

Virtual Mentor

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CLINICAL CASE

Treating and Repatriating: An Unacceptable Policy

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Mr. Garcia was a legal immigrant who was a migrant worker in Arizona. Driving home from work one day, he was in a near-fatal car accident and was transported to a local community hospital where doctors were able to stabilize him. There, he was diagnosed with TB, and, after spending 3 weeks in the ICU, he was awake and able to communicate even though he remained connected to a ventilator. His prognosis for being weaned from the ventilator was poor because of a cervical spine injury resulting in phrenic nerve injury; he also had sustained multiple fractures including a hip fracture during the crash.

The hospital was unable to secure a transfer to a U.S.-based rehabilitation facility, however, because Mr. Garcia was uninsured. Confronted with rising costs for Mr. Garcia's care, hospital administrators told the attending physicians that they were considering repatriating him to his ancestral and legal home country, Guatemala, if a long-term rehabilitation center did not accept him within a week. One of Mr. Garcia's attending physicians, Dr. Smith, was concerned because she knew Guatemala did not have many long-term rehabilitation facilities that could take care of patients in need of chronic ventilator support. She also knew that the hospital was suffering financially and could not afford care for Mr. Garcia over the long term without reimbursement.

Commentary

Dr. Smith has the primary responsibility for her patient's well-being. She finds herself amid conflict after realizing that her hospital (and many others) are not being paid for charitable care by the U.S. government or her state. Many hospitals receive uninsured patients in the emergency department when they are desperately ill and end up providing costly intensive care. Some states such as Maryland factor into hospital rates an extra amount to cover the charitable care they deliver, but most states do not. Thus, the larger issue at hand is the basic responsibility of the United States, the wealthiest country in the world, to care for all its citizens as well as its visitors. In most health care systems, all people who become ill in that country are given care. Certainly the United States can do this if less-affluent countries are able to. The present case places a physician in what may seem to be an untenable situation. Dr. Smith must choose between what she knows is the best care for Mr. Garcia and her responsibility for the fiscal welfare of her hospital and its workers.

In his 1927 monograph, "The Care of the Patient," Dr. Francis Wild Peabody said:

When a patient goes to a physician he usually has confidence that the physician is the best, or at least the best available, person to help him in what is, for the time being, his most important trouble. He relies on him as a sympathetic advisor and a wise professional counselor. When a patient goes to a hospital he has confidence in the reputation of the institution...[1].

Peabody goes on to say, “The best way of caring for a patient is to care for the patient” [1]. From the earliest times, once a physician takes responsibility for a patient, this obligation trumps all other considerations. With respect to financial considerations, the *American College of Physicians Ethics Manual* asserts that, “When care is free, every effort must be made to preserve the dignity and self-respect of the patient. The indigent patient should receive *equal care* and be treated with the same respect and thoughtful concern as the patient who can pay for services” [2]. Regardless of cost to the hospital, Dr. Smith is responsible and must fight for Mr. Garcia’s best care as she perceives it.

I am personally responsible for long-term ventilator patients and find that Mr. Garcia’s predicament is not restricted to immigrants—legal or illegal—but affects all patients who cannot be liberated from ventilators in a “reasonable” time. Once stable, long-term ventilator patients are faced with pressure from payors to transfer to facilities with lower costs and lower staff-to-patient ratios. Transfer is often recommended without assessment of risks or outcomes. It is an unfortunate fact that, from an economic point of view, the patient who dies is the poorest patient. No one directly responsible for patient care—nurse, doctor, or any member of the bedside team—should agree to moving a patient to a high-risk situation. Hence, Dr. Smith has an obligation not to allow Mr. Garcia’s transfer to what is likely to be inadequate care. The financial strains on her hospital must be considered as secondary. If Mr. Garcia can communicate or understand, he should be informed of expected risks and be included in the decision-making process, as should his family members.

Mr. Garcia has tuberculosis, a curable condition that, if treated properly, may allow him to be liberated from the ventilator, and he is not in an end-stage, medically futile situation. Thus he is not a candidate for end-of-life care. It would be illegal and dangerous to transport a patient with active TB. Health officials would need to be informed if the hospital were to execute a deportation plan, and precautions would need to be taken to protect the public.

A physician must advocate for his or her patient even if the hospital administration has debts or is near bankruptcy. If this is truly the case, an appeal should be made to the state for financial help. If the hospital administration insists on an unsafe transfer, the legal aid society can be brought in to stop the transfer through an injunction and orderly legal process. An example of this procedure took place in Maryland when the state ordered movement of ventilator-dependent patients who were stable to lower-cost skilled nursing facilities; physicians and patients’ families who believed the criteria used to judge stability were flawed asked for hearings in an administrative

court, and the legal aid society provided assistance. This resulted in a dialogue in which the state has agreed to review the criteria by which a safe transfer is judged.

Dr. Smith may have to oppose her hospital administration and, if necessary, use all legal means possible—including bringing in the press and seeking legal assistance. Usually, however, hospital administrators would rather accept a bad debt than be seen as exercising poor judgment and care, so it is the attending physician's responsibility to push back first by direct dialogue with her hospital, then with legal counsel if persuasion fails, and lastly by going public to save the patient. If the hospital chooses to cooperate, the publicity can help bring in supplemental funds for the hospital budget. A physician working in this way with the hospital's administration for the excellent care of Mr. Garcia could benefit both the patient and the hospital.

A further avenue of approach is asking the embassy of Guatemala to advocate for Mr. Garcia, and perhaps raise funds for his care.

The ethical course is quite clear. First, Dr. Smith must fight for Mr. Garcia's care. Second, there are many resources, both formal and informal, to persuade responsible hospital leadership to agree to this position. Third, there are both national and international means and opportunities to address the problem. Finally, what appears to be a sow's ear can be turned into a silk purse by convincing the hospital to make public its financial dilemma, with regard to the care of this and other patients who cannot pay. The act can raise awareness among local and national policymakers and help raise charitable funds for the hospital.

References

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