To Keep Them From Injustice: Reflections on the Care of Unauthorized Immigrants With Cancer

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Abstract

Estimates from 2010 suggest that more than 11 million unauthorized immigrants reside in the United States. Many oncologists have struggled with how to fulfill their perceived obligation to treat unauthorized immigrant patients with cancer and no access to financial resources. Because of current realities in medical economics and reimburse-

ment policies, there is simply not a large enough profit margin in most practices to offer free care to everyone who needs it. In this article, I attempt to clarify why we feel such an obligation to do so and whether the reasons behind this sense of obligation point us toward a consistent stance we should have toward unauthorized immigrant patients who seek treatment from us.

“I will use regimens for the benefit of the ill in accordance with my ability and my judgment, but from what is to their harm or injustice I will keep them . . . Into as many houses as I may enter, I will go for the benefit of the ill . . .”

The Oath, Hippocrates¹

Introduction

You see in your office for an initial visit a 45-year-old Spanish-speaking man with newly diagnosed metastatic pancreatic cancer. His workup includes a computed tomography scan and needle biopsy of a liver lesion, which are performed at a county public access hospital with which you are not affiliated. In the course of your encounter with the patient and his wife, he informs you that he immigrated to this country from Oaxaca, Mexico, nearly 9 years ago and that he has worked in a meat-packing facility since that time. He entered the United States without documentation and obtained working papers illegally. In your state, the patient cannot obtain access to Medicaid without proof of citizenship, and his employer does not provide health insurance.

You see another patient who has been in the United States since he was 6 years of age, when he emigrated from Guatemala with his parents. He was previously treated for acute myelogenous leukemia at the age of 16 and suffers a late relapse at the age of 22. He is evaluated by the bone marrow transplantation service at your institution and told that based on his prognostic features and clinical history, he has approximately a 20% chance of long-term survival if he receives a matched, unrelated bone marrow transplant. The initial and chronic costs of this treatment are calculated to be between \$300,000 and \$500,000, if there are no major complications. The patient is no longer eligible for emergency state Medicaid coverage, because the law only grants such coverage to minors.

Another patient, 24 years of age, is found to have rapidly progressive choriocarcinoma of testicular origin after presenting

to a county hospital emergency department with cough and shortness of breath. He is hospitalized and admits to his care team that he is an unauthorized immigrant from Ethiopia and that his Social Security papers and other documents were obtained based on a fraudulent identity. He has no health insurance.

The situations presented in these vignettes are now common in many locations across the United States. Estimates from 2010 suggest that more than 11 million unauthorized immigrants reside in the United States.² The US government, state governments, and individual health care institutions have all wrestled with this issue in ways that have not led to a satisfactory resolution for anyone.³ I do not know of any systematic assessments of the attitudes of oncology professionals toward this emotionally charged issue. However, in many informal conversations with colleagues around the country, I know that many have struggled with how to fulfill their perceived obligations with unauthorized immigrant patients with cancer and no access to resources. Some oncologists—in states like Texas, Arizona, and others—face such issues every day. Because of current realities in medical economics and reimbursement policies, there simply is not a large enough profit margin in most practices realistically to offer free care to everyone who needs it. I cannot offer any easy, neat, or roundly satisfying answers to the difficult questions raised by the challenge of providing cancer care to unauthorized persons who come to us with a cancer diagnosis. I offer instead some thoughts in which I attempt to clarify why it is we feel such an obligation to do so and whether the reasons behind this sense of obligation point us toward a consistent stance we should have toward the patients who seek treatment from us.

Rights to Health Care

I want to begin by attempting to dispense with issues surrounding the right to health care, which I think confuse us when

attempting to wrestle with our personal obligations.⁴ A full discussion of this important issue is beyond the scope of this essay. But the decades-old debate about a human right to health care involves an issue that is relevant to this discussion and therefore merits mention.

The main issue raised by discussions of a right to health care involves what has been called the correlativity hypothesis.⁵ This hypothesis holds that rights and obligations are logically correlated. Beauchamp et al⁵ write, “One person’s right entails an obligation on another’s part, and all obligations similarly entail rights.”^{5(p121)} Although there exists no explicit right to health care in the United States even among citizens, if there did, such a right could only be conferred by society collectively. So when people raise the issue of a right to health care in the context of their personal obligation to provide that care, they confuse our sense of obligation by yoking it to a conversation about the aspirational, theoretic rights many have argued must be granted to persons living in the United States. I personally believe in a right to health care, but as a practicing clinician, I have no ability to confer such a right, and certainly no obligation stemming directly from such a right that has been granted by society. Thus, conversations about rights—however much I might admire them—are certainly relevant to a larger discussion of our deeply held professional obligations. They are less relevant, however, to a discussion of our individual obligations, because we cannot individually control the forces that drive such society-level decisions. Such an understanding must be sought elsewhere. One clue is to be found in the Hippocratic Oath.

Personal Professional Ethics

The excerpt from the Hippocratic Oath holds an important clue about how our foundational ethical framework compels us to feel an obligation toward this group of patients. I quote the passage above because the words raise two important issues.

The first is the striking use of the word “injustice.” Although we immediately feel at home with the first part of the passage, which concerns our overall obligation to advocate for the good of our patients, the meaning of the second construct, which asserts that one of our central obligations is to protect our patients from injustice, is less immediately apparent. It is difficult to determine exactly what the authors of the Oath meant by the use of the term injustice. But we recognize that the unauthorized immigrant with cancer who seeks treatment from us seems exactly like all of our patients with cancer: having cancer in and of itself seems unjust. Unauthorized immigrants live in a world where treatments that may help, and are available to those around them, are not accessible. This seems like a double injustice. We know this and are frustrated by our inability to administer the treatments without obstacles.

The second part of the quotation is even less obvious but has always provided me with a key to understanding what I take from the Oath. The Oath reminds us that our patients are the people into whose houses we go to care for the sick. The Oath says nothing about treating the population at large, or any particular group of patients. It defines our patients as those we encounter individually. In ancient times—and occasionally in

ours—such encounters happened in patients’ homes. Yet unauthorized immigrants with cancer, just like patients who are citizens, come into our home—our hospitals, clinics, and offices. They are then no longer the population at large; rather, they seem to us just like all of our other patients—like human beings afflicted with illness who need help, care, treatment, and relief from suffering. The profoundest sense of obligation we feel as physicians—regardless of our personal political beliefs—stems from these two dimensions of our ethic: we want to help the sick, especially those we encounter directly.

So far, I have tried to establish that the sense of duty to care for every individual patient who comes to us for care stems from deep, foundational, shared views of our obligations as oncology professionals interested in the welfare of the patients with cancer who seek our help (some of which may derive from ideas found in the Oath). However, current economic, governmental, and regulatory realities make it impossible to offer every treatment to every patient irrespective of ability to pay. So we feel trapped by two conflicting and irreconcilable priorities: we deeply want to help the patients who come to us for care, but we cannot place all of our available personal resources in jeopardy to do so. It should be said that this set of conflicting obligations may feel different for those of us who practice in large health care organizations as salaried employees (like me) than to those who practice in office-based practices that they themselves own.

Circumstance and the Nature of Professional Obligation

I think it is important to recognize that as much as we may feel for the suffering patients who come to us for help, the limitations of circumstance they face are not of our making. Having cancer is an example of an unfortunate circumstance. Having no access to resources is another. This is troublesome and, in some global sense, unjust. We would like to fix it. But it is not our fault. So I believe that those who might ascribe to us an ethical obligation to treat every patient we encounter at all costs, even if it would harm our ability to deliver care more broadly, mistakenly characterize our real obligations.

I strongly believe that we should in the strongest possible ways advocate for justice for all of our patients. We should lobby the government, meet with hospital and institutional administrators, make the case for our patients and their needs, and tenaciously pursue every possible resource that we can cobble together on behalf of our patients. We should be expected to provide a reasonable amount of our own resources to help them—whether time, effort, or in some cases money. That we do not achieve justice for all of our patients does not mean that we fail them. Moreover, we cannot realistically be expected to achieve it to the detriment of our overall practice or to the other patients for whom we care.

For the patients described in the vignettes above, we might thus choose to refract our sense of obligation in different ways. For each of these patients, in a common way, we should strongly advocate for the best feasible treatment, recognizing that some factors are within—and some beyond—our control.

Examples of factors beyond our control include the nature and prognosis of each individual's cancer and the fact that each is also a victim of circumstance (in this case, living as an unauthorized person in a country that cannot provide everything to all people). Next, the varying prognoses and relative potential for benefit afforded by expensive cancer therapies in each of these patient's circumstances can ethically be considered material and relevant facts in decisions about who should get limited resources and the extent to which we should entertain personal and institutional sacrifice to provide the treatments. To state the obvious, the cost to potential benefit ratio of chemotherapy for each of these patients is vastly different, with outcomes as different as a small chance of prolongation of survival by weeks (in the case of the patient with pancreatic cancer) to a reasonable chance of cure for the patient with the germ cell tumor. Wringing the necessary resources out of the system, including even the profit margin of an individual practice or hospital system, thus becomes more obligatory in the last patient's case.

Some will argue that this situational framework of ethical analysis that I am outlining is not acceptable. The reason an objector could offer is that we have an obligation (by implication, an absolute obligation) to treat the sick patient before us in ways that are equitable. But equity cannot be obtained when circumstances not of our making are an inescapable dimension of a given patient's situation. We do have an obligation to advocate for every one of our patients by virtue of their presence in our institutions irrespective of their circumstances, while recognizing that some factors (prognosis, ability to pay) are simply beyond our control.

Providing all treatments to all patients at all costs out of some false sense of absolute obligation, however, is misguided and, fundamentally, financially and practically unrealistic. This will mean that there will be times when we cannot provide

treatments that we wish we could provide to some patients. The degree of ethical acceptability will depend partly on the degree to which specific treatments might benefit the patients. When we cannot provide every available expensive treatment to patients, our deepest obligation to continue to care for them within the limits of their particular circumstances might still be fulfilled in other ways. Even if we find that we cannot provide the same expensive anticancer therapy we might provide to a patient with insurance, continuing to care for a patient with no access to payer resources by providing free office visits, prescriptions for medicines important to palliative care, referrals to any and all available resources, empathic and respectful communication, and emotional support is an element of care that can be provided relatively cheaply. These acts represent a pathway for fulfilling our ethical obligation to care for such patients irrespective of their ability to pay.

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