

Virtual Mentor

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CLINICAL CASE

Communicable Disease and Immigration Fears

Commentary by Sonal S. Munsiff, MD

Joseph had been feeling sick for a few weeks, with a severe cough and poor appetite. He even started losing weight. Despite his condition, Joseph did not seek medical care because if he called in sick at the construction company where he worked (either to visit the doctor or to stay home after being diagnosed) his paycheck would be docked. Joseph had a family of five to support: himself, his wife, and three small boys. A few years earlier with the help of some distant relatives, the family had managed to cross the border from Mexico—where Joseph had worked as a farmer and earned a few dollars a day—to California.

In America Joseph was earning nearly 10 times the amount of money he made in Mexico. Still, he couldn't afford a loss in his daily pay. One morning, Joseph woke up coughing violently and eventually spit up blood. He decided to go to work anyway. When he arrived at work, his condition drew the attention of his boss, who sent him to the community health clinic where he saw Dr. Monroe. After hearing how long Joseph had had the cough, Dr. Monroe ordered a chest X-ray which showed that Joseph had active tuberculosis (TB).

When Dr. Monroe talked to Joseph about the test results, he cautioned him that his tuberculosis was highly infectious, imposing special restrictions on his life. He would have to isolate himself to limit the exposure of others. The public health department would also have to be notified, an idea which terrified Joseph. He pleaded with the doctor not to take this step, citing fears that he would be arrested and sent back to Mexico. Dr. Monroe assured Joseph that deportation would be a highly unlikely outcome, although he was unable to guarantee it would not happen. Dr. Monroe added that the health care system in the United States operated outside of immigration law enforcement. Still, Joseph was not reassured. He tried to bargain with Dr. Monroe, repeatedly promising to isolate himself voluntarily so long as neither he nor anyone else alerted the authorities.

Commentary

We are presented with the case of a young man with a communicable form of TB who does not want his doctor to notify the local health department of his condition. Joseph is afraid that he will be arrested and sent back to Mexico. We assume that he is in the United States as an undocumented immigrant and fears that the health department, a government entity, will discover his status and notify the U.S.

Immigration and Customs Enforcement (ICE), or the Department of Homeland Security (DHS).

The case poses many challenges for Dr. Monroe. It is clear that he has to report Joseph to the local health department, which is responsible for ensuring that the family members and appropriate worksite contacts are identified and evaluated. Tuberculosis is a reportable disease in all jurisdictions in this country, and the diagnosing or treating physician is required to notify the local health departments [1]. Dr. Monroe also has to clearly explain Joseph's rights and responsibilities to him, the public health need for reporting, and the consequences of nonadherence [2, 3].

The physician also has a direct responsibility to the patient—to treat him and “do no harm.” By reporting Joseph, Dr. Monroe risks damaging Joseph's trust in him and in the health care system, and Joseph may not continue follow-up or adhere to treatment, which can further endanger the public. Effective treatment will render most TB patients noninfectious quickly, and also prevent further morbidity and possible death.

Directly Observed Therapy

Health departments usually follow up with clinicians and the patient to ensure adequate treatment is being given, and, in the case of TB, they offer or arrange for directly observed therapy (DOT), a program in which a health care worker ensures all doses of the treatment are ingested. A health department worker interviews the patient to identify his or her routine activities and elicit contacts in home, work, leisure and other settings in order to evaluate them or follow up on the evaluation done by other clinicians. Exposed contacts in worksites and congregate settings such as schools or shelters usually have to be investigated by the health department [4]. Most health departments offer free screening and treatment for active TB cases and for their contacts.

Patients are often diagnosed and managed at different facilities or by different clinicians, so it is possible that no single person or clinic has all the relevant information on a given patient. Patients themselves may not recall or provide key information to each health care entity. The health department plays an important role by having complete records of evaluation and treatment given at all facilities.

Many jurisdictions have a double reporting system for communicable diseases: both the clinician and the laboratory are required to report the results of specified tests [2]. Double reporting regulations are based on the practical fact that the clinician and the laboratory have information on different aspects of a patient's condition, and the patient may not be with the same clinic or physician by the time these lab results are available. *Mycobacterium tuberculosis*, for example, is a slow-growing bacteria and results of cultures usually return after 2 to 6 weeks of specimen collection. Furthermore, drug susceptibility testing of the isolate takes at a minimum 1 to 2 weeks.

In the case we are discussing, Joseph is more than 75 percent likely to have had a positive sputum smear for acid-fast bacilli (AFB), and eventually a positive culture for *M. tuberculosis*, and the laboratory will have to report these results to the health department. But the laboratory usually has no clinical information and often no address for the patient, so the report from the physician with the necessary clinical and demographic information is essential for public health actions.

Protecting the Patient and the Public

The patient has a right to privacy and confidentiality, *and* the individuals who have been in contact with Joseph have a right to know that they have been exposed to TB and to be offered appropriate evaluation and treatment. Though release of medical information about reportable communicable disease to a public health entity is exempt from patient consent requirements under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the information cannot be passed on to others. Patients are told during their first encounter that their privacy will be protected to the fullest extent possible [5]. Health departments usually have stringent confidentiality requirements for staff who handle patient data. In New York City, for example, it is made clear to staff of the city's Bureau of Tuberculosis Control that the *name* of the person not be provided to contacts when they are told that they were exposed, except in very unusual circumstances, even after the death of the patient. If a contact asks directly whether he or she was exposed through a specific individual, staff are instructed to state that they cannot confirm or deny this information. If there are no alternatives to identifying potentially exposed people at worksites, managers are asked for contact information and are clearly advised that the name must be kept confidential.

Joseph's Immigration Status

Two New York City mayoral orders direct city employees not to ask about the immigration status of an individual when providing city services [6]. And if information is obtained for work-related needs, it can be considered "confidential information." There is no need to know the legal status of a patient who needs evaluation and treatment for TB. All services in the city's health department chest clinics are free to all who go there. Patients who refuse to take their treatment may be detained under the health code, and civil detention takes place in a hospital ward with 24-hour security [7, 8]. Over the last several years 338 patients have been detained to complete TB treatment in the city, according to unpublished data from Department of Health and Mental Hygiene [9]. Many have come before judges who decide whether their detention is justified. Even so, immigration status is neither revealed nor addressed, because it is not considered relevant to the decision.

That said, it is often easy to tell whether a patient's status is undocumented. The information gathered from patients during routine interviews often reveals the complex routes they have taken to get into the country. Thus we know many TB patients in the city are undocumented immigrants with backgrounds and fears of deportation as seen in our story. In the last 15 years, however, no TB patient in New York City has been jailed or deported because of notification by a health department

staff to ICE or DHS. Sharing these data with Joseph should go far toward easing his mind.

On the other hand, there has been much publicity about requiring various types of health care professionals to report all undocumented individuals they come across in their daily work to the INS. A recent Georgia case involved a teen who was jailed for refusing TB treatment and who is now awaiting deportation hearing because he was undocumented. That can only increase the fear among such desperately ill and insecure individuals [10, 11]. The Georgia case is an exception, however. The health departments in certain instances may be able to work closely with ICE or DHS and Health Resources and Services Administration (HRSA) to try and ensure completion of treatment for TB cases—and delay deportation proceedings. Policies differ from place to place, though, and physicians should check the policy within their practice jurisdictions.

Joseph's Other TB-Related Worries

TB patients have many concerns and fears other than the fear of deportation. In this country TB is most often a disease of the poor, socially marginalized, or unstably employed people [12]. Being asked to stay at home or remain in isolation at a hospital for long periods of time usually means a significant loss of income for anyone who does not have paid sick leave or disability or workers' compensation benefits through an employer. Health departments do not compensate for lost income of TB patients, and the incentives that some health departments provide to promote treatment adherence are not sufficient to make up for lost income.

Joseph has a family of four and he is the principal breadwinner. Though he will have to forgo some income, his time away from work will depend on how fast his disease responds to treatment and the type of work he does [13, 14]. Someone like Joseph, who is working in an outdoor setting with little close human contact, can return to work while his sputum smear is still positive for AFB as long as he is improving clinically, has completed two weeks of treatment, and further treatment is ensured via DOT. Dr. Monroe may have to tell the worksite manager to assign Joseph to work that minimizes contact with others for a while. Since workers at the site will have been tested following the report of Joseph's case to the health department, the manager should understand the necessity of the special assignment for Joseph.

Joseph should also be made aware of social services that he or his family may be eligible for, such as food pantries, WIC (women, infants, and children) programs, and soup kitchens. In some states emergency Medicaid will cover medical expenses that may not be provided by the health department. Inpatient care is usually covered by Medicaid, regardless of immigration status. Most infectious TB patients do not need to be hospitalized and have their full diagnosis and evaluation conducted as an outpatient.

Dr. Monroe has a responsibility to educate Joseph about the disease and what can be done to treat it and to develop a plan for follow-up and return to work. It is equally

important for Dr. Monroe to make sure Joseph understands the impact of this disease on the public and his (Dr. Monroe's) responsibility to the public, not just the patient. Dr. Monroe cannot shun that responsibility and, since it is unlikely that he can fulfill all the roles of patient care, contact evaluation, and social service provision, he must work closely with his local public health department to cure the patient and protect the community.

Conclusion

Health departments need to have funds to hospitalize infectious individuals who may be refusing treatment, rather than putting them in jail where undocumented status is much more likely to be revealed. Once the individual is known to the correctional system, it is no longer possible to keep immigration status secure or confidential. The health department has a mandate to protect the public, but it is not responsible for implementing immigration laws and should be separated from the correctional system. If they are separate there is much less chance of deportation being an issue in TB treatment. The patient can be reassured by the physician and the health department that his or her TB can be treated without ICE involvement.

Patients who fear and avoid treatment could infect many more people; it is in all of society's interest to ensure that all patients with TB are fully and confidentially treated. While one conversation will not reassure most patients, ongoing reassurance and support can usually gain their commitment. Most patients want to get well and get on with their lives and are willing to follow necessary instructions to ensure their cure. Both the provider and the local health departments need to work together to assist the patient to develop the least restrictive and efficient plan that also protects the public.

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