Patients Crossing Our Borders: An Ethical or Economic Conundrum?

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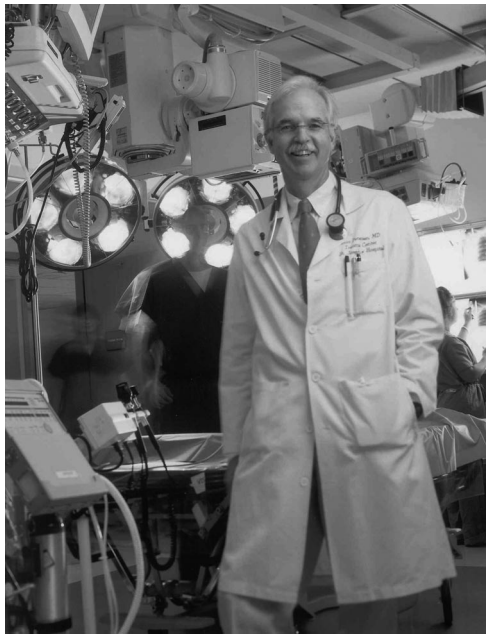
I would like to thank the Members of the Western Trauma Association for the opportunity to serve as your President for the past year. There are many reasons why I enjoy being part of this organization. The cultivation of lasting friendships, the camaraderie and collegiality of the scientific meetings and the family atmosphere that has been created make the Western Trauma Association one of the best kept secrets in American surgery.

The memories that I have of our annual meetings often make me reflect on the priorities that we set for our careers. Skiing with my children throughout the West and Canada, having my sons be on a first name basis with leaders in the field of trauma and watching them take off with the "pack" not caring whether I was present or not was sometimes painful, but always gratifying.

The title of my presidential address came from a communication I had with one of my former hospital administrators. He approached me about a critically ill trauma patient that I was caring for in the intensive care unit, saying, "Dr. Petersen, what are we going to do about the ethical conundrum concerning Case JC?" He did not say, "Mr. JC" or "your patient JC," just "Case JC."



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CASE PRESENTATION

The patient was a 37-year-old Guatemalan National, from the town of San Marcos, an area in the Northern part of Guatemala that borders Mexico. To support his family, JC made the decision to leave Guatemala and come to *El Otro Lado* (the other side). He paid a smuggler, or "Coyote," as they are termed in the Southwest, approximately one thousand dollars to transport him through Mexico and across the Rio Grande River into America. He described crossing the Rio Grande into Texas as a harrowing experience because he did not know how to swim and his "guides" abandoned him and his other migrant associates at the water's edge. Three days later, after crossing the desert from Texas into New Mexico, they were picked up and taken to Phoenix. When he arrived, he did not even speak Spanish. He spoke a Guatemalan Indian dialect that had been handed down from his Mayan ancestors centuries earlier. JC contacted a cousin in Phoenix and was soon incorporated into the local economy of the day worker. JC would get picked up every day from a street corner, work hard, six or seven days a week for minimum wage (approximately $5 per hour), and was paid in cash. His employers paid no withholding or FICA taxes on his wages and no health insurance was provided. Most of the money he made was sent back to his wife and daughter in Guatemala.

One evening, JC was struck by a pickup truck while riding his bicycle; a victim of a "hit and run accident." According to witnesses, he was dragged underneath the vehicle for approximately one-half mile before being thrown free. He was transported to our trauma center "in extremis" with a serious closed head injury, fourth-degree abrasions to the skull, right shoulder, right hip and flank (approximately

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15% total body surface area), a pelvic fracture, and bilateral ligamentous knee injuries. In addition, JC had eviscerated through his flank wound, and his entire small bowel and ascending colon were lying on the gurney beside him. He was intubated, resuscitated, and taken to the operating room where he underwent resection of all but 75 cm of jejunum with an end jejunostomy and a right hemicolectomy with a mid-transverse colon mucous fistula.

Over the course of the next six weeks, he underwent multiple debridements, skin grafting procedures, free flaps, and survived an episode of fungal sepsis. JC had no health care insurance and did not meet eligibility requirements for state Medicaid. Our social workers and case managers began working on arrangements for his eventual transfer to Guatemala for long-term care. This was the situation when our Chief Medical Officer approached me with the "ethical conundrum" question. He proceeded to tell me about *MY* patient —ventilator dependent, six inches of small intestine with the duodenum attached to his rectum. It was clear that he had not seen the patient, reviewed the chart or talked to any of the other physicians caring for him. I informed him that his facts were incorrect, and explained to him the patient's current condition, the care that he had received, and the fact that it was a miracle that the patient was alive.

During the conversation, the CMO, a physician, did not suggest that we should not have been as aggressive with the patient as we had been, but he implied it. He specifically asked me what I would do if the patient became septic, hypotensive and required vasopressors to maintain his blood pressure. I replied that we would proceed with a "full court press," as I would treat any salvageable patient with a similar condition. The conversation then proceeded as to our treatment plans and our long-term goals for the patient's care. I informed him, in some detail, of the plans for the eventual transfer of the patient to Roosevelt Hospital in Guatemala City, of the superb job our social work team, nursing staff, operating room personnel and my colleagues (plastic surgery, and infectious disease) had done to get the patient to his present state of health. "With proper care," I told him, "JC will survive, regain complete gastrointestinal functionality and return to his prior life. To suggest any less of an effort, at our hospital, was unconscionable." The problem, or conundrum, was not an ethical question, but purely an economic one.

ILLEGAL IMMIGRANTS AND HEALTH CARE

The United States is in the midst of the largest wave of immigration ever experienced.[1] Recent data from the U.S. Immigrations and Customs Enforcement Agency indicate that each day more than 8,200 immigrants enter the country. According to 2000 Census Bureau statistics, there are 30.7 million immigrants residing in the United States (11% of the population). Approximately 70% of these individuals are non-citizens (legal or illegal).[2] It is estimated that between 7–8 million immigrants are in the United States illegally; 30–40% of these people entered the country legally but overstayed their visas.[3] Figure 1 demonstrates the countries of origin of illegal migrants. Mexico and Central America account for over 72.8% of this migration.[4] The states with the largest population of illegal immigrants are shown in Figure 2.[4] California has the largest proportion of undocumented individuals with approximately 2.2 million or 31.5% of the total. The number of illegal immigrants in the U.S. has nearly doubled in the last 10 years from 3.6 million in 1990 to 7.0 million in 2000.[3]

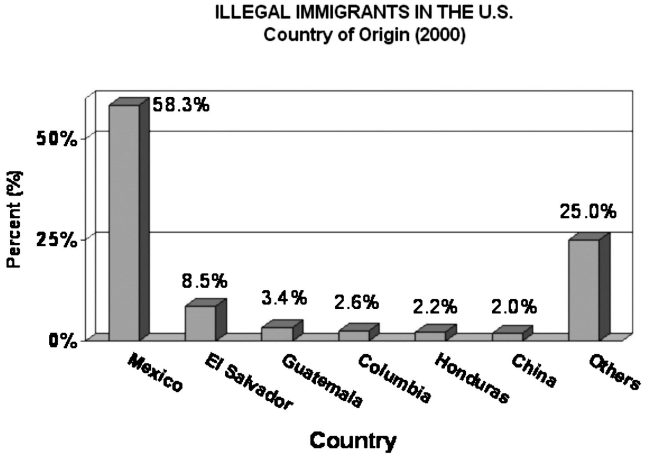

Fig. 1. *Country of origin of illegal immigrants in the United States – adapted from U.S. Census Bureau – 2002.*

There is conflicting data concerning the cost of immigration to the economy. The Social Security Administration estimates that illegal workers paid over $20 billion in Social Security Taxes between 1990–1998.[4] A report from the National Research Council concluded that low-income immigrants contribute over $10 billion per year to the economy, but also use more government services.[5] Nonetheless, most immigrants and their descendents will pay $80,000 more in taxes than they will use in government services over their lifetime.[6]

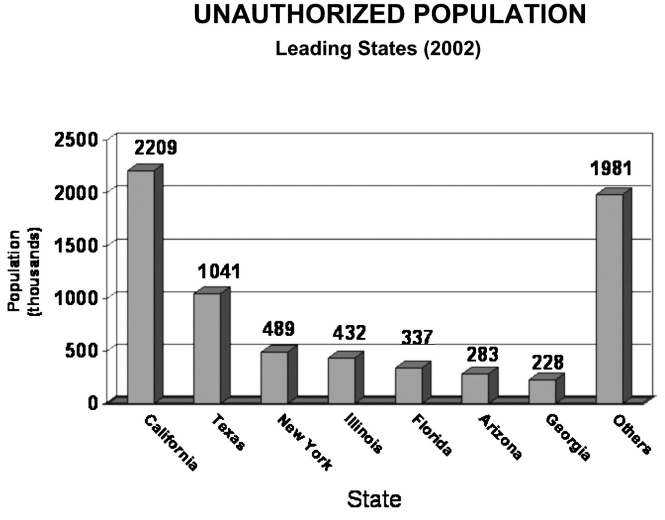

Fig. 2. *States with the largest population of illegal immigrants – adapted from U.S. census Bureau – 2002.*

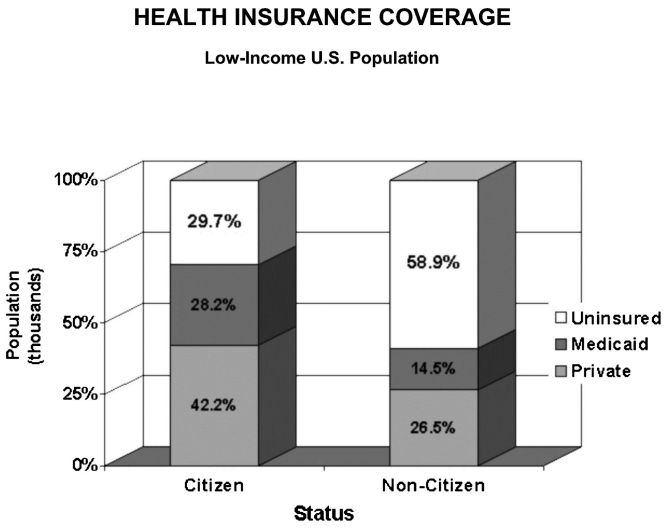

Fig. 3. *Health Insurance coverage of the Low-Income U.S. Population – adapted from Immigrants Health Care: Coverage and Access. Kaiser Commission on Medicaid and the Uninsured, WA, D.C. August, 2000.*[2]

Nationwide, 31.6% of all immigrants have no health insurance compared with 11.4% of the U.S. born population. Low-income immigrants are twice as likely to lack insurance as low-income U.S. citizens. For 9.8 million low-income non-citizens in 1999, almost 59% had no health insurance compared with 30% of low-income citizens. In addition, citizens had nearly double the Medicaid coverage (Fig. 3).[2] The likelihood of non-citizen immigrants obtaining health insurance depends upon a number of factors.[4] Lack of education, specifically the failure to finish high school, nearly doubles the risk of being uninsured in non-citizens. Salary is also an important predictor of having employer-based health insurance. Fifty-three percent of immigrants who earn less than $25,000 per year are uninsured as opposed to 24.4% among those earning over $60,000 per year. Moreover, the uninsured rate for immigrants who have resided in the U.S. for less than five years is 48%, compared with 29% for those in the country for more than 15 years. Finally, 44.6% of non-citizen immigrant children under 18 are uninsured versus 17.6% of naturalized citizens and 14.4% of U.S. born.[7]

The type of insurance varies among immigrants. In 1998, 39% of non-citizens were uninsured, only 13% were covered under Medicaid; 42% had employer based coverage compared with 81% of U.S. citizens and 75.6% of naturalized citizens.[2] Immigrants who lack health insurance often have no usual source of health care. They depend on public clinics, community health centers, and hospital outpatient departments—the so-called, health care "safety net." Thirty-seven percent of non-citizens with incomes below the federal poverty level have no usual source of care, as opposed to 19% for U.S. born individuals. Interestingly, non-citizens are more likely to use clinics and less likely to go to physicians offices or emergency rooms.[2]

In addition to lack of insurance coverage, many immigrants experience additional barriers to obtaining care. The high cost of health care causes immigrants to forego or postpone care. Cultural differences, specifically language barriers, hinder accurate communication and create uncertainty concerning diagnosis and treatment. Lack of understanding of public programs or fear that seeking help from a government agency may lead to deportation, are other factors that limit health care access in non-citizens.[2]

GOVERNMENT FINANCED HEALTH CARE FOR IMMIGRANTS

Immigration status is the most important reason whether or not low-income workers are eligible for government health benefits. Because of the 1996 Welfare Reform Act, even new legal immigrants have to wait 5 years before they are eligible for health care coverage. On the other hand, naturalized immigrants are eligible for the same benefits as U.S. born citizens. The impact of this policy has been to shift the fiscal burden of health care for legal and illegal immigrants from the federal government to the states and local communities. Fortunately, or unfortunately, depending on your point of view, the Emergency Medical Treatment and Labor Act of 1987 (EMTALA) mandates that hospitals must provide emergency care to all patients regardless of their immigration status or ability to pay. This further burdens states, and subsequently, hospitals to provide uncompensated care. Illegal and qualified aliens who are injured are always eligible for emergency services under the Federal Emergency Services Program (FES).[4]

It is unlikely that harsh enforcement of immigration laws will stop the influx of illegal migration. Thus, the population of undocumented individuals from Mexico and other countries will continue to grow and further economically burden our health care system. There are two major ideological differences concerning health care delivery to undocumented aliens. First, there are those who believe that illegal immigrants should not be eligible for any benefits except "safety net" services and those who acknowledge the economic contribution of immigrants and want to provide health care through state and federal funding. Caught in the middle of this ideological struggle between the patients' health care needs and the economy of payment are the providers (physicians) and hospitals that assume, not only the physical load of providing care, but also the fiscal burden of lack of compensation.

TRAUMA AND ILLEGAL IMMIGRANTS

There is a paucity of information in the literature with respect to the impact of immigration status and its affect on trauma centers. Several reasons for this lack of data include: reluctance of patients to divulge their immigration status, unwillingness of hospital clerks and staff to question patients regarding citizenship to avoid violating an individual's civil rights, and, on occasion, presentation of false information or

Table 1 Trauma Ethnicity and Payor Mix (FY 2003-2004)

Payor	White	Hispanic	Black	Native American	Asian, Pacific	Other	Total
Medicare	315	43	23	10	0	15	406
Medicaid	895	1160	206	176	11	227	2675
Workers Compensation	138	105	11	4	0	11	269
Uninsured	561	855	82	69	12	104	1683
Managed Care	723	220	40	20	8	54	1065
Commercial	909	236	39	32	9	71	1296
Military/Champus	81	17	12	2	2	4	118
Other	17	90	1	5	0	10	123
Total (%)	3639 (47.7)	2726 (35.7)	414 (5.4)	318 (4.2)	42 (0.5)	496 (6.5)	7635 (100)

forged documents from patients or their families. St. Joseph's Hospital and Medical Center in Phoenix is an American College of Surgeons verified Level I Trauma Center. Thirty-six percent of our patients are of Hispanic origin (Table 1). Of those, 31.4% are uninsured (70% of which are undocumented). Although, this group of patients does not account for non-citizens who may have insurance coverage, this group represents a substantial proportion of patients at our trauma center (7.8% overall; 599 patients in FY 2003-2004) (Fig. 4). In addition, the number of uninsured illegal immigrants who present to our trauma center is increasing significantly (2003 – 207 patients, 5.7%; 2004 – 391 patients, 9.8%; $\chi^2 = 46.196$; $p < 0.001$). The overall uninsured trauma population at our institution is 22.6%.

In 2004, our hospital's charity committee spent $309,000 to facilitate safe discharges for undocumented patients who were not eligible for Medicaid or any follow up services. These expenditures were for transporting patients to their country of origin (primarily Mexico), purchasing mechanical ventilators for long-term care, paying for local home care, arranging for short-term stays in extended care facilities, and buying durable medical equipment or prescription drugs. This is the first year that this data has been consistently collected and no data are available for earlier years. Inpatient costs that were not reimbursed in FY 2004 equaled $11.7 million dollars, an increase of $2.6 million from FY 2003 (28.6%). Of the uncompensated and charity care provided by our hospital in FY 2004, $22 million (68.7%) was associated with the trauma service. The majority of this uncompensated care (57% - $12.5 million) was provided to undocumented trauma patients.

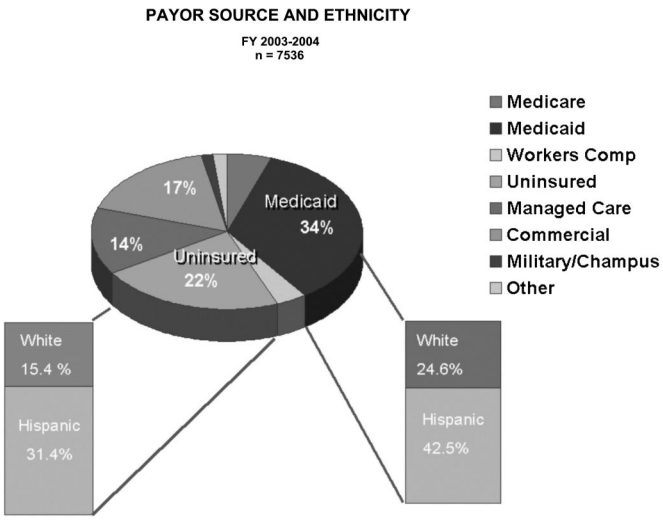

Fig. 4. *Payor Source with White and Hispanic Ethnicity at St. Joseph's Hospital and Medical Center, Phoenix, FY 2003–2004.*

ILLEGAL IMMIGRANTS AND SOCIAL RESPONSIBILITY

The professional obligation to assure proper medical care for all patients regardless of immigration status is a tenet that we as physicians must uphold. Many secular faiths espouse an ethic of reciprocity. For example, traditional Judeo-Christian doctrine implores us that ". . .if a stranger sojourn with thee in your land, ye shall not vex him. But the stranger that dwelleth with you shall be unto you as one born among you, and thou shalt love him as thyself" (Leviticus 19:34). In the New Testament, Christians are taught to treat their neighbors as themselves. The Hippocratic Oath we took as graduating medical students reminds us of our responsibilities to humanity, "I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm."[8] Finally, the Fellowship Pledge of the American College of Surgeons states: ". . . .I pledge myself to pursue the practice of surgery with honesty and to place the welfare and rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position. . . ."[9]

These moral duties recognize the vulnerability of the sick and acknowledge the ongoing responsibility that doctors have to act with beneficence toward patients under their care. Moreover, the ethical duty of physicians not to abandon patients who have no real opportunity to secure another source of care has been upheld by courts as a legal duty, regardless of the patient's ability to pay for continued necessary treatment.[10]

The ethical question of whether societies have a responsibility to provide health care for illegal immigrants sometimes becomes a political issue. In 1996, Congress passed the Illegal Immigration Reform and Immigrant Responsibility

Act. This law made all immigrants ineligible for Medicaid, although it did allow the federal government to reimburse states for emergency treatment of these individuals. In 1994, the citizens of California debated Proposition 187, an even more restrictive measure. This initiative proposed to deny publicly funded health care, social services, and education to illegal immigrants. The Proposition was approved by 59% of the voters. It has never been implemented because the courts found problems with its constitutionality, but the debate for and against its provisions remains active.[11]

Despite the limited public budget for health care, the argument that U.S. citizens and legal residents are more deserving of benefits than are illegal aliens is wrong. It frames the issue as a choice between competing "goods."[11] It is true that a society cannot have everything; universal health care, public schools, public parks, public services, and low taxes. What is false is that we have to make a choice between basic health care for illegal immigrants and basic health care for our citizens. Many tradeoffs are possible, including an increase in public funding, changes in other entitlements or decreases in defense spending.

We have a societal responsibility to provide all members with basic care. Ziv and Lo, in discussing the physician's responsibility to care for patients in medical need, regardless of nationality, residency, immigration status or ability to pay, state that it is immoral to turn patients away when society has no other provision or institution to provide them with care.[12] This notion does go beyond professional ethics and has more to do with social justice than the practice of medicine. However, it makes the ethical argument, based on a belief of social responsibility, that illegal immigrants are contributing members to the economic and social life of our nation.[13] They are workers, parents, students, and part of our community life. During the industrial revolution, children, women, and men without property were also not treated as full citizens. They were vulnerable people, doing undesirable work for which society needed to take responsibility. Such is the case with undocumented workers today. I believe we have a social responsibility, as well as a professional one, to care for them.

OUTCOME

JC survived his injuries. Our discharge challenge was to meet his long-term needs of nutrition and rehabilitation. Beyond his emergency care, he was not eligible for Medicaid, and other than friends and cousins, he had little social support in the United States. The best concentration of resources (clinical, financial, and social) was in Guatemala, where JC had the social support of his family and the medical treatment necessary for his recovery. We closed his jejunostomy, weaned him from ventilator support, and subsequently flew him to Guatemala. He was admitted to the intensive care unit of Roosevelt Hospital in Guatemala City, his care was assumed by the surgical staff, and he was reunited with his family. I am told that he was eventually weaned from total parenteral nutrition to oral alimentation and has returned to his home in San Marcos. JC's bill for 83 days in the hospital was $965,354. FES reimbursement equaled $141,859.

Our hospital provided resources for his eventual transfer, and established a fund through our charity committee to assure that his parenteral nutritional needs would be met as he transitioned to enteral feedings. His outcome was engineered by our staff based on moral and ethical principles, not purely on economic ones; namely, treat all patients with respect, and as people whose best interests matter.

I believe it is our duty to recognize the vulnerability of all injured patients in our care and to continually advocate for the provision of excellent treatment. Although JC was an illegal worker in relationship to our state and federal governments, he should be viewed as a legal member of our community. Our moral responsibility is to assure that trauma care is available to all individuals and that a person's immigration status, the color of his skin, or the foundation of his religious beliefs does not diminish that responsibility. Indeed, for society, what seems on the surface as an economic issue based on access and payment of health care truly is an ethical problem based on social justice and societal responsibility .

REFERENCES

1. Weitzmann M, DuPlessis HM, Fisch SI, et al. Health care for children of immigrant families. *Pediatrics.* 1997;100:153–156.
2. Immigrants' Health Care: Coverage and Access. The Kaiser Commission on Medicaid and the Uninsured. Washington, D.C. March, 2001.
3. Burkholder B. Magnet Force: Immigration, Health and Social Policy in Arizona. In Arizona Health Futures, February, 2002.
4. U.S. Immigration and Naturalization Service. Illegal Alien Resident Population, Available at: http://www.ins.gov/graphics/aboutins/statistics/illegalalien/illegal.pdf, Accessed January 5, 2005.
5. The New Americans: Economic, Demographic and Fiscal Effects of Immigration. The National Research Council of the National Academy of Science. Washington, D.C. National Academic Press; 1997. Available at http://www.nap.edu/html/newamer. Accessed January 7, 2005.
6. Lillie-Blanton M, Hudman J. Untangling the web: race / ethnicity, immigration and the nation's health. *Amer J Pub Health.* 2001; 91:1736–1737.
7. Carasquillo O, Carasquillo AL, Shea S. Health insurance among immigrants. *Amer J Pub Health.* 2000;90:917–293.
8. Lasagna L. Hippocratic Oath—Modern Version. Tufts University. Boston. 1964. Available at: http://www.pbs.org/wgbh/nova/doctors/oath_modern.html. Accessed February 5, 2005.
9. American College of Surgeons. Fellowship Pledge. Available at: http://www.facs.org. Accessed February 1, 2005.
10. Hall MA, Ellman IM, Strouse DH. *Health Care Law and Ethics in a Nutshell.* 2nd ed. St. Paul, MN. West Group 1999; pp 112–116.
11. Illegal Immigrants, Health Care, and Social Responsibility. The Hastings Center Report, January, 2004.
12. Ziv TA, Lo B. Denial of care to illegal immigrants. *New Engl J Med.* 1995;332:1095–1098.
13. Farmer P. The major infectious disease in the world—To treat or not to treat? *New Engl J Med.* 2001;345:208–210.