

## MEDICINE AND SOCIETY

### Is It Ethical to Bend the Rules for Undocumented and Other Immigrant Patients?

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#### Abstract

Physicians and other health care professionals who work in hospitals and clinics serving low-income populations will encounter undocumented immigrants as patients, family members, community members, and persons whose health-related rights can be overlooked, imperiled, or difficult to use. The routine uncertainty arising in how to provide good care to patients who are excluded from key public insurance provisions, together with the desire to be a good advocate for this patient population, can give rise to so-called workarounds as problem-solving strategies. This article explores the ethics of workarounds in the care of undocumented patients and considers how advocacy by health care professionals and organizations can assist immigrants in communities they serve.

#### Responding to Ethical Challenges in Care of Undocumented Patients

Physicians and other health care professionals who work in hospitals and clinics serving low-income populations, especially in the 20 metropolitan areas that are home to most immigrants who live in the United States,<sup>1</sup> are likely to encounter undocumented immigrants in at least 4 ways: as patients with structural barriers to health care access and insurance coverage; as family members of patients with the same or a different immigration or citizenship status; as community members; and as persons whose health-related legal rights can be overlooked, imperiled, or difficult to use. A new federal rule (commonly known as the “public charge” rule) proposed in September 2018 would consider the use of federally funded programs by legally present (authorized) immigrants as a factor in an application for permanent resident (“green card”) status. The proposed rule is a new factor in the care of immigrant patients who are eligible for these programs but apprehensive about using them.<sup>2,3</sup> This article focuses on undocumented (unauthorized) immigrants, who are excluded from federally funded programs,<sup>4</sup> mindful that health care access for authorized immigrants is also being affected by the so-called chilling effects of proposed policy (in particular, the proposed public charge rule) and anti-immigrant rhetoric.<sup>5</sup>

In caring for this patient population, professionals routinely face uncertainty in how to provide good care and [meet standards of care](#) when patients’ undocumented status and

inability to change this status exclude them from public provisions that cover medically appropriate treatment for low-income populations. Broad exclusion of undocumented immigrants from federally funded benefits because they are “not qualified” aliens means they cannot make use of benefits for which they would otherwise qualify due to low income,<sup>4</sup> eg, Medicaid, the Children’s Health Insurance Program, the Supplemental Nutrition Assistance Program, or insurance subsidies under the Affordable Care Act (ACA). There is significant variation in how state Medicaid programs, local public health systems, and nonprofit (also known as private or voluntary) health systems invest in and sustain access to services to undocumented patients in light of federal restrictions. It is often the responsibility of medical social workers to identify potential sources of coverage or care (such as prenatal care) for uninsured patients in a system, municipality, county, or state and then to determine whether these sources include or exclude patients based on immigration status.<sup>6</sup>

As a result of the immigration enforcement priorities reflected in executive actions since the beginning of the Trump administration, a set of separate but related problems has arisen for professionals in health care systems serving populations targeted by immigration authorities or serving communities that include immigration detention facilities; other facilities in which immigrants and asylum seekers might be held; or shelters housing children who crossed the border alone (unaccompanied minors) or who were separated from a parent after crossing the border.<sup>7</sup> This article focuses on undocumented immigrants outside the detention context; professionals should keep in mind that this related context may shape the concerns and fears of patients who are immigrants.

Examples of ethical questions arising in this complex practice environment include the following: (1) How should I provide good care to a patient who is or is presumed to be undocumented? (2) How could my actions have harmful consequences for this patient? (3) Which actions of mine could introduce bias or be unfair to this patient or to others? (4) What should I do when my practice is constrained by a policy that is clearly harmful to patients?

### **Workarounds**

Complex systems, such as health care systems, characteristically produce situations in which rules intended to guide normal work do not match the conditions of work as they are experienced by workers. Devising, using, and sharing strategies known as workarounds<sup>8-10</sup> relieves pressure resulting from a perceived mismatch between work rules and work reality. Because health care work is work that happens under pressure, using workarounds to manage workflow problems is a normal, if unofficial and semisecret, part of how work gets done. Ethically relevant motives for different types of workarounds include efficiency, problem solving, fairness, and—more negatively—avoidance.

For example, a worker who aims to “get the job done” and satisfy a system’s continuous pressure to be efficient may look for ways to complete tasks more quickly through strategies that she may call “shortcuts,” or simply describe as “my way.” These workarounds tend to involve judgments about how tasks can be abbreviated and whether rules can be ignored or steps skipped without harm. Research on the implementation of checklist memory aids suggests that these patient safety tools are vulnerable to shortcut-type workarounds when they are perceived as too time-consuming and therefore out of synch with the drive to work efficiency and when they are perceived as “imposed” on workers.<sup>11</sup>

Workarounds that aim to solve problems, not merely save time, are often called “fixes,” “patches,” “hacks,” or even “inventions.” These can involve the unofficial creation, adaptation, or nonstandard use of a clinical tool, and they can be associated with the idea of clinical judgment and the application of clinical wisdom to practical problems (“getting creative”).

Workarounds that aim to solve a problem of fairness in patient care tend to be called “bending the rules,” “working the system,” or “advocacy.” Tailoring the chart to emphasize a patient’s [eligibility for a resource](#) or to de-emphasize factors detracting from eligibility is one example of this type of workaround. Workarounds that aim to secure resources for undocumented patients are also likely to be of this type. The idea of “getting creative” concerning resource allocation often applies to unofficial efforts to assist this population or other uninsured or underinsured populations.

Workarounds that aim to avoid or relocate a problem, often for reasons of cost, can take the form of “turfig,” for example, as when undocumented uninsured patients are referred to public health systems by systems that have community benefit obligations as a condition of nonprofit status. Efforts to medically repatriate patients to their countries of origin could also reflect this motive, or they could be consistent with a patient’s preferences. Medical repatriation requires informed consent.<sup>12</sup>

### **Moral Murkiness of Rule Bending**

Workaround behaviors are hard to avoid. They can be perceived by some as good advocacy, a way of “going the extra mile” for a patient or population in need. But, even when their aim is justice, they are ethically problematic for several reasons. First, a professional’s or group’s decision to help a patient or population secure resources through an unofficial route—for example, by stashing supplies for ad hoc distribution—may involve biased judgments against another patient or population with equivalent needs. Without scrutiny of why one patient or population is being helped while another is not, an effort to promote justice risks introducing a new source of injustice, without challenging the resource allocation policy that is perceived as unsatisfactory. The association of workarounds with secrecy is another problematic factor, contributing to

“siloed” solutions rather than a comprehensive approach to understanding what a population needs, the barriers to meeting these needs, and how an organization’s resources should be allocated in recognition of these needs.

Health care organizations that serve undocumented patients and other uninsured populations should provide opportunities for clinicians and administrators to discuss how patients’ lack of insurance coverage—or other barriers to accessing medically appropriate services—creates an ethically challenging practice environment on top of the built-in pressures of health care work.

Greater transparency about how organizations address or could address these challenges using internal resources may help to alleviate pressures that drive workaround behaviors. Public policy advocacy aimed at state or local policymakers may, in some situations, be possible even given the highly charged politics of immigration. However, as a rule, “shadow systems,” such as municipally funded direct access services or hospital food pantries, cannot fully compensate for broad federal exclusions or for the [consequences of federal policy](#) that trigger chilling effects on health program enrollment even when a population is technically eligible for these programs.

A hospital’s ethics service or an academic medical center’s social medicine program may play a convening role, facilitating efforts to describe common and less common resource allocation challenges and providing a nonpunitive forum for professionals to talk about their unofficial solutions and explore those solutions’ ethical dimensions. Just as some “fixes” can be the first drafts of innovations, so incidents of “bending the rules” can point to justice problems with potential solutions that can be discerned through open discussion.

### **Avoiding Complicity in Unjust Policy**

Acceleration of immigration enforcement in the United States has threatened or harmed immigrant health in multiple ways.<sup>13</sup> These threats and harms to undocumented immigrants themselves may also threaten or harm the ethical integrity of health care professionals and others responsible for the health, safety, and well-being of immigrant adults and children. These issues of professionalism in the practice of medicine in the contemporary United States should be squarely addressed in undergraduate medical education and clinician education for house staff; through venues such as journal clubs and ethics committee discussions; and through professional societies. Important topics for reflection and discussion and for professional or organizational guidance for patient care situations tend to involve complex human rights issues, including situations in which health care professionals may observe evidence of harm, such as psychological trauma, among immigrants in federal custody or in the custody of local subcontractors, such as shelters or jails.<sup>14</sup> Guidance for situations in which health care personnel interact with

immigration officials or their subcontractors could also help motivate justice for patients and mitigate conflict and distress for caregivers.<sup>15</sup>

## References

1. Passel JS, Cohn D. 20 metro areas are home to six-in-ten unauthorized immigrants in US. *Fact Tank*. February 9, 2017. <http://www.pewresearch.org/fact-tank/2017/02/09/us-metro-areas-unauthorized-immigrants>. Accessed June 29, 2018.
2. National Immigration Law Center. How to talk about public charge with immigrants and their families. <https://www.nilc.org/issues/economic-support/how-to-talk-about-public-charge-pif/>. Published September 25, 2018. Accessed October 10, 2018.
3. Jacobs D. A tortured choice for immigrants: your health or your green card? *New York Times*. October 10, 2018. <https://www.nytimes.com/2018/10/10/opinion/immigration-trump-health-public-charge.html?action=click&module=Opinion&pgtype=Homepage>. Accessed October 10, 2018.
4. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub L No. 104-193, 110 Stat 2105.
5. Page KR, Polk S. Chilling effect? Post-election health care use by undocumented and mixed-status families. *N Engl J Med*. 2017;376(12):e20.
6. Wherry LR, Fabi R, Schikedanz A, Saloner B. State and federal coverage for pregnant immigrants: prenatal care increased, no change detected for infant health. *Health Aff (Millwood)*. 2017;36(4):607-615.
7. Henry J Kaiser Family Foundation. Key health implications of separation of families at the border. <https://www.kff.org/disparities-policy/fact-sheet/key-health-implications-of-separation-of-families-at-the-border/>. Published June 27, 2018. Accessed July 12, 2018.
8. Berlinger N. Turfing, bending and gaming. In: *Are Workarounds Ethical? Managing Moral Problems in Health Care Systems*. New York, NY: Oxford University Press; 2016:74-105.
9. Berlinger N. Dirty hands and the semiclear conscience. In: *Are Workarounds Ethical? Managing Moral Problems in Health Care Systems*. New York, NY: Oxford University Press; 2016:106-133.
10. Berlinger N, Raghavan R. The ethics of advocacy for undocumented patients. *Hastings Cent Rep*. 2013;43(1):14-17.
11. Berlinger N, Dietz E. Time-out: the professional and organizational ethics of speaking up in the OR. *AMA J Ethics*. 2016;18(9):925-932.
12. Kuczewski M. Can medical repatriation be ethical? Establishing best practices. *Am J Bioeth*. 2012;12(9):1-5.
13. Schaffer A. A physician in South Texas on an unnerving encounter with an eight-year-old boy in immigration detention. *New Yorker*. June 21, 2018.

<https://www.newyorker.com/news/as-told-to/a-physician-in-south-texas-on-an-unnerving-encounter-with-an-eight-year-old-boy-in-immigration-detention>. Accessed July 17, 2018.

14. Schaffer A. An ER physician on what it's like to treat toddlers who have been separated from their parents at the border. *New Yorker*. June 21, 2018. <https://www.newyorker.com/news/as-told-to/an-er-physician-on-what-its-like-to-treat-toddlers-who-have-been-separated-from-their-parents-at-the-border>. Accessed July 21, 2018.
15. Illing S. Why border patrol agents obey immoral orders. *Vox*. June 20, 2018. <https://www.vox.com/2018/6/20/17478738/family-separation-trump-border-bureaucracy>. Accessed July 12, 2018.

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