. *Id.* at 43. Both “spin” the facts and involve “the perfect victim—someone who is genuine, articulate, and sympathetic.” *Id.* at 43. This argument is not persuasive; it is hard to think of any attempt to pass legislation that does not rely, to some degree, on extreme cases or sympathetic victims.

35. Medical repatriation has not achieved the same level of notoriety as the practice of patient dumping in the 1980s. *Cf.* Hyman, *supra* note 34, at 33 (explaining the prevalence of anecdotes recounting patient dumping stories in the 1980s). However, medical repatriation is even more complicated than patient dumping because of its entanglement with immigration policy. It remains to be seen whether and to what extent anti-immigrant sentiment will affect the chances for legislative action. See, e.g., Mahmoudzadeh, *supra* note 23, at 486–88. If federal action is not taken on medical repatriation, it is likely that the practice will persist in states where anti-immigrant sentiment is strongest, such as Arizona. See generally, Sontag, *Deported in a Coma*, *supra* note 8, at 38 (identifying Arizona as an exceptional state with regard to anti-immigrant sentiment).

36. PASSEL & COHN, *supra* note 16, at i (estimating that 500,000 undocumented immigrants enter the United States yearly, with a total of 11.9 million undocumented immigrants in the United States as of March 2008); NAT’L HEALTH EXPENDITURE DATA, *supra* note 16, at tbl.1 (estimating that the United States spent over \$2.2 trillion on healthcare in 2007, which amounted to 16.2 percent of the United States’ gross domestic product).

37. To the extent that anti-immigrant attitudes are dominant in a given area, or at least are seen as acceptable, hospitals are more likely to repatriate foreign patients than they are in areas where support for immigrant communities is stronger. This explains, at least in part, the particularly extensive use of medical repatriation in Arizona, a state where anti-immigrant sentiment is notoriously strong. Sontag, *Deported in a Coma*, *supra* note 8, at 38. For more on

utilize medical repatriation as a means to rid themselves of costly patients.

II. THE EMERGENCE OF MEDICAL REPATRIATION

The combination of three main factors can explain why medical repatriation has become a common practice. First, indigent undocumented (and some documented) immigrants are ineligible for public assistance, and hospitals are unable to receive reimbursement for their care. Second, hospitals have legal duties to treat all patients with emergent health needs and to discharge patients to appropriate facilities for further care, but receive no funding to compensate for treatment of indigent patients who are ineligible for public assistance. Third, the medical ethical standards arguably violated by medical repatriation are unenforceable.

A. Undocumented Immigrants and Government-Funded Healthcare

Undocumented immigrants are ineligible for publicly funded health care except in the case of medical emergencies.³⁸ A hospital that treats an indigent undocumented immigrant for a non-emergent medical condition will not receive public reimbursement for its expenses.³⁹

the role of anti-immigrant fervor and its impact on immigration policy, see Ghoshray, *supra* note 23, at 336–40; Okie, *supra* note 25, at 528–29.

38. The federal regulations governing Medicare and Medicaid define eligibility for publicly funded health care. See 42 C.F.R. pt. 440 (2008). The limited circumstances under which an individual may be eligible notwithstanding his immigration status can be found at 42 C.F.R. § 440.255 (2008). Courts charged with interpreting the Medicaid regulations have reached vastly differing conclusions. Compare *Greenery Rehab. Group v. Hammon*, 150 F.3d 226, 233 (2d Cir. 1998) (holding that once a patient has stabilized, his emergency has ended) with *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 98 (Ariz. 2003) (finding that the proper inquiry is not whether the patient is stable at one point in time, but rather whether the absence of medical attention could reasonably be expected to cause him adverse consequences).

39. This has changed somewhat since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”), under which providers can recoup some costs incurred in treating indigent undocumented immigrants. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066 (codified as amended in scattered sections of 42 U.S.C.).

While non-citizens have long experienced diminished access to government benefits relative to citizens,⁴⁰ the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA” or “Welfare Reform”) marked a new era in their exclusion.⁴¹ Congress enacted welfare reform in 1996 in an attempt to reduce federal spending and, famously, to “end welfare as we know it.”⁴² It not only dramatically changed public assistance programs such as Aid to Families with Dependent Children (“AFDC”),⁴³ but also imposed heightened restrictions on the ability of immigrants to access public benefits.⁴⁴ PRWORA limits eligibility for medical assistance programs to “qualified aliens”—a new category in the field of immigration classifications.⁴⁵ “Qualified alien” is a term that includes lawful permanent residents, refugees, asylees, and a few other select groups; it does not include undocumented immigrants or lawful permanent residents who have maintained this status for fewer than five years.⁴⁶

There are conflicting opinions regarding PRWORA’s goals and the extent to which these goals have been achieved.⁴⁷ For the

40. See Ghoshray, *supra* note 23, at 344–49.

41. Moua et al., *supra* note 26, at 191–93; Seam Park, Note, *Substantial Barriers in Illegal Immigrant Access to Publically-Funded Health Care: Reasons and Recommendations for Change*, 18 GEO. IMMIGR. L.J. 567, 571–74 (2004); Jeffery T. Kullgren, *Restrictions on Undocumented Immigrants’ Access to Health Services: The Public Health Implications of Welfare Reform*, 93 AM. J. PUB. HEALTH 1630, 1630 (2003).

42. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105. For an account of the intent surrounding the passage of PRWORA, see Park, *supra* note 41, at 571–74; Kullgren, *supra* note 41, at 1630; and The Personal Responsibility and Work Opportunity Act, http://en.wikipedia.org/wiki/Personal_Responsibility_and_Work_Opportunity_Act (last visited Apr. 17, 2010).

43. The provisions establishing the Temporary Assistance to Needy Families program, which replaced Aid to Families with Dependent Children, are found in Title I of PRWORA, 110 Stat. 2105.

44. Moua et al., *supra* note 26, at 191; Park, *supra* note 41, at 573.

45. Moua et al., *supra* note 26, at 192.

46. *Id.* For the statutory language, see PRWORA § 401, 110 Stat. 2105.

47. Kullgren, *supra* note 41, at 1630–32 (asserting that the immigrant restrictions in PRWORA have resulted in burdens to health care providers and threats to public health). See also Park, *supra* note 41, at 568. Stated goals of the limitations on immigrant receipt of medical care included creating a disincentive for immigration to the United States and decreasing federal spending. Kullgren, *supra* note 41, at 1360; Park, *supra* note 41, at 572–73. Illegal immigration rates are higher now than they were in 2000. See PASSEL & COHN, *supra* note 16, at 4. Additionally, federal spending on health care has steadily increased despite the passage of

purposes of this Note, the most important stated goal of Welfare Reform was to save the federal government money by cutting funding for immigrants' medical care and narrowly defining the groups of non-citizens who qualified. Because the general ban on healthcare funding for immigrants was accompanied by an exception allowing for treatment of emergency medical conditions, PRWORA did not completely eliminate funding for the treatment of medical conditions among undocumented immigrants.⁴⁸

While PRWORA effectively prohibited undocumented immigrants from receiving most forms of public assistance,⁴⁹ an exception allows for coverage of emergency medical care.⁵⁰ An individual who is ineligible for Medicaid due to his immigration status must receive the medical services necessary to treat an emergency medical condition if withholding such treatment would be reasonably expected to seriously jeopardize the patient's health, result in serious impairment of bodily functions, or damage an organ or body part.⁵¹ To qualify for this emergency medical coverage, the

PRWORA. NAT'L HEALTH EXPENDITURE DATA, *supra* note 16, at tbl.1 (showing that health care costs have increased at rates between 5.4 percent and 9 percent per year since 1997).

48. The exception for emergency medical treatment can be found at PRWORA section 401. Many have argued that, because preventive care generally is more cost-effective than emergency care, PRWORA's elimination of funding for routine and preventive care might actually cost the federal government more money. For more on the cost-effectiveness of PRWORA, see Kullgren, *supra* note 41, at 1630–31. In addition to arguing that PRWORA's restrictions on immigrant receipt of healthcare are not cost effective, some scholars assert that these restrictions limit the ability of the government to respond to public health emergencies, undercut policies for healthy children and decreased infant mortality, and undermine the functioning of the American health system as a whole. *Id.* at 1631–32; Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS HEALTH L. 175, 197–204 (2008).

49. Kullgren, *supra* note 41, at 1630.

50. The statutory basis for this exception can be found in PRWORA section 401. The exception also appears in the Code of Federal Regulations. See 42 C.F.R. § 440.255 (2008); see also Sean Elliot, Comment, *Staying within the Lines: The Question of Post-Stabilization Treatment for Illegal Immigrants under Emergency Medicaid*, 24 J. CONTEMP. HEALTH L. & POL'Y 149, 151 (2007).

51. The regulation provides:

... aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be

individual must meet other eligibility criteria for Medicaid, including income and asset limitations.⁵²

It is unclear, though, what constitutes an “emergency medical condition.”⁵³ There is not a consensus on either the definition of an emergency medical condition or when an emergency medical condition ceases to be an emergency.⁵⁴ The narrowest construction of the meaning of emergency medical condition was adopted by the Second Circuit Court of Appeals in *Greenery Rehabilitation Group v. Hammon*.⁵⁵ The court emphasized that only conditions characterized by acute symptoms could be classified as emergencies.⁵⁶ Chronic conditions, despite their severity, would not meet this test.⁵⁷ Courts considering the *Greenery* rule in future cases often took broader approaches to the concept, finding that emergency medical conditions existed in a more expansive class of cases.⁵⁸ These courts reasoned that the language of the emergency medical exception indicates that an emergency exists when the absence of medical care would reasonably be expected to result in serious danger to the individual’s health or in injuries to his bodily functions, organs, or body parts.⁵⁹

expected to result in: (i) Placing the patient’s health in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part, and (2) The alien meets the requirements in §§ 435.406(c) and 436.406(c) of this subpart.

42 C.F.R. § 440.255 (2008).

52. *Id.*

53. Elliot, *supra* note 50, at 152; McKeefery, *supra* note 12, at 403–04.

54. Elliot, *supra* note 50, at 152. *See also* McKeefery, *supra* note 12, at 403–04.

55. *Greenery Rehab. Group v. Hammon*, 150 F.3d 226, 233 (2d Cir. 1998). *See also* McKeefery, *supra* note 12, at 401–03.

56. *Greenery*, 150 F.3d at 232 (“In the medical context, an ‘emergency’ is generally defined as ‘a sudden bodily alteration such as is likely to require immediate medical attention’ . . . emergency medical conditions are sudden, severe, and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm.”).

57. *Id.* at 232–33 (rejecting a lower court’s determination that a patient who required chronic care for a severe head injury suffered from an emergency medical condition).

58. *See Szewczyk v. Dept. of Soc. Servs.*, 881 A.2d 259, 268–69 (Conn. 2005). *See also* *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 97–98 (Ariz. 2003).

59. *Szewczyk*, 881 A.2d at 268; *Scottsdale Healthcare, Inc.*, 75 P.3d at 98. These courts use the regulatory language to find that the likely consequences of withholding care are determinative. *See, e.g., id.* For the relevant text of the regulations, see 42 C.F.R. § 255(c) (2008) (explaining that an emergency medical condition exists when the patient is in an acute state and “the absence of immediate medical attention could reasonably be expected to result in:

The definition of emergency medical condition is incredibly significant because it determines a hospital's reimbursement for treatment of a non-citizen.⁶⁰ Hospitals will not be reimbursed for treatment of conditions that are not deemed emergent.⁶¹

B. Hospitals' Legal Duties to Patients

Hospitals have legal duties to treat patients with emergency medical conditions and to discharge patients to appropriate facilities.⁶²

1. The Duty to Treat Patients Experiencing Emergency Medical Conditions

Congress passed the Emergency Medical Treatment and Active Labor Act ("EMTALA") in 1986.⁶³ EMTALA provides that any hospital⁶⁴ with an emergency department must assess each patient that presents himself for treatment.⁶⁵ If a patient presents with an

(i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part").

60. Elliot, *supra* note 50, at 161. The degree to which a hospital can expect to be reimbursed for treatment affects the treatment provided to a patient. *Id.* at 161–62.

61. *See id.* at 151–52. This does not mean that a hospital will not receive reimbursement at all, just that it cannot receive payment through the Medicaid program if the patient is ineligible for Medicaid and does not fall under the emergency medical exception. One alternate route for a hospital to receive reimbursement is available in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432 (2003) (codified as amended in scattered sections of 42 U.S.C.). It is unclear, however, to what extent this funding is actually accessible to hospitals. *See* Robin Mejia, *Emergency Care for the Undocumented: Who Bears the Burden and Where to Draw the Line?*, 50 ANNALS EMERGENCY MED. 445, 446 (2007).

62. The duty to treat patients experiencing medical emergencies was established as part of EMTALA. Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (2000). The duty to discharge patients to an appropriate facility emerges from regulations promulgated by the Department of Health and Human Services's Centers for Medicare & Medicaid Services. 42 C.F.R. § 482.43 (2008).

63. 42 U.S.C. § 1395dd.

64. The regulations set forth in EMTALA can be enforced only against a "participating hospital." 42 U.S.C. § 1395dd(d). Participating hospitals are those that receive reimbursement for treatment of patients insured through Medicare. 42 U.S.C. § 1395dd(e)(2). Congress has the power to promulgate and enforce regulations against participating hospitals. 42 U.S.C. § 1395dd(d).

65. 42 U.S.C. § 1395dd(a) provides:

“emergency medical condition,” the hospital must treat him until his condition stabilizes or transfer him to another hospital.⁶⁶ EMTALA, widely referred to as the “Patient Dumping Act,”⁶⁷ was proposed and enacted in response to public outcry at highly publicized instances of hospitals denying life-saving treatment to people in need. Hospitals are bound to comply with the provisions of EMTALA to the extent that they receive federal funding through participation in the Medicare program.⁶⁸

EMTALA requires hospitals with emergency departments to conduct preliminary screening examinations on any individual who comes to the emergency department and requests an exam or treatment.⁶⁹ If an emergency medical condition is found,⁷⁰ EMTALA requires that the hospital provide treatment to stabilize the condition

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination

Id.

66. 42 U.S.C. § 1395dd(b). Specifically, this section requires that once a doctor identifies an emergency medical condition, the hospital must either: “(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.” § 1395dd(b).

67. Hyman, *supra* note 34, at 32–33 (explaining the history behind EMTALA's enactment).

68. 42 U.S.C. § 1395cc (2000). *See also* Morgan Greenspon, Introduction, *The Emergency Medical Treatment and Active Labor Act and Sources of Funding*, 17 ANNALS HEALTH L. 309, 311–12 (2008) (explaining that the provision is a de facto requirement of all hospitals because in order to receive federal funding, hospitals must participate in the Medicare and Medicaid programs, and the receipt of federal funds is crucial to a hospital's financial viability).

69. 42 U.S.C. § 1395dd(a)(2000). A medical screening sufficient under EMTALA is one that is “within the capacity of the hospital's emergency department.” § 1395dd(a). The purpose of the screening is to determine whether an emergency medical condition exists. *Id.*

70. Under section (e)(1) of EMTALA, “emergency medical condition” means:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part.

42 U.S.C. § 1395dd(e)(1).

or transfer the individual to another medical facility.⁷¹ EMTALA imposes monetary penalties on both hospitals and doctors who violate its requirements.⁷² Importantly, the requirements EMTALA places on hospitals are not matched with federal funding to compensate hospitals for the treatment they are required to provide. When a patient cannot pay and is either ineligible for or not enrolled in Medicare or Medicaid, a hospital will not be compensated.⁷³

2. The Duty to Discharge Patients Appropriately

A hospital's duties in discharging patients are consequences of its participation in the Medicare and Medicaid programs.⁷⁴ These duties include identifying patients who need discharge planning,⁷⁵ conducting a discharge planning evaluation for such patients,⁷⁶ creating a discharge plan,⁷⁷ and transferring or referring patients for

71. 42 U.S.C. § 1395dd(b). EMTALA defines "to stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility" and "stabilized" as meaning "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur." 42 U.S.C. § 1395dd(e)(3)(A),(B). The treatment provided need not continue indefinitely, but it must last either until the patient stabilizes or until the patient can be transferred to another facility. 42 U.S.C. § 1395dd(c). EMTALA does not mandate that hospitals provide treatment to patients whose conditions fall outside the strict definition of emergent, nor does it require that hospitals treat patients beyond the minimum intervention required to stabilize their conditions. *See* § 1395dd.

72. 42 U.S.C. § 1395dd(d)(1).

73. 42 U.S.C. § 1395dd(a). *See also* Greenspon, *supra* note 68, at 312. There is some potential for hospitals to receive funding for their treatment of undocumented immigrants in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C.).

74. 42 C.F.R. § 482.43 (2008). *See* Greenspon, *supra* note 68, at 311-12 (explaining that participation in Medicare and Medicaid is a prerequisite for receipt of federal funds and, as such, is a financial necessity for hospitals).

75. 42 C.F.R. § 482.43(a) (2008).

76. 42 C.F.R. § 482.43(b). This discharge planning evaluation must include "an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services" and "an evaluation of the likelihood of a patient's capacity for self-care or the possibility of the patient being cared for in the environment from which he or she entered the hospital." 42 C.F.R. § 482.43(b).

77. 42 C.F.R. § 482.43(c). Notably, this provision requires that "the patient and family members or interested persons must be counseled to prepare them for post-hospital care" and that "the hospital must include in the discharge plan a list of HHAs [Home Health Aide] or SNFs [Skilled Nursing Facilities] that are available to the patient." § 482.43(c)(5),(6). This

future care.⁷⁸ The language of these regulations suggests that the rules included are obligations⁷⁹ and that failure to comply will result in significant penalties.⁸⁰ For the purposes of this Note, the most important of these duties is that a hospital “must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup [sic] or ancillary care.”⁸¹

C. Ethical Norms and Obligations of the Medical Profession

The American Medical Association’s “Principles of Medical Ethics” impose standards by which medical professionals are obligated to abide.⁸² These include principles such as accepting the rights of patients, providing competent care, and upholding standards of professionalism.⁸³ The most recent update to the Principles of

section does not articulate what should be done when there are no facilities available to the patient due to his ineligibility for Medicaid. *See* § 482.43(c).

78. 42 C.F.R. § 482.43(d). Specifically, a hospital is required to “transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow up or ancillary care.” *Id.*

79. Each provision in 42 C.F.R. § 482.43 includes the mandatory “must” rather than a suggestive “should.” *See* § 482.43.

80. 42 C.F.R. § 482.1 (2008) (detailing requirements that must be met in order for a hospital to continue to be eligible for the Medicare and Medicaid programs). It is widely accepted that hospitals must participate in these programs in order to remain financially solvent. *See* Greenspon, *supra* note 68, at 311.

81. 42 C.F.R. § 482.43(d).

82. PRINCIPLES OF MEDICAL ETHICS, *supra* note 18. The preamble to these principles makes clear that they “are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.” *Id.*

83. *Id.* The principles include:

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Medical Ethics occurred in 2001 and involved the addition of two new principles: (1) "A physician shall, while caring for a patient, regard responsibility to the patient as paramount,"⁸⁴ and (2) "A physician shall support access to medical care for all people."⁸⁵ However, neither version provides language relating to the citizenship or financial status of a patient.⁸⁶

There are more foundational principles of medical ethics than those adopted by the American Medical Association. The Hippocratic Oath lies at the root of these fundamental ethical duties, which include autonomy, non-maleficence, beneficence, and justice.⁸⁷ Even within these well-established and widely respected ethical tenets, however, it is unclear how the principles should be handled when they conflict. For example, it is unclear how a doctor should react

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Id.

84. *Id.*

85. *Id.*

86. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS, in CODE OF MEDICAL ETHICS (1980), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/1980_principles.pdf; PRINCIPLES OF MEDICAL ETHICS, *supra* note 18.

87. Robert A. Baldor, *Ethical Considerations in Disease Management: A Managed Care Perspective*, 11 DISEASE MGMT. & HEALTH OUTCOMES 71, 72 (2003). These principles mean, respectively, that medical professionals are bound by the ethics of their profession to respect a patient's informed decisions, to "do no harm" by not acting in a way that would cause positive injury to a patient, to do good for the patient by taking action to help him or her, and to treat each patient fairly. *See id.* at 72–75; *see also* Robert N. Swidler, Terese Seastrum & Wayne Shelton, *Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues*, 7 AM. J. BIOETHICS 23, 24–25 (2007).

when a patient refuses treatment that the doctor believes is medically necessary.⁸⁸

Medical ethical standards, unlike legal standards and regulations, are generally unenforceable.⁸⁹ While violations of legal requirements can result in civil or criminal liability, violations of ethical standards are not violations of a strict code of conduct. Instead, they constitute failures to live up to behavioral ideals.⁹⁰ The incentive to comply with ethical standards is a desire to live up to the aspirations of a noble profession, in contrast to a desire to avoid civil or criminal liability.⁹¹

The line between legal standards and ethical ones becomes blurred when primarily ethical ideals are codified as law. When an ethical ideal is converted into a legal duty, the legal duty is likely to be a diluted version of the ethical ideal and create a minimum standard of legally acceptable behavior.⁹² Professor Charity Scott has identified the tension inherent in the process of transforming an ethical ideal into a legal obligation: when a complex ethical issue requiring careful weighing is incorporated into law, medical professionals are likely to focus on the legal inquiry rather than the ethical one.⁹³ In the process, they may forget that the ethical issue is what gave rise to the legal requirement in the first place.⁹⁴

Despite the risk that the transformation of ethical ideals into legal obligations may dilute those ideals, the enactment of ethical standards into law has the advantage of making such standards enforceable.⁹⁵ Absent the threat of legal liability, Professor Scott argues, medical

88. Baldor, *supra* note 87, at 72–73 (discussing the tension between utilitarianism and principles of social justice in the field of health care ethics).

89. Scott, *supra* note 25, at 257–58.

90. *Id.* at 257–58. *See also* PRINCIPLES OF MEDICAL ETHICS, *supra* note 18 (“The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.”).

91. Scott, *supra* note 25, at 257–58.

92. *Id.* at 259.

93. *Id.* at 261–63.

94. *Id.* at 261–63 (“[W]hen law pervades ethical inquiry and backs its resolutions up with the punch of potential liability, people frequently focus solely on avoiding the punch [W]hen law becomes pervasive, we often forget about the original ethical questions that prompted the legal resolutions.”).

95. *Id.* at 260 (explaining that codifying ethical standards in law tends to dilute them, but that the creation of enforcement mechanisms has its advantages as well).

professionals are not as likely to comply with ethical ideals.⁹⁶ Historically, laws concerning health care have found their basis in ethical doctrines.⁹⁷

In some cases, though, the issue is not whether there should be a legal duty where there arguably is an ethical duty, but rather what should be done when legal and ethical standards conflict.⁹⁸ In such cases, hospitals and medical practitioners must choose whether to comply with legal standards at the cost of violating the principles of their profession, or to instead comply with ethical standards while potentially exposing themselves to civil or criminal liability. This is an untenable choice.⁹⁹

ANALYSIS

The federal regulatory and legislative scheme imposes huge financial burdens on hospitals. This creates an incentive to discharge immigrant patients who are ineligible for public assistance, even when doing so conflicts with ethical standards of the medical profession. The unenforceability of ethical standards when compared to the potential liability attached to violations of legal duties complicates this problem.¹⁰⁰

96. *Id.* at 273–74.

97. *Id.* at 248 (“Frequently, the law is a reaction to a perceived ethical wrongdoing in health care.”). The codification of these concepts into legislation such as EMTALA reflected society’s recognition that practices such as patient dumping were ethically wrong, and that life-saving treatment should be provided to all who arrive at a hospital in emergent need of care. *Id.* at 251–53.

98. *See id.* at 253–56. The difference between legal and ethical standards in such cases is not merely one of degree. With ethical standards requiring more of physicians than the legal “floors” created by federal legislation like EMTALA, in some cases, legal requirements actually conflict with ethical standards. Mary Chris Jaklevic, *This Side of the Ethical Border: Hospitals Feel Duty of Keeping Immigrants Healthy Despite Federal Limits*, MOD. HEALTHCARE, Sept. 3, 2001, at 52, 52. For an example of how this has played out, consider the case of Texas. In 2001, Texas Attorney General John Cornyn issued an opinion that under the state’s interpretation of the 1996 Welfare Reform Act it was illegal to use any public funds to provide non-emergency care for undocumented immigrants. *Id.* This was a case in which the legislation enacted was not merely reflective of a looser standard than the ethical one, but was actually in conflict with an ethical norm. *Id.*

99. *See* Scott, *supra* note 25, at 273–75; Jaklevic, *supra* note 98, at 52.

100. Scott, *supra* note 25, at 257–58.

The federal regulatory system contributes to the growth of medical repatriation. By requiring hospitals to treat patients experiencing medical emergencies but denying medical coverage to immigrants,¹⁰¹ regulations impose financial burdens on hospitals if they treat immigrants beyond the minimum necessary to stabilize an emergency.¹⁰² The uncompensated provision of services creates several financial incentives for hospitals. It encourages hospitals to enroll as many uninsured patients as possible in medical assistance programs for which they might be eligible.¹⁰³ In the case of uninsured indigent patients who are ineligible for any government-funded medical assistance, though, the hospitals' incentive becomes not how to assist the patient in applying for coverage, but rather how to avoid providing uncompensated treatment to the patient while complying with the minimum strictures of EMTALA. Undocumented immigrants rarely are eligible for government medical assistance programs that would compensate hospitals for their care, and thus are likely to fall into the category of patients whom a hospital has incentives not to treat.

The conflicting obligations imposed on hospitals and the concomitant lack of federal funding to support compliance creates a situation in which hospitals face difficult choices. All must comply

101. The requirements that hospitals treat patients with emergent conditions are found in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (2000). The ineligibility of undocumented immigrants for most types of federally funded health care was established by the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

102. Elliot, *supra* note 50, at 165. The ban on government-funded medical assistance for immigrants not only creates incentives for hospitals to discharge or avoid treating immigrants altogether to avoid the financial responsibility of their care, though; it also has been found to result in racial profiling by hospitals, create financial burdens on hospitals, cost more money to taxpayers in the long run, and create significant public health risks. Kullgren, *supra* note 41, at 1630–32. For information regarding the potential for racial profiling as a result of financial burdens, see Sontag, *Deported in a Coma*, *supra* note 8, at 38 (describing the case of a United States citizen child assumed to be repatriable as a result of the undocumented status of his parents). For a discussion of public health implications of failure to treat undocumented immigrants, see Mejia, *supra* note 61, at 447; Okie, *supra* note 25, at 528–59; Jaklevic, *supra* note 98, at 52.

103. In some states, the incentive to assist uninsured patients in applying for Medicaid is not just economic; public hospitals are legally obligated to assist patients in ascertaining eligibility for public aid programs and completing necessary paperwork. See, e.g., *N.Y. City Health & Hosps. Corp. Goldwater Mem'l Hosp. v. Gorman*, 448 N.Y.S.2d 623 (N.Y. Sup. Ct. 1982).

with EMTALA,¹⁰⁴ but beyond that, many attempt to rid themselves of immigrant patients through repatriation or other means. The tension between fulfilling an ethical obligation that results in enormous financial costs and complying with the minimum requirements imposed by law results in minimal compliance by some hospitals.¹⁰⁵ Others choose to fulfill their ethical obligations and comprehensively treat immigrant patients, despite the resulting financial costs.¹⁰⁶ The different choices made by hospitals reflect divergent philosophies on the weight that should be afforded ethical, legal, and financial obligations. Moreover, they reflect prevalent societal values and the realities of a hospital's financial circumstances.¹⁰⁷

It can be argued that hospitals that repatriate patients regularly do so for a variety of nefarious reasons,¹⁰⁸ but to classify medical repatriation as simply a rogue action by anti-immigrant hospital executives oversimplifies the issue. Hospitals should not have to choose between financial solvency and compliance with fundamental principles of medical ethics. The relationship between law and ethics may be complex, but at the very least law should not preclude the exercise of higher ethical standards.

PROPOSAL

Medical repatriation highlights serious flaws in two of the most complex and impenetrable regulatory schemes: health care and immigration.¹⁰⁹ To the extent that medical repatriation implicates fundamental policy questions in each of these areas, the questions

104. Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (2000).

105. *Id.* at 261 ("[W]hen law pervades ethical inquiry and backs its resolutions with the punch of potential liability, people frequently focus solely on avoiding the punch."); Sontag, *Deported in a Coma*, *supra* note 8, at 38 (describing behavior of a hospital in Arizona).

106. Sontag, *Deported in a Coma*, *supra* note 8, at 38 (describing the behavior of the facility, El Centro Regional Medical Center, that ultimately treated the patient discussed in Sontag's article).

107. *Id.* (describing the effect of particularly strong anti-immigrant sentiment in Arizona on the attitudes taken by hospitals). *See also* Scott, *supra* note 25, at 258.

108. *See* Sontag, *Deported in a Coma*, *supra* note 8, at 38 (examining ulterior motives of some hospitals).

109. For a discussion of the "brokenness" of both immigration and health care, and an analysis of the problems resulting when the two combine, see Okie, *supra* note 25.

that it raises are unlikely to be resolved without complex reform of both systems. However, in the short term, the government can act in ways that mitigate its potential problems. This Note offers a twofold proposal. First, changes to the federal regulations concerning immigrant access to health care can be made to enhance the ability of hospitals to receive funding for their treatment of undocumented immigrants. Second, a statement by a reputable voice of the medical community, such as the American Medical Association, should reaffirm that the ethical standards of the profession apply regardless of the patient's citizenship and denounce the practice of forced or coerced medical repatriation.

The first part of this Note's proposal addresses the major causes of the growth in medical repatriation: the legal obligations of hospitals to treat patients in emergent situations and concomitant inability to receive reimbursement for the care of such individuals when they are ineligible for state medical assistance and are uninsured.¹¹⁰ This Note proposes that the definition of "emergency medical condition," which provides the one exception under which undocumented immigrants are eligible for public medical assistance, be expanded to include not only life-threatening medical conditions, but also those which if left untreated could have deleterious effects on one's health.¹¹¹ Under this broader definition, previously unfunded treatments for patients such as Mr. Jimenez would be covered,¹¹² and hospitals no longer would be left in the untenable position of being required to treat patients with medical emergencies, but being unable to receive reimbursement for treatment beyond the initial intervention and stabilization.¹¹³ Such an expansion of the definition would also

110. For a full discussion of the causes and forces behind the emergence of medical repatriation, see *supra* Part II.

111. The current definition of "emergency medical condition" may be found at 42 U.S.C. § 1395dd(b). For an analysis advocating a broader definition of "emergency medical condition," see McKeefery, *supra* note 12.

112. Mr. Jimenez would fit under my proposed broader definition to the extent that his medical situation is such that if care were discontinued, it would be expected to result in risks to his health. For proof that his medical condition was serious at the time of his repatriation, see *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004). For proof that the discontinuation of treatment has resulted in continued risks to Mr. Jimenez's health, see Sontag, *Deported, by U.S. Hospitals*, *supra* note 1, at 18.

113. Because the definition of "emergency medical condition" determines eligibility under the Medicaid program, an expanded definition would expand the number of patients and

recognize that serious but not yet life threatening conditions, if left untreated, can quickly become life-threatening.¹¹⁴ It would encourage immigrants to seek treatment for illnesses at an earlier stage, when they are more likely to be treated more effectively and at a lower cost.¹¹⁵ This Note also proposes revising the language in the Welfare Reform Act that currently prevents states from providing more expansive medical coverage to immigrants.¹¹⁶ States that would choose to adopt a more expansive system of coverage than the newly broadened but still relatively narrow one in the federal regulations would have the option to do so. Finally, and perhaps most importantly, this Note proposes to amend the federal regulations so that they contain explicit language banning the practice of involuntary or coerced medical repatriation. This Note does not propose a ban on the practice of repatriation outright. There are limited but significant instances in which repatriation would genuinely be in the patient's best interest and might be chosen voluntarily.¹¹⁷ Hospitals that wish to repatriate a patient, however, would have to prove that the action was voluntary. In order to show that a repatriation action was voluntary, hospitals would be required to take significant steps to demonstrate their patients' wishes, taking into account language and other communication barriers. Additionally, even in voluntary cases, the discharge procedures already included in the federal regulations should be amended to include a specific set of steps to be followed when discharging a patient to a facility in another country and set clear standards for assessing whether that facility can effectively treat the patient.¹¹⁸

treatments eligible for government funding. This would alleviate some of the financial pressures on hospitals.

114. It is widely accepted that a condition, if left untreated, is more likely to become life-threatening. See Kullgren, *supra* note 41, at 1631–32; Park, *supra* note 41, at 580–82.

115. Kullgren, *supra* note 41, at 1632; Park, *supra* note 41, at 581–82.

116. Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”) of 1996, Pub. L. No. 104-193, 110 Stat. 2105. PRWORA bans funds from being provided for health care for immigrants, with few noted exceptions. *Id.* at 2107.

117. Medical repatriation is the term used any time a non-national of a state is transported to his country of origin for medical treatment. A ban on this practice would affect anyone from being repatriated for medical treatment—for example, a Canadian seriously injured in the United States could not repatriate to Canada for ongoing treatment.

118. The discharge requirements with which hospitals must comply are found at 42 C.F.R. § 482.43 (2008).

This Note's second proposal requests that a respected medical organization—for example, the American Medical Association—renounce forced repatriations and affirm the applicability of its ethical standards to non-citizens. Such a statement would give doctors who might currently oppose medical repatriation stronger footing upon which to reply if objecting to policies in their work environments. This statement would both encourage support for the regulatory changes envisioned in Part I and provide support to the medical profession's opposition to the practice until Congress passes a law that bans its use.

CONCLUSION

Medical repatriation and the legal and ethical questions it raises provide a lens into two of the most complex and confused aspects of United States law: immigration and health care. Although medical repatriation has emerged as a common practice among some health care treatment facilities and particularly among those located in border states, its legality and ethics have not been fully assessed. It calls into question the legal duties of hospitals to treat patients and to discharge them responsibly, the rationale behind restrictive health care access for immigrants, and the ethical aspirations and obligations of the medical profession. The proposals advanced in this Note take into account the legal and ethical aspects of medical repatriation.

This Note's proposals understand that the underlying causes of medical repatriation will not be fully remedied until full-scale immigration and health care reform occur, which is a process that likely will take years. These proposals are not capable of completely solving the problem. What they can do is to quickly and effectively limit the practice of medical repatriation until its legality and ethics can be fully examined.