Care of an undocumented immigrant

Case and comment

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Summary

This commentary addresses the care of an undocumented immigrant with neuromyelitis optica in the context of a state law designed to deny state-funded medical services to individuals whose presence in the United States is unlawful. It considers specific circumstances in which the law would permit or require medical care for undocumented persons in state medical facilities, including a duty to “stabilize” an “emergency medical condition” and the provision of care necessary to “protect life or safety.” It also addresses dilemmas clinicians may experience when faced with an apparent tension between their professional ethical obligations and legal rules aimed at enforcing immigration policies.

A Colorado neurologist has posed dilemmas arising from potential application of a state law that aims to deny state-funded health services to individuals whose presence in the United States is unlawful. This commentary addresses some pertinent legal and ethical concerns and how they may play out with respect to the medical care of undocumented immigrants at state health care facilities.

Dilemmas

A young man who lacks health insurance and whose immigration status is suspect presents for care at a state-funded university hospital in Colorado. Examiners conclude he has neuromyelitis optica (NMO) and requires treatment. One contemplated treatment, a monoclonal antibody, costs \$17,000. A pharmaceutical company has in the past donated such treatment for uninsured patients. State law requires state employees to verify the immigration status of persons seeking medical care in state facilities and bars provision of

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state-funded care unless a medical emergency exists. This scenario raises various concerns: 1) providing treatment for the patient’s NMO without first determining his immigration status may violate state law, 2) asking the pharmaceutical company to donate treatment without disclosing his uncertain legal status may undermine the company’s willingness to donate care for other patients with NMO or related conditions, and 3) denial of medically indicated care may equate to abandonment of a patient who urgently needs treatment.

Legal context

Constitutional The US Constitution declares that Congress “shall have Power...to regulate Commerce among nations, to establish a uniform Rule of Naturalization...and to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers.”¹ Exercising these powers, Congress has enacted laws respecting criteria for immigration, procedures for securing lawful entry and eventual citizenship, and penalties (including deportation) for unlawful presence in the United States. At issue currently is the constitutionality of several recently enacted state laws (notably including Alabama and Arizona) that respond to public demand for more vigorous enforcement of immigration laws.² Opponents of such laws argue that they are preempted by federal immigration law or unduly intrude on federal regulatory powers. With respect to health care specifically, rulings of the Supreme Court reveal that, absent some form of “special relationship,” even citizens have no constitutionally protected entitlement to state-funded health care. Thus, in *DeShaney v Winnebago*,³ the Court held that a state was not constitutionally bound to seek custody of an abused child where state social workers had received reports the child was being abused. The Court reasoned that receiving the reports did not establish a “special relationship” between the state and the child that would impose a duty of care on the state, implying that citizenship alone does not entitle one to receive beneficent state services. And in *Youngberg v Romeo*,⁴ a case addressing the constitutional obligations of a state institution for the mentally retarded, the Court asserted that “as a general matter,” a state is “under no constitutional duty to provide substantive services for those within its border.” Federal or state governments may through legislation take on an obligation to provide health care for citizens (e.g., Medicare and Medicaid laws, Affordable Care Act, state involuntary civil commitment laws). But they are not constitutionally obligated to do so.

Statutory Federal legislation Two federal statutes are pertinent here. One addresses allocation of powers to enforce immigration laws among federal, state, and local governments. The other applies to hospitals that receive federal dollars (virtually all hospitals) and operate emergency rooms. Such hospitals must evaluate all comers, documented or not, for the presence of an “emergency medical condition” and must try to “stabilize” these individuals before discharge or transfer to another facility.

The first such statute is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (hereinafter “PRWORA”).⁵ This law allows “qualified aliens” arriving after August 22, 1996 to receive publicly funded health benefits. It further allows *all* (emphasis supplied) immigrants to receive emergency medical services, immunizations, testing and treatment for communicable diseases, and any other assistance necessary to protect life or safety except for organ transplants.⁶ The law also gives states latitude to extend public benefits to unqualified immigrants or, conversely, to restrict public benefits to even “qualified aliens.”⁷

The second federal statute is the Emergency Medical Treatment and Active Labor Act (EMTALA).⁸ Under this law, a hospital emergency department must provide for all persons who come there “an appropriate medical screening examination” to determine whether an “emergency medical condition” exists. Such a condition is one “manifesting itself by acute symptoms of sufficient severity...such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual...in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.” If such a condition exists, the hospital must either “stabilize” the condition or transfer the patient to a facility with “available space and qualified personnel.”

State legislation Colorado is but one of many states that have enacted statutes intended to limit the use of state monies for the benefit of undocumented individuals.² Thus, Colorado law provides that “each agency or political subdivision of the State shall verify the lawful presence in the United States of each natural person eighteen years of age or older who applies for federal, state or local public benefits.”⁹ The law further provides that it “shall be unlawful for an agency of a political subdivision of this State to provide a federal public benefit or a state or local public benefit in violation of this section.”¹⁰ However, the law also specifies that such verification shall not be required “for obtaining health care items and services that are necessary for the treatment of an emergency medical condition.” The Colorado statute adopts the definition of “emergency medical condition” set forth in EMTALA and would not require a state provider to verify the immigration status of a patient in such a condition.¹¹ It would also excuse verification for “programs, services, or assistance, such as soup kitchens, crisis counseling and intervention, and short-term shelter...that (I) deliver in-kind services at the community level...; (II) do not condition...assistance...on individual recipient’s income and resources; and (III) are necessary for the protection of life or safety” or for “prenatal care.”¹² Under the Colorado statute, it thus appears that a state entity can lawfully forgo verification of a patient’s immigration status where an EMTALA-defined medical emergency exists and where delaying treatment would probably result in serious harm to the patient. Where no such emergency exists, verification would be required unless it could be shown that the patient qualified for programs, services, or assistance “necessary for the protection of life or safety.” The statute does not designate which state employees are obligated to verify lawful status.

Case law In *Arizona v United States*,¹³ the Supreme Court recently upheld the constitutionality of an Arizona law that empowered state enforcement officers to require lawfully detained individuals (e.g., traffic stops) to provide evidence of lawful presence in the United States. The Court noted, however, that certain applications of the law might be unconstitutional, such as when detention is based on racial or other unlawful profiling. The Court also found more expansive provisions of the Arizona law to be preempted or to be unconstitutional intrusions on federal authority to enforce immigration laws.

As to the duty of physicians to provide care of persons with life-threatening illnesses, 2 federal appeals court cases are of interest. Exemplifying enforcement of EMTALA against a noncompliant physician is *Burditt v US Department of Health and Human Services*.¹⁴ The defendant was an obstetrician who was on call for obstetrical emergency care at a hospital where he held clinical privileges. He was called to evaluate a woman with symptoms of active labor and elevated blood pressure. After noting that she had had no prenatal care and represented more “malpractice risk” than he was willing to accept, he prescribed magnesium sulfate and ordered her transfer by ambulance to a hospital nearly 3 hours away. She delivered a healthy baby in the ambulance, returned to the defendant’s hospital, and was discharged in good condition a few days later. After investigation, the US Department of Health and Human Services imposed a fine on the defendant. The fine was upheld by a federal appeals court. The court reasoned that she was in active labor when the defendant examined her, that this condition imposed on him a duty to “stabilize” her before ordering transfer, and that he failed to comply with this lawful duty. Illustrating a highly literal interpretation of EMTALA is *In re Baby K*.¹⁵ At issue here was

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whether emergency room physicians had a duty under EMTALA to provide mechanical ventilation to an anencephalic infant in respiratory distress. The hospital contended that use of mechanical ventilation in this context was medically and ethically inappropriate. Rejecting this argument, a federal appellate court reasoned that respiratory distress was an “emergency medical condition” and that the “plain language” of EMTALA required the physicians to try to “stabilize” the condition by mechanical ventilation.

Addressing the dilemmas

Legal aspects By virtue of EMTALA, any person, citizen or not, who presents to a Colorado hospital with an “emergency medical condition” is entitled to whatever stabilizing care that hospital can reasonably provide. Thus, a patient with NMO who is exhibiting visual loss or progressive limb weakness on arrival at an emergency room must receive care for such symptoms that is consistent with prevailing standards of medical practice. If the hospital is unable to provide appropriate treatment, it must arrange transfer to a facility with the necessary capacity. In this scenario, the hospital is not required by Colorado law to inquire into the patient’s immigration status before initiating treatment. However, if a patient’s symptoms do not indicate an “emergency medical condition” and the treating hospital qualifies as a state agency, Colorado law would obligate hospital employees to determine the patient’s immigration status before initiating treatment. It would also bar any state-funded treatment for a nonemergency patient whose lawful status has not been verified. To avoid these requirements, one might argue that the need for ongoing care in a person with NMO (e.g., infusions, complex drug regimens) qualifies him or her for “services necessary for protection of life or safety.” One might surmise that the Colorado legislature did not intend to excuse state-employed medical providers from verifying the lawful status of persons undergoing long-term treatment in state facilities, perhaps even where such treatment is “necessary...for life and safety.” But the language of the Colorado statute at least suggests that the urgency of need for ongoing neurologic care is relevant, and the federal statute, PWRORA,⁵ would apparently allow a state to provide such care where the rationale is protection of life or safety.

Ethical aspects Colorado’s adoption of an “attrition by enforcement” strategy with respect to undocumented immigrants could, as illustrated here, intrude on physicians’ obligations to provide medically appropriate care.¹⁶ Excluding treatment of a medical emergency from the reach of such an enforcement strategy lessens its impact. But enlisting physicians to enforce immigration policies is problematic, especially when the result might be abandoning care of a patient whose need for treatment is undeniable. The Colorado statute does not specifically require physicians to act as inquisitors or adjudicators of the immigration status of their patients. But some Colorado physicians are state employees and work in state facilities, and their patients could be effectively removed from their care as a consequence of inquisitions by other state employees. As to the ethical dimensions of a physician’s relationship with a pharmaceutical company that has previously provided free drugs for the physician’s patients, full disclosure seems the preferred approach. The corporation’s governing board can then decide whether it is in the company’s best interests to restrict donation to lawful residents or to offer its product to anyone who might benefit. Issues relating to corporate image, corporate ethics, policies underlying immigration laws, and relations with clinical providers and investigators can be addressed in the board’s deliberations. A state-employed physician who

perceives that compliance with the Colorado law is a form of forced abandonment of a patient who urgently needs care could address this concern by carefully documenting medical facts indicating that withholding care would endanger the patient and communicating this assessment to hospital officials. If such officials nevertheless determine that withholding treatment would not be unlawful, the state-employed physician might try to refer the patient to a private practitioner or hospital that is agreeable to providing needed care. Alternatively, the concerned physician could seek to identify private charitable entities that fund or provide care for undocumented immigrants and make an appropriate referral. In any case, the assumption is that an ethical medical professional, state employed or otherwise, would ordinarily provide whatever care is medically appropriate and would not allow concerns about a seriously ill patient's immigration status to influence decisions about what level of care to provide.

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