

Virtual Mentor
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Medical Care for U.S. Immigrants

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FROM THE EDITOR

Why We Can't Turn Our Backs

As a newly minted physician receiving my residency training at a large, urban, mostly charity-driven hospital in Dallas, I spend much of my day treating recent immigrants from south of our border with Mexico. I have great affection for my patients and, as the cliché goes, I feel as though I get more from them during our time together than they receive from my care. They remind me daily of the importance of family and of living a good and honest life—basic truths that can become lost in the midst of long hours on call and other demands of our profession. In this edition of the *Virtual Mentor* I hope to illuminate some of the ethical challenges physicians confront when working with patients who are immigrants.

According to United States Census projections, there are 37.9 million immigrants in the United States—nearly 1 in 8 members of our population—and nearly 1 in 3 are undocumented [1]. The growth of the immigrant population has been exponential. Since 2000, 10.3 million people are believed to have immigrated, and more than half of those (5.6 million) are estimated to have done so illegally [2]. One-third of all immigrants lack health insurance—approximately two-and-a-half times the number of native-born U.S. citizens who are uninsured—and many of them seek care at hospitals like mine [1].

Over the past decade, as the immigrant population has increased, the federal government has reacted by restricting access to Medicaid and other social service programs including SCHIP (State Children's Health Insurance Program) [3]. In some instances, states have stepped in to fill the gap, providing care—some preventive, some emergency—to immigrants without requiring proof of citizenship [4]. In Texas, the state's attorney general determined that certain preventive medical services could no longer be provided to illegal immigrants and that physicians would be required to obtain proof of citizenship before treating any patients [5]. Some counties adopted the attorney general's interpretation of the federal legislation; others did not. In *Virtual Mentor's* first clinical case, Patricia Evans discusses the debate over the attorney general's ruling and the ethical ramifications of forcing a physician to act as an agent of the U.S. Citizenship and Immigration service (formerly the INS) in his or her clinic.

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, commonly known as the Welfare Reform act [3], along with other legislation, had a chilling effect on access to care not only for the undocumented, but also for legal immigrants and native-born citizens [4]. In her policy forum article, Laura Hermer

discusses the obstacles to obtaining adequate reimbursement from different funding sources for care of immigrants.

Despite decreases in coverage of immigrant health care in recent years, proponents of more stringent immigration restrictions assert that hordes of “illegals” are flooding across the border to “steal” medical care [6]. In fact, however, an Immigration Policy Center report found that, in 1998 immigrants (both legal and undocumented) received about \$1,139 per capita in health care, compared to \$2,546 for native-born residents. Although immigrants comprised 10 percent of the U.S. population at that time, they accounted for only 8 percent of U.S. health care costs [7]. With regard to illegal immigrants in particular, a study of Emergency Medicaid use in North Carolina, reported in the *Journal of the American Medical Association*, showed that, although 99 percent of those whose care was reimbursed under Emergency Medicaid were undocumented immigrants, that spending represented only 1 percent of total expenditures by Medicaid in that state. Anjana Lal analyzes this *JAMA* article in her journal discussion.

Immigration reform proponents frequently criticize Hispanic immigrants for failing to assimilate, pointing specifically to their failure to achieve proficiency in English. I am fluent in Spanish, and I speak to most of my patients in their native tongue. Indeed, I can pass an entire day in clinic rarely speaking any English. In the medical education section, Katherine Clarridge, Ernest Fischer, Andrea Quintana, and James Wagner consider whether Spanish should become a requirement in the medical school curriculum and whether such a requirement would even be beneficial.

Another argument advanced in support of tougher border controls and other immigration reforms is the fear of the spread of disease. Reformers point to recent increases in multidrug-resistant tuberculosis as an example and argue that we should tighten borders and re-institute Ellis Island-style health exams [6]. As Alison Bateman-House and Amy Fairchild explain in their history of medicine article, Ellis Island health exams looked for more than infectious disease and had the potential to discriminate against certain ethnicities and those with physical deformities or weaknesses.

Jason Yeh and Jeanne Sheffield explore another aspect of immigrant medicine. In the clinical pearl, they write about the rise in diseases that affect immigrants but are relatively uncommon in the United States where sanitation and inoculation programs are well established. In our hospital population, neurocystercosis, generally considered a rare neurological disorder and cause of seizures, is fairly common. Yeh and Sheffield discuss the duty of physicians treating predominantly immigrant populations to educate themselves about conditions that are rare in their practice specialty but more common in their patient population.

As mentioned above, immigrants, despite claims that they use health services disproportionately, have limited access to care in the United States [7]. In the medicine and society article, Charu Gupta points to the disparity between

immigrants' access to organ transplantation and their contribution to the pool of available organs. By contrast, Reza Yassari writes that immigrants with rare disorders might be offered treatment because American programs welcome the opportunity to perform advanced procedures. The motivations for the American hospital may include media attention and enhanced reputation. In these situations, patients benefit greatly from the initial procedure, which is usually provided free of cost, but are then expected to provide for their own expensive follow-up care [8]. Yassari asks the complex question of what duties arise when physicians initiate care for patients from countries where that type of care is not available.

In a somewhat similar vein, Peter Bundred addresses the conundrum faced by many residency programs that are unable to fill all their training positions but have qualified foreign applicants. This constitutes an ethical conflict because foreign graduates are unlikely to return to their home countries, many of which need doctors, after their training, choosing instead to remain in the United States. Bundred describes the responsibilities residency directors might consider when recruiting foreign medical graduates, responsibilities both to their own programs and to the populace of the trainee's country of origin who will be deprived of a well-trained physician despite a great need.

Returning to my opening statement, I have always received more from my patients than I believe I have been able to give them. I have found this especially true with members of the Hispanic population who boast a rich cultural tradition of alternative medicine, as described by medical student Kimberly Aparicio. As physicians, we must treat all of our patients with dignity and respect and never make them feel as if we are doing them a "favor."

I hope this edition of *Virtual Mentor* succeeds in addressing some of the primary ethical disputes inherent in the medical treatment of the immigrant population. As a society that relies heavily on an immigrant labor force, we have a duty to provide members of that workforce with basic medical care. Defining this level of care is difficult, as illustrated by the pieces herein. Ultimately, to quote Ron Anderson, who writes eloquently about this duty in his op-ed, as physicians we are "left with a human being...who needs [our] help" [9]. It would be unethical to turn our backs.

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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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CLINICAL CASE

Recruiting Residents from Abroad

Commentary by Peter Bundred, MD

Dr. Wilson is the director of a family medicine residency program at a community hospital in North Dakota. In the last residency match process, she was unable to fill the available positions for incoming interns and is looking for one more qualified applicant for the 3-year program. At this point, the most promising applicants have all trained overseas, and the applicant she and her program wish to hire is from Ghana. Dr. Wilson is well aware that most foreign medical graduates tend to settle in the United States after residency, thereby depriving their home country of their expertise and the benefit of their training. In fact, the applicant from Ghana was educated at the state's expense with the expectation that the investment would be returned.

Commentary

This case presents a number of ethical and moral dilemmas, both for Dr. Wilson and for the applicant from Ghana. It also highlights a problem that many U.S. institutions will face in the next few years—a shortage of qualified doctors to fill positions at all levels of the health care delivery system. In fact, Cooper and colleagues have suggested that by 2020 the U.S. will be in need of 200,000 doctors [1]. Dr. Wilson is one of many medical administrators confronting the problem of how to fill physician vacancies when an insufficient number of qualified U.S. students apply. Her dilemma is whether she should fill the post with someone from a developing country or leave it vacant. If she chooses the former option she may indirectly damage the health of many Ghanaians who have significantly fewer doctors than their U.S. counterparts. If she chooses the latter she may not have the staff to run her service ideally and may compromise the health of patients attending her hospital. One way for Dr. Wilson to begin to resolve her dilemma is to evaluate which course of action would do greater harm. To do this she may examine some basic health and economic statistics for the two countries, shown in table 1.

Dr. Wilson will find that U.S. citizens have, at birth, a life expectancy 20 years longer than that of Ghanaians—children born in Ghana are 10 times more likely to die in the first year of life than their American counterparts—and that the maternal mortality rate in Ghana is 60 times that of the U.S. In 2006, a total of 540 women died during child birth and the puerperium in the U.S. compared to an estimated 4,000 women who died in Ghana, despite the fact that Ghana has less than 10 percent of the U.S. population. In the U.S. there are 250 doctors for every 100,000 people; Ghana has a mere 13. Finally, the average third-year medical resident's salary in the

U.S. is 20 times that of the third-year medical resident in Ghana, highlighting the economic disparities between the countries [2-9].

Table 1. Basic health and economic statistics in the U.S. and Ghana

| | USA | Ghana |
|---|------------|-----------|
| Life Expectancy at birth [2, 3] | 77 | 57 |
| Infant mortality rate [2, 3] | 6.8 / 1000 | 68 / 1000 |
| Maternal mortality rate per 100,100 live births [2,3] | 8.9 | 540 |
| Number of maternal deaths [3, 4] | 540 | +/- 4000 |
| Doctors /100,000 [5, 6] | 266 | 13 |
| Per Capita GDP [7] | \$43,000 | \$2,700 |
| Annual salary for a resident (2006) [8, 9] | \$50,000 | \$2,500 |

Once aware of this information, Dr. Wilson faces a difficult decision. In rural Ghana there is often only one doctor for every 40,000 people, and Dr. Wilson may think that removing the only doctor in the area is inequitable. Many of the health problems in Ghana have been shown to be directly related to a breakdown in the primary care or public health systems or a systematic problem in both. These problems are exacerbated by a lack of adequately trained physicians. Writing recently in the *New England Journal of Medicine*, Rosenfeld said of the high maternal mortality rate in sub-Saharan Africa, “deaths are only part of the tragedy. For every woman who dies at least thirty others are injured. Many of these injuries are disabling and, in the case of obstetrical fistula, they are socially devastating” [10]. This dire medical portrait may motivate Dr. Wilson to contemplate where the greater need for this doctor exists—in Ghana or in her community-based program in North Dakota.

The Ghanaian doctor also has much to ponder before accepting the offer of a residency in the U.S. On the one hand, she would be cognisant that her undergraduate training in Ghana cost the government a considerable amount, and she might believe that she owes it to her country to use her skills locally. On the other hand, she may feel that the 3 years she has spent working as an unspecialised medical officer in a rural hospital has repaid that debt. Almost certainly, that work was professionally difficult. Most likely she was the only medical officer on call in the hospital which, while it gave her the experience of caring for a population of more than a half-million people, could also have been daunting and overwhelming.

The financial incentive Dr. Wilson offers will be hard for the student to resist because the salary will be many times greater than what she currently earns. It will provide her with an opportunity to repay her family who have also invested in her education. If she decides to take the residency position she may repatriate a percentage of her salary each month to support her family. In a report published by the U.K. government in 2004, it was estimated that Ghanaians living abroad remitted \$400 million (U.S.) annually, a substantial proportion of Ghana’s foreign exchange [11].

We can also imagine the student's wanting to work in the United States (or another location abroad) because of the lack of health care facilities and training available to her at home. A Nigerian doctor recently explained his desire to specialise abroad in these terms:

Today very few of my classmates remain in Nigeria. Most have gone to places like the US or the UK or Trinidad and Tobago. Anywhere but Nigeria. Here in Nigeria, everything is dilapidated. We don't have the basic infrastructure to do the job. Everyone wants to get out. All the time I am here, I am making plans to get out. It's not just about money. I want to specialise, I want to do medical research, I want proper training and I want to enhance my knowledge. I can't get any of that in Nigeria [12].

Articles about the American health care system published in Western medical journals are often sent to foreign hospitals by charity groups. Even the articles that are several years old confirm that the scope of medical practice in the U.S. is much broader and more advanced than what is available in Ghana.

At bottom, Dr. Wilson and the Ghanaian doctor are facing the same professional dilemma; namely, what is the doctors' responsibility to a wider society? Is medicine a moral enterprise or an occupation like any other? If medicine is inherently moral, it could be argued that the Ghanaian doctor should not be recruited away from the society that needs her services more.

Dr. Wilson and the Ghanaian doctor may wish to consider a creative solution. Could they arrange an exchange in which both doctors and technology could be shared between the two health systems? Opportunities for doctors from developed countries to spend a short period of their training in a developing country are increasing, and it seems that many find this popular elective to be a valuable experience. Both institutions may wish to examine ways of funding such exchanges. One subject that raises some concerns is the appropriateness of the training that the Ghanaian doctor would receive in the U.S. The Ghanaian system functions at a different level than that in developed countries. It would not surprise me to learn that physicians who return to developing countries following a period of training abroad find that they are unable to put into practice much of what they have learned. This would explain why doctors—even those with high ideals—remain in or return to the developed country where they received their graduate training.

As in so many ethical and moral dilemmas, there are no clearly right or wrong answers for Dr. Wilson and the Ghanaian physician. Very often the solution to such problems lies in a compromise. By setting up an exchange plan, Dr. Wilson and the Ghanaian physician could produce a win-win solution to what is a complex moral dilemma.

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Virtual Mentor

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CLINICAL CASE

Miracle Surgery for Foreign Patients

Commentary by Reza Yassari, MD, MS

Dr. Jackson is an accomplished neurosurgeon at a large academic health center. He is approached by a colleague on behalf of a patient who recently came to the United States from Guatemala with her twin sons who are joined at the head. Image studies are encouraging about the survival of both infants, but they will need intensive hospital care for many months after the surgery. Further predictions about their long-term functioning and capabilities cannot be made at present.

Dr. Jackson's department is interested in performing this ground-breaking surgery. He and other surgeons have offered to perform the surgery without pay, and the hospital has agreed to provide post-operative inpatient care at no expense to the family. Funding for care after the twins leave the ICU and for outpatient follow-up has not been secured, and the family cannot pay for it privately. In Dr. Jackson's judgment, the sooner the surgery is done the better the boys' chances for recovery. He must decide whether to proceed with the initial surgery even though long-term care is not assured.

Commentary

This case poses two fundamental questions: First, should the family's ability to afford long-term—perhaps even life-long—care for these children play a role in the physician's medical decision making about whether to perform the surgery? And second, would the answer change depending on the patient's immigration status or country of origin?

In considering question one, it is helpful to know that patients with devastating neurological diseases are treated every day. Many need extensive post-operative care and medical management associated with a high rate of complications. A great number have some degree of neurological sequelae that require long-term care. The physician's role is to be actively engaged in helping the patient's family understand the disease, the treatment options, and the prognosis, while preparing caregivers for the possible outcomes and conveying realistic expectations for long-term care. The role of the medical staff is to act as patient advocates and facilitate the best possible outcome. Securing funding, however, can be a more difficult, but related, task. Unfortunately, under the U.S. health financing system, few people have the financial means to guarantee payment for long-term care, and most would face dire financial hardships in the event of a devastating medical problem.

Even when a patient has adequate insurance at the time of an acute medical problem, there is no guarantee that coverage will be available perpetually; financial situations change, insurance can be revoked or terminated, and caretakers who give up their jobs to care for sick parents, children, or spouses lose their benefits. Is it then acceptable to consider the patient's economic situation—even partly—as a factor in the medical decision making process? Should we refuse to do surgery because the patient will probably not be able to afford this extensive care? Would it be permissible to refuse performing surgery with only a 1 percent risk of a potentially devastating outcome, unless the patient could demonstrate secured funding for long-term care? What about a 20 percent complication rate? In other words, at what point does a surgeon decide that the probability of unaffordable or financially crippling follow-up care overrides the benefit that the surgery is likely to confer, and is there such a point at all?

Most people are not able to comprehend immediately and fully the emotional and economic consequences of a devastating illness. It is the duty of physicians and the medical staff to support and guide the family toward understanding the ramifications and then the possible solutions to the expected implications of the disease. This process should include discussion of the likelihood of long-term care and its cost. The physician has an ethical duty to do his best to create solutions for both the immediate and long term. That said, does the physician undermine his commitment to nonmaleficence if he proceeds with surgery without securing funding for all the steps of the surgery and postoperative care? Some might argue that if no funds are available for future care, the surgery sets the patients on a path that could harm them (and their family), because with suboptimal care, the outcome will be suboptimal. I would argue that, if the immediate medical or surgical intervention helps the patient, refraining from that treatment because of economic reason poses a far graver violation of the physician's duty to do no harm.

Financial and economic considerations should not be an obstacle to immediate medical treatment for an acute problem, be it an appendectomy or the separation of craniopagus. Likewise, the medical decision-making process for the long-term care of the patient has to be done outside the constraints of the patient's immediate financial restrictions. Not all solutions will be immediately available, nor should it be a requirement that they be. Sometimes solutions only become perceivable during the search.

The situation of the conjoined twins is better than that of the average uninsured patient; at least the immediate costs are covered. The funding for the perioperative and immediate postoperative care is available, and the surgical team has donated their services. The surgeon, Dr. Jackson, believes that delaying the surgery puts the twins at a higher risk. Some would argue, then, that delaying the surgery because funding for long-term care has not been secured is negligent.

Is the Offer Purely Charitable?

There is an aspect of this case that is hinted at in the scenario that must be examined. The donation of time and resources by the hospital and the surgical team may seem purely altruistic at first glance, but the procedure is likely to attract a lot of media attention. The institution will be in the national and maybe international news, the doctors will give press conferences, and all of their colleagues will be waiting to read the case report when it is published. The reputations of both the hospital and the surgeon could benefit. Might these factors influence the decision to operate and, if they do, is that ethically acceptable? The ideal way to avoid this potential conflict of interest is to maintain anonymity. After all, the purest form of philanthropy is anonymous charity. But the number of personnel involved and the accessibility to media in the electronic age make the ideal impossible to achieve.

If one were to accept the fact of media attention, it might become a solution for securing long-term care. The hospital could forgo all publicity except for that which is of direct benefit to the patient and use the media to help secure the necessary funding. In high profile cases, physicians are under intense scrutiny, and duty to their patient's well-being must be adhered to even more stringently, although one hopes that a high standard of personal responsibility is always set by the physician, independent of whether the case attracts media attention or not.

My answer, then, to the first question is that, where surgery can benefit the patient, a surgeon need not wait for all funding to be in place, although he or she has a duty to inform the patient of the likely need for follow-up care and its costs and to help the care team assist the patient in securing the funds.

Treating Non-Citizens

The second question remains: do physicians have the same responsibilities when treating foreign nationals without immigration status in the U.S. or people traveling to the U.S. for medical care? Should these "medical tourists" be required to provide proof of sufficient medical coverage before undergoing treatment? Foreigners who would like to study in the U.S., for example, have to document secured funding for their studies when applying to universities and for immigration purposes. The U.S. health care system has a difficult time providing adequate services to a large portion of its own population. Is it permissible, then, to expend our limited resources on those who are not U.S. citizens and live in other countries when they cannot afford their own care? Should the hospital concentrate on allocating its resources to American citizens, the population for which they are most responsible? Would it be ethically acceptable to limit care to foreign nationals with insurance or otherwise secured funding? Who is responsible for the cost of the postoperative and long-term care for those without secure funding, in the U.S. and when they return to their country of origin?

If the principles of beneficence and nonmaleficence have any merit, then, in accordance with Kant's categorical imperative, they should be "universal laws," i.e., they should apply regardless of gender, race, culture, political affiliation, and legal

status. The U.S. health system cannot and should not do everything for everyone, but the limitations should be established within the frameworks of U.S. legal structures and be consistent with the principle of distributive justice. The resources of the hospital are valuable, and the decision to offer major surgery without compensation must be made with a clear understanding of the economic circumstances of the institution and full consent of the administrative and medical staff. Once there has been a commitment to care for a patients, the institution should seek to provide the best long-term and follow-up care for the patients, especially if it cannot be obtained in their home country. In the case of the twins and other high-profile cases, there may be secondary gain for the hospital and the physician. Hence the hospital may have a moral obligation to allow patients to use its infrastructures to secure long-term care while the patients are in the U.S.

Nevertheless, the twins will eventually return to Guatemala, to their little rural village and to an underdeveloped health care system. Who will provide for their future care? If one or both of the twins had a shunt placed to treat drainage of the cerebrospinal fluid, who will assist them if there is a malfunction? The absence of infrastructure in countries like Guatemala where basic sanitary and health care provisions are nonexistent is the real problem here. Medical missions abroad by U.S. physicians put band-aids on this global disparity, but do not address the underlying causes of the infrastructure inadequacy.

Ultimately, the answer is the development of educational programs for the training of physicians, nurses, and medical personnel in countries that currently lack adequate health system infrastructures. One could train people in the U.S. with the commitment that they will return to their home countries. Another approach is to develop educational programs that are mutually beneficial for students and trainees alike. The Virtue Foundation, in collaboration with its partners, has developed a program to train local doctors and nurses in some of the least developed nations of the world, such as Burundi. Integrating a rotation of physicians and other health care workers and support staff to continually teach the local personnel during their stay helps build the necessary infrastructure and knowledge that creates sustainable development. This arrangement allows the visiting physicians from the U.S. and other developed nations to gain experience abroad while teaching and assisting local physicians. With continual coverage throughout the year provided by these rotations, a “mini-residency program” is created that allows the local physicians and nurses to learn and adapt their new knowledge to the realities on the ground and perpetuate this replicable and scaleable model.

These longer-term solutions do not help our twins, but I do believe that Dr. Jackson should not limit their care because they are not U.S. citizens. All possible venues should be explored to use the existing resources in Guatemala, as inadequate as they may be, to give the twins the best possible long-term care, including a possible return to the U.S. for follow-up if necessary.

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MEDICAL EDUCATION

Should All U.S. Physicians Speak Spanish?

Katherine E. Clarridge, Ernest A. Fischer, Andrea R. Quintana, and
James M. Wagner, MD

Patients and physicians increasingly find they speak different languages. This is due largely to the growing number of people with limited English proficiency immigrating to the United States and seeking care from physicians, most of whom speak only English. Inadequate communication contributes heavily to disparities in health care quality, a point highlighted in the Institute of Medicine's (IOM's) 2002 "Unequal Treatment" report [1]. It has been found that 64 percent of U.S. patients with limited English speak Spanish [2], and a case could be made that all physicians in this country should learn Spanish to minimize the disparity.

Language concordance between patient and physician has been shown to reduce overall cost to the patient and minimize costs to the hospital [3]. In that light, we could look upon physicians' learning of Spanish as a type of medical intervention. As with any sound medical tool, it is designed to positively affect as many patients as possible with minimal investment of resources.

The Burden of Learning a New Language

Why should the burden of learning a new language fall to the physician rather than the patient? Just as it would help diabetics to control their blood sugar and overweight persons to lose weight, it would behoove foreign-language-speaking patients to learn English. We want all these patients to make the suggested lifestyle changes. The charge of a physician, however, is to treat disease given the reality of the patient, and for many patients that reality is lack of proficiency in English.

There are other reasons why having physicians learn a new language is more practical. There are fewer physicians than Spanish-speaking patients. According to the 2000 Census and the Bureau of Labor Statistics, the ratio of physicians to patients who speak English less than "very well" is approximately 22:1 [4-5]. In other words, fewer individuals would be responsible for learning a new language if we placed that responsibility on physicians. Second, physicians have better access to language programs and resources, including their universities or medical training facilities. Finally, physicians have a long preprofessional training period during which to learn another language, and many will have learned Spanish prior to studying medicine.

The Ethical Impetus

The ethical case for all doctors being proficient in Spanish is based on the idea that all patients should have control of their health care decisions. A recent article by Volandes and Paasche-Orlow in the *American Journal of Bioethics* maintains that the “autonomy of healthcare users with limited literacy is thwarted if the [consent] forms intended to preserve their individual autonomy are inaccessible” [6]. The autonomy of patients with limited English is similarly threatened: the lack of true informed consent has been confirmed in at least one study, which found that hospitalized patients with limited English were less likely than their English-speaking peers to have documented informed consent for common invasive procedures, even when given access to professional interpreters [7].

Volandes and Paasche-Orlow further cite the implications of language differences for the just distribution of health care services: “In Rawls’ framework, decision-makers, who are behind a veil of ignorance and unaware of their positions in a society, would design a system in which the position of the least well-off is maximized regardless of the potentially negative impact on those better off” [6]. Many patients with limited English are, like English speakers with limited literacy, among the “least well-off,” yet no one could argue that the health care system is designed with them in mind. One small step to closing this gap would be introducing Spanish, when appropriate, as a required part of the health care delivery system; it would largely benefit the least well-off patients and meet this standard of justice.

Medical Professionalism

Medical professionalism requires that the physician act as an advocate for the patient. In the most recent and widely accepted definition of medical professionalism—“The Physician Charter”—published in the *Annals of Internal Medicine*, two of the three fundamental principles—patient welfare and social justice—apply to patients with low English skills or literacy [8]. The IOM report suggests a rampant lack of social justice for patients with limited English language skills, and one of these principles is often compromised unless professional interpretation is provided [9]. For example, patients being seen by health professionals who speak only English were more likely to report less understanding of their diagnoses and treatment plans than patients with similarly limited English proficiency who were seen in the company of a Spanish-speaking caregiver [10].

Possible Solutions

We do not believe that the above arguments mandate the teaching of medical Spanish to all physicians; rather, we think they mandate that medical Spanish be a part of the standard of care. The distinction is an important one.

In reality, teaching *all* medical students Spanish would be nearly impossible and could actually prove detrimental to care. While bilingual doctors do have a positive impact on quality of care for patients who speak limited English [9], this outcome assumes that both parties are fluent in the same language. The addition of medical Spanish to the already overstuffed curriculum would probably not result in language

proficiency adequate for better care. Medical students with substandard Spanish skills might be recruited to serve as ad hoc interpreters for their health care teams, potentially compromising patient care and creating further confusion during the patient-physician interaction.

In the literature, an ad hoc interpreter is defined as any “untrained person who is called upon to interpret” [11]. The use of ad hoc interpreters was shown in a systematic review to have adverse effects on quality because the ad hoc interpreters in the study explained side effects of medication less frequently, distorted statements, and committed errors that could have clinical consequences [9].

Instead of teaching Spanish to all medical students, elective programs with incentives for enrollment should be made available to native Spanish-language speakers and those with extensive prior Spanish education. All medical students should, as part of the general curriculum, learn how to communicate properly with an interpreter who is a part of the interdisciplinary health care team.

The growing complexity of medicine has been the impetus for change from the model of the autonomous, solo practitioner to the interdisciplinary health care approach, in which patients receive care from a team trained in a variety of professional and nonprofessional disciplines. The value of the interdisciplinary model has been shown in several clinical settings [12-14], and integrating it into the existing medical school curriculum could start with building translation services into standardized patient stations. The experience and future plans of UT Southwestern offer an example of a practical approach to the challenge of caring for patients who have limited English skills.

An Example Curriculum

In 2005, 36 percent of Dallas County’s population identified themselves as Latinos [15], and many had limited ability to speak English. For reasons explored above, the needs of this large, growing segment of the population should be accommodated in the health care setting.

In response, medical students at the UT Southwestern Medical School initiated an extracurricular translator apprenticeship program (TAP) designed to increase the number of students who could serve as competent medical interpreters. The program enlisted fluent or native Spanish-speaking students and students of intermediate-to-high Spanish proficiency because these are the students who are most likely to be recruited as ad hoc interpreters.

The students translated components of the medical and physical exam, practiced interactions between “doctor” and “patient” (played by fluent or native speakers), expanded their medical vocabularies, and learned about dynamics of the patient-provider-interpreter relationship. Then each intermediate-to-high proficiency student was paired with a fluent mentor to volunteer as translators at a community clinic serving a Spanish-speaking population. TAP has increased the numbers of available

and proficient translators and has facilitated better communication between patients and health care workers.

Eighteen of the 21 students involved in TAP expressed interest in having extended opportunities to improve their oral communication, and 19 were receptive to participating in more mock clinics. The TAP curriculum is being shaped to become an important extracurricular resource in future years and, if proven efficacious, to be integrated as an elective at UT Southwestern.

Future Challenges

The many obstacles to adding cultural proficiency to an already dense medical school curriculum have blunted medical schools' responses to the growing needs of patients with limited English. The best and most recent survey of medical schools found that "most U.S. and Canadian medical schools provide inadequate instruction on cultural issues, especially the specific cultural aspects of large minority groups" [16]. Only 26 percent of the schools in that study, for example, taught about aspects of Latino culture that could affect health care.

We have a long way to go before we reach the goal of ensuring that patients with limited English receive the care they deserve on ethical, professional, and legal grounds. The heightened awareness among medical educators and researchers of this shortcoming in our health system gives us hope for continued progress towards giving *all* patients the best possible care.

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JOURNAL DISCUSSION

Use of Emergency Medicaid by Undocumented Immigrants

Anjana Lal

DuBard CA, Massing MW. Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *JAMA*. 2007;297(10):1085-1092.

The question of whether or not to provide health care for immigrants, especially those who are undocumented, has been hotly debated in the national arena in recent decades, but few studies have actually attempted to explore how members of this population use health care. In their *Journal of the American Medical Association* article, “Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants,” C. Annette DuBard and Mark Massing examined how Emergency Medicaid was used by recent, undocumented immigrants in North Carolina, a state that has experienced a surge in its immigrant population in the past few years [1]. The authors’ laudable goals are to “improve knowledge of the health care needs of this population and permit better identification of conditions that are preventable or treatable in the primary care setting, or amenable to other public health interventions” [2]. The authors hope their insights will “lead to more effective use of available resources and improved health care for this population” [2].

Methods and Results

DuBard and Massing chose to study expenditures related to Emergency Medicaid because, although federal law does not provide Medicaid coverage to those who are in the country unlawfully or to legal immigrants who have lived in the United States for less than 5 years, it does provide coverage in emergency situations to adults, children, pregnant women, families with dependent children, and elderly or disabled individuals who meet state income and residency requirements [3].

Using Emergency Medicaid claims data for almost 50,000 patients who received coverage between 2001 and 2004, the authors described the sociodemographic trends of health care spending, and the most frequent diagnoses were broken down by cost and frequency of hospitalization [2].

There were four main findings from this study. First, the authors found that patients receiving Emergency Medicaid were most likely to be between the ages of 18 and 40 (almost 90 percent), female (95 percent), pregnant (90 percent), undocumented immigrants (greater than 99 percent), and Hispanic (93 percent) [2]. Second, although North Carolina Emergency Medicaid spending rose by about 30 percent during the study’s time period, this amount “represented less than 1% of total North

Carolina Medicaid spending each year” [4]. Third, about 82 percent of 2004 Emergency Medicaid spending was related to pregnancy and childbirth [5]. Finally, although injury was the most common reason for hospitalization across all ages (not including pregnancy) when acute cerebrovascular disease, congestive heart failure, and acute myocardial infarction were grouped together, they accounted for more hospitalizations in the older age group [5].

DuBard and Massing conclude that “Emergency Medicaid is primarily filling 3 gaps in the health care needs of this population: child-birth related costs, emergency care of sudden-onset problems, and emergency care for severe complications of chronic disease” [6]. The authors go on to make several suggestions for change. First, they say that it may be more cost-effective to provide coverage for contraceptive and prenatal care, given the major toll that pregnancy and postpartum complications take on Emergency Medicare spending, and it is in everyone’s best economic interest that the children are born healthy, given that they are U.S. citizens and eligible for Medicaid. Second, the authors argue that, since major injuries rank second behind pregnancy as the cause of both hospitalization and Emergency Medicaid spending, injury-prevention education and interventions should be developed, especially in the areas of worker and motor vehicle safety. Finally, the authors note that the prominence of chronic renal failure, cerebrovascular disease, and heart disease reveals the need to identify risk factors for these diseases and suggests that case management of uninsured immigrants with chronic diseases may be a partial solution to this problem [7].

DuBard and Massing also note three potential obstacles to improving health care for immigrants in areas with new growth in this population sector. The first is the need for culturally and linguistically appropriate care that is readily accessible and affordable. Second, immigrants are “vulnerable to the local political climate and availability of funds during state budget crises” because the bulk of the money for covering them is allocated at the state level [7]. Finally, hospitals continue to have a rising number of unsustainable, uncompensated care cases because of federal or state nonpayment, which threatens funding for prenatal and preventive care.

In summary, DuBard and Massing have used the findings from the analysis of the 2001 to 2004 expenditures under the North Carolina Emergency Medicaid program to highlight some thought-provoking and important immigrant health care challenges. Their work has brought us one step closer to their stated goal of better understanding the health care needs of recent and undocumented immigrants and identifying areas for effective public health interventions. Unfortunately, their study is narrow in scope, as it looks at only emergency services provided under the umbrella of Emergency Medicaid to immigrants whose status was determined by social services workers in one state in the nation. To explore these issues more deeply, more studies on a broader scale are needed.

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CLINICAL PEARL

Cysticercosis: A Zebra in the Neighborhood

Jason Yeh and Jeanne S. Sheffield, MD

One of medicine's most quoted aphorisms is, "when you hear hoofbeats, don't look for zebras." This, of course, is a pithy reminder to physicians that they should be wary when tempted to diagnose a rare condition: it is far more likely to be a common disease than an uncommon one. But as medicine becomes, like trade and travel, more globalized, the proverbial zebra is much less rare.

Between 2000 and 2007, the immigrant population of the U.S. increased by more than 24 percent, with an average of 1.04 million immigrants per year [1]. Estimates project that by the year 2050, whites will be the minority, and 1 in 5 Americans will be foreign-born [2]. The growth of the immigrant population poses diagnostic challenges for physicians in all fields. The increasing immigrant population and ever-broadening scope of pathology force us to ask just how proficient each physician should become in recognizing medical zebras.

It is unrealistic to expect all physicians to become experts in recognizing and treating the rarest of diseases; doing so is an ineffective way to spend one's career. The medical community as a whole has the responsibility to educate physicians about changes in medicine. Compared to the physician in solo practice, large medical institutions have better vantage points from which to recognize gradual shifts in global pathology. Medical communities can shed light on these thematic changes through journal articles and conference presentations and can encourage physicians to apply new information in novel ways.

The compartmentalization of medical knowledge into specialties has also improved physician competence by allowing doctors to maintain greater expertise within their own fields, so that each has to be aware of a limited number of uncommon diseases.

At the same time, physicians have a duty to expand their medical knowledge so that they can anticipate the needs of the unnamed and unknown future patient. One way for professionals to approach this goal is to study the culture and characteristics of their particular patient populations.

Knowing One's Patients

Knowing the characteristics of a population—age, race, cultural traditions, and where they live—offers physicians clues about which medical conditions (common and uncommon) they are more likely to see. A thorough understanding of

demographic themes can guide one's study of medicine and allow each physician to make decisions about the specific type of medical knowledge he or she needs beyond what is required for board certification. A physician who understands the complexities of his or her patient population is more likely to recognize an extraordinary medical condition when it appears.

Cysticercosis

Cysticercosis is one example of a disease that has become more prevalent in certain areas of the U.S. as a result of recent population changes. As the Hispanic population grows in Texas, we at Parkland Hospital are caring for more people infected with cysticercosis.

The tapeworm that causes cysticercosis is endemic to many parts of the world including China, Southeast Asia, India, sub-Saharan Africa, and Latin America. Some studies suggest that the prevalence of cysticercosis in Mexico is between 3.1 and 3.9 percent [3]. Other studies have found the seroprevalence in areas of Guatemala, Bolivia, and Peru as high as 20 percent in humans, and 37 percent in pigs [4, 5]. It is crucial for the physician who deals with a substantial Hispanic or Southeast Asian population to be familiar with the symptoms and treatment of cysticercosis.

The infection starts in the gastrointestinal tract as a result of swallowed foodstuffs contaminated with the larva or eggs of the pork tapeworm, *Taenia solium*. Once in the gastrointestinal tract, the egg hatches and is able to penetrate the intestinal wall and spread to the bloodstream where it can consequently infect the skin, heart, eyes, skeletal muscle, and brain tissue. When the infection reaches the central nervous system, it is called neurocysticercosis. The immunomodulatory nature of the parasite allows live cysts to persist for up to 5 years before dying or causing symptoms in humans.

Symptoms of cysticercosis infection are generally mild, and infections of the muscle and skin are largely asymptomatic. In the eye, cysticercosis can cause blurry vision and, in more severe cases, swelling and detachment of the retina. Symptoms of brain infection depend on the location and size of the infection. Headaches and seizures are common, but other symptoms include confusion, personality changes, and disequilibrium.

Diagnosing neurocysticercosis is often difficult; lab tests are frequently inaccurate and neuroimaging findings are varied. Still, both CT and MRI are useful for diagnosis and also for monitoring treatment outcomes. The choice of therapy depends on many factors and typically combines the use of antiparasitic drugs, surgery, and medication for symptom control. Both albendazole and praziquantel are effective in treating parenchymal neurocysticercosis. At Parkland we use albendazole as the standard treatment because it costs less and has stronger cysticidal activity than praziquantel [6].

Neurocysticercosis can cause seizures in pregnant women. There are even case reports of neurocysticercosis having been confused with eclampsia [7, 8]. Distinguishing between these conditions is tricky at best, and the complexity of each illustrates why identifying the populational themes of our patients is important.

Alternatively, presumptive knowledge about a population can complicate the diagnostic process. Medical literature reports an unlikely outbreak of neurocysticercosis in an orthodox Jewish population from New York City [9]. Among this group of people with no history of pork consumption, the source of the infection was not dietary. Instead, the infection was found to have resulted from improper sanitation practices by Hispanic laborers in the community. As this story illustrates, physicians must avoid the rigid application of cultural stereotypes to a population. An overreliance on such assumptions endangers patient safety and risks the breakdown of what should be an objective diagnostic process.

Final Thoughts

Understanding the cultural characteristics of a specific population does not in itself guarantee better patient care. It is merely one method of realistically approaching the ideal of becoming a fully knowledgeable and capable physician. Achieving our goals as healers and physicians demands that each of us absorb and react to many things, from current events to subtle changes in local demographics. It is an endless pursuit, but ignoring the medical needs of a diversifying patient population is easily a violation of our promise to first, do no harm.

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POLICY FORUM

Reimbursement of Medical Care for Immigrants

Laura D. Hermer, JD, LLM

Physicians who serve large immigrant populations know that it can often be difficult to collect reimbursement for care of patients who are not citizens, due to their economic status, lack of private insurance, or ineligibility for public health coverage. Immigrants generally use substantially fewer health services than the native-born population, but, of course, still need medical care [1]. How can a physician get paid for providing services to this often poor and uninsured population?

There are two main reasons why reimbursement can be difficult. First, some immigrants have less income and less access to private health insurance than native-born Americans. Second, federal law places many restrictions on the eligibility of uninsured immigrants for federally funded programs.

With respect to the first point, fully 45 percent of unnaturalized U.S. residents are uninsured [2]. This problem is multifactorial. Immigrants to the United States tend to be either highly educated (often science PhDs) or poorly educated [3]. Those in the first group are often better paid and more likely to be insured than the native-born population [3], but they are far outnumbered by immigrants who fall into the latter group [3]. While less-educated immigrants are as likely or more likely than native-born Americans to work, they disproportionately work in low-paying jobs in the service sector that usually don't provide health benefits [4]. Accordingly, foreign-born workers, taken as a whole, are significantly less likely to have employer-sponsored private health insurance [5, 6]. And because they also have lower incomes, they're less able to pay for care out-of-pocket.

With respect to the second point, federal law prohibits many immigrants from participating in programs such as the State Children's Health Insurance Program (SCHIP) and other publicly funded programs. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) bars *legal* immigrants—other than a few limited groups such as refugees and asylees—from participating in public benefits including Medicaid for the first 5 years of their residence in the United States [7]. It prohibits sponsored immigrants from participation for at least twice as long, and it excludes undocumented immigrants altogether from participation in nearly all federally funded benefits [8, 9].

There are a handful of exceptions to these rules. PRWORA allows both federal and state funds to be used to provide immunizations and testing and treatment for communicable diseases [10]—services that are often made available by departments

of public health. It also allows federal and state funds to be used for treatment of emergency medical conditions that do not involve organ transplants [11]. This provision is commonly called “Emergency Medicaid.” Congress enacted Emergency Medicaid in part because another federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), mandates that most hospitals with emergency departments stabilize any patient who presents to the emergency department in active labor or with an immediately dangerous medical condition, regardless of the patient’s ability to pay. It would be particularly problematic if federal law then prohibited emergency medical providers from obtaining reimbursement for that care, merely because of the immigration status of their patient. Finally, under SCHIP regulations, states can receive federal matching funds for prenatal care provided to pregnant women, regardless of the women’s immigration status [12].

PRWORA allows states to choose whether or not to fund benefits for legal immigrants who haven’t yet met federal requirements for assistance and for undocumented immigrants. But states that choose to do so must pay out of their own “pockets.” Twenty-three states presently offer some medical benefits to legal immigrants who are temporarily excluded from federal assistance [13]. If a state or local government wishes to fund benefits for undocumented immigrants, it can only do so if it enacted a law after August 22, 1996 that expressly provides for such eligibility [14].

Accessing public funds for physician services to immigrants who are not part of federal programs can be complex and time consuming. Undocumented immigrants who otherwise *meet Medicaid eligibility requirements* in their state of residence (e.g., on the basis of income, or because they have children, or because they are disabled) and who present with an emergency medical condition may qualify for Emergency Medicaid [15]. Those who qualify for state or locally funded medical assistance programs must apply through the regular channels. Some counties in Texas, for example, have chosen to use their own monies to provide health care to their indigent residents, regardless of immigration status [16]. Physicians are then reimbursed according to the relevant state or local program rules.

Obtaining public funds for physician services to immigrants who *do not* otherwise qualify for assistance is more difficult. To obtain reimbursement for services rendered through 2008, physicians must apply through section 1011 of the Medicare Modernization Act, under which the physician must first establish that no third-party funding other than Emergency Medicaid exists for the specific care in question or that, if it does, the physician has extracted all possible reimbursement from those third parties prior to seeking section 1011 funding [17]. If a balance remains, then Medicare providers must first submit a form CMS-10115 to Trailblazer Health Enterprises, L.L.C., which administers the program for the federal government, within 30 days of the close of the federal fiscal quarter following the quarter for which the reimbursement is being sought [18]. Physicians who are not already Medicare providers must either enroll or file an additional form [18] and then submit Form CMS 10130A 05/05 with supporting documentation to TrailBlazer [19].

The supporting information and documentation are not easy to obtain. Physicians must first determine whether the patient is eligible for or enrolled in Medicaid or Emergency Medicaid [20]. For those patients who are not, physicians must state the reason for the lack of enrollment [20]. They must then determine whether the patient is a foreign national with one of two types of entrance documents [20]. If not, then they must establish that the patient was born in a foreign country and provide one of several forms of supporting documentation [20].

In sum, obtaining reimbursement for care provided to many immigrants who lack private health insurance and cannot afford to pay for their care out-of-pocket can be difficult, and, except in emergency situations, often may not be possible under present law.

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MEDICINE AND SOCIETY

Immigrants and Organ Sharing: A One-Way Street

Charu Gupta

Organs for transplant represent the extreme example of scarce resources in high demand. Because organ allocation decisions determine who lives and who dies, accusations of unethical transplant distribution practices raise public concern and directly impact organ donation rates. In 1984, the National Organ Transplantation Act defined organs as a “scarce public resource,” the distribution of which should be governed “by criteria based on need, effectiveness, and fairness that are publicly stated and publicly defended” [1]. This article looks at how current transplantation guidelines sidestep the question of whether immigrants can receive organs. Do the guidelines meet various standards for justice and ethical treatment of illegal immigrants? If not, what is the possible impact of having unjust organ allocation policies?

Designation of Immigration Status

An individual granted permission by the U.S. government to enter the country on a temporary basis for purposes of tourism, business, education, medical care, or temporary employment is known as a *non-resident alien* (NRA). Another citizenship status designation is *resident alien*, that is, a person who is granted lawful permanent residence or asylee status, is admitted as a refugee or as a non-immigrant for a temporary stay in the United States, or is eligible for health care entitlement funds from state or federal government sources [2]. Lastly, the classification *illegal alien* or *unauthorized resident* is assigned to all foreign-born persons who enter the United States without inspection or are admitted temporarily and stay past the date they were required to leave [3].

The UNOS 5 Percent Rule

There are no written regulations addressing the receipt of organs by resident or illegal aliens at this time. There is regulation, however, regarding non-resident aliens. Member transplant centers where more than 5 percent of organ donation recipients are non-resident aliens are subject to review according to current UNOS (United Network of Organ Sharing) policy. UNOS is the federally appointed agent that coordinates all aspects of organ donation, from placing patients on the waiting list to allocating organs. In all likelihood, this policy was established to prevent well-connected foreign citizens from coming to the U.S. for the sole purpose of receiving organs through expert transplant surgery and care. The UNOS concern over this matter seems misplaced, however; the number of non-resident alien organ recipients from 1988 to 2007 was only 3,777 of 414,901 total recipients—less than 1 percent of all transplants [4]. Thus, it would seem that NRAs’ receipt of organs is not

significant, and the implications of the 5 percent rule cause questions and concern [5].

The Evidence about Immigrants and Organ Transplantation

Looking at heart transplantation, King and co-authors found that, at the time of donation, 25 percent of all organ donors did not have insurance or the private funds to pay for the surgery and care, and therefore would not have been eligible to receive an organ had they needed one [6]. This data applies to U.S. citizens and noncitizens alike. As King et al. explain in a *Journal of the American College of Cardiology* article, a system that allows individuals to donate to a pool of resources that they cannot draw from is inherently flawed [6].

Though there is no legislation that prevents illegal immigrants from obtaining transplants in the United States, lack of insurance coverage accomplishes that end [7, 8]. It is this sort of indirect exclusion that leads to misunderstanding and distrust of the system.

No comprehensive data on citizenship status of organ donors is available from procurement organizations, but there is detailed information available about the citizenship status of those awaiting transplant and those receiving organs. From 1988 to 2007 only 2,599 of the 414,901 organ transplants were received by individuals of unknown or unreported citizenship, a mere 0.63 percent [4]. A compilation of volunteered citizenship information from deceased donors collected by UNOS and the Organ Procurement and Transplantation Network (OPTN) revealed that 593 donors were of unknown citizenship and 7,670 donors were of unreported citizenship status, which accounted for a total of 2.5 percent of all organ donations from 1988 to 2007. This number (7,670) offers an approximate number of organ donations from those of unknown immigrant status and provides reason to believe that more organs are obtained from illegal immigrants than are received by this same group.

Despite evidence that immigrants donate more organs than they receive, articles in the media sensationalize a few instances in which illegal immigrants have received organs [9-11]. Will this biased portrayal, coupled with a general lack of access to organs, lead to fewer individuals donating a resource that is already in high demand and low supply? Moreover, how can we justify allowing illegal immigrants to donate, but not receive, organs?

The Justice Argument

Justice is the basis for our political and judicial systems, though the practical application of being “just, impartial or fair” [12] is not often discussed. John Rawls proposed that justice is reflected in standards set by people who act as though they were unaware of their own social standing [13]. People designing policy from behind this “veil of ignorance,” as he calls it, act without self-regarding bias.

When Rawls’s theory of justice is applied to organ transplantation, the key question to ask is, if individuals were unaware of their own citizenship status and their

possible future need for organ transplantation, would they create a system in which an individual may donate to the organ pool but will most likely be unable to draw from it? Even those altruistic individuals who would donate an organ with no expectation of reciprocity would be unlikely to design a system in which this one-way participation existed. More importantly, is it just to have no policy whatsoever on illegal immigrants' eligibility for organ receipt when this lack fosters distrust of the system and impacts donation rates? Rawls's standard of justice is not met by the current UNOS policy. Are there other frameworks for moral behavior that are satisfied by the current policy?

The Social Contract Argument

As Hobbes explains, when individuals enter into a social contract, they forfeit certain rights and entitlements in return for peace and security within the community. Illegal immigrants have failed to abide by the laws of the United States and therefore are not prima facie participants in the social contract that ensures the rights of citizens. It could be argued, however, that a decision to admit an individual into the health care system as a donor should entail admitting that person into the community. Moreover, a failure to enact legislation on the matter neglects the society's obligation to create laws that make the terms of its social contract known to the whole community. Because there are worries about illegal aliens receiving scarce organs, society has an obligation to address the situation legislatively to maintain trust and cohesiveness within the society.

The Utilitarianism Argument

John Stuart Mill believed that a decision or action is judged as ethical or unethical by its outcomes rather than by its intentions. His doctrine of utilitarianism seeks the best outcome for the greatest number of people. This philosophy can be applied to organ allocation. Using the OPTN data cited earlier, illegal immigrants have contributed as much as 2.5 percent of all donations between 1988 and 2007, but have only received 0.63 percent of the organs [4]. Allowing illegal immigrants to donate and not receive augments the number of organs available to UNOS. On the utilitarian argument then, current policy produces the greatest good for the entire U.S. population, increasing the absolute numbers of organs donated. Unfortunately it fails to adequately address public concerns about the receipt of organs by illegal immigrants. This oversight impacts every immigrant awaiting transplantation and the entire health care system [14-17].

Conclusion

The perception of inequality in the organ allocation system makes all individuals less likely to donate and decreases the total number of organs available for transplant [18, 19]. Recent political debates about the "problem" of illegal immigration contribute to the emotional nature of the subject [20, 21]. Because so few people understand the allocation system's intricacies, the minuscule number of illegal aliens who receive organ transplants is held up as evidence of an unfair and corrupt system [15, 22-24]. The imperative to be both ethical and to augment donation rates makes it particularly challenging to design a transplant policy.

UNOS should develop a policy regarding illegal immigrants and transplantation so that the public will have greater confidence in the system. To best serve its mission, UNOS must re-evaluate public opinions regarding illegal immigrants' right to organ transplantation, acknowledge their impact on donation rates, and create a transparent policy regarding organ donation and receipt by illegal immigrants.

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HISTORY OF MEDICINE

Medical Examination of Immigrants at Ellis Island

Alison Bateman-House, MA, MPH, and Amy Fairchild, PhD, MPH

SARS, avian flu, bioterrorism: such threats to national security at the dawn of the 21st century have renewed anxieties about controlling disease at the nation's borders. Control of infectious agents also provided the impetus for immigrant medical inspections along the U.S. coasts in the late 19th century, but, in practice, it was the weeding out of chronic disease and disability that actually motivated public health officers on "the line" at Ellis Island and other U.S. immigration stations during the first 30 years of federal control of the nation's borders.

From the colonial era to the end of the 19th century, each state had borne responsibility for regulating immigration. But with the swelling numbers of immigrants in the 1880s and 1890s, an increasingly complex industrial economy, and mounting concern about the international spread of infectious diseases, the federal government took control of the nation's borders in 1891.

While admission decisions were made by the Immigration Service (IS), the law required medical inspection of immigrants by the United States Public Health Service (PHS). When a PHS medical officer formally diagnosed an immigrant with a disease or defect, throwing his or her admissibility into question, that individual was considered "medically certified." The law required the PHS to issue a medical certificate to those who suffered from a "loathsome or a dangerous contagious disease" [1]. Exclusion of those diagnosed with infectious diseases such as tuberculosis, venereal disease, trachoma, and favus was mandatory [2].

The PHS defined its mission rather narrowly—preventing the entrance of disease to the nation—but PHS officers interpreted their job more broadly. In their eyes, the goal was to prevent the entrance of undesirable people—those "who would not make good citizens" [3]. In the context of industrial-era America, immigrants who would wear out prematurely, requiring care and maintenance rather than supplying manpower, would not make "good" citizens. By 1903 the PHS had elaborated two major categories: "Class A" loathsome or dangerous contagious diseases and "Class B" diseases and conditions that would render an immigrant "likely to become a public charge." A subset of Class A conditions included mental conditions such as insanity and epilepsy.

Inspection on the "Line"

Medical examination centered on the “line,” which became shorthand for the set of techniques and procedures that medical officers used to examine thousands of immigrants quickly. Ellis Island—where roughly 70 percent of immigrants entered the United States—set the standard. After an arriving ship passed the quarantine inspection in New York Harbor, IS and PHS examiners boarded and examined all first- and second-class passengers as the ship proceeded up the harbor [4]. Upon docking, PHS officers transferred steerage or third-class passengers to Ellis Island by barge. Proceeding one after the other and lugging heavy baggage, prospective immigrants entered the station and moved slowly through a series of gated passageways resembling cattle pens. As they reached the end of the line, they slowly filed past one or more PHS officers who, at a glance, surveyed them for a variety of serious and minor diseases and conditions, finally turning back their eyelids with their fingers or a buttonhook to check for trachoma.

The diagnostic protocol emphasized the physician’s “gaze,” demonstrating the conviction that disease was written on the body. Dr. Albert Nute, while stationed in Boston, argued that “almost no grave organic disease can have a hold on an individual without stamping some evidence of its presence upon the appearance of the patient evident to the eye or hand of the trained observer” [5]. Exemplifying this notion, PHS regulations encouraged officers to place a chalk mark indicating the suspected disease or defect on the clothing of immigrants as they passed through the line: the letters “EX” on the lapel of a coat indicated that the individual should merely be further examined; the letter “C,” that the PHS officer suspected an eye condition; “S” indicated senility; and “X,” insanity [6].

In practice the PHS focused on those diseases and conditions that were transparent not only to highly experienced medical examiners but also to ordinary immigrants. Everyone could see that the elderly were turned aside for further inspection. Everyone could see a stooped back or a pregnant women traveling alone. Everyone could see the attention that was given to eyes and could thus gauge the importance of vision. And everyone could see that the young (except those too young to work), the muscular, and the robust were not turned aside.

Among the immigrants’ many apprehensions, the fear of rejection loomed foremost as they undertook passage from abroad. Prospective immigrants were forewarned of the medical examination through immigrant aid guides, steamship brochures, and the initial steamship company medical and quarantine examinations needed to secure passage to America. The PHS faced the immigrant as an adversary of sorts, for the PHS officers encountered “the shrewdest evasion and concealment” [7]. Aware of some of the conditions for which PHS officers searched, immigrants attempted to hide deformities of the arms and hands and to mask disease either physically or pharmacologically. They may not have been able to decipher the code that the PHS officers inscribed on their clothing, but the meaning of the writing was clear, as each marked individual was turned off the line, separated from friends, family, and fellow passengers, and directed into cage-like areas.

PHS officers immediately transferred those bearing chalk marks—typically 15 to 20 percent of arrivals—to either the physical or mental examination rooms. In the semi-private, single-sex physical examination rooms, immigrants partially disrobed and were examined with stethoscopes, thermometers, and eye charts. Sometimes height and weight were measured. Those suspected of having mental defects met with a PHS officer who asked them simple questions, such as their name or age, and gave them tests that required manipulation of cubes or puzzles or interpretation of events depicted in photographs. At the conclusion of the medical or mental examination, the immigrant would receive an OK card or a medical certificate.

Treatment for the Medically Certified

The PHS encouraged its officers to spend as much time as necessary to make accurate diagnoses of those “turned off the line” [8]. Some were confined, often for many months and sometimes years, in the isolation units in the southernmost wing of Ellis Island. Over time, the IS granted medical treatment to more and more immigrants, often justifying it on humanitarian grounds. Of those who applied for hospitalization after 1907—which included not only the medically certified but also those in need of treatment for a condition not covered under the immigration law, such as diarrhea—only 13 percent were denied treatment. Most did not apply for treatment of Class A conditions because, if the request was granted, the immigrant was required to pay all medical expenses. Immigrants granted hospital treatment at Ellis Island and other ports were often deported for inability to pay hospital expenses associated with Class A conditions [9].

Each medically certified individual received a hearing before an IS Board of Special Inquiry (BSI). Here, a panel of three IS officers questioned the immigrant about his or her occupation, finances, and family residing in the United States. In most instances the BSI overruled the medical certificate and did not reject the immigrant. From approximately 1906 to 1930, only a handful (1.6 percent) of the medically certified ever appealed an excluding decision; the odds of success for those launching an appeal were, at best, even [10]. Deportation could split up families; husbands and wives were often separated, and children could be deported without their parents (though a parent might decide to go back with a child).

The procedure was intimidating, and, indeed, between 1891 and 1930 nearly 80,000 immigrants were barred at the nation’s doors for diseases or defects. Yet the vast majority were allowed to enter the country—on average, fewer than 1 percent were ever turned back for medical reasons [11]. Of those who were denied entry, most were certified, not with “loathsome and dangerous contagious diseases,” but with conditions that limited their capacity to perform unskilled labor. Senility (old age), varicose veins, hernias, poor vision, and deformities of the limbs or spine were among the primary causes for exclusion. That so few of the more than 25 million arriving immigrants inspected by the PHS were excluded sets into bold relief the country’s almost insatiable industrial demand for cheap labor.

Origin-Related Differences in Inspection Procedures

Yet the demand for labor conformed to racial ideology. Influenced by scientific racism, the medical examination procedures differed for European, Latin American, and Asian immigrants. On the East Coast, the medical exam served more of a processing than exclusionary function for European immigrants. Non-Europeans faced more considerable medical obstacles to entry at the nation's Pacific Coast and Mexican border immigration stations. At Texas border stations, PHS medical inspectors stripped, showered, disinfected, searched for lice, and physically examined large groups of immigrants. All second- and third-class Asians immigrants arriving in San Francisco endured a physical exam similar to that conducted along the Mexican border in addition to routine laboratory testing for parasitic infection, which required detention at Angel Island for one or more days. Disease, health officials argued, was not so easily "read" in the "inscrutable" Asians, particularly the Chinese [12].

But while the demand for labor had assured that the flow of European immigrants to the U.S. would continue relatively unrestricted, in the years after World War I political elites successfully argued that the immigration of "undesirable" southern and eastern Europeans had to be cut off at the source. The Immigration Act of 1924 restricted immigration numerically and made national origin the basis for admission into the U.S. On the European front, the 1924 Act transferred immigrant medical inspection abroad and established the visa system: immigrants could no longer depart for the United States until an American consular office abroad had granted them visas. Medical inspection, which was now conducted along the lines of private medical exams, became a prerequisite for consular approval. One of the consequences of this shift was an increase in the percentage of immigrants denied entry on the basis of disease. Between 1926 and 1930, nearly 5 percent of those examined abroad were ultimately refused visas for medical reasons—a significant increase over the medical exclusion rate of less than 1 percent that had prevailed in the United States since 1891 [13]. As a result, the medical exam came to be viewed as more "scientific" and "objective."

Medical Screening Today

Today guidelines for the medical screening of aliens seeking permanent residency or certain categories of temporary residency in the United States are set by the Centers for Disease Control and Prevention's Division of Global Migration and Quarantine (DGMQ). Health-related grounds for barring admission to the United States include having a "communicable disease of public health significance," including chancroid, gonorrhea, HIV infection, infectious leprosy, infectious stage syphilis, and active tuberculosis [14].

Tuberculosis (TB) provides a vivid example of the complexities that continue to bedevil immigrant medical screening. After decades of decreasing incidence, a TB epidemic occurred in the United States during the late 1980s and early 1990s, reawakening the nation to the presence of what had been considered a conquered disease. Not surprisingly, links between TB and the foreign-born spurred calls for

more screening of immigrants, both before and after their arrival in the United States [15]. By law, an applicant for a visa or permanent residency who has TB is inadmissible only if the disease is clinically active, and waivers for prospective immigrants with active disease are available. Individuals with latent TB infection (LTBI) are not barred; however, such infections lead to active disease in about 5 percent of cases, and reactivation of latent TB is believed to account for the majority of active cases in immigrants [16]. The possibility that latent cases will reactivate has led immigration policy to address LTBI. In 2000, the Institute of Medicine (IOM) called for an overhaul of TB screening procedures for prospective immigrants in order to enable more accurate detection of LTBI [17]. The IOM also proposed that aliens with LTBI complete treatment for the infection before receiving a permanent residency card [18].

In keeping with the IOM's recommendations, the DGMQ's updated Technical Instructions for Tuberculosis Screening and Treatment for Panel Physicians, released in 2007, includes a new classification (Class B2 TB) for applicants with suspected LTBI [19]. No such classification was in the previous Technical Instructions (1991). Prospective immigrants with Class B2 TB are cleared for travel to the United States but are to be evaluated for LTBI once in the country [20]. Contemporary screening for TB is thus following the historical trajectory of immigrant medical screening: expanding its scope from infectious agents to chronic ones, but, importantly, not strictly for the purposes of excluding immigrants with disease.

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MEDICAL NARRATIVE

Asking for Care, not Favors: Experience of Immigrants in the U.S. Medical System

Kimberly Aparicio

To this day, I get nauseated at the sight of the green cap from a bottle of Pompeian olive oil. Home remedies were the closest I got to visiting a doctor's office while growing up in inner city Dallas with an extended and ever-present Guatemalan family. For stomach aches the diagnosis was always "un empacho"—chronic indigestion—and, as much as I dreaded getting sick, my grandmother would do all she could to soothe my pains. She would start by massaging me with warm oil, then thump on my stomach to hear if it sounded hollow or obstructed. She would then pick me up by the skin of my back only to finally wrap my stomach with a tight cloth called an "ombliguero." The final step was drinking three to four teaspoons of olive oil with salt (while pinching my nose) to cleanse the digestive system.

Not many can say that their earaches were "cured" by inserting a large paper funnel into the ear with the outer tip burning to "suck out all of the bad air" that was causing the pain. By these and similar methods I managed perfect attendance throughout elementary school without ever seeing a physician. Although they arouse considerable humor now, the process of diagnosing and curing my illnesses was serious business. As I, now a medical student, reflect on those times, I realize that my attitude toward medicine was shaped not by a one-time epiphany but by the constant reminder of how different my experiences were from those of most of my classmates.

For my immigrant family there was no insurance policy, nor any savings account for emergencies—calling 911 was seen as especially wasteful because the bill would come later with a charge for the ambulance ride. As my father always said, "There is no money to get sick." What I had instead were the herbs, teas, ointments, and wonder pills from pharmacies in Mexico and Guatemala that ostensibly cured everything. Prayer for health was always a central part of my family's approach to illness. When a family member was pregnant, Parkland Hospital would deliver the baby. I grew up thinking that physicians were the people you went to when all the home remedies failed. Even trusting a physician was hard for my family, especially for my Spanish-speaking relatives, who often could not talk directly to their doctors.

When seeing a doctor did become necessary for my grandmother, I was the family translator, with the responsibility of telling the doctor her symptoms, no matter how personal, awkward, or uncomfortable it became for both of us. This arrangement was usually met with frustration by the doctor, who often responded demeaningly, as

though just seeing us was doing us a favor. My grandmother never complained because she, too, felt as though he was doing her a favor. Practically, she had two options: She could either stop treatment and lose the progress she had made, or she could endure the scolding attitude from her physician because she had no where else to go.

After a certain point in her life, going to the doctor every couple of months became routine for my grandmother. When I couldn't accompany her, I would ask her what he had said about her illness, but she couldn't tell me because no one had translated for her. As she would later tell me, the trip was spent initialing some paperwork she didn't understand, sitting for hours in the waiting room, then seeing the doctor for 10 minutes only to be greeted with frustration, no explanation of her progress, and perhaps an identification bracelet as a souvenir. There was no end to this cycle, and each time it happened she missed work and spent money without learning anything about her health.

After being a long-time patient in the Parkland system and now a citizen of the United States, my grandmother recently opted to go to Guatemala for health care. She believed that doctors in the United States looked only at disease, processed her through the legality of the paperwork, and moved on. When she told me she was leaving for this reason, I couldn't help but think of the irony of it all. She rejected the health care system just as I, her trusted link to it, began the formal medical training that she had lost hope in.

Perhaps what I find most striking is that this isn't just a patient who is simply reluctant to follow doctor's orders. Rather it is a reflection of an ongoing lack of trust in the medical system on the part of the immigrant population, is fueled in part by a lack of compassion, the very essence of the patient-physician relationship. While many will point out that the reasons why many immigrants are less likely to comply with medical advice are their legal status, culture, lack of education, inability to pay, and language barriers, we seem to neglect the possibility that the problems may begin at the bedside.

My experience as a medical student, as an employee in a hospital, and as an immigrant patient have provided me with valuable insight into the inadequacies of health care delivery and availability in the U.S. Having viewed the medical profession from these various perspectives, I have seen the difference in attitude that workers have toward the immigrant patient. There is not exactly a reluctance to diagnose and treat them, but bedside manner seems to be an unnecessary amenity for patients who "don't know the language and shouldn't complain because at least they're being treated." We would like to think that this attitude isn't lurking in our hospitals, but we know it is. The problem is not whether the immigrant population is receiving proper medical treatment, but the way in which we are administering it. By simply adopting the idea that "we are doing them a favor," medical systems create a barrier far greater than that posed by language difference. As a furious patient once

told me after seeing her doctor, “I come here for help, not to be treated like a child for not knowing English.”

What will happen in a couple of months when my grandmother returns from Guatemala, feels ill again, and goes back for treatment after having received medication and possibly even a different diagnosis from other doctors? As both her granddaughter and a medical student, this concerns me. To be sure, the immigrant population has to learn to trust the American medical system, but that trust must be earned. For their part, as the demographics of their patient population continues to change, American physicians must recognize that earning trust takes more than cold competence. No, their patients from the South will not expect their stomachs to be massaged and wrapped in ombligueros. What they will expect is to be treated with dignity and respect.

Kimberly Aparicio is a first-year medical student at the University of Texas Southwestern Medical School and a 2006 graduate of Southern Methodist University, both in Dallas.

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OP-ED

Why We Should Care for the Undocumented

Ron J. Anderson, MD

Health care for undocumented workers and their families has become an emotionally charged subject in my community. As the leader of a tax-supported public health system in Texas, I often find myself defending the provision of hospital care for the undocumented—a position that is not only rooted in the health system's legislative mandate but is consistent with its founding vision and mission statement and with federal and state law. Moreover, I believe our approach is economically prudent because it applies public health interventions to a vulnerable population, thereby diminishing the burden of illness and preventing higher costs to the community.

It is my position that our health system should in no way allow the care of someone who is seriously ill or injured to be compromised because of citizenship status. We have a clear mandate to provide medical care to all who enter our health system.

One of the main reasons for the creation in 1953 of the health system I administer was that the Texas legislature recognized the need to care for indigent and needy persons in the community. The Texas legislature has never revised this law to limit care to only United States citizens. Instead, the law's mandate has been, and remains, to provide medical care to indigent persons residing in the community. All people, documented or not, are persons under the law.

Other laws reinforce our duty to provide medical care to all. In 1985, I played a major role in the passage of landmark legislation concerning indigent health care in Texas. The legislation banned "patient dumping," the practice of transferring medically unstable patients from private to public hospitals because of their inability to pay. This law inspired the federal Emergency Medical Treatment and Active Labor Act of 1986, better known as EMTALA. Under EMTALA [1], all hospitals that have emergency departments and receive federal funding must provide urgent care to all patients regardless of the patients' ability to pay. In addition to EMTALA, the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Older Americans Amendments of 1975, and the Americans With Disabilities Act of 1990, all prohibit health care facilities from denying medical care on the basis of race, color, national origin, age, or handicap. The spirit of these national legislative mandates is that medical care, especially emergency care, should not be denied on the basis of one's social status, ethnicity, or place of origin.

This, in fact, is the position of the hospital system that I administer. Care must be based upon a patient's medical need and not upon medically unrelated and irrelevant

factors such as race, creed, color, or nationality. A hospital is not the place to negotiate or enforce immigration policies. I believe that we *do* need to identify those who are working in the U.S. without the proper paperwork and make health care coverage part of the social contract between them and their employers, but this should not be the responsibility of a hospital or physician.

Contrary to some views, undocumented immigrants are not the cause of crowding in our emergency department. Today, most emergency rooms are crowded with patients seeking treatment because they do not have access to an ongoing source of primary care (i.e., they have no “medical home). Texas has the highest rate of people without medical insurance in the nation, the majority of whom seek care in our emergency department for urgent, but not necessarily emergent problems. Also, because many counties adjacent to ours do not have public, tax-payer-supported health systems, many out-of-county residents who are U.S. citizens come to us for care. Thus, it is unfair and inaccurate to place the blame of overcrowding in our health system on the backs of undocumented workers.

Moreover, despite claims to the contrary, undocumented workers *do* pay taxes. They pay sales taxes on purchases, ad valorem taxes through rent or home ownership, and many pay social security, Medicare, and worker’s compensation via payroll deductions. In my home state of Texas, there is no personal income tax; thus, there is no dodging of state income tax by undocumented workers because the bulk of state revenues are raised through sales and ad valorem taxes.

Local governments also receive federal level assistance to provide extra funding for services that many undocumented workers and their families use. According to the Institute of Medicine, the U.S. reaped a \$50 billion surplus from taxes paid by undocumented immigrants to all levels of government in 1997 [2]. The government spends these dollars in a variety of ways, but some of it assists schools, hospitals and health systems, and other local human services, all of which are commonly used by undocumented immigrants.

In 2007 Texas received \$43 million in federal funds through the Medicaid Section 1011 program for the first 48 hours of emergency care provided for undocumented residents, of which my health system received \$3 million. In addition, Medicaid Type 30, which is funding for ineligible aliens (both legal and illegal) with emergency conditions, contributed roughly \$36 million. We also receive federal dollars in the form of Disproportionate Share and Upper Payment Limit Medicaid adjustments. Taken together, these federal programs provide funding to support the care of undocumented immigrant patients and lessen the burden on the local tax payer. Although my institution is supported by local taxes, approximately 70 percent of the funding we receive for patient care services comes from traditional payer sources such as Medicare, Medicaid, and commercial insurance, and the other 30 percent comes from ad valorem taxes.

Providing health care to undocumented workers and their families also makes good business sense. Consider that every dollar we spend on prenatal care allows us to avoid spending at least four dollars in neonatal intensive care services for low-birth-weight or premature babies. Regardless of parentage, the babies that we deliver in our hospital are American citizens, and it is important that they be healthy children who have the best chance of becoming productive and contributing members of our community. We know that we can reduce infant mortality, number of days of neonatal care, intracranial hemorrhage, and a variety of other complications all while saving thousands of dollars per child simply by providing access to prenatal care.

Next consider the situation of an undocumented domestic worker who has active tuberculosis or some other contagious condition. Then consider that many undocumented immigrants work in a variety of jobs that bring food to our table. Common sense dictates that it is in the best interest of our community to control the spread of infectious and communicable diseases. By providing lower cost primary and preventive services, we can avoid expensive disease and illness and deploy our system resources in a cost- and community-effective way.

Finally, beyond the legal and business considerations, I am guided both by my training as a physician and my religious convictions. As a physician, I took the Hippocratic Oath, and nothing in that oath condones denying care to a person because of citizenship status. I cannot ask other physicians who work in an institution that I run to compromise their professional obligations, nor can I ask nurses, pharmacists, allied health professionals, social workers, or others to do so. We must not judge any individual as worthy or not worthy of fundamental health services. To do so would diminish us all.

My religious convictions also guide me to take care of those that scripture calls “strangers” in our midst. This vulnerable population can be likened to widows and orphans in both the Old and New Testament passages, and we are admonished by the prophets and the apostles to give them special consideration [3].

While those who immigrate without proper documentation are breaking the law by working in the U.S., in most other respects they are law abiding. Many of the “anti-immigrant” voices are misdirecting their anger toward people who contribute in many ways to the quality of our life, more for good than for bad. If we educate members of the immigrant population and keep them healthy, we will all benefit. We need better policy on immigration to bring the undocumented out of the shadows. And that policy should confront immigration at the workplace and at the border—not in the hospital emergency room. We must not pit immigration policy and health care needs against one another, rather, we must find a uniquely American way to affordably solve this issue. We can, and must do better. That will require courage, compassion, and ingenuity.

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