

SURGICAL ETHICS CHALLENGES

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My brother's keeper: Uncompensated care for illegal immigrants

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Sometimes give your services for nothing. . . and if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. Where there is love of man, there is also love for the art. Hippocrates (**Precepts**, Sect. VI)

An undocumented immigrant appeared in the emergency department with severe hypotension. He was diagnosed with a rupturing aortic abdominal aneurysm and underwent a successful graft replacement. Since his arrival in the United States from Latin America 2 years ago, he has made a bare but steady living as a brick mason for home builders who pay him a fraction of the prevailing union wage and provide him with no health insurance or other benefits. He has lived hand-to-mouth trying to support his family of six, and is effectively destitute. His postoperative course was complicated by a massive myocardial infarction, low cardiac output, and multiple organ system failure. After nearly 6 weeks in the intensive care unit, he became stable enough for transport to a hospital near his home. Hospital charges have reached the high six figures. Who should bear the financial responsibility for his care?

- A. The government of the country of his origin.
- B. The patient's wages should be garnished when he returns to work.
- C. The hospital should accept the loss. It can bill added indirect costs to patients with insurance to compensate.
- D. The patient's employers.
- E. Enact a system of mandatory universal health insurance, with workers' premiums deducted from payrolls with indigent premiums subsidized by federal and state governments.

The ongoing unabated flow of unauthorized immigrants into the United States is commanding unprece-

dent attention from the nation's government, news media, and citizenry. Few nations have been so intently sought as a destination by the citizens of other countries, and fewer still have been so ineffectual at compelling new arrivals to comply with its immigration laws. Since 2001, demands for better border control and tighter accountability for landed aliens who have evaded immigration laws have been loud and clear. Threats to national security, to the prevalence of the English language, to the country's predominant Eurocentric culture, to jobs and the economy, and to the capacity of tax-supported services to sustain the surge in demand from a large new underclass have all been perceived and articulated. These concerns have been countered on a lesser scale by pleas to insure that all immigrants, regardless of legal status, be afforded access to education, employment, and health care as basic human rights.

Problems associated with illegal immigration are complex, worldwide, and still evolving in how national conceptual and operational realities can vary. Their modern political recognition, and attempts to accommodate to them, essentially began with the Bracero Agreement in 1942. The pact arranged for Mexican agricultural laborers to be granted temporary work permits to harvest crops in Texas and California to compensate for depletion of the US work force during World War II. US farmers found the arrangement profitable, had the program extended until 1962, and gave the Mexican laborers continuing work. Texas in particular refused to enforce the legislation because illegals were abundant and cheaper. The laborers were happy to stay for much better wages than what they could earn at home, and many determined never to go home. From that time until recently, the American border patrols allowed unrestricted entry, although the Mexican authorities tried to prevent departure of their nationals.¹ When the problem boiled over as unmanageable 20 years ago, the Immigration Reform and Control Act of 1986 granted amnesty to almost 2 million aliens living in the United States, but resulted in no measurable reduction in illegal immigration.² President Reagan supported free movement across the borders of the United States with Mexico and Canada through a guest worker program that Congress never enacted.¹

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As it did when it adopted slavery early in the nation's history, America wanted cheap laborers to do the back-breaking jobs, but not the cultural baggage they carried, and certainly not their human needs. The large policy questions consequent to these issues are beyond the scope of a discussion of surgical ethics, but there is an important question that medical and surgical ethics must address: How should essential medical care be provided to a large population of undocumented and uninsured foreign nationals who can't pay for it?

American medical care has been deeply affected by massive immigration. Half of the cases of tuberculosis diagnosed in the United States, more than 30,000 in a recent survey, occurred in foreign-born patients who comprised <10% of this country's population.³ Poverty and fear of discovery and deportation among illegal immigrants with tuberculosis invariably delays their presentation for care by months, and in the interim they can infect as many as 10 others.⁴

Along sparsely populated sections of the US-Mexican border, trauma surgeons have described the prevalence of a new location-specific event that produces multiply-injured victims and a 9% mortality rate: the overcrowded motor vehicle accident.⁵ In a 4-year period, 663 persons, averaging 17 per vehicle, were involved in high-speed rollovers of poorly maintained vehicles used to smuggle Hispanics into the United States along the Arizona border. Rural hospitals, and many major medical centers, are poorly prepared, either clinically or financially, for the sudden and simultaneous arrival of 17 severely injured indigent patients.

Is medical care a right? In 1986, the US Congress enacted the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), effectively declaring each individual's entitlement to emergency care. Access to non-emergent medical care, even if the uncorrected condition will become life-threatening, can be a problem for the uninsured and some cultural groups.⁶ After a Dutch hospital administrator disallowed emergency care for an undocumented immigrant to the Netherlands because the injury was not life-threatening, the *British Medical Journal* led an international uproar by editorializing that treatment of alien patients must be equivalent to that of a nation's citizens.⁷

Hospitals have historically covered the expenses of uncompensated care by cost-shifting to paying patients and resorting to government subsidies. Disproportionate-Share Funds (DSH, or "Dish"), made available to hospitals by the US government for indigent care, are never adequate to meet expenses, have exasperating strings attached, and often find their way to hospitals providing less, not more, indigent care. In 2005, Houston's Ben Taub General Hospital spent \$128 million to treat 57,000 uninsured undocumented aliens. Only \$31 million was reimbursed through government and other sources.⁸

Cost-shifting strategies can create additional ethical problems. As the uninsured nonelderly population has grown beyond 16% of the national total, fewer hospitals have been providing indigent care, and abusive billing

practices have become more common.⁹ Many hospitals have strained to the limit and beyond their creative efforts to extract even more from paying patients. Private insurers and government medical programs wind up paying not only for those who have policies or eligibility, but indirectly for those who don't. Eventually, these additional costs wend their way back to the productive members of society as higher premiums and higher taxes. Medical insurance reduces the individual financial burden of treatment; it doesn't eliminate it. Premiums, co-pays, and deductibles are increased annually for all of us, and more and more employers are seeking ways to limit and even escape from subsidized coverage as a standard employee benefit.

Should these trends continue, only the most affluent among us will have regular access to medical care, and the strength of the culture will be markedly diminished. The medical profession itself could wither and weaken without an adequate workload of compensated care. No national systems are currently in place to prevent this eventuality, and as many as 45 million uninsured Americans are in the same straits as 11 million poor and undocumented immigrants when they become sick or injured. In this context, Weissman's assessment is pertinent: "Until the country decides to provide health coverage for all residents, the problem of uncompensated care will not go away."⁹

How should physicians address these issues clinically when presented with individual patients like the unfortunate man in our scenario, desperately ill, destitute, and far from home? In the absence of guiding governmental policy at any level, one thing is certain in surgical ethics: Physicians and hospitals have a fiduciary responsibility to protect and promote the health-related interests of their patients.

A key element in this ethical standard is the question of when an individual becomes a patient. People become patients when they present to a physician in some manner of distress that medical interventions can be reliably expected to limit or resolve.¹⁰ None of these qualifying conditions is dependent upon citizenship or immigration status, nor should they be. The moral condition of becoming a patient is independent of an individual's national identification, and without regard to the statutory, administrative, or bureaucratic procedures legitimizing one's presence within one national border or another. Humanity precedes nationality. And finances.

There has long been an outraged cry that undocumented immigrants place an intolerable parasitic burden upon educational, welfare, and medical systems to which they do not contribute. Many immigrants, both legal and illegal, in fact pay substantially the same taxes as citizens. Although they are often stereotyped as itinerant yardmen who deal only in cash and declare no taxable income, most undocumented aliens have organizational jobs and earn wages from which state and federal income taxes, Social Security, Medicare, and sales taxes are withheld. They realize no return on their contributions to Social Security and Medicare, and these payments constitute a net gain to the US and state treasuries.¹¹ Most social services, however, are provided by local governments. As taxpayers, they have

the same economic and moral claim on publicly funded services as do citizens.

It is generally conceded that undocumented foreign nationals make major contributions to local and national economies. Their lower wages may result in many commodities and services being priced lower than they otherwise would be. They provide the greatest economic advantage (about \$1.5 billion annually after subtracting the lost wages to citizen laborers) to employers and owners of capital that is only partially passed on to consumers because free-market pricing is based on what the market will bear.¹²

While it may seem reasonable that the nation of origin should be responsible for such expenses as public assistance, incarceration, burial, and medical care incurred by its unauthorized emigrants in another country, responsibility effectively vanishes when borders are crossed. The 1848 Treaty of Guadalupe Hidalgo, which ended the Mexican War and added almost 25% to the landmass of the young and avaricious United States, did not address economic responsibilities for emigrants traveling from one country to the other, nor has any subsequent pact between the United States and another nation. Our patient properly received the accepted standard of care for his diagnosis. No prior authorization to treat was sought or received from his native country. As a resident and an economic contributor to this country, there is no statutory assignment of responsibility for reimbursement of his medical costs to the country from which he emigrated. Option A is not available.

Neither ethical standards, nor humanitarian instincts, nor the provisions of EMTALA preclude the entitlement of surgeon and hospital to reasonable compensation for their services. Insured patients accept financial responsibility for their premiums, co-payments, and deductibles. Expecting this patient to make some financial contribution toward the cost of his care is entirely reasonable. It is not, however, practicable. He is virtually penniless, and his meager living as a contract laborer is scratched from a different source with every job. Although his short-term employers make required payroll deductions, there is no steady salary to garnish, and for purposes of cost recovery, his situation is identical to the uninsured indigent citizens whom most hospitals regularly treat. Option B is not available either.

Option C imposes upon the hospital sole responsibility for a cost it did not solely incur. EMTALA should not be an unfunded mandate, but in practical application it often is. DSH reimbursements are maddeningly meager. The abject failure of the US government to enforce its own policies on immigration into this country effectively placed this patient at the hospital's doorstep. Perpetuation of the Robin Hood method currently used by hospitals to shift costs is ultimately unsustainable and could disable the entire health care system. It is patently unfair, and therefore unethical, for the insured, their employers, heavily taxed workers, and the elderly on fixed incomes to bear an ever-increasing burden they had no hand in fashioning. Medical cost-shifting amounts to financial deception that is falsely inflating the cost of medical care and poisoning the relationship between the at-large population and the medical profes-

sion. Hospitals that have provided enough charity care to have satisfied their tax exempt status should not be expected to bear these additional costs. Option C is a poor and destructive choice.

Option D would make support of health care the responsibility of the employers who have exploited this immigrant's undocumented status to pay him an unfair wage for his skilled labor and deny him the health insurance that is regularly available to other full-time workers in similar trades. By deflecting an employer's regular responsibility for subsidizing health insurance, the building contractors who hire our patient are effectively stealing the cost of his treatment from the societal institutions that will ultimately pay for this episode of care. Unfortunately, there is presently no statutory provision requiring these employers to support their employee's healthcare, and Option D cannot be enforced.

Medical treatment for illegal immigrants is a growing problem complicated and inflated by elements of jingoism, fear, and cultural identity. It is nevertheless just a small subset of this country's larger problem of uninsured healthcare. Despite the current political furor around them as election year fodder, the 11 million illegal immigrants distributed around the country represent too small a sample of uninsured indigents to statistically affect the larger problem the individual states confront in caring for all the patients who can't pay their medical bills because they are uninsured.¹³ Congress, and the insurance lobby, roundly rejected a detailed program for national health insurance in 1994, and no federal official has stepped forward in the years since to propose a plan that will guarantee medical coverage to everyone as a basic human right. Schroeder noted that, "A constant feature of health care in the United States is our national willingness to tolerate having large numbers of people without health insurance. This is in stark contrast to the situation in virtually every other developed country, where guaranteed health insurance is provided either by the state or through employers, with government backup for the unemployed. Whatever the number of uninsured people, we put the values of the entire health care system at risk by accepting their condition as inevitable."¹⁴ At its Board of Delegates meeting in Chicago this year, the American Medical Association recommended that all Americans who can afford it be required to purchase health insurance, with premium surpluses used to support the care of indigent patients. The state of Massachusetts has recently passed landmark legislation requiring that all state residents have medical insurance.¹⁵ Under the bill, plans would be offered by private insurers but be subsidized by the state. Impoverished residents would have premiums and deductibles fully paid for by the state. Poor but solvent residents would pay at a means-tested reduced rate. Individuals who can but don't buy coverage would lose their personal state income tax exemption and be charged an annual state fee equivalent to half the annual premium rate of the cheapest available policy. Employers who don't agree to offer health insurance coverage would face fines of about \$300 a year per employee, a charge the state expects will raise about \$45

million a year. These and other fines and fees would be used to subsidize premium charges for poor and indigent patients. No exception for undocumented foreign nationals was written into the bill, guaranteeing their access to the same health care as legal immigrants and citizens of the state. Community leaders cited the "spirit of generosity and respect for the dignity of the person written into this bill," acknowledging its soundness as ethical policy. It is a unique and possibly definitive solution to the issues of universal coverage and indigent care without regard to extraneous conditions such as immigration documentation. Although legislation of this sort will not solve the immediate problem of assigning financial responsibility for the care of our patient, it is an excellent application of the principles described in our Option E, and we believe it is an ethical and effective choice. Bertrand Russell captured the essence of the problem well when he stated, "In America everybody is of the opinion he has no social superiors, since all men are equal, but he does not admit that he has no social inferiors, for, from the time of Jefferson onward, the doctrine that all men are equal applies only upwards, not downwards." In the receipt of necessary medical care, we cannot allow a social underclass to exist in the world's richest nation.

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Wiki Targeted (Entertainment). Do you like this video? Play Sound. "I would give my life for that man. And he knows that. So why? Why would a man that I would give my life for try to try to take my life from me?" "Maybe he was never who you thought he was." "Or maybe I'm not. Because I just I don't remember." • Billy Russo and Krista Dumont[src]. My Brother's Keeper is the eighth episode of the second season of the television series The Punisher. Start studying Exam 3: My Brother's Keeper. Learn vocabulary, terms and more with flashcards, games and other study tools. A health care provider may be liable for the consequences of another's wrongful acts/omissions where: A. Vicarious liability applies: second exception: apparent or ostensible agency. A. Vicarious liability applies: 1. Respondeat superior 2. Apparent or ostensible agency. both exceptions have in common: both allow a patient to hold a healthcare provider or institution liable for another person. Jackson v. Power Factors: (know by name). Uncompensated Care* / ethics. Uncompensated Care* / legislation & jurisprudence. United States. Universal Health Insurance / ethics. My Brother's Keeper: Directed by Karlton T. Clay. With Nelson J. Davis, Jamarious McCullough, Shatareia Stokes, Nicole M. Williams. Brandon's world is turned upside down when he receives a phone call from Maurice, revealing himself to be his long lost brother. However, the complexities in their budding relationship becomes more complicated after Brandon discovers that the woman he has been secretly seeing is his newfound brother's wife. Brandon's world is turned upside down when he receives a phone call from Maurice, revealing himself to be his long lost brother. However, the complexities in their budding relationship become Read all Brandon's world is turned upside down when he receives a phone call from Maurice, revealing himself to be his long lost brother.