

## Ethics Case Study

# Providing Care to Undocumented Immigrants

Susan Coyle, PhD, for the Ethics and Human Rights Committee

### Case History

Mr. Villalobos is a 37-year-old, Spanish-speaking migrant worker from central Mexico. On his brother's recommendation, he came to Pennsylvania seeking employment and soon began working 10 to 12 hours a day in local mushroom houses. His employer does not provide insurance. He has no medical history, takes no medications, and is generally fit. He is illiterate, with a sixth-grade education. His wife and five children remain in Mexico. His daughter has a chronic illness that taps much of the family's resources.

Some months after arrival, Mr. Villalobos developed palpitations and shortness of breath. His brother brought him to the emergency department of a rural community hospital. He was in atrial flutter with a heart rate of 150 beats per minute. Dr. Graham noted a III/VI holosystolic murmur heard best at the lower left sternal border and auscultated a II/VI diastolic at the apex. Mr. Villalobos had bibasilar crackles and moderate right upper quadrant tenderness on deep palpation. His chest radiograph confirmed moderate congestive heart failure and cardiomegaly. His heart rate was controlled with diltiazem, and symptoms improved with furosemide and oxygen.

Mr. Villalobos was admitted for further evaluation. An echocardiogram showed mild aortic insufficiency, severe mitral stenosis, severe mitral regurgitation, severe pulmonary hypertension, and severe tricuspid regurgitation. His medical condition was stabilized, and

he was discharged on a beta-blocker, furosemide, and warfarin. The attending physician, Dr. Graham, instructed him not to return to work until he met with a primary care physician at a local migrant health center.

One week later, Mr. Villalobos presented to the migrant health center. He was markedly symptomatic with minimal exertion. Dr. Greene, the medical administrator, found he was in mild congestive heart failure and recognized the precarious situation of her patient's clinical condition. The resources of her tiny clinic would be insufficient for his needs and, as an undocumented immigrant, he had little hope of accessing the local health care system, except in emergencies. Unable to work, Mr. Villalobos grew frightened by the uncertainty of his health and the financial difficulties of his family in Mexico.

### Commentary

Both Dr. Graham and Dr. Greene recognize that Mr. Villalobos needs a heart valve replacement, but the cost for the procedure is dear. Mr. Villalobos has no health insurance and cannot afford to pay for the care he needs. Inadequacies in the health care system often limit the options of needy patients such as him, but options for Mr. Villalobos' care are further limited by inadequate communications and his unauthorized immigrant status, the latter barring his eligibility for Medicaid.

One ethical challenge for his physicians is to involve Mr. Villalobos in decisions

about his health care. A second challenge is to explore financial arrangements or provide uncompensated care if the patient has no other means. The latter decision extends the ethical dilemma beyond individual physicians to the health care facilities in which they practice their profession.

### Patient Autonomy

The patient-physician relationship is central to the delivery of health care. Physicians need to build mutually respectful relationships with their individual patients, which requires candid communication back and forth. In particular, physicians are responsible for providing information that will enable a patient to make an informed choice about treatment (1).

The case history does not show whether Dr. Graham spoke Spanish or used an interpreter with Mr. Villalobos. It appears that Dr. Graham did not discuss his patient's treatment options at discharge. Notably, Mr. Villalobos "grew frightened" after Dr. Greene found him in a "precarious condition" one week later. By not fully exploring the implications of his condition with the patient, did Dr. Graham mislead him to think he would not require extensive care? Given the seemingly sparse number of options for Mr. Villalobos' health care, did Dr. Graham compromise his patient's autonomy by excluding him from the decision-making process? Perhaps Dr. Graham should have told his patient outright that he needed a valve replace-

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ment and that it was up to Mr. Villalobos to make the necessary financial arrangements or return to Mexico for health care.

### **Beneficence, Justice, and Uncompensated Care**

While the issue of autonomy and doctor-patient communications is important to address, the key ethical questions in this case scenario involve beneficence and justice: physician responsibility for the patient, decisions to allocate resources to undocumented immigrants, and the prospects for—and limits of—charity care.

The *Ethics Manual* of the American College of Physicians says that members of the medical profession must do their best to ensure that all sick people receive

According to estimates based on the 2000 Census, Mr. Villalobos' shares his immigration status with over 8 million individuals in the United States (2). By federal law, undocumented immigrants—plus the 2.5 million legal immigrants who have been here less than 5 years—are not qualified for Medicaid, except for a handful of services, which includes the emergency and stabilization treatments he received from Dr. Graham and the hospital. It should be noted that approximately 5.3 million undocumented immigrants are unauthorized workers (3), the majority of whom are in low-wage, low-skill occupations that often do not provide health insurance for workers.

With respect to Medicaid insurance, legal definitions of who is "qualified" or "not qualified" undercut medicine's ethi-

legally allow them to take extra measures to prevent the patient's condition from becoming precarious?

Would knowingly stretching the law's definitions to secure financing for a heart valve replacement be an abuse of medical professionalism? Medical institutions and hospital administrators may be at risk if they openly breach the law. For example, hospitals in Texas were warned in 2001 that they could lose millions of dollars in federal payments and their medical administrators could face criminal prosecution, if they provided nonemergency treatment to undocumented immigrants (5).

If the health care providers determine that Medicaid insurance does not cover the care that Mr. Villalobos needs, they will have to decide whether their professional principles of justice and beneficence obligate them to provide uncompensated care (6, 7) and, if so, whether there are justifiable limits to such care.

The ACP Ethics Manual advises that, "as professionals dedicated to serving the sick, all physicians should do their fair share to provide services to uninsured and underinsured persons" (1).

Individual physicians should, indeed, make good faith efforts to contribute some of their time to caring for the needy. Dr. Graham should ask himself whether it is possible and timely to absorb the cost of his services for Mr. Villalobos.

The Ethics Manual also advises, "When barriers diminish care for a class of patients because the patients themselves

### ***In a physician's eyes, Mr. Villalobos' status as an undocumented migrant laborer should not have a bearing on whether or not he should be treated.***

appropriate treatment (1). Justice means that discrimination against any class or category of patients is impermissible; thus, the physician's duty to act in a patient's best interest applies to the uninsured, as well as the insured.

In a physician's eyes, Mr. Villalobos' status as an undocumented migrant laborer should not have a bearing on whether or not he should be treated.

In the government's eyes, however, his status means he is "not qualified" for most health care treatment paid by Medicaid insurance (8 U.S.C. 1601 et seq.).

cal commitment not to discriminate against categories of patients. Many physicians are deeply troubled by having to make health care decisions for needy patients based on the law's classification of who they can treat and what compensated services they can or cannot provide.

Medical ethics may also be put to the test in interpreting the legal definitions of emergency and stabilization (42 U.S.C. 1395dd) (4). If a narrow reading of "emergency" legally precludes coverage for a valve replacement, is it ethical for Dr. Graham and the hospital to instruct Mr. Villalobos to go home and wait for his condition to deteriorate? Or does latitude in the definition of "stabilization"

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are less capable of self-representation, physicians must advocate on their behalf for equitable treatment” (1). The case history does not indicate that Dr. Graham advocated within his institution for extended treatment for Mr. Villalobos. Does this mean that he shirked his ethical responsibility? Taking the long view, the Ethics Manual advises that resource allocation decisions are made more appropriately at the policy level than at the level of an individual patient–physician encounter. It thus will be important for Dr. Graham to advocate for equitable treatment of undocumented immigrants as part of overall hospital policy. This does not rule out the option of advocating “at the bedside” if Dr. Graham has serious concerns about Mr. Villalobos’ health status.

If Dr. Graham’s institution rules out charity care for undocumented immigrants, he might be prepared to break with institutional policy to arrange the necessary care. This can be a viable option for airing ethical grievances and seeking change (8). At the same time, however, such an action would almost certainly place Dr. Graham at risk of institutional discipline or dismissal. His suspension or expulsion would serve to weaken the pool of already limited medical resources available to other patients in the community.

What should be an institution’s position on providing charity care to undocumented immigrants? Presumably, a public institution’s values include serving the needy. Ethically, policy about distributing medical resources should focus on material characteristics of the individual patient, such as the urgency of medical need and the likelihood of treatment success, not on the patient’s social class or category (9). From that perspective,

immigrant status should not be a factor. At the same time, however, economic and legal considerations—and the needs of the patient population as a whole—may render institution-wide commitments to such patients difficult. The tension between ethical versus fiscal and legal issues poses a challenge to institutions.

Just as physicians are urged to contribute a “fair share,” there are justifiable limits for institutions to extend uncompensated care. Public hospitals face very real fiscal constraints. Moreover, it is likely that some of the cost of charity care will be passed on eventually to taxpayers or to the insured population in the form of higher premiums, which puts social pressure on the hospitals to limit such care. Charity care for undocumented immigrants has put increasing strain on hospitals in recent years. Officials in Arizona, for example, conservatively estimate that such care costs the state \$50 million annually (10). While national estimates are not available, the General Accounting Office recognizes the concern and is planning a study to measure U.S. hospital costs for unauthorized immigrants. With the ethical and fiscal “tug of war” in mind, hospitals should explore several issues. Should they set clear limits on the level or type of uncompensated treatments they will provide? Should they specify the number of nonpaying patients they can absorb? Would fixed policies limit their medical discretion in individual cases?

### Making Ethical Choices

The physician’s primary ethical responsibility is to provide quality care for individual patients. When the patient is an immigrant, however, many clinicians face unfamiliar barriers to establishing a

patient–physician relationship and reaching decisions on an appropriate course of action. Physicians should be sure that their immigrant patients understand the meaning of their illnesses and their treatment options, including legal and societal limitations bearing on their options (11). With all patients, physicians should be cognizant of and should strive to understand cultural differences—among them language, gestures, values, religion—that bear on decisions being made by the patient and that affect communication between physicians and patients (12). Attention to cultural differences enhances patient education, counsel, and care.

Ideally, health care decisions should be based on what is in the patient’s best interests. However, making this decision does not take place in a vacuum, as physicians and medical institutions also have moral responsibilities toward other patients, society, and the law. Health care providers formulating ethical decisions and policies about treating undocumented immigrants are advised to advocate on behalf of their patients; to assess available resources, institutional goals, and potential legal sanctions; and to participate in developing policy that promotes equitable access to health care.

## Take-Home Points

- Respect patient autonomy by providing immigrant patients complete information on illness, treatment options and any societal limits on those options.

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## Ethics Case Study (cont.)

### Take-Home Points (Cont.)

- Use an interpreter where necessary and offer culturally competent care by understanding cultural differences that may bear on patient understanding, perception and decision-making.
- Be mindful of the hospitalist's ethical duty to act in the patient's best interest, regardless of ethnicity, race or ability to pay for care.
- Understand state law regarding treating undocumented immigrants; hospitalists can legally care for these immigrants with emergency and stabilization treatments.
- Be aware of the tension between the hospitalist's obligation to act in the patient's best interest versus the legal and fiscal constraints that sometimes mandate no treatment.
- Keep in mind the hospitalist's ethical obligations to contribute some time and care to charity, and to advocate to institutions for equitable treatment for those in need.

### Endnotes

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4. The Emergency Medical Treatment and Active Labor Act law allows treatment of patients with emergency health needs and prevents discharging or transferring such patients until they have been stabilized. The Act characterizes emergency conditions as those "that could reasonably be expected to result in serious impairment or dysfunction," and it defines stabilization to mean that "no material deterioration of the condition is likely to result."
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