

# Virtual Mentor

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## CLINICAL CASE

### Nonemergency Medical Care for Illegal Immigrants in Texas

Commentary by Patricia Evans, MD

Dr. Burke just completed his residency in internal medicine and he is now transferring from his training hospital in Dallas to a small rural hospital in Nueces County outside Corpus Christi, Texas. He specializes in preventive medicine and is particularly interested in working with the large immigrant population that this border town is home to. Dr. Burke is soon informed that, unlike in Dallas County, Nueces County has chosen to adhere to the attorney general's 2001 statement that interprets federal legislation as barring hospitals from providing anything but emergency care to illegal immigrants. Thus, part of Dr. Burke's responsibility will be to ask if his patients are legal residents.

Mr. Sanchez arrives at Dr. Burke's clinic with a recent but vague history of headaches and a possible seizure. He is a poor historian, and there was no witness to his seizure. Dr. Burke knows of parasitic illnesses (such as cysticercosis) unique to recent immigrants from Latin America and the Far East that could cause seizures, and he wants to ask Mr. Sanchez whether he has recently immigrated. On the other hand, Dr. Burke knows that he might be legally prohibited from receiving reimbursement for Mr. Sanchez's care if he learns of his immigration status, and it might be better not to ask about his patient's recent travel, even though the answer could influence the diagnosis.

## Commentary

The ethical question of whether societies have a duty to care for illegal immigrants has become a volatile topic this election year, especially in the current atmosphere of economic uncertainty. How do we as physicians approach the complex medical, social, and political problems raised by the needs of immigrants for preventive health care? A simple gut response to basic human rights does not address this difficult subject that encompasses ethics, economics, and human need. Trying to understand the issue from both the "nationalist" and "humanist" points of view exposes inherent conflicts. The former viewpoint might define access to health care as belonging only to legal citizens of the country. A humanist view might define health care as a basic right to which all are entitled. As outlined in James Dwyer's report "Illegal Immigrants, Health Care, and Social Responsibility," neither of these views captures the dilemmas well: one is too narrow, the other is too broad, and both neglect the intricacies that make up the vast middle view [1].

It has been said that, while human migration is not new, illegal immigration is a uniquely 20th-century phenomenon [2]. Societies have always tried to exclude people who were viewed as undesirable, such as criminals, certain ethnic groups, and people with contagious diseases, but only in the last 100 years have governments attempted to legislate and systematically control both the numbers and types of immigrants [1].

The number of U.S. immigrants—both documented and undocumented—grew by more than 40 percent between 1980 and 1990. An additional 4 million foreign-born people entered the country between 1990 and 1995. About three-quarters of all of these arrivals settled in only six states between 1980 and 1995, making economic stresses and trends difficult to manage and to predict [3].

Because of public outcry regarding inequities in health care, Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act in 1996, which made illegal immigrants ineligible for Medicaid and forced legal immigrants to wait 5 years before receiving Medicaid dollars. Two years earlier California citizens had voted to accept Proposition 187, which required publicly funded health care facilities to deny care, except in medical emergencies, to people who could not prove that they were U.S. citizens or legal residents. Although passed into law, Proposition 187 has never been implemented because courts found that parts conflicted with existing state law [4].

The justification for restricting health care for illegal immigrants typically focuses on rights, taxation, and benefits. While proponents of restricting care often point out that illegal immigrants pay no taxes, opponents counter that they do indeed pay many different types of taxes, including sales, gas, and value-added taxes, and often property and even income taxes. A better question might be, do illegal immigrants pay sufficient taxes to offset the cost of health care they would receive? Nevertheless, even such a measured response prompts us to consider whether it is appropriate to use a business venture model. That is, should one receive a proportionate amount of goods relative to the amount invested with regard to public services, including health care [1]? We don't ask this question about citizens who are poor or disabled and receive Medicaid benefits.

Validated studies that assess the effect of legal restrictions on access to health care suggest that they create serious ethical conflicts for medical professionals [1, 5]. They may, for example, prevent illegal immigrants from seeking care that is *not* restricted (e.g., care for infectious disease) and is important for protecting the public. A child with tuberculosis may be a danger to other school children if he or she is not identified and treated, but a family without legal status that is concerned about being reported to the county health department has legitimate reason to worry about deportation, even if the child is a natural-born U.S. citizen.

As Dwyer points out, appealing to the prudent argument for treating both documented and undocumented persons for the good of society's legal citizens may

be a practical step in the right direction, but it does not deal with the larger question: are illegal immigrants considered part of the public? It is important to determine whether persons who are in this country illegally are to be considered part of the public discourse, or whether, because they are undocumented, they must be marginalized in public discourse as well as not receiving services.

Further, it cannot be stated often or emphatically enough: it is wrong to ask physicians to screen for patients' immigration status. While physicians may need state and federal agencies to intervene on behalf of vulnerable patients, like minors or elders, such interactions protect the patient-physician relationship so that physicians are still able to advocate on behalf of their patient. When physicians work with federal and state governmental bodies to seek protection for patients it is ideally based on direct concern for a patient's welfare. But when physicians are asked to use the patient-physician relationship in a way that does not benefit the patient—and indeed may compromise the integrity of that relationship, or even cause harm by interfering with a patient who needs care—by, for example, reporting an illegal immigrant to the INS, the boundaries of ethical medical care have been breached.

Physicians are first and foremost committed to *primum non nocere*: above all, do no harm. Impairing the patient-physician relationship strictly to help a government agency—without apparent benefit to the patient—violates the ethics of beneficence at the very least, and probably the principle of nonmalifecence, too. When physicians become agents of states or political regimes to the detriment of their patients or the patient-physician relationship, the population is at risk for horrific abuse. Precedents are abundant enough that such a stance must be avoided at all costs by physicians and other health care professionals.

The state in our vignette, Texas, has had its own maelstrom concerning health care for illegal immigrants. The former state attorney general, John Cornyn, acknowledged that federal law required that illegal immigrants receive emergency room care, immunizations, and treatment for communicable diseases. But he also said that federal law prohibited all other care unless states passed legislation to provide it. Cornyn went on to say that the Texas legislature had enacted no such law and that state hospitals could lose millions of dollars in federal aid if they continued offering the services [6].

Mr. Cornyn's opinion has come under legal attack from various state hospitals and organizations. "The National Association of Public Hospitals and Health Systems maintains that a 1999 Texas law met the federal requirement for continuing care for all residents" [6]. Others argue "that federal law merely states that illegal immigrants are not *entitled* to such benefits, not that states or localities are prohibited from providing them" (emphasis added) [6]. Certainly this is an argument that places physicians and their code of ethics directly in the path of political fire.

Nueces County, where our fictional Dr. Burke practices, is so far the only county in Texas that has opted to follow Mr. Cornyn's restrictive interpretation of the federal

law. Given this fact, Dr. Burke may need to weigh his legal and ethical options and decide whether to remain in the county or transfer to an environment that is more friendly to his chosen specialty. Since patients' immigration status does not directly affect Dr. Burke's capability to treat them, and since he is not an agent of the federal government, one could argue effectively and persuasively that assessing his patients' immigration status compromises the patient-physician relationship and hinders access to and quality of care. Dr. Burke can proceed with Mr. Sanchez's clinical evaluation on the assumption that the parasite infection is a possible diagnosis.

Texas State Senator Jane Nelson, as chair of the Health and Human Services Committee, wrote to the current attorney general, Greg Abbott, in 2004 and asked him whether physicians could see undocumented immigrants with impunity. Specifically, she asked whether "section 285.201 of the Health and Safety Code requires a hospital district to provide non-emergency public health services to undocumented persons who are otherwise ineligible for those benefits under federal law" [7]. In response, Abbott wrote that,

this chapter affirmatively establishes eligibility for a person who would otherwise be ineligible under 8 U.S.C. Section 1621(a), provided that only local funds are utilized for the provision of non-emergency public health benefits. A person is not considered a resident of a governmental entity or hospital district if the person attempted to establish residence solely to obtain health care assistance [7].

In other words, local funds could be used to serve persons who were undocumented and needed nonemergency care. The term "local funds" can be interpreted simply as nonfederal dollars, arising from any number of sources. Those of us who have worked in rural parts of Texas serving indigent and often undocumented persons in primary care fields have depended upon the charities of faith-based organizations, but other relief organization funds may also be available. While not ideal, organizations such as Catholic Family Services and the United Way may be the only available monies in such settings, and, for the physician, it can make a difference when caring for patients with serious but not necessarily urgent conditions.

With regard to Dr. Burke's dilemma, since he cannot receive federal funds, he might consider relocating to any of the other 255 Texas counties where local funds may or may not be available but are certainly not banned from use in providing nonemergency health care for undocumented immigrants. Alternatively, he may feel strongly enough about staying in Nueces County to become politically more active and assume an advocacy-based practice, challenging the inherent unfairness and shortsightedness of the county's policy through legal avenues and the current interpretation of Texas law.

Not having the time, energy, or funds to choose this path would color Dr. Burke's decision about whether to stay or leave Nueces County. If he leaves, it could be argued that county policy has caused its citizenry to be abandoned and placed greater

burdens on neighboring counties. In the absence of a large metropolitan city in the county, neighboring areas are burdened with caring for patients from Nueces in addition to those from their own, typically with inadequate resources to address the growing problem. Hence, Dr. Burke should consider his decision not only in terms of how one county operates but on how his choice will affect the entire society and the overall health of the people.

As Dwyer notes [1], medical care is only one means by which the public creates healthy individuals and a healthy society; to limit one's examination to access and payment of medical care focuses the ethical concerns far too narrowly. By contrast, the communities that attract illegal immigrants should think more broadly about what makes a healthy society, i.e., better pay and conditions for the most grueling forms of work; better structure and organization of work sites so that employees have more empowerment and a chance to develop their individual talents; and, finally, linking unskilled laborers to local communities more broadly so that workers and their families have increased self-respect and dignity.

Finding solutions for the continued inequity of health care distribution among Americans is not easy, and finding creative ways to serve the needs of all residents—both documented and undocumented—living in the U.S. will continue to challenge resources and resolve. Using a business model—in which the bottom line is rigidly and always given highest priority—to design health care systems creates ethical and moral problems. The healthiest society is one in which social justice and responsibility are the framework for such discussions.

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