The Illegal Alien Who Needs Surgery

MARK G. KUCZEWSKI

Case Summary

A 24-year-old Hispanic male came into the emergency room of a large public teaching hospital with acute cardiac failure and chest pain. He was admitted and diagnosed with rheumatic heart disease and regurgitation and stenosis of both mitral and aortic valves. Medical judgment concluded that the patient needed to be medically stabilized and then undergo cardiac surgery to repair heart valves. The patient spoke only Spanish. Investigation through an interpreter revealed that he was an illegal alien from a Central American country who has lived in this country for five to seven years. He came to the United States so that he could receive treatment for his heart condition, evidently fearing that he would not receive treatment in his home country. The patient entered this country through the assistance of some distant relatives. He did not have a strong support system.

The hospital has as its major missions the education of health professionals and caring for the indigent population of its area. Its major source of funds are from federal and state reimbursement programs. The institution is the major provider of charity care within the state. Although the hospital receives these funds to provide free care to any area resident who presents for care, it must also generate a percentage of revenue from other sources. Currently, this is a major problem, and hospital administration has instituted a number of procedures to increase revenue from paying patients and limit unnecessary charity care expenses. Social services works with patients from other states (who are returned to their home state for care), and with legal aliens (whose embassies are contacted for help in financing and/or obtaining care), but they cannot do anything in this case. However, as one social worker stated, "We are not in the business of deporting illegal aliens."

The surgical team wants to schedule the patient for open-heart surgery. Utilization review maintains that the patient should not be a surgical candidate, given his illegal status. They want him told that he will be stabilized but must seek further treatment in his home country. If the surgeons insist on surgery, the hospital administration wants the patient to be informed that he must raise a $20,000 down payment and provide evidence of a steady job before the surgery will be authorized.

Given this impasse, the case is referred to the ethics committee with the question, "What is our duty to this patient?"

Cambridge Quarterly of Healthcare Ethics (2000), **9**, 128–135. Printed in the USA.

Commentary

Andrew Thurman

In this case, when the ethics committee is asked "What is our duty to this patient?" the questions that should be addressed are "What is *whose* duty to the patient, and whose duty has primacy?"

One of the great intellectual stimulations of being a lawyer is reading how the U.S. Supreme Court reconciles cases that involve conflicting constitutional rights. Constitutional rights, because of their very nature, receive primacy; but generally speaking, there is not primacy among them. Rather than deciding that a particular article of the constitution has primacy over another, the Court tends to take a very fact-based approach to such cases and usually ends up deciding to uphold the constitutional right that is not factually entwined in the case.

In this case it seems that the primary duty of the physicians to this patient is to provide him the necessary medical care. The facile approach is to accord this duty of the physicians overall primacy and up until recently the ethical obligation of physicians was routinely accorded primacy in the healthcare arena regardless of any perceived competing ethical obligations. However, institutional healthcare's imperatives and community and society's resources have increasingly been accorded weight similar to the physician's obligations. As with constitutional rights, there is no persuasive argument that the physician's duty has primacy over the hospital's or the community's.

The ethical duty of the hospital is less clear. Does its duty to care for the indigent population include illegal aliens, and, if so, does providing all necessary care for illegal aliens jeopardize its ability to continue to provide care to the rest of its constituency? If there is a duty, does it extend to complete care or only to stabilization? Will providing "complete" care to this or other illegal aliens within the community cause it to become a haven for illegal aliens seeking unreimbursed medical care, and, if so, how does that affect the hospital's ethical obligations and mission to continue to provide a range of services to the broadest possible spectrum of the community? It is certainly appropriate for those responsible for establishing and maintaining the hospital's mission to determine what level of services will be provided to, and what reimbursement will be required of, this patient, consistent with the hospital's mission.

Additionally, there should be some community/society representatives on the ethics committee to address community-wide issues, which are complicated and not readily resolvable. Does the hospital or the community have a legal obligation to provide some level of healthcare to this particular illegal alien or illegal aliens in general? Is the population of illegal aliens sufficiently large that the community has an obligation to address its healthcare needs, either by making financial provision, by reducing or eliminating the population, or by some other means? Will the provision of surgery to this patient, or to this class of patients, ultimately jeopardize the ability of the community to provide necessary healthcare to its citizens? All of these issues require factual study and rational balancing. An argument can credibly be made that the surgery should not be provided even if it could be paid for, since to do so creates an environment in which individuals illegally enter the country to seek medical care. More analysis is needed to determine the community implications of providing or not providing the care.

It is particularly important that facility and community issues be consid-

ered since merely providing surgery will not address all of this patient's needs. Follow-up care will have to be provided by the hospital or through community resources. The obligations of the hospital and the community to this patient, and this class of patients, must be balanced with the availability or scarcity of resources and the draw on those resources that will come by providing the care.

The issues raised cannot be easily resolved, and certainly cannot be resolved without more facts. However, it is important to acknowledge at the beginning of the process that there are competing obligations and that there is no constituency whose ethical duties are automatically entitled to primacy. The fact that the physician's duty is fairly cut and dried does not mean that it should receive a sort of constitutional primacy. Like the Supreme Court weighing conflicting constitutional claims, the ethics committee needs to balance the conflicting ethical obligations and award a fact-based primacy to those that seem most strongly implicated in these particular circumstances. That may result in a decision to meet the patient's needs, but that should by no means be a foregone conclusion.

* * *

Commentary

Patrick McCruden

This is a case that speaks directly to the issue of an organization's mission. As private insurance and government reimbursement decline, the economic pressures facing healthcare systems both public and private continue to increase. For many institutions it is no longer a question of prospering but surviving. As this case accurately describes, survival is dependent on continually reducing costs and maximizing reimbursement. These strategies often include reducing the number of nonpaying or charity cases while attempting to remain faithful to the mission of the organization, whether this be a religious or civic mission. The ethics committee, although it may be an appropriate forum for discussions to begin concerning this patient, is not the appropriate decision-making body regarding whether this gentleman receives the treatment he needs. That task should fall to whichever group defines or articulates the mission and values for the organization, normally the hospital's administration in concert with the board of directors or trustees.

Laudably, the hospital has decided not to turn the patient in to the Immigration and Naturalization Service in order to spare itself the financial burden of his care. Also, it is not inappropriate for the institution to search for reasonable alternatives that respect the principle of beneficence to the patient and also safeguard the financial viability of the institution. Do such alternatives exist in this case? It appears not. Clearly, the "solution" offered by the hospital, that the man raise $20,000 and provide evidence of employment, can be dispensed with rather quickly. He may as well be asked to bring back the broom from the Wicked Witch of the West. Any seriously ill person with few or no English language skills would have considerable difficulty gaining employment sufficient to raise $20,000. This man's illegal immigration status makes the recommendation from the hospital completely implausible (and may incite him to break more laws, as he would only be able to acquire employment through forged papers of some sort). This type of recommendation appears to be based on the hope that discharging the patient may make the problem go away.

The case seems to answer its own query. A patient has arrived at a medical institution that has an avowed mission of caring for the medically indigent. The patient has an acute medical problem and is indeed indigent. After appropriate stabilization, the medical professionals are recommending a course of treatment in keeping with generally accepted standards of care. There is no possibility of transferring to a more appropriate institution based on medical need or of finding an alternative source of payment. This institution is the major provider of charity care in the state. If it was built with Hill–Burton funds it has a legal obligation to provide the care. Even if this is not the case, there are no alternatives. Either the patient is treated as a charity case or he is discharged contrary to the medical opinions of the staff. The duty to this patient is to provide the care being recommended by the hospital's own medical staff.

* * *

Case Commentary

Ann B. Hamric

Ethics raises questions about what kind of society we ought to be, questions that are at the heart of this case. Increasingly, inequalities in healthcare fueled by lack of access, inadequate insurance coverage, and rising costs are creating dilemmas in the proper distribution of healthcare resources. Questions of distributing scarce and valuable resources are fundamentally questions of justice. The classic definition of justice is the duty to give to each person what they deserve and can legitimately claim[1] so that justice is understood as a moral obligation to help persons exercise their rights. Distributive justice, i.e., what distribution of resources is fair, equitable, and appropriate, thus turns on the concept of rights. One of the key questions in this case is whether and to what extent this patient has a right to treatment for his heart disease. In the classic understanding of justice, he must assert and we as a society must agree that he has a right to treatment for his heart condition before we are morally obligated to provide this care. Are there limits to this patient's right to healthcare? If so, what are they? The differing principles of distributive justice use different criteria to rank or weight decisions regarding the proper and just distribution of healthcare services. In this case, at least two competing but ethically valid principles can be identified: the humanitarian principle and the libertarian principle.

The humanitarian principle of justice dictates that we have a duty to give to each person according to his or her individual need. From this perspective, it is clear that this patient needs specialized and sophisticated cardiac care to remedy his underlying cardiac disease. Healthcare professionals are most comfortable with this view, as they are strongly socialized to value this principle of justice—if patients need special treatment, whether palliative or preventive, there is a primary obligation to provide it. In addition, this is the principle most strongly reflected in the various professions' codes of ethics,[2] and it is the principle that routinely guides individual decisionmaking for individual patients. There are also important reasons why this patient can claim that he has a right to treatment, e.g., the resources for performing this surgery may not exist in his home country; even if they do exist, he may not have access to this treatment in a timely way there; his medical condition is worsening, and immediate surgery may be more cost-effective in the

long run in terms of his level of recovery and need for subsequent treatment. The real potential of the surgery for improving this patient's quality of life and preventing needless suffering and disability are important arguments that appeal to humanitarian considerations of fairness.

However, there is another principle of justice that challenges the humanitarian view. As healthcare is increasingly a business dominated by market forces, the libertarian perspective has assumed a strong *de facto* position in distributive justice decisions. In this view, differences in individual effort, merit, or contribution that translate into ability to afford insurance and/or treatment, create legitimate differences between persons that are not unjust. Most institutions and decisions regarding distribution of goods and resources in our country operate within a fundamentally libertarian frame. Given this perspective, the patient in this case cannot assert the same rights to treatment as bona fide citizens of the area served by the public hospital. He is not a citizen; indeed, he is not even legally in this country. He does not have health insurance or the ability to pay for his treatment. It is unclear whether he has worked or contributed in other ways to the state's economic welfare. Given the cost constraints being faced by the hospital (an increasingly difficult problem for many public teaching hospitals that have traditionally been the major providers of uncompensated charity care), providing treatment to this patient may mean that resources will not be available to treat a subsequent area resident. In the libertarian view, the institution has a legitimate right as well as a responsibility to view this issue from a marketplace, libertarian perspective. Looked at in the aggregate, the institution's moral obligation is to distribute resources from a business perspective to benefit the citizens of the state. Indeed, good, prudent fiscal management requires the utilization review staff to question offering expensive medical services to this particular patient.

A third approach that offers something of a middle ground to explore has been advanced by John Rawls.[3] According to Rawls, everyone is owed a fair opportunity of access to the goods of the marketplace and they are owed a "decent minimum" level of these goods to protect their vital interests. However, everyone is not owed access to every possible service: more extensive and expensive services would only be provided to those who could afford them. In this case, the challenge becomes identifying the minimum level of treatment this patient deserves. This level would be provided, but not more expensive treatment, such as surgery. Could this patient be stabilized and returned to his country for surgery? Is the best option in terms of a cost–benefit analysis to operate on him, or are the concerns about postoperative medication and treatment sufficient to question the outcome of the surgery? Certainly, wasting resources on ineffective, expensive treatment is unjust from all of these perspectives, so the clinical judgment regarding the most cost-effective treatment option is important in deciding which course of treatment to pursue.

Many ethicists argue that the individual decisionmaking level should and must remain distinct from the institutional decisionmaking level.[4] It is important to recognize that this is becoming increasingly difficult, and may even become impossible in the current healthcare system, as insurers and managed care companies increasingly dictate individual treatment decisions based on aggregate calculus. These dictates place clinicians in the uncomfortable position of balancing their

traditional and, most of us believe, primary duty of patient advocacy against their obligations as responsible stewards of an institution's resources.

Notes

1. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th Ed. New York: Oxford University Press 1994. This discussion of justice principles draws heavily from their Chapter 6, "Justice."
2. American Nurses Association. *The Code for Nurses with Interpretive Statements*. Washington, DC: American Nurses Association, 1985 (this code is currently under revision); American Medical Association, Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions with Annotations*, 1996–1997 ed. Chicago: American Medical Association, 1996.
3. Rawls J. *A Theory of Justice*. Cambridge, MA: Harvard University Press, 1971.
4. The Joint Commission for Accreditation of Healthcare Organizations' new "organization ethics" standards mandating a code of ethical behavior and evidence that the institution operates according to its code are also challenging ethics committee to broaden their mission beyond their traditionally individual patient-centered role. See Spencer EM. A new role for institutional ethics committees: organizational ethics. *Journal of Clinical Ethics* 1997; 8(4):372–6.

* * *

Commentary

Kenneth W. Goodman

To ask whether and to what extent there is an obligation to treat illegal immigrants implies—just in the asking—that any duty to treat an illegal resident is different from or lesser than the duty to treat a citizen. What could be the reason for thinking that morality affords fewer benefits or rights to illegal residents?

One reason might be that they have broken the law. They have either entered the country without proper authorization or overstayed a visa, and these actions are illegal, so they are criminals on the lam. The proper response to this is, of course, "so what?" The obligation to treat prisoners, including the nastiest of felons, is straightforward and should be uncontroversial. Surely illegal activity related to visa status (rarely proven in the case of illegal immigrants seeking medical attention, and often involving children) is insufficient to warrant any sort of punishment by withholding healthcare.

Maybe it is the cost. Illegal immigrants individually can and collectively do run up sizable medical bills. But this won't do, either. If garden-variety big bills provide inadequate warrant to withhold care from legal residents, then there is no sense in which they become adequate to cut off the illegal ones.

Suppose it is not legality or cost, but the fact that the immigrants are outsiders to whom we owe less than is due to bona fide members of society. Well, neither will this work—the concept of "outsider" status is ethically vague, potentially racist, and it must meet the burden of showing how one set of humans ("she is not one of us") might be entitled to less than another set ("us"), all things being equal.

Perhaps, then, illegal activity, high cost, and outsider status are jointly sufficient to accomplish the task of denial. Well, this is nasty work, a fishing expedition in search of something to feed an unfocused and uninspired intuition.

At the bedside, at least, there is no ethical problem here. If someone needs medical attention, give it. The law captures the gist of this, requiring hospitals to treat all (emergency) comers without regard for ability to pay, national origin, immigration status, or what-have-you. This represents a significant burden for some hospitals,

though. Not all illegal residents suffer mere cuts, bruises, or other maladies that can be patched up and the patient sent merrily on his or her way. Many have kidney disease and require dialysis, heart disease and need surgery, HIV and must have complex and costly drugs.

At Miami's Jackson Memorial Hospital, a county-owned facility that is also the primary teaching institution for University of Miami medical students, interns, and residents, the burden is daunting. In one recent three-year period, illegal immigrants accounted for an estimated 26,000 admissions and 200,000 visits, generating charges of $312 million. Of that, $70 million was reimbursed. Similar, albeit lesser, challenges face a number of other South Florida hospitals, as well as many in California, Texas, and other states.

There are, moreover, at least 5 million illegal immigrants in the United States, with an annual net increase of some 300,000 (though this figure has been criticized as too low). Some of them, perhaps many, emigrate in search of healthcare services unavailable in their homelands. Such medical immigration is self-perpetuating. The word on the streets of many Latin American cities is that you can get good, free care here; you just have to get there. In other words, it has been suggested that a generous policy toward illegal immigrants serves to increase the rate of illegal immigration. It is another example of a social or political problem—we have seen it with drug abuse, violence, and driving like lunatics—being turfed to healthcare professionals.

So although we should disdain the idea of bedside rationing based on visa status, surely there is something out of balance when a subset of the nation's hospitals bear a disproportionate burden of the failure of immigration policy. This suggests the need for better and fairer national laws and compensation. Equally important, it demonstrates why hospitals need to have sound, ethically optimized policies. And that, in fact, has been the task put to the two ethics committees (one pediatric) at Jackson Memorial.

As part of the effort to help the institution craft such a policy, the committees are gathering data about the nature and extent of healthcare provided to illegal residents. This is difficult, because it is not always clear which patients are, in fact, illegal residents and because it is inappropriate—even wrong—for health professionals to inquire after their patients' visa status or turn them over to immigration authorities. The goofy requirement in California's Proposition 187 that hospital staffers report illegals to the Immigration and Nationalization Service is in part what landed the law in judicial limbo.

The committees are also trying to find other hospitals that have drafted policies to address the challenge of illegal immigrants. (Readers aware of such policies and cases are entreated to share them as part of an eventual policy and research clearinghouse on the issue.) We can nevertheless imagine that such a policy will need to address proper methods for managing chronically ill patients, treating serious but nonemergency cases, identifying resources to pay for the care, developing preventive measures to reduce the need for it, and so forth. And there already are some data suggesting that current seat-of-the-pants strategies for managing illegal residents are more costly than standard but unreimbursed treatment would be. The policy will need to take this into account. One can even identify a number of situations in which it would be acceptable to stabilize patients and return them to their homelands for treatment—as long as they will in fact receive the needed treatment there.

Such a policy bids fair to guide institutions facing the kind of situation

described in the case study on the table. It could also go a long way to helping healthcare professionals go about the business of providing healthcare without worrying which of their patients really deserve it, and without laboring under the illusion they need to try to solve major social problems at the bedside.

What Actually Happened

The ethics committee was in agreement that the patient should be operated on, given his emergent status. Initially, he was too medically unstable, and for three weeks was in an intensive care unit until his condition stabilized to the point that he could tolerate the surgery. He became sufficiently stable to permit surgery and both of his heart valves were replaced. He did very well after surgery. His pitting edema and jaundice reversed, and he was discharged after a week to the care of a relative. He received follow-up care in the hospital's cardiac clinic and was provided needed medications. He stated his intent to return to his home country once he recovered from the surgery.

The ethics committee debated whether a policy regarding treating illegal aliens should be developed, but deferred any decision, electing instead to survey other institutions to see whether they had developed policies for such patients.