



NYLPI

LAW

SETON HALL

DISCHARGE, DEPORTATION, AND DANGEROUS JOURNEYS:

A STUDY ON THE PRACTICE OF MEDICAL REPATRIATION

"They told me, 'Today you are going to your home,'" Ojeda Jimenez said, recalling being struck with terror and unable to get words out. "I wanted to say something, but I couldn't talk. I wanted to ask why."

- Quelino Ojeda

December 2012

*A joint project from the Center for Social Justice at Seton Hall Law School
and the Health Justice Program at New York Lawyers for the Public Interest*

■ TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	2
EXECUTIVE SUMMARY	3
INTRODUCTION.....	11
METHODOLOGY.....	13
SCOPE OF THE PROBLEM	14
DOMESTIC HEALTH LAW REGIME.....	17
(UN)INFORMED CONSENT.....	29
(DIS)UNITY IN INFORMED CONSENT LAWS AND GUIDELINES.....	30
IMMIGRATION CONSEQUENCES.....	32
GUARANTEED HUMAN RIGHTS.....	35
RIGHT TO DUE PROCESS	35
RIGHT TO LIFE AND PRESERVATION OF HEALTH AND WELLBEING.....	42
THE DUTY OF DUE DILIGENCE UNDER INTERNATIONAL HUMAN RIGHTS LAW	45
CONCLUSION.....	51
RECOMMENDATIONS	51
GLOSSARY OF TERMS.....	53

ACKNOWLEDGEMENTS

This report, and the accompanying website, represent the culmination of years of research and advocacy on the practice of medical repatriation. The report was researched and written by students in the Immigrants' Rights/International Human Rights Clinic, under the supervision of Professors Lori A. Nessel and Rachel Lopez at Seton Hall Law School and Shena Elrington and Nisha Agarwal at New York Lawyers for the Public Interest. The primary student authors of the report were In Pyo Lee, Erica Sibley, Todd Tolin, and Sarah Vander Woud. In the summer of 2010, Seton Hall Law student Kimberly Krone conducted a fact-finding mission to Guatemala to document the practice of medical repatriation, interviewing victims of this practice and their families. She was supervised by Anjana Malhotra, Esq., former Practitioner in Residence at Seton Hall Law School. Andrew Darcy, Jennifer Scott, Dawn Pepin and Labinot Berljajolli drafted advocacy documents to assist those challenging medical repatriations. Jessica Charniga and Alicia Lera drafted a request for a thematic hearing before the Inter American Commission on Human Rights on the practice of medical repatriation. Katherine Terenzi provided helpful research and Lindsey Hennawi provided invaluable editorial and production assistance. Anjali Bali and Katharine Naples-Mitchell created and developed the accompanying website to the report.

The Center for Social Justice and New York Lawyers for the Public Interest express their sincere appreciation to the organizations who lent their support and expertise to this project. In particular, Jaime Ferrant at the Border Action Network and Moe Ginsburg, Esq. helped us to understand the issues in Arizona. Lisa Palumbo, Esq. at the Legal Assistance Foundation educated us as to issues arising in Chicago hospitals. John DeLeon and members of his firm and networks help us to understand the issues in Florida and nationally. Clinical Law Professors Sarah Paoletti, Carrie Bettinger Lopez and JoNel Newman all provided insight into the human rights implications of medical repatriation. We would also like to thank the members of the Medical Deportation Workgroup, all of whom provided critical input and expertise concerning the practice of medical repatriation.

Finally, CSJ and NYLPI thank the survivors of medical repatriation, as well as the family members and advocates of those that have not survived, for having the courage to come forward and share their stories.

EXECUTIVE SUMMARY

This report, a collaborative project of Seton Hall University School of Law's Center for Social Justice (CSJ) and the Health Justice Program at New York Lawyers for the Public Interest (NYLPI), utilizes a human rights framework to critique the widespread but barely publicized practice of forced or coerced medical repatriations of immigrant patients. Through this practice, private and public hospitals in the United States are engaged in unlawful, and frequently extrajudicial, deportations of ill or injured immigrant patients to medical facilities abroad, completely circumventing the federal government's exclusive authority to deport individuals.

While most medical repatriations occur in the shadows, there is enough information to establish that the U.S. is in systematic violation of its human rights obligations under a variety of treaties that the U.S. has signed and/or ratified. Overall, hospitals, non-governmental organizations (NGOs), journalists, and advocates have been able to document more than 800 cases of attempted or successful medical repatriations across the United States. As these medical deportations are likely to increase in frequency due to certain aspects of the Patient Protection and Affordable Care Act (PPACA), which will be discussed in more depth below, it is a particularly timely concern for both immigration and health care advocates.

Furthermore, standing at the intersection of these two highly controversial and complex political issues—immigration and health care policy—the debate about medical repatriation, to the extent that people are aware of it, largely focuses on the illegality of the immigrant and the costs to hospitals. In an effort to refocus the debate, this report takes a human rights-based approach to medical repatriation by examining (1) the fundamental human rights that all people should be afforded regardless of immigration status; and (2) the role of the U.S. in perpetuating this practice. The purpose of this report is to:

- Raise awareness about the practice of medical repatriation before we begin to see the practice increase, which it is likely to do in the near future, and quantify the accompanying harm to both the immigrants that face forced or coerced medical repatriation and their family members.
- Demonstrate how medical repatriation violates both international and domestic law.

- Persuade the U.S. Department of Health and Human Services to track medical repatriations, impose sanctions on hospitals that perform involuntary medical repatriations and develop regulations that impose greater accountability for hospitals discharging patients to facilities abroad.
- Encourage Congress to convene hearings on the practice and better comply with international human rights obligations.
- Promote dialogue between the U.S. State Department and foreign consulates with the goal of developing a formal procedure for international medical transfers.
- Impart to hospitals the importance and necessity of “informed consent” through disclosures of potentially severe immigration and health consequences regarding medical repatriation.
- Contribute to the current dialogue on the need for more humane immigration and health care laws and policies, particularly in light of the passage of the PPACA, which will make the conditions under which medical repatriations occur more common.

Why Does Medical Repatriation Happen?

Generally, medical repatriation occurs when a hospital sends critically injured or ill immigrant patients back to their native country without their consent. Although hospitals are required to provide emergency medical care to patients regardless of their immigration status, this obligation terminates once the patient is stabilized. At this point, federal law requires hospitals to create a discharge plan and transfer patients to “appropriate facilities” that ensure the health and safety of the patient. Unfortunately, many long-term care facilities, rehabilitation centers, and nursing homes are reticent to accept immigrant patients because many are ineligible for public health insurance due to their immigration status and cannot otherwise afford private health insurance.

This combination of vulnerable immigrant patients and lack of a reimbursement stream for their care has contributed to a situation in which many hospitals take matters into their own hands. Acting alone or in concert with private transportation companies, such hospitals are functioning as unauthorized immigration officers and deporting seriously ill or injured immigrant patients directly from their hospital beds to their native countries. Such hospitals are engaging in

de facto deportations either without the consent of the immigrant patient or by exercising coercion to obtain consent.

How Often Does Medical Repatriation Occur? Is It Increasing?

The secrecy surrounding medical repatriations and the failure of federal or state agencies to monitor these *de facto* deportations makes it difficult to assess the true magnitude of the situation. Despite this fact, hospitals, NGOs, journalists, and advocates have been able to document many cases of forced or coerced medical repatriations in the U.S. A snapshot of cases from media and CSJ research indicates that between 846 and 978 immigrant patients have been involuntarily repatriated. CSJ has documented medical repatriation cases from 15 states; hospitals have deported these individuals to seven different countries including El Salvador, Guatemala, Honduras, Lithuania, Mexico, Philippines, and South Korea. This count, however, does not include the many medical repatriations that went unreported by hospitals and the federal government.

In all likelihood, the reduced allocation of federal funding under the PPACA will lead to more medical repatriations as hospitals, particularly those that provide a disproportionate amount of care to uninsured and publicly insured patients, face additional financial strain. Beginning in 2014, the federal government will dramatically reduce Medicaid Disproportionate Share Hospital (DSH) payments.¹ Historically, the federal government has distributed this funding to states to assist hospitals that provide a large volume of care to Medicaid and uninsured patients. Under health reform, millions of previously uninsured patients will become eligible for Medicaid. Since the number of uninsured patients is expected to decrease dramatically, the federal government will reduce the amount of DSH funding it distributes to states. Unfortunately, despite health reform, some patients, including many patients who may face medical repatriation, will remain uninsured. Faced with the prospect of decreased DSH payments, many hospitals that regularly treat this patient population may resort to medical repatriation in an effort to offset the costs of providing post-acute care to undocumented immigrants.²

¹ PATRICIA BOOZANG ET AL., NEW YORK STATE HEALTH FOUNDATION, IMPLEMENTING FEDERAL HEALTH CARE REFORM: A ROADMAP FOR NEW YORK STATE 62 (2010).

² See generally Nina Bernstein, Hospitals Fear Cuts in Aid for Care to Illegal Immigrants, N.Y. TIMES (July 26 2012) available at <http://www.nytimes.com/2012/07/27/nyregion/affordable-care-act-reduces-a-fund-for-the->

Who Does Medical Repatriation Affect?

Medical repatriation most obviously affects the lives, health, and well-being of immigrant, and at times even U.S. citizen, patients who have suffered a serious injury or illness. Hospitals have attempted to medically repatriate patients across a variety of age ranges with various immigration statuses, including a two-day-old U.S. citizen child born to undocumented immigrant parents, a nineteen-year-old lawful permanent resident, and an undocumented teenager who lived in the U.S. for eighteen years prior to being repatriated.

Medical repatriation also dramatically affects the lives of the patient's family, both in the U.S. and abroad. Medical repatriations often separate families in the U.S. at a time when family support is urgently needed. Similarly, when critically injured or ill immigrants are repatriated to countries and families that do not have the resources or medical advances to care for them, family members are helpless to sustain the lives of their loved ones.

What is the Harm That Follows Medical Repatriation?

When critically ill or catastrophically injured immigrant patients are transferred to facilities abroad, their lives and health are often jeopardized because these facilities cannot provide the care they require and the transfers themselves are inherently risky, resulting in significant deterioration of a patient's health, or even death. This report documents some of these tragic stories: a nineteen-year-old girl who died shortly after being wheeled out of a hospital back entrance typically used for garbage disposal and transferred to Mexico; a car accident victim who died shortly after being left on the tarmac at an airport in Guatemala; and a young man with catastrophic brain injury who remains bed-ridden and suffering from constant seizures after being forcibly repatriated to his elderly mother's hilltop home in Guatemala.

Unfortunately, the U.S. has failed to provide an adequate process through which immigrants who are unlawfully repatriated can seek redress. While there are some documented cases in which the hospital has admitted that it failed to obtain consent to transfer the patient abroad, immigration laws preclude the majority of unlawfully repatriated undocumented patients from returning to the U.S. For example, once an immigrant who has been in the U.S. without

[uninsured.html?pagewanted=all](#) (noting the pressure that reduced DSH funding will place on hospitals that provide care to undocumented immigrants in need of emergency care).

lawful immigration status for over a year voluntarily departs from the country, s/he will be prohibited from returning to the U.S. for ten years, without special permission. Similarly, immigrants that voluntarily depart after more than six months (but less than a year) of unlawful status will be barred from reentering for three years, without special permission. Although the Immigration and Nationality Act (INA) establishes some form of recourse for immigrants who are ordered deported, these avenues are only available when a removal order exists. When a patient is repatriated by a hospital, outside of the federal immigration process, no such order exists. Thus, the U.S. effectively allows the hospital, a private actor, to circumvent the immigration process, leaving the immigrant patient without recourse to challenge serious immigration consequences of medical repatriation.

MEDICAL REPATRIATION VIOLATES INTERNATIONAL HUMAN RIGHTS LAW AND DOMESTIC LAW

The practice of repatriation violates a host of guaranteed human rights, including the right to a fair trial and due process; the right to life, liberty and personal security; the right to protection of the family; and the right to preservation of health and well-being. International human rights law mandates that countries exercise due diligence in order to protect individuals within its borders from human rights violations. Specifically, countries have a duty to prevent, investigate, and punish violations of human rights, and, when possible, ensure adequate compensation to victims as warranted for damages resulting from these violations. Under this standard of due diligence, even when the violation of a human right is not the result of any governmental action, responsibility can be imputed to the country when it fails to fulfill its duties. Because the U.S. has failed to exercise due diligence and enact a domestic legislative scheme to protect immigrant patients' rights, it is in systematic violation of the human rights obligations it has under a variety of treaties.

Medical Repatriation Violates Due Process

When hospitals remove immigrant patients from the U.S. against their will or under coercion, this action is tantamount to a *de facto* deportation, which violates the patients' right to due process. The U.S. is bound to protect immigrants' rights to due process under both international law and the U.S. Constitution. The United States has ratified a number of

international treaties that mandate protection of the right to due process for immigrants, including the International Covenant on Civil and Political Rights (ICCPR), and the American Declaration on the Rights and Duties of Man (American Declaration). In addition, although the U.S. has not yet ratified the American Convention on Human Rights (American Convention) or the International Covenant on Economic, Social, and Cultural Rights (ICESCR), it has signed both treaties and thereby obligated itself not to engage in actions that would undermine the object and purpose of the treaties. The Fifth and Fourteenth Amendments of the U.S. Constitution also guarantee immigrants the right to due process.

Medical Repatriation Violates Rights to Life and Preservation of Health and Well-Being

When critically ill or catastrophically injured immigrant patients are transferred to facilities abroad that cannot adequately provide the care they require, their health, and in some instances even their lives, are put in jeopardy. Accordingly, these patients' rights to life and preservation of health and well-being are undermined. These rights are protected by the ICCPR, the American Convention, the American Declaration, and the ICESCR. Regrettably, the U.S.'s current legislative scheme restricts immigrants' access to public health programs, limits hospitals' ability to seek reimbursement for the care they provide to uninsured immigrants, inadequately enforces existing protections regarding patient dumping and federal discharge laws, and fails to create a regulatory framework concerning informed consent. Thus it does not protect immigrant patients' rights to life and preservation of health.

CONCLUSION

The practice of forced or coerced medical repatriation violates international and U.S. law and must be curtailed. The federal government has failed to remedy serious deficiencies in its overall legislative scheme, particularly with respect to patients' rights to due process, life, and the preservation of health and well-being. These deficiencies have very real and sometimes fatal consequences for immigrant patients, who find themselves back in their native countries, separated from their families, and in need of critical care they are unable to access. As medical deportations are likely to increase in frequency in the near future, there is an urgent need for state

and federal governments to address the issue of medical repatriation and prevent the escalation of these human rights violations.

RECOMMENDATIONS

To the U.S. Congress:

- Convene hearings to investigate the practice of unlawful medical repatriations by private hospitals under international and domestic law.
- Repeal all laws that impose bars to Medicaid benefits based upon immigration status.

To the Department of Health and Human Services:

- Immediately promulgate regulations that prohibit and impose sanctions on any hospital that performs an involuntary repatriation.
- Develop a process by which hospitals must document and report international patient transfers.
- Develop an auditing process through which the department can monitor compliance with such rules and regulations.

To the Department of State:

- Engage in a dialogue with foreign consulates within the U.S. and implement a formal procedure for international medical transfers, so that transfers can be verified with receiving hospitals prior to the issuing of travel documents.

To Hospitals:

- In the absence of state or federal regulations, establish protocols to ensure that consent to unlawful, international transfers is *informed*, which would include disclosure of potential immigration consequences.
- Confirm (in cooperation with foreign consulates) that destination hospitals can provide the necessary long-term care before a transfer is deemed viable.
- Train hospital social workers and advocates on the special issues of working with immigrants, both documented and undocumented.

To States:

- Repeal any bars to funding for means-tested and long-term medical care based on immigration status.
- Establish a fund for long-term care for catastrophically injured immigrants.

To State Courts:

- Acknowledge federal preemption limitation on jurisdiction when discharge proceedings involve *de facto* deportations.
- Stay any orders of international discharge until determinations of immigration status, removability, and potential relief have been rendered by an Immigration Court.

- Direct any appointed guardians to consider immigration consequences when acting on behalf of the patient and seek independent assessment of the patient's situation

To Community Groups and Advocates:

- Document cases of actual or threatened medical deportation.
- Raise awareness concerning discharge and language access rights and Emergency Medicaid.
- Create a rapid response working group to assist undocumented immigrants at risk of medical deportation.

■ INTRODUCTION

At only sixteen years old, Quelino Ojeda Jimenez left his village of small wood- and straw-roofed houses in Mexico in search of work in the United States. Hoping to earn enough money to support his family—his common law wife, two-year-old daughter, parents, and six sisters—he traveled to South Carolina and then Georgia, where he found work as a roofer.

For four years, Quelino’s hard work put roofs over the heads of hundreds of Americans. In August of 2010, when Quelino was twenty years old, he moved to Chicago to work on a building near Midway Airport. While removing sheet metal from the building’s roof, he fell backwards and plummeted over twenty feet to the ground below. Comatose for three days, he awoke at a hospital nearly quadriplegic and reliant on a ventilator.

The hospital cared for Quelino for four months before deciding it was “best to return him close to his family,” although his family contested his repatriation.³ Three days before Christmas, hospital staff disconnected him from equipment and rolled him away on a gurney as one of his caregivers pleaded for them to stop. Crying and unable to speak, Quelino could do nothing.

In February of 2011, the hospital in Chicago acknowledged that it never obtained Quelino’s consent to transfer him to Mexico and “regret[ed] the way this process flowed and the steps that were taken.”⁴ Notwithstanding the hospital’s remorse, its actions in removing Quelino from the country after his having been here without permission for at least a year meant that he would be barred from returning for ten years.⁵ Quelino languished for more than a year in a Mexican hospital that had no rehabilitation services and lacked the funding for new filters needed for his ventilator. After suffering two cardiac arrests and developing bedsores and a septic infection, Quelino died there on January 1, 2012.⁶

³ Judith Graham et al., *Undocumented Worker Who Became Quadriplegic is Moved to Mexico Against His Will*, CHI. TRIB., Feb. 6, 2011, at <http://www.chicagobreakingnews.com/news/local/ct-met-quadruplegic-immigrant-deporte20110206,0,5042915.story>.

Id.

⁵ 8 U.S.C. 1182(a)(9)(B)(i)(ii) specifying that any alien who has been unlawfully present in the United States for one year or more, and who again seeks admission within 10 years of the date of such alien’s departure or removal from the United States, is inadmissible.

⁶ Becky Schlikerman, *Quadriplegic immigrant dies after Chicago-area hospital returned him to Mexico*, CHI. TRIB., Jan. 4, 2012, at http://articles.chicagotribune.com/2012-01-04/health/ct-met-quelino-death-20120104_1_quelino-ojeda-jimenez-mexican-family-mexican-hospital.

Quelino's story is just one of many that have been uncovered by the news media and advocates across the country in recent years. Overall, non-governmental organizations (NGOs), journalists, and advocates have been able to document more than 800 similar cases across the United States.⁷ This report, a collaborative project of Seton Hall University School of Law's Center for Social Justice (CSJ) and the Health Justice Program at New York Lawyers for the Public Interest (NYLPI), seeks to bring attention to medical repatriation, a practice in which U.S. hospitals unlawfully deport ill or injured immigrant patients against their will to medical facilities abroad, completely circumventing the federal government's exclusive deportation powers.

Medical repatriation stands at the intersection of two of the most controversial political issues in the U.S.: immigration and health care policy. As a result, to the extent that people are aware of the practice, the debate is largely focused on the illegality of the immigrant and the costs to hospitals. In an effort to recast the debate, this report takes a human rights-based approach to medical repatriation by examining (1) the fundamental human rights that all people are entitled to; and (2) the United States' role in allowing for immigration and health care regimes that perpetuate this practice.

Part I describes the methodology employed by the CSJ and NYLPI for this report. Part II defines medical repatriation and sheds light on the magnitude and frequency of the practice. Part III sets forth the domestic health law regime. Part IV analyzes how the patient's consent is often coerced, uninformed, or completely absent in these medical repatriations. Part V explains how medical repatriation violates immigrant patients' human rights under international and U.S. domestic law. Specifically, this section examines how medical repatriation violates the right to due process, a fair hearing, and humane treatment as well as a victims' rights to life and preservation of health and well-being; Part VI examines the U.S. government's duty to exercise due diligence to protect vulnerable victims' human rights. Lastly, Parts VII and VIII conclude with a list of recommendations to curtail the practice.

⁷ In some of these cases, the efforts of the hospital to repatriate the patient were halted.

METHODOLOGY

The report is based on case studies collected by the Seton Hall University School of Law Center for Social Justice (CSJ) through court decisions, newspaper reports, interviews with local advocates and organizations, and accounts obtained from relatives of patients who were repatriated by hospitals. From June to August 2010, CSJ's International Human Rights and Rule of Law Initiative conducted fieldwork in Guatemala to document the availability of medical services to Guatemalans repatriated from U.S. hospitals and to investigate specific patient outcomes. Two Seton Hall law students⁸ conducted interviews with patients, their families, advocates, health care providers, attorneys, Guatemalan Consular officials, and public health experts in Guatemala and the U.S. In addition, the Health Justice Program at New York Lawyers for the Public Interest (NYLPI), along with New York Immigration Coalition (NYIC), conducted two dozen structured interviews with advocates, health care providers, and hospital social workers throughout New York City to determine the frequency with which medical repatriations took place at health care facilities throughout the city, as well as the reasons underlying these facilities' decisions to repatriate immigrant patients.⁹

⁸ In the summer of 2010, Seton Hall Law student Kimberly Krone conducted a fact-finding mission to Guatemala to document the practice of medical repatriation, in conjunction with law student Jennifer Scott, and supervised by attorney Anjana Malhotra, practitioner in residence in CSJ's International Human Rights/Rule of Law Project.

⁹ Nisha Agarwal & Liane Aronchick, *A Matter of Life and Death: Advocates in New York Respond to Medical Repatriation*, 46 HARV. C.R. – C.L. L. REV (2011), at http://harvardcrcl.org/wp-content/uploads/2011/02/Agarwal_Aronchick_Matter_of_Life.pdf.

■ SCOPE OF THE PROBLEM

Medical repatriations often begin with an undocumented immigrant suffering a catastrophic injury or illness and arriving in a hospital's emergency room. Under U.S. law, hospitals must "stabilize" any individual who needs emergency care regardless of his or her immigration status or ability to pay. The hospital may transfer a patient who has not been stabilized to another facility that can provide appropriate medical treatment, but the patient must consent.¹⁰ Once the hospital determines that the patient has been stabilized, its obligation to treat the patient ends even if he or she is still in critical condition.¹¹ At this point, if the patient requires further care, the hospital must develop a discharge plan and may transfer the patient to another medical facility, but only one that can meet the patients' needs.¹²

Unfortunately, long-term care facilities, rehabilitation centers, and nursing homes are often reticent to accept uninsured immigrant patients, primarily because immigrant patients who lack lawful immigration status or have been lawful permanent residents for less than five years are not eligible for federally funded healthcare benefits.¹³ Additionally, many of these immigrants have low-wage jobs that do not provide them with private health insurance and are unable to pay out of pocket for their care.

This scenario combining vulnerable immigrant patients with a lack of reimbursement streams for their care has led hospitals to take matters into their own hands. Acting alone or in concert with private transportation companies, a growing number of hospitals are functioning as unauthorized immigration officers and sending seriously ill or injured immigrant patients from their hospital beds to their native countries. As will be shown below, hospitals have engaged in such *de facto* deportations without the consent of the immigrant patient or his/her family or by exercising coercion to obtain consent.

¹⁰ In order for a transfer plan to be deemed appropriate, it must ensure that the patient will be received at a facility that is likely and able to provide a patient with necessary post-hospital services where any risks to the patient's health will be minimized. 42 U.S.C.A. § 1395dd (2010).

¹¹ Some states, however, have adopted laws, like New York's anti-patient dumping law (New York Emergency Medical Service Reform Act), requiring that hospitals treat patients beyond stabilization.

¹² 42 C.F.R. § 482.4 (2010).

¹³ Lawful Permanent Residents are ineligible for federal Medicaid coverage for five years after obtaining lawful permanent residency. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or "1996 Welfare Act"), Pub. L. No. 104-193, 110 Stat. 2105 (1996).

The secrecy surrounding these unlawful repatriations and the failure of federal or state agencies to monitor these *de facto* deportations make it difficult to assess the true magnitude of the situation. Nevertheless, hospitals, NGOs, journalists, and advocates have documented a substantial number of unlawful forced or coerced medical repatriations. A snapshot of cases from the media and investigation by the CSJ indicates that there have been between 846 and 978 executed and attempted repatriations in the U.S.¹⁴ The CSJ has identified cases of immigrant patients being unwillingly repatriated from hospitals in Arizona,¹⁵ California,¹⁶ Florida,¹⁷ Georgia,¹⁸ Illinois,¹⁹ Maryland,²⁰ Michigan,²¹ Nebraska,²² Nevada,²³ New Jersey,²⁴ New York,²⁵ North Carolina,²⁶ Ohio,²⁷ Tennessee,²⁸ and Texas²⁹ to El Salvador, Guatemala, Honduras, Lithuania, Mexico, the Philippines, and South Korea. This sampling, however, does not do justice to the number of medical repatriations that go unreported.

The scale of this practice is further evidenced by the growth of private enterprise which developed to assist hospitals in carrying out such repatriations. These companies employ private airplanes and ambulances to transfer patients from hospitals in the U.S. to facilities in the patients' native countries. Unfortunately, many times these countries are incapable of providing

¹⁴ See, e.g., Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1 [hereinafter Sontag, *Immigrants*] (reporting that "some 96 patients a year [are] repatriated by St. Joseph's Hospital in Phoenix; 6 to 8 patients a year [are] flown to their homelands from Broward General Medical Center in Fort Lauderdale, Florida; 10 [have been] returned to Honduras from Chicago hospitals since early 2007."). Chicago hospitals also send patients to Lithuania, Poland, Guatemala, and Mexico. See Judith Graham, *Sending Sick Undocumented Immigrants Back Home*, CHI. TRIB., Aug. 20, 2008, <http://newsblogs.chicagotribune.com/triage/2008/08/sending-sick-un.html>.

¹⁵ Case of Antonio de Jesús Torres, see Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 8, 2008, at A1 [hereinafter Sontag, *Deported*].

¹⁶ Case of Jose Lopez, see Lisa Richardson, *Patients Without Borders*, L.A. TIMES, Nov. 5, 2003, at A1, <http://articles.latimes.com/2003/nov/05/local/me-transfer5>.

¹⁷ Case of Jimenez, see Lori A. Nessel, *The Practice of Medical Repatriation: The Privatization of Immigration Enforcement and Denial of Human Rights*, 55 WAYNE L. REV. 1725 (2009).

¹⁸ Case of Monica Chavarria, see Kevin Sack, *For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES, Dec. 31, 2009, at A1, <http://www.nytimes.com/2010/01/01/health/policy/01grady.html?pagewanted=all>.

¹⁹ Case of Orlando Lopez, see Colleen Mastony, *For Patient, Time Runs Out*, CHI. TRIB., Nov. 9, 2005, http://articles.chicagotribune.com/2005-11-09/news/0511090305_1_nursing-long-term-care-patient.

²⁰ Case of Manuel L, documented by the CSJ.

²¹ Case of Jose G, documented by the CSJ.

²² Mastony, *supra* note 19.

²³ Case of Antonio D, documented by the CSJ.

²⁴ Case of Enrique, documented by the CSJ.

²⁵ See Agarwal, *supra* note 9.

²⁶ Case of Fernando C, documented by the CSJ.

²⁷ Case of Sonia M, documented by the CSJ.

²⁸ Case of Santos V, documented by the CSJ.

²⁹ Case of Miguel H, documented by the CSJ.

the medical services necessary for patients' rehabilitation or survival.³⁰ Mexcare, a private transfer company engaging in medical repatriations to Latin America, describes itself as the "alternative choice for the acute care of unfunded Latin American Nationals."³¹ Mexcare boasts "over 50 hospitals and treatment centers" in places such as Mexico, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama.³² And, as previously mentioned, with the pending decreases in DSH funding to hospitals with disproportionately large uninsured and undocumented patient bases, it is likely that this industry will grow, and repatriations will become more and more common.

Although medical repatriations usually occur without governmental oversight or public knowledge, the case of Luis Jimenez wound its way through the courts in Florida and received a good deal of media coverage. In February 2000, Luis Alberto Jimenez, a 35-year-old undocumented landscaper in Florida, was in a car that was struck by a drunk driver with a blood alcohol level four times the legal limit.³³ The head-on crash left Luis with traumatic brain damage and severe physical injuries, leading a Florida court to appoint his relative, Montejo Gaspar Montejo, as his legal guardian. Martin Memorial Medical Center treated Luis until June 2000 when he was transferred to a nursing home. However, Luis was readmitted to Martin Memorial in January 2001 due to a severe infection that doctors feared could be terminal. Almost a year later, when Martin Memorial could not find a domestic long-term care provider that would accept Luis, the hospital intervened in Montejo's guardianship proceedings to seek court approval to discharge Luis and transport him to a hospital in his native Guatemala. The court authorized the hospital to transport Luis to Guatemala in June 2003. Although Montejo appealed, the hospital flew Luis to Guatemala the next morning before the court could rule on his appeal.

Despite Luis's "deportation" to Guatemala, Montejo continued to challenge the order that allowed Martin Memorial to remove him to Guatemala where there were no public health care

³⁰ See Nessel, *supra* note 17, at 1728-1729.; see also Sontag, *Immigrants*, *supra* note 14.

³¹ As advertised on Mexcare's site, "Mexcare provides [sic] an alternative in the care of the unfunded [L]atin American National. With *over 50 hospitals and treatment centers*, MexCare reduces cost per discharge for U.S. hospitals seeking to alleviate the financial [sic] burden of unpaid services." MexCare at <http://www.mexcare.com> (follow "locations" link) (last visited November 16, 2012)

³² *Id.*

³³ See Nessel, *supra* note 17, at 1728-1729. See also Sontag, *Immigrants*, *supra* note 14.

facilities that could provide traumatic brain injury rehabilitation.³⁴ Finally, on May 5, 2004, while Luis, bedridden and suffering from routine seizures,³⁵ was living with his elderly mother in a remote area of Guatemala, the Florida District Court of Appeals overturned the lower court's order. Because the Court found that "federal immigration law preempts deportation"³⁶ by state courts, it invalidated the state court's order that had authorized the hospital to transport Luis. While the Florida District Court of Appeals decision was significant for holding that state courts lack the authority to engage in what are essentially hospital deportations, it was too late to help Luis, who languished without medical treatment in Guatemala.³⁷

The Florida District Court of Appeals decision does not come as a surprise. The U.S. Supreme Court has long held that the authority to admit or exclude foreigners "is an incident of sovereignty belonging to the government of the U.S."³⁸ and that "the power to regulate immigration is unquestionably exclusively a federal power."³⁹ When patients or their families do not consent to repatriation, hospitals resort to securing state court orders, as in Luis's case. Despite well-established law concluding that only the federal government is vested with the power to deport foreigners, hospitals still unilaterally transport patients abroad without federal authorization and without due consideration for the well-being of the patient sent abroad.

DOMESTIC HEALTH LAW REGIME

Due to deficiencies in its overall federal legislative scheme, the U.S. has fostered an environment in which hospitals engage in medical repatriation with little or no oversight, placing the health and well-being of immigrant patients at risk. Specifically, the U.S. has (1) deprived hospitals of the primary funding stream available to treat undocumented immigrants; (2) failed to enforce the limited protections available to undocumented immigrants under the Medicare statute concerning the provision of emergency care and discharge planning; and (3) failed to enact a

³⁴ *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 874 So.2d 654, 658.

³⁵ Sontag, *Immigrants*, *supra* note 14.

³⁶ *Montejo*, 874 So. 2d. at 656.

³⁷ See Sontag, *Immigrants*, *supra* note 14 (reporting that as of 2008 when a New York Times reporter last visited Luis in Guatemala, she found that he had not received medical care in the five years since he was forcibly repatriated).

³⁸ *Chae Chan Ping v. United States*, 130 U.S. 581, 609 (1889).

³⁹ *De Canas v. Bica*, 424 U.S. 351, 354 (1976).

legal or regulatory framework outlining informed consent requirements within the medical repatriation context.

Manuel

Following a car accident in 2009, Manuel was admitted as an emergency patient to a hospital in Maryland and was diagnosed with a serious neck injury. Despite his suffering and need for neck surgery, hospital administrators advised Manuel and his family that he should return to Guatemala where he would receive better care and less expensive treatment. Manuel's family objected to a transfer, believing that he would not receive the required care in Guatemala.

In light of the family's refusal, the hospital informed them that if Manuel were to receive treatment in the U.S., he would be held financially liable and would also need a U.S. citizen to underwrite the debt. Because of the hospital's continuous pressure and misrepresentations about health care options in Guatemala, the family eventually agreed to Manuel's transfer.⁴⁰

The hospital, however, made no arrangements for Manuel's care once he arrived in Guatemala. Manuel had to independently find a hospital and pay for his neck surgery. The hospital to which Manuel was admitted ended up lacking not only proper technology, but also the doctors with the technical expertise required for the surgical procedures. Today, Manuel continues to experience excruciating pain and suffer serious problems with his neck.⁴¹

Public Health Programs

Medicaid, a federal-state public insurance program enacted pursuant to Title XIX of the Social Security Act, serves as one of the primary vehicles through which hospitals receive reimbursement for the care they provide to low-income patients. In fact, Medicaid is *the* largest source of funding for health centers and public hospitals that serve the poor and uninsured.⁴² The program currently provides coverage to over 60 million people, many of whom are severely low-

⁴⁰CSJ Interview with Henry Gomez, advocate from Grupo Cajola, Cajola, Guatemala, August 3, 2010.

⁴¹CSJ Interview with Henry Gomez, advocate from Grupo Cajola, Cajola, Guatemala, August 3, 2010. By financially pressuring Manuel, the hospital also misrepresented his eligibility for benefits and violated Maryland law. Under Maryland law, non-profit hospitals are required to have free and reduced-cost care policies and to affirmatively inform patients of the availability of such charity care. *See* MD. CODE, HEALTH-GEN. § 19-214.1 (a)(1) (requiring every non-profit "hospital to develop a financial assistance policy for providing free and reduced-cost care to all patients whose health care coverage does not pay the full cost of their hospital bill."), (a)(2) ("Each policy shall include, at a minimum, free medically necessary care for patients with income below 150 percent of the Federal Poverty Level, and reduced-cost medically necessary care for low-income patients with family income above 150 percent of the Federal Poverty Level").

⁴²*Medicaid and the Uninsured*, THE HENRY J. KAISER FAMILY FOUND. (Feb. 2011) <http://www.kff.org/medicaid/upload/8157.pdf>.

income,⁴³ with “spending for hospitals and physicians reach[ing] \$91.5 billion.”⁴⁴ Despite the central role Medicaid financing plays in the health care delivery system, the federal government has increasingly limited the scope of coverage available to both documented and undocumented immigrants. In 1996, as part of a large-scale restriction on means-tested federal assistance to immigrants, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”), which created a five-year residency requirement for entering lawful immigrants to receive federal funding through Medicaid or the State Children’s Health Insurance Program (SCHIP).⁴⁵ PRWORA also explicitly barred undocumented immigrants from receiving any federal medical funding except for emergency care. As a result of these restrictions, many immigrants, even those with lawful immigration status, may have difficulty obtaining coverage for their care.

Recent federal legislation has restricted immigrants’ access to federal health insurance even further. The Patient Protection and Affordable Care Act of 2010 (PPACA), one of the most sweeping pieces of health care legislation ever enacted in the U.S., requires citizens and all lawfully present residents to have health insurance.⁴⁶ The mandate, however, specifically excludes undocumented immigrants.⁴⁷ In addition, PPACA prohibits undocumented immigrants

⁴³ *Id.*

⁴⁴ *Medicaid and the Uninsured*, THE HENRY J. KAISER FAMILY FOUND. (Mar. 2011) <http://www.kff.org/medicaid/upload/8165.pdf>.

⁴⁵ See Robin K. Cohen, *PRWORA’s Immigrant Provisions* (Dec. 13, 2007) <http://www.cga.ct.gov/2007/rpt/2007-R-0705.htm>. Some states provide health care for LPRs present for fewer than five years using state funds. Certain state laws also allow immigrants to obtain state benefits under the Person Residing Under Color Of Law (“PRUCOL”) category. See e.g., *Medical Assistance Programs for Immigrants in Various States*, NAT’L IMMIGR. L. CTR., <http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-02-24.pdf>. In New York, aliens who are residing in the United States “with the knowledge and permission or acquiescence of the federal immigration agency and whose departure from the US such agency does not contemplate enforcing” are eligible for Medicaid benefits. N.Y. COMP. CODES R. & REGS. tit. 18 § 360-3.2 (j)(2)(i)(a) (2010). These state laws may indirectly provide alternatives to medical repatriation for noncitizen patients because hospitals are able to enroll some non-citizen patients in public health insurance programs, which enables them to discharge the patients to domestic long-term care facilities. See e.g. Agarwal, *supra* note 7, at 9 (a patient from St. Lucia was determined to be eligible for PRUCOL status and therefore avoided repatriation). However, while these state laws provide local relief, they are not the norm and are not sustainable as a long-term solution to the medical repatriation problem, given the enormous pressures to cut state Medicaid programs instead of expand them. States may also use SCHIP funds to provide prenatal care to pregnant women regardless of immigration status. *Medicaid and the Uninsured*, THE HENRY J. KAISER FAMILY FOUND. (Apr. 2006) <http://www.kff.org/medicaid/upload/7492.pdf>.

⁴⁶ *How Are Immigrants Included in Health Care Reform?* NAT’L IMMIGR. L. CTR., (April 2010) <http://www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf>.

⁴⁷ Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or “1996 Welfare Act”), Pub. L. No. 104-193, 110 Stat. 2105 (1996).

from receiving premium tax credits or cost-sharing reductions aimed at reducing health care costs.⁴⁸ As a result, an estimated 4.3 million undocumented immigrants will remain uninsured after this provision goes into force.⁴⁹ PPACA also reduces the pool of Medicaid Disproportionate Share Hospital (DSH) payments available to help support hospitals that provide a large volume of care to Medicaid and uninsured patients, including undocumented patients.⁵⁰ As a result, despite health reform, many patients, including undocumented patients, will remain uninsured and seek care from hospitals. Consequently, hospitals will continue to face the problem of burdensome uncompensated care costs that PPACA seeks to reform. Faced with the shrinking availability of DSH funds, many hospitals that provide care to uninsured undocumented patients may be tempted to turn to medical repatriation as a means to reduce costs.

Discharge Planning and Anti-Dumping Laws

The federal government has sporadically enacted piecemeal legislation to address the very real health hazards under-insured and uninsured patients face when seeking health care, including the Emergency Medical Treatment and Active Labor Act (“EMTALA”) and Medicare discharge planning requirements. Although these laws provide some measure of protection to undocumented immigrants, they do so only in very narrow circumstances. Furthermore, the federal government has failed to adequately enforce these provisions or provide sufficient funding to incentivize compliance, effectively blunting any bite these provisions may have otherwise had.

Emergency Medical Treatment and Active Labor Law (“EMTALA”)

In 1986, Congress enacted EMTALA “to address the increasing number of reports that hospital emergency rooms [were] refusing to accept or treat patients with emergency conditions if the patient [did] not have medical insurance.”⁵¹ Under EMTALA, if a patient appears at a facility with “an emergency medical condition that has not been stabilized,” the hospital *must* provide emergency treatment for the condition in order to stabilize the patient or transfer the

⁴⁸ *Id.*

⁴⁹ *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, THE LEWIN GROUP (June 8, 2010) <http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf>.

⁵⁰ PATRICIA BOOZANG ET AL., NEW YORK STATE HEALTH FOUNDATION, IMPLEMENTING FEDERAL HEALTH CARE REFORM: A ROADMAP FOR NEW YORK STATE 62 (2010).

⁵¹ *St. Anthony Hosp. v. U.S. Dep’t of Health & Human Servs.*, 309 F.3d 680, 692 (10th Cir. 2002); *See also* Agarwal, *supra* note 9, at 14.

patient to an “appropriate” medical facility.⁵² The requirement applies only to those facilities that participate in the Medicare program and provide emergency services. A facility’s obligations under EMTALA end when the patient has been “stabilized.”⁵³ In order to determine whether a patient has been stabilized, the facility must make a determination “within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility....”⁵⁴ This determination is largely factual, requiring an inquiry into the reasonableness of the transfer under the circumstances.⁵⁵ Although counter-intuitive, courts have held that a “stabilized” patient is not the same as a patient in “stable condition.”⁵⁶ As a result, hospitals may lawfully transfer patients who have been “stabilized,” within the narrow meaning of the term under EMTALA, while they still require critical ongoing care. EMTALA, therefore, does not fully protect immigrant patients from being transferred to facilities abroad with inadequate capacity, supplies, or staff.

Antonio

“At the end of the day... I realized it was not about the dignity of a person, it was about a bottom line.”

Antonio is no stranger to hard work. Growing up in Mexico, he watched his father regularly trek to Arizona for employment as a farm worker. At nineteen, Antonio and his family obtained green cards and joined their father in Gila Bend, AZ where they tended the alfalfa fields. On June 7, 2008, Antonio set out to work as usual, unaware that a car accident would leave him comatose, connected to a ventilator, and fighting for survival.

When Antonio was admitted to the intensive care unit at a hospital in Arizona, his parents were informed that he had a severe brain injury, bruised lungs, and abdominal injuries. Two days later, a social worker at the hospital suggested they unplug him, as there was little hope for his recovery. When Antonio’s parents refused, they were told that since Antonio had not been a permanent resident for five years, he did not qualify for financial assistance—and without insurance; the hospital could not keep him. Five days later, the social worker arranged for Antonio’s transfer to a public hospital in

⁵² 42 U.S.C. § 1395dd (b) - (c) (2010).

⁵³ *Id.*; See also 42 C.F.R. § 489.24 (d)(2) (2010).

⁵⁴ § 1395dd (e)(3)(A) (2010).

⁵⁵ *Cherukuri v. Shalala*, 175 F.3d 446, 454 (6th Cir. 1999).

⁵⁶ *St. Anthony Hosp.*, 309 F.3d at 694 (finding that stabilizing treatment required by the Act is “medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility” 42 U.S.C. § 1395dd (e)(3)(A), while stable condition “indicates that a patient's disease process has not changed precipitously or significantly”).

Mexicali, Mexico. At the time of transfer, Antonio remained comatose, dependent on a portable ventilator, and suffering the lingering effects of pneumonia. The director of the Mexicali hospital where Antonio was transferred stated that he would not have transferred a patient in such a state.

Antonio's parents were not going to give up on their son. Because he was a lawful permanent resident and due to differences in state funding schemes, Antonio's parents were able to bring their son back to the U.S. for treatment in California. Antonio arrived at the California hospital still comatose and with potentially fatal septic shock. After only eighteen days of treatment, however, Antonio awoke from his coma, had the breathing tube removed from his throat, and asked "Where's my mom?"

Antonio's health continues to improve, and he looks forward to returning to work in the fields and driving his combine. His father is still haunted by the thought of what would have happened had he listened to the social worker at the Arizona hospital and agreed to unplug his son.⁵⁷

Additionally, courts have held that a hospital's EMTALA duties to stabilize only extend to the "immediate aftermath" of the presentation of an emergency medical condition and the period of time during which the hospital decides whether it will admit or transfer the patient to another facility.⁵⁸ As a result, the requirements of EMTALA only apply to a very limited group of people—those who present themselves in the "immediate aftermath" of their injury and suffer from a medical condition of sufficient severity that their transfer to another facility would likely result in material deterioration of their health. EMTALA does not extend to undocumented immigrants—or any patients, for that matter—who fall outside of this category.

Furthermore, the provision that permits hospitals to transfer patients who have not yet been stabilized to "appropriate" facilities⁵⁹ is inadequate to prevent hospitals from transferring these patients to foreign countries where their conditions might deteriorate. First, EMTALA provisions allow a physician to transfer a patient if the physician "determines that the medical benefits of transfer outweigh the potential risks."⁶⁰ This standard is largely discretionary, leaving open the possibility that physicians, facing pressure from their institutions, may authorize

⁵⁷ See Sontag, *Deported*, *supra* note 15.

⁵⁸ *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996); *see also* 42 C.F.R. § 489.24 (d)(2) (2010) ("If a hospital has screened an individual . . . and found . . . [an] emergency medical condition, and admits the individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section...").

⁵⁹ § 1395dd (c)(1).

⁶⁰ *Id.*

transfers. Secondly, patients, who are vulnerable due to their deteriorating health and uncertain immigration status, may consent to transfer even if they are not yet in stable condition.⁶¹

Although EMTALA provides some protection to immigrant patients in need of emergency care, its reach is limited in scope because the federal government does not adequately enforce EMTALA provisions. Under EMTALA, the federal government may impose a hefty penalty of \$50,000 per violation on non-compliant hospitals or terminate their participation in Medicare.⁶² The federal government, however, rarely invokes these remedies. Of the roughly 400 EMTALA-related investigations conducted each year, only half result in confirmed violations.⁶³ Of these confirmed violations, fewer than half have resulted in the imposition of monetary fines. It is also exceedingly rare that a hospital's Medicare agreement will be terminated due to EMTALA violations.⁶⁴ In addition, the federal government has not uniformly enforced these provisions: "Some hospitals have a greater chance of being investigated than others, not because they are more prone to violate EMTALA terms than others, but because they are geographically closer" to the regional offices of the Centers for Medicare & Medicaid Services (CMS), the agency charged with monitoring EMTALA compliance.⁶⁵ As a result of the federal government's uneven and limited enforcement of EMTALA provisions, immigrant patients in need of emergency care may not receive the care to which they are entitled.

Miguel

After being hit by a car, Miguel was rushed to an emergency room in Houston, Texas. He suffered a head wound and severe damage to his arm. The hospital sutured Miguel's head wound but administrators informed Miguel that it was too expensive for them to treat his broken arm, which would require prosthesis. Sitting in the hospital with his arm useless at his side, administrators interrogated Miguel about how he would pay for the prosthesis and urged him to go to Guatemala for his treatment. At first,

⁶¹ Caitlin O'Connell, *Return to Sender: Evaluating Medical Repatriations of Uninsured Immigrants*, 87 WASH. U. L.REV. 1429, 1449-50 (2010).

⁶² § 1395dd (d)(1)

⁶³ UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL COMMITTEES, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3(June 2001) *available at* <http://www.gao.gov/new.items/d01747.pdf>.

⁶⁴ *Id.* at 17.

⁶⁵ Jeffrey Kahntroff & Rochelle Watson, *Refusal of Emergency Care and Patient Dumping*, 11 AM. MED. ASS'N J. OF ETHICS 49, 53 (January 2009) (citing U.S. DEP'T OF HEALTH & HUMAN SERV. OFF. OF THE INSPECTOR GEN. THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS 1-2 (2001)), *available at* <http://virtualmentor.ama-assn.org/2009/01/pdf/hlaw1-0901.pdf>.

Miguel protested, but eventually relented under the continuous pressure.

While Miguel was in intense pain, arm still untreated and in need of the prosthesis, the hospital arranged his transfer to Guatemala. When Miguel arrived, he found that no post-transfer care had been arranged with a Guatemalan medical facility, leaving him to fend for himself.⁶⁶

The federal government's under-funding of the treatment required by EMTALA has further exacerbated the problem. For example, in 2003, the U.S. Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act ("MMA").⁶⁷ The MMA provided funding to reimburse hospitals for emergency treatment of uninsured immigrant patients.⁶⁸ Unfortunately, hospitals in states with large immigrant populations exhaust this funding quickly, and the federal government has not provided additional funding.⁶⁹ Further, the MMA only covers care that must be provided under EMTALA.⁷⁰ Therefore, patients who enter hospitals with conditions that can become life-threatening if untreated may not be covered by the MMA. This gulf between the need for non-emergency treatment and the lack of government reimbursement for such care leaves uninsured immigrants vulnerable to *de facto* deportations by hospitals that are unwilling to absorb such costs.

Hector

In 2008, while walking down the street in New Jersey, Hector was struck by a car. Rushed to an emergency room, Hector suffered brain injuries and lapsed into a coma. Hospital administrators and a physician contacted his brother, a New Jersey resident, informing him that there was no hope for Hector. They stated that the best course of action was to transfer Hector to Guatemala and wait for him to pass away. Hector's brother and his family objected to any transfer and, in response, hospital administrators began to apply financial pressure, demanding his brother explain how he was going to pay for Hector's bills.

As Hector's family fought back against the hospital's attempt to repatriate him,

⁶⁶CSJ Interview with Henry Gomez, advocate from Grupo Cajola, Cajola, Guatemala, August 3, 2010.

⁶⁷ All hospitals that accept federal Medicare insurance, which is virtually every facility in the nation, are bound by the regulations set forth in the MMA.

⁶⁸ Ctr. for Medicare and Medicaid Serv., Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Fact Sheet (2006), *available at* https://www.cms.gov/MLNProducts/downloads/Sect1011_Web05-19-06.pdf.

⁶⁹ Ctr. for Medicare and Medicaid Serv., Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Fact Sheet (2011), *available at* http://www.cms.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf.

⁷⁰ *Id.*

Hector emerged from his coma. The hospital ceased its attempts to transfer Hector once he awoke. New Jersey police had managed to apprehend the hit-and-run driver, allowing Hector to collect insurance payment for his injuries. One advocate involved believes that the decision to allow Hector to stay was purely financial in basis. Hector's brother and family are relieved that Hector is alive and his health continues to improve.

Federal Discharge Law

In addition to EMTALA, federal discharge laws provide some protection to immigrant patients at risk of medical repatriation. Like the protections under EMTALA, however, discharge laws are limited in their reach. Furthermore, the federal government does not adequately enforce discharge planning requirements, placing immigrant patients at risk of medical repatriation.

Long-Term Care in New York City

The New York City Health and Hospitals Corporation (HHC), the country's largest municipal healthcare organization, frequently encounters the financial and ethical challenges that are associated with providing uncompensated care to undocumented immigrants. HHC's mission requires it to provide care to all New Yorkers, including undocumented immigrants, regardless of their ability to pay. As a result of its mission, HHC stands as one of the very few healthcare institutions across the country that provides post-acute care to undocumented immigrants.

Rather than medically deporting these patients, HHC either provides such patients with post-acute care at its hospitals or transfers them to its Coler-Goldwater Specialty Hospital and Nursing Facility, if there is available space. Neither of these options provides a true long-term fix. Many undocumented patients receiving care at HHC's facilities are ready to be moved to less expensive post-acute care facilities. However, because patients lack family to care for them or access to supportive housing, they cannot be discharged. Coler-Goldwater currently provides long-term care to a limited number of undocumented immigrants. Some of these patients are in a vegetative state and cannot be moved. Some of these patients have gotten well enough to leave the facility. However, they lack access to community-based supportive services and cannot be moved. Unfortunately, there are only a limited number of beds available at Coler-Goldwater and many undocumented immigrants in need of long-term care are unable to access the appropriate level of care.

HHC's experience highlights the very real challenges healthcare institutions face when providing care to undocumented immigrants. Despite these challenges, HHC refrains from engaging in medical repatriation.

As a condition of participation in Medicare, hospitals must provide discharge planning services to all patients, regardless of their insurance or immigration status, to ensure that all

patients receive appropriate post-hospital care.⁷¹ The services, which may include the creation of a discharge plan, are “essential to the health and safety of all patients.”⁷² Federal discharge planning regulations require that hospitals transfer patients to “appropriate facilities, agencies, or outpatient services” that comply with federal and state health and safety standards.⁷³

The federal discharge planning regulations provide that patients (or their representatives) should consent to their discharge plans.⁷⁴ As discussed below, defining “consent” within the medical repatriation context can be a murky and complicated endeavor.

Guidance from the American Medical Association’s Council on Ethical and Judicial Affairs

CEJA cautions that physicians should not authorize discharges unless “they have confirmed that the intended destination has adequate human and material resources for the patient[s’] medical needs.”⁷⁵

Given the potential hazards of international transfers, the American Medical Association’s Council on Ethical and Judicial Affairs (“CEJA”) has provided additional recommendations to guide hospitals engaged in transporting patients abroad. Specifically, CEJA advises that before authorizing an international transfer, physicians should carefully assess the patient’s specific medical stability for international transport and ensure that the patient receives sufficient care during the trip to mitigate the risks inherent in long-distance transport.⁷⁶

⁷¹ 42 C.F.R. § 482.43 (“The hospital must have in effect a discharge planning process that applies to all patients”).

⁷² *Id.* at (a), (b)(1).

⁷³ *Id.* at (d).

⁷⁴ *See* § 482.43 (c)(7) (“The hospital, as part of the discharge planning process, must inform the patient or the patient’s family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed”).

⁷⁵ Relative to a local discharge, an international discharge may require additional efforts to coordinate care effectively, such as speaking with the receiving physician through an interpreter or seeking reliable information about the standard of care at the facility in question”). *Id.* The report outlines the specific factors a physician should consider when deciding whether or not to transfer a patient internationally. “The physician should clarify expectations regarding a patient’s needs, and the minimum technological capabilities as well as provider expertise necessary to deliver an appropriate level of care.” *Id.* (“For patients with extensive care needs, the physician should keep in mind that many countries throughout the world are struggling to provide even basic medical care for their citizens, and are unlikely to be able to provide resource intensive care with public funds. Regardless of whether or not the discharging hospital is the best environment for the patient’s needs, the physician should not discharge the patient to care conditions that are inadequate to his or her needs.”). Physicians should also verify the country’s “availability of appropriate sustainable care at the destination.” *Id.* Medical ethicists have confirmed that it is imperative to “make sure that if we send someone abroad, there is no question that the foreign facility can properly take care of them.” Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 155 (2009).

⁷⁶ Dudley M. Stewart, Jr., AM. MED. ASS’N, CEJA REPORT 2-I-09, PHYSICIAN RESPONSIBILITIES FOR SAFE PATIENT DISCHARGE 5 (2009), available at <http://www.ama-assn.org/ama1/pub/upload/mm/interim-2009/i-09-council-reports.pdf>. (Physicians must ensure patients are “medically stable enough to leave the hospital setting and to travel distances ... before authorizing a discharge”).

Recognizing the limited health resources in countries outside the U.S., CEJA recommends that physicians assess the standard of care in the receiving country as well as the available technological and professional resources.

Despite CEJA's guidelines, hospitals rarely exercise such care in examining the appropriateness of international transfer for immigrant patients. Furthermore, due to weaknesses in federal discharge law, immigrant patients often find themselves in facilities that cannot meet their needs. For example, the U.S. Department of Health and Human Services (HHS) is charged with ensuring that discharges are appropriate. While HHS may be able to investigate and sanction hospitals that transfer patients to inappropriate domestic facilities, the federal government lacks the legal authority to investigate the appropriateness of international facilities. As a result, critically ill immigrant patients may be transferred to facilities that simply lack the capacity, supplies, or staff to adequately care for the patient.

Eduardo

As a result of a car accident, Eduardo suffered from severe head injuries and was admitted to a hospital in Charlotte, NC. The injuries from the accident induced a stroke and a brain hemorrhage. Eduardo was placed on a ventilator and in May of 2009, the hospital transferred him to Guatemala.⁷⁷

The hospital did not arrange for Eduardo to receive continued care at a Guatemalan hospital upon his arrival. A physician in Guatemala City who diagnosed Eduardo once he arrived said that he was in terminal condition. Eduardo had suffered an aneurism, which caused further brain injury and required the continued use of a ventilator. He was unable to communicate and could only move his head. Eduardo spent one night in a hospital and then was taken to his family's home in San Marcos where he died 15 days later.⁷⁸

Additionally, while virtually all domestic facilities are bound by discharge and transfer laws including EMTALA and the federal discharge requirements, international facilities may not be similarly bound by comparable laws. As a consequence, even when critically ill immigrant patients are discharged to facilities abroad with adequate services to treat them, they may

⁷⁷Case of Eduardo P, documented by the CSJ.

⁷⁸CSJ Interview with Dr. Herbert Castillo on August 9, 2010 in Guatemala City, Guatemala; Email correspondence with Dr. Castillo, October 13, 2010.

subsequently be transferred to facilities that lack proper resources to provide for their care. These patients may languish or even die as a result.

(UN)INFORMED CONSENT

Hospitals engaging in medical repatriation do so with varying degrees of patient consent.⁷⁹ Patients may consent to transfers without receiving the information necessary to make their decisions in a truly informed manner, including information about the medical risks and immigration consequences of transfer.⁸⁰ The issue of consent becomes even murkier in cases where a patient is comatose or otherwise lacks the capacity to consent by virtue of his or her medical condition, has a mental disability, or has a guardian appointed. In addition, even when an immigrant patient possesses the capacity to consent to transfer, hospitals may fail to provide adequate translation or interpretation services when necessary,⁸¹ rendering the patient's consent meaningless.

Enrique

In 2008, a stroke left Enrique brain-damaged and paralyzed on one side of his body. A New Jersey hospital admitted and treated Enrique but also immediately began efforts to repatriate him to Guatemala.

A nurse called Enrique's sister in Guatemala multiple times to convince her to consent to his repatriation, questioning her about Enrique's ability to pay and his immigration status. Enrique's sister made clear her family did not wish to have him sent back to Guatemala because he would not be able to obtain the care he needed. Despite his sister's objections, the hospital persisted in its calls and eventually informed her that Enrique's condition was near-death, even though Enrique was alive and undergoing rehabilitative therapy. Based on the hospital's false representation, Enrique's sister and family agreed to the repatriation. The hospital flew Enrique to Guatemala on a commercial plane where he was met by his family. In a rented van, they journeyed to their home in Chimaltenango.

The New Jersey hospital did not arrange for Enrique to receive any medical services once he reached Guatemala. The hospital simply sent him home with prescriptions for medication and provided his sister—who has no medical training—with instructions on his dietary needs and restrictions and for exercises to aid his

⁷⁹ See Sontag, *Deported*, *supra* note 15.

⁸⁰ See Agarwal, *supra* note 9.

⁸¹ Title VI of the Civil Rights Act of 1964 and its regulations require hospitals and health care providers to provide language assistance and interpretation services where appropriate. See 42 U.S.C. § 2000d ; *see also* U.S. DEP'T OF HEALTH AND HUMAN SERV., NAT'L STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERV. (CLAS), *available at* <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> (last visited Aug. 9, 2011). All 50 states have enacted language access laws in order to adequately address the health care needs of limited English proficient patients. See JANE PERKINS & MARA YODELMAN, NAT'L HEALTH L. PROGRAM, SUMMARY OF STATE LAW REQUIREMENTS: ADDRESSING LANGUAGE NEEDS IN HEALTH CARE , *available at* <http://www.healthlaw.org/images/stories/issues/nhelp.lep.state.law.chart.final.0319.pdf> (Last visited Aug. 9, 2011).

recovery. Enrique's sister has five children and works all day. She does not have sufficient time to care for Enrique, nor does she or other members of Enrique's family have the financial means to pay for the prescribed medications. In addition, the nearest medical facility that has the capacity to care for Enrique's special needs is more than an hour away. Since Enrique arrived in Guatemala, he received none of the treatment or rehabilitation required for his recovery.⁸²

(DIS)UNITY IN INFORMED CONSENT LAWS AND GUIDELINES

There are no uniform federal requirements for obtaining informed consent from a patient regarding medical treatment or procedures, let alone medical repatriation.⁸³ Individual states develop their own parameters for informed consent. The majority of states follow the “professional community standard,” which requires doctors to provide patients with “information as would be disclosed by a doctor of good standing within that community.”⁸⁴ Under this standard, doctors must disclose “available choices with respect to proposed therap[ies] and... the dangers inherently and potentially involved in each.”⁸⁵ This standard, however, is so nebulous that at least one state Supreme Court has noted that physicians could potentially exercise unlimited discretion in determining the amount and type of disclosure a patient receives.⁸⁶ Other states have adopted a “materiality standard,” which requires physicians to disclose such

⁸²CSJ interview with Enrique and his family members, San Martin Jilotepeque, Chimaltenango, Guatemala, August 11, 2010.

⁸³ See Constantine A. Mathous, Angela DeGirolamo, Christopher Haddad and Yaw Amaoteng-Adjepong, *Informed Consent for Medical Procedures: Local and National Practices*, CHEST, November 2003, at 1978 (“Although informed consent is mandated for surgical procedures, there are no explicitly stated national standards of practice regarding patient/surrogate consent for invasive medical procedures.”). Hospitals that participate in Medicare or Medicaid must comply with federal regulations that prescribe requirements for informed consent forms as a condition for participation. The Center for Medicaid and Medicare Services has issued interpretative guidelines for informed consent for medical procedures, stating “[T]he [patient’s] right to make informed decisions...includes the patient’s participation in the development of their plan of care..and in planning for care after discharge from the hospital.” CTR. FOR MEDICAID AND MEDICARE SERV., STATE OPERATIONS MANUAL, APPENDIX A,-0131, INTERPRETIVE GUIDELINES FOR 42 CFR § 481.13(B)(2), *available at* http://www.cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf. However, these guidelines do not specifically outline the information that should be provided to patients so that they can make informed decisions.

⁸⁴ Cobbs v. Grant, 8 Cal 3d. 229, 241 (1972).

⁸⁵ *Id.* at 243.

⁸⁶ *Id.* (“Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion... Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeablely consents to be subjected”).

information that would be material to a reasonably prudent patient in the patient's position.⁸⁷ The laws with respect to informed consent differ even for states that have adopted the same standard.⁸⁸ Despite the differences among state informed consent laws, a physician must, at a minimum, provide the patient with information concerning the risks of treatment in order for a patient's consent to be fully informed.⁸⁹ To date, no state laws regarding informed consent have dealt squarely with the issue of medical repatriation, specifying the types of information a patient must receive to make an informed decision.⁹⁰

Barbara

In September 2009, 58-year-old Barbara, a Polish citizen who had overstayed her visa, suffered a massive stroke while scrubbing a bathtub in a La Grange, Illinois home where she worked as a maid. The homeowner called 911, and Barbara was transported to La Grange Memorial Hospital for emergency care. The bleeding in her brain left her weak and paralyzed on her left side. As a result of the stroke, Barbara required around-the-clock care.

The day after she was admitted, the hospital social work team began planning her discharge. The team contacted over 30 agencies and facilities to find resources to assist Barbara with her long-term care needs. Because of her undocumented status, none of the agencies were willing to help her. The hospital considered medically repatriating Barbara. However, since no person or facility in Poland agreed to care for her, the hospital initially refrained from dumping her there.

La Grange Memorial Hospital provided care to Barbara, who lacked insurance and family resources, for two-and-a-half years at a cost of over \$1.4 million. Hospital administrators knew they could not afford to keep her indefinitely, but staff acknowledged that her departure would feel like losing a family member.⁹¹ In early

⁸⁷ Other states such as Oregon, Ohio and Texas have adopted the materiality standard, which requires physicians to disclose to patients such information that would be material to a reasonably prudent patient in the patient's position. Ohio Rev. Code Ann. § 2317.54 (2011); Or. Rev. Stat. § 677.097 (2011); Tex. Code Ann. art. 4590i-6.02.

⁸⁸ State laws subtly differ from one another. Oregon requires detailed disclosure and Ohio requires disclosure of reasonably known risks. Ohio also does not require written informed consent in certain situations and sets forth elements of informed consent for the written consent form, which, if satisfied, will constitute valid informed consent absent lack of good faith, fraud, or language barriers. *See generally* OHIO REV. CODE ANN. § 2317.54 (LexisNexis 2010).

⁸⁹ For example, California follows the professional community standard, imposing a duty upon doctors to disclose the "available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each." *See* Cobbs, 8 Cal 3d. at 241. New York adopts a similar standard and provides that informed consent should include the specific treatment and the reasons for it, reasonably foreseeable risks and benefits involved, and alternatives for care" N. Y. PUB. HEALTH LAW § 2805-D (McKinney 2010). *See also* N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7 b (9)(2010).

⁹⁰ *See* Wolpin, *supra* note 75, at 153.

⁹¹ Becky Schlikerman, *Undocumented immigrant's hospital stay stretches to 2 years*, CHI. TRIB., Sept. 18, 2011, http://articles.chicagotribune.com/2011-09-18/news/ct-met-polish-immigrant-hospital-20110918_1_undocumented-patients-emergency-care-closest-hospital.

2012, arrangements were made to transfer Barbara to a stroke specialty unit in Poland. Barbara refused to consent to the transfer, which would permanently separate her from her immediate family and rip her from the U.S., her home of over twenty years. In the face of her refusal, La Grange Memorial sought judicial permission to send Barbara to Poland. A Cook County judge granted their request at the end of February.⁹²

Barbara faced the relocation with reticence; she understood the financial burden she had placed on the hospital, but she knew she'd never be able to return to the U.S.—the place she'd called home.⁹³

In addition to state standards for informed consent, the American Medical Association has outlined elements of informed consent, requiring physicians to inform patients of their diagnosis—the nature, purpose, risks, and benefits of a proposed treatment or procedure, alternatives to the procedure and their associated risks and benefits, and the risks and benefits associated with foregoing the proposed treatment altogether.⁹⁴

IMMIGRATION CONSEQUENCES

Neither the standards set forth under state law, nor those set forth under the AMA, adequately address the unique circumstances surrounding patients facing medical repatriation. Patients at risk of medical repatriation are often non-citizens, with undocumented or limited status. For these patients, medical repatriation implicates a host of immigration concerns. One commentator, cognizant of the gravity of these concerns, has suggested that hospitals inform patients at risk of medical repatriation of the immigration consequences of their departure in much the same way that attorneys must inform non-citizen defendants in criminal cases of the immigration consequences of entering a not guilty plea.⁹⁵

⁹² Kate Snow, Janet Klein, and Dustin Stephens, *Health care laws leave hospitals overwhelmed by 'permanent patients,'* Rock Center with Brian Williams, MSNBC, Apr. 24, 2012, http://rockcenter.msnbc.msn.com/_news/2012/04/24/11371569-health-care-laws-leave-hospitals-overwhelmed-by-permanent-patients?lite.

⁹³ Becky Schlikerman, *Polish immigrant headed home*, CHI. TRIB., Mar. 1, 2012, http://articles.chicagotribune.com/2012-03-01/news/ct-met-polish-immigrant-goodbye-20120302_1_hospital-staff-poland-adventist-midwest-health.

⁹⁴ *Patient Physician Relationship Topics: Informed Consent*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page> (last visited Aug. 9, 2011).

⁹⁵ See Wolpin, *supra* note 75, at 154 (noting that awareness of immigration consequences is “particularly important for non-citizen patients because once outside the country, they will face significant logistical obstacles to obtaining legal remedies in U.S. courts and will be unable to challenge any part of their repatriation”).

For noncitizen patients, the immigration consequences of medical repatriation may be extremely important. For example, a lawful permanent resident may be ineligible for naturalization if, as a result of medical repatriation, s/he is absent from the U.S. for a period of six months or more. S/he may not be able to satisfy the continuous residency requirement⁹⁶ or physical presence requirement⁹⁷ necessary for naturalization and his or her application may be dismissed. Depending on the length of absence, the federal government may consider him or her to have abandoned his or her lawful permanent resident status.⁹⁸ A lawful permanent resident who abandons his or her status may not be able to re-enter the U.S. without first seeking admission, triggering the entire immigration process again.⁹⁹

Medical repatriation also has serious immigration consequences for undocumented immigrants. Federal immigration law prohibits persons who are unlawfully present within the U.S. for at least six months but less than a year from re-entering the U.S. for three years.¹⁰⁰ Also, as mentioned above, immigrants who are unlawfully present within the U.S. for more than a year and then voluntarily leave may not return to the U.S. for ten years.¹⁰¹

An undocumented patient, depending on his or her circumstances, may be eligible to adjust his or her status and remain in the U.S.¹⁰² When patients do not receive this type of

⁹⁶ The applicant must have a continuous residence in the U.S. subsequent to admission as a legal permanent resident for a period of at least five years. INA § 316 (a)(1), 8 U.S.C. § 1427 (a)(1) (2010).

⁹⁷ See INA §§ 316(a)(1), 319(a), 8 U.S.C. §§ 1427 (a)(1), 1430(a) (2010). The applicant must have been physically present in the U.S. for at least half the five (or three) years immediately prior to application.

⁹⁸ Matter of Huang, 19 I&N Dec. 749, 14 (BIA 1988).

⁹⁹ See 8 U.S.C. §§ 1101 (a)(13)(c)(i)-(ii) (“An alien lawfully admitted for permanent residence in the United States shall not be regarded as seeking an admission into the United States for purposes of the immigration laws unless the alien -(i) has abandoned or relinquished that status, (ii) has been absent from the United States for a continuous period in excess of 180 days...”).

¹⁰⁰ INA § 212 (a)(9)(B)(i)(I), 8 U.S.C. § 1182 (a)(9)(B)(i)(I) (2010).

¹⁰¹ INA § 212 (a)(9)(B)(i)(II), 8 U.S.C. § 1182 (a)(9)(B)(i)(II) (2010).

¹⁰² Immigration options that allow persons facing traditional deportation to remain in the United States are also available to those facing medical repatriation. For example, in the deportation context, undocumented aliens may actually qualify for cancellation of removal if they have resided in the United States for more than ten years and if their deportation would result in extreme and exceptional unusual hardship to a US citizen or legal permanent resident family member. INA § 240A (b)(1), 8 U.S.C. § 1229b (b)(1); see also Nessel, *supra* note 17, at 1741. Certain undocumented immigrants with mental disabilities can also qualify for political asylum if they can demonstrate that they have a well-founded fear of future persecution within their home country as a result of their mental disability. *Id.* at 1735. Others can also qualify for asylum under the United Nations Convention Against Torture if they can demonstrate that the medical treatment within their home country is so grossly inadequate as to constitute torture. *Id.* Still other undocumented persons can qualify for temporary protected status if they are from certain designated countries, such as Haiti. *Id.* Patients who are victims of certain serious crimes can also qualify for a U visa and later apply for adjustment of status and remain in the United States. INA § 245(m); 8 U.S.C. 1255. These crimes include rape, torture, felonious assault, domestic violence, trafficking in persons, among others. INA

information, they may unwittingly consent to transfers that place their health and ability to return to the U.S. at risk. Patients who consent to medical repatriation without understanding the full ramifications of their decisions may deprive themselves of the ability to return to the U.S., with the unfortunate consequence of severing their connections to family members who remain in the U.S.

§ 101 (a)(15)(U)(iii), 8 U.S.C. § 1101 (a)(15)(U)(iii)(2010). Patients who are victims of human trafficking (and their immediate family members) may also be eligible to apply for a T visa which allows them to remain and work temporarily in the U.S. if they assist law enforcement in investigating and prosecuting their trafficking perpetrators. Once a T nonimmigrant visa is granted, a victim can apply for permanent residence after three years. INA § 101 (a)(15)(T)(i), 8 U.S.C. § 1101 (a)(15)(T)(i)(2000).

GUARANTEED HUMAN RIGHTS

“We were so scared. They said we had no rights, the baby neither. They said they would send the baby with or without me. When Elliot was two weeks, they told me to gather my things because the baby was leaving in fifteen minutes with a lady.”

-Gricelda Mejia Medehuari

RIGHT TO DUE PROCESS

When hospitals remove immigrant patients from the U.S. against their will or through coercion, this action is tantamount to a *de facto* deportation, which violates the patients’ right to due process. The U.S. is bound to protect immigrants’ right to due process under both international law and the Constitution.¹⁰³

Due Process under International Human Rights Law

The U.S. has signed a number of international treaties that explicitly mandate protection of the right to due process for immigrants. Pursuant to Article 13 of the ICCPR, the U.S. has agreed that any immigrant “lawfully in its territory” will only be removed by “a decision reached in accordance with law,” after that individual has had the opportunity to “submit reasons against ... expulsion” and after the case has been “reviewed by... the competent authority or a person or persons especially designated by the competent authority.”¹⁰⁴ The UN Human Rights Committee, which monitors compliance with the ICCPR, has broadened the definition of who is considered “lawfully in its territory” to include immigrants whose “entry or stay is in dispute.”¹⁰⁵ As will be explained in further detail below, immigrant patients who are subject to removal by hospitals may have multiple bases through which to challenge their deportation. However, when hospitals deport immigrants unlawfully, they usurp the government’s responsibility to interpret

¹⁰³ See U.S. CONST. amend. V (“No person shall... be deprived of life, liberty, or property, without due process of law...”); See also amend. XIV (“...nor shall any State deprive any person of life, liberty, or property, without due process of law...”)

¹⁰⁴ International Covenant on Civil and Political Rights, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR] (signed by the United States Oct. 5, 1977 where the United States declared that “the provisions of articles 1 through 27 of the Covenant are not self-executing.”) Thus, the provisions of the ICCPR and other non-self-executing treaties only come into force in domestic law when the treaty is included in domestic legislation. As of the present time, the United States has not enacted such legislation.

¹⁰⁵ See Human Rights Comm., General Comment No. 15, The position of aliens under the Covenant, UN Doc. HRI/GEN/1/Rev.1 at 18 (April 11, 1994), *available at* <http://www1.umn.edu/humanrts/gencomm/hrcom15.htm>.

and apply domestic immigration law and deny immigrant patients the opportunity to pursue these avenues for immigration relief.

Marlene

"... they moved Marlene, a patient with an unhealed wound, through the area where they remove the hospital's garbage..."

Marlene was a typical teenager. An athletic and vibrant nineteen-year-old, she loved to dance, play baseball, and was described by her aunt as "always smiling." Marlene dreamed of becoming a police officer and serving on the SWAT team. But just two months after her high school graduation, a family friend entered her home and shot Marlene in the head. She was rushed to a public hospital in Arizona.

Marlene was different than many Arizona teenagers in one way—she was an undocumented immigrant. As a one-year-old, prior even to her first memory, Marlene was brought into the U.S. by her parents. Therefore, despite living virtually her entire life in America, Marlene was not eligible for medical financial assistance. Upon arrival at the hospital, Marlene was admitted and initially "stabilized" by doctors. After learning that she was undocumented, the hospital began pressuring Marlene's relatives to agree to repatriation. The pressure by the hospital persisted while the family attempted to find any avenue of assistance. Meanwhile, Marlene developed an intestinal infection, severe fever, pneumonia, and suffered a heart attack.

Desperate to get Marlene treatment, the family agreed to her transfer, but still asked their attorney to investigate any possible relief which would allow Marlene to stay in the U.S. One option was a U-Visa, which, if granted, would have allowed Marlene to remain in the country to assist in the investigation of the crime. The hospital, however, would not delay Marlene's transfer, and the doctors at the hospital said that she was stable and able to travel. At 9:00 AM on August 10, 2010, Marlene was wheeled out a back entrance of the hospital and taken to Mexico. Upon her arrival, she was diagnosed with septicemia, pneumonia, and meningitis. Marlene died at 5:05 AM on August 11, 2010.

Additionally, within the Inter-American system of human rights, there are a number of provisions that aim to protect the due process rights of all individuals, regardless of their immigration status. Article XXVI of the American Declaration of the Rights and Duties of Man establishes that "[e]very person accused of an offense has the right to be given an impartial and public hearing, and to be tried by courts previously established in accordance with pre-existing

laws, and not to receive cruel, infamous or unusual punishment.”¹⁰⁶ The Inter-American Court has observed that the due process of law guarantee must be observed in administrative proceedings.¹⁰⁷ The Inter-American Commission on Human Rights (IACHR) has therefore concluded that mechanisms regulating entry and departure of immigrants “must *always* be applied with *strict regard* for the guarantees of due process and respect for human dignity,”¹⁰⁸ and further established that “to deny an alleged victim the protection afforded by Article XXVI simply by virtue of the nature of immigration proceedings would contradict the very object of this provision and its purpose.”¹⁰⁹

The IACHR has also examined the relationship between the right to due process and the right to be free from inhumane treatment in the context of deportation to a country that cannot provide required medical treatment. In a case involving a critically ill woman in need of life-sustaining medication that was unavailable in Jamaica, the IACHR recommended that the U.S. refrain from deportation. The Commission also provided important guidance for balancing the right of a sovereign nation to control its borders with the individual’s right to humane treatment and due process when lack of medical care in the home country is at issue. As set forth by the IACHR,

The appropriate test is whether the humanitarian appeal of the case is so powerful that it could not reasonably be resisted by the authorities of a civilized State. More specifically, the question to answer is whether, on humanitarian grounds, a person’s medical condition is such that he or she should not be expelled unless it can be shown that the medical and social facilities that he or she undeniably requires are actually available in the receiving state. Therefore, the applicable standard will consist of whether the deportation will create extraordinary hardship to the deportee and her family and may well amount to a death sentence given two principal considerations: (1) the availability of medical care in the receiving country and (2) the availability of social services and support, in particular the presence of close relatives.¹¹⁰

¹⁰⁶ American Declaration of the Rights and Duties of Man, O.A.S. Res. XXX, adopted by the Ninth International Conference of American States (1948), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1, art. XXVI (1992).

¹⁰⁷ *Sawhoyamaya Indigenous Community v. Paraguay*, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 82 (March 29, 2006).

¹⁰⁸ INTER-AM. CT. H.R., REPORT ON IMMIGRATION IN THE UNITED STATES: DETENTION AND DUE PROCESS 11 (2010), available at <http://cidh.org/pdf%20files/ReportOnImmigrationInTheUnited%20States-DetentionAndDueProcess.pdf> [hereinafter REPORT ON IMMIGRATION].

¹⁰⁹ *Mortlock v. United States*, Admissibility and Merits, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 12.534, ¶ 83 (July 25, 2008).

¹¹⁰ *Id.* at ¶ 91.

The due process rights protected in Article XXVI of the American Declaration were further reaffirmed in Article 8 of the American Convention.¹¹¹ Article 8 provides that “every person has the right to a hearing, with due guarantees and within a reasonable time, by a competent, independent, and impartial tribunal, previously established by law.”¹¹² The IACHR has observed that the due process rights set forth in Article 8 of the American Convention “establish a baseline of due process to which all immigrants, whatever their situation, have a right.”¹¹³ Additionally, Article XXV of the American Declaration states that “[n]o person may be deprived of his liberty except in the cases and according to the procedures established by pre-existing law.”¹¹⁴

When hospitals engage in forced or coerced medical repatriations of ill or injured immigrants directly from their hospital beds, such actions are tantamount to deportation. However, because the hospitals circumvent immigration proceedings and there is no governmental involvement or oversight, the repatriated immigrants are denied the right to due process that is guaranteed by international human rights law. As the IACHR articulated in the *Mortlock* case above, deporting a critically ill immigrant to a country which lacks both required medical care and a social support network violates the right to due process and to be free from inhumane treatment. Hospitals should not be allowed greater leeway to violate immigrant patients’ human rights than would be afforded to the governmental entities entrusted to control the admission and removal of noncitizens.

¹¹¹ Although the United States has not ratified the American Convention, it has a duty as a signatory not to undermine the object and purpose of the treaty. Vienna Convention on the Law of Treaties, adopted May 29, 1969, UN Doc. A/Conf.39/27, 1155 U.N.T.S. 331, entered into force Jan. 27, 1980, art. 18(1). See Report on Immigration, *supra* note 41, at 19.

¹¹² American Convention on Human Rights, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123, entered into force July 18, 1978, reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 25 (1992).

¹¹³ See INTER-AM. CT. H.R., SECOND PROGRESS REPORT OF THE SPECIAL RAPPORTEURSHIP ON MIGRANT WORKERS AND THEIR FAMILIES IN THE HEMISPHERE, ¶ 90 (April 16, 2001), available at <http://www.cidh.oas.org/annualrep/2000eng/chap.6.htm>; see also *Wayne Smith v. United States*, Admissibility, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 12.562, ¶ 51 (July 20, 2006); and *Loren Laroye Riebe Star et al. v. Mexico*, Merits, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 11.610, ¶ 46 (April 13, 1999) (finding that three legal residents of Mexico were arbitrarily deprived of their liberty by being expelled in a summary fashion and without a hearing).

¹¹⁴ American Declaration, *supra* note 39, at Art. XXV.

Due Process Pursuant to the Constitution

U.S. domestic law regarding the rights of immigrants comports with these international standards. Since the early 20th Century, the Supreme Court of the U.S. has recognized that immigrants within the U.S. are entitled to due process under the U.S. Constitution. The Fifth and Fourteenth Amendments provide all “persons” the protection from being deprived “of life, liberty, or property, without due process of law.”¹¹⁵ As articulated by the Supreme Court, even immigrants “whose presence in this country is unlawful, have long been recognized as ‘persons’ guaranteed due process of law by the Fifth and Fourteenth Amendments.”¹¹⁶ Furthermore, the courts have long held that the power to regulate immigration is plenary and rests exclusively with the Executive and Legislative branches of the federal government.¹¹⁷

Thus, non-citizens can only be deported from the U.S. in accordance with a carefully designed federal statutory and regulatory scheme and due process protections. Specifically, Congress has delegated to the Secretary of Homeland Security and the U.S. Attorney General the exclusive authority to deport persons¹¹⁸ and mandated that deportation “proceeding[s] under [the Immigration and Naturalization Act] shall be the *sole and exclusive procedure* for determining whether an alien may be...removed from the U.S.”¹¹⁹ This proceeding entails: a hearing before an Immigration Judge¹²⁰ at which the government carries “the burden of establishing by clear and convincing evidence that...the alien is deportable;”¹²¹ notice of the right to appeal the decision;¹²² an opportunity to move the immigration judge to reconsider;¹²³ an opportunity to seek discretionary relief of removal;¹²⁴ and an opportunity to obtain habeas review of the

¹¹⁵ U.S. CONST. amend. V, XIV.

¹¹⁶ *Plyler v. Doe*, 457 U.S. 202, 210 (1982), *citing* *Shaughnessy v. Mezei*, 345 U.S. 206, 212 (1953).

¹¹⁷ See e.g. *Chae Chan Ping v. United States* (“The Chinese Exclusion Case”), 130 U.S. 581 (1889); *Kleindienst v. Mandel*, 408 U.S. 753 (1972)

¹¹⁸ 8 U.S.C. § 1103 (a)(1) (2010) (“The Secretary of Homeland Security shall be charged with the administration and enforcement of this chapter and all other laws relating to the immigration and naturalization of aliens”).

¹¹⁹ 8 U.S.C.S. § 1229a (a)(3) (2010) (“[A] proceeding under this section shall be the sole and exclusive procedure for determining whether an alien may be... removed from the United States”).

¹²⁰ 8 U.S.C. § 1229a(1) (2006).

¹²¹ 8 U.S.C. § 1229c(3)(A) (2006).

¹²² 8 U.S.C. § 1229c(5) (2006).

¹²³ 8 U.S.C. § 1229c(6) (2006).

¹²⁴ 8 U.S.C. § 1229c(4) (2006).

decision not to consider waiver of deportation.¹²⁵ Immigrants must be notified of the grounds for their removal, their right to an attorney, and their right to a fair hearing that allows them a reasonable opportunity to examine the evidence against them and to present evidence on their behalf.¹²⁶ As a further protection, the Immigration Judge who oversees the hearing must inform immigrants of their eligibility for relief from deportation—such as fear of ill-treatment or hardship they may suffer as a result of removal—and afford them the opportunity to apply for such relief.¹²⁷ If a judge orders an immigrant deported, the immigrant still has the right to appeal to the Board of Immigration Appeals and a federal court.¹²⁸ In each stage of this process, an immigrant must be informed of all of his or her rights in this process in a language s/he understands or the deportation order will be considered invalid.¹²⁹

Given the federal government’s plenary power to determine immigration policy and the procedures explicitly established by Congress, state courts and private actors such as hospitals have no legal authority to deport people.¹³⁰ Immigration status is complex, often changes over

¹²⁵ *INS v. St. Cyr*, 533 U.S. 289, 314 (2001). For a discussion of the due process rights of immigrants in removal proceedings, see Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CIN. L. REV. 657, 680 (2009).

¹²⁶ 8 U.S.C. § 1229a, § 1229b (2010); and 8 C.F.R. §§ 287.3 (c), 1240.10.

¹²⁷ See e.g., *United States v. Muro-Inclan*, 249 F.3d 1180, 1183-4 (9th Cir. 2001); 8 C.F.R. § 1240.49(a), 1240.11(a)(2) (“The immigration judge shall inform the alien of his or her apparent eligibility to apply for any of the benefits enumerated in this chapter and shall afford the alien an opportunity to make application during the hearing”). See also *United States v. Arrieta*, 224 F.3d 1076, 1079 (9th Cir. 2000) (“[W]here the record contains an inference that the petitioner is eligible for relief from deportation, ‘the immigration judge must advise the alien of this possibility and give him the opportunity to develop the issue’”) (internal citations omitted) and *Moran-Enriquez v. I.N.S.*, 884 F.2d 420, 422 (9th Cir. 1989) (holding that there is a due process right to be informed if one appears to be eligible for relief from deportation).

¹²⁸ 8 U.S.C. § 1252.

¹²⁹ See *United States v. Mendoza-Lopez*, 481 U.S. 828, 840 (1987) (failure of immigration judge to advise alien of his right to appeal and his eligibility for a waiver of deportation violated his due process rights and “amounted to a complete deprivation of judicial review of the determination”); *United States v. Lopez-Vasquez*, 1 F.3d 751, 754 (9th Cir. 1993) (holding that hearing deprived petitioner of his right to due process even where the immigration judge explained the right to appeal and provided petitioner with a form explaining his right to an appeal in Spanish because the information was given to him in a group format). If an immigrant forgoes her right to appeal the removal order, her waiver of appeal “must be both ‘considered and intelligent.’” *Arrieta*, 224 F.3d. at 1079, citing *Mendoza-Lopez*. An immigrant who does not speak English must also be provided an interpreter during immigration proceedings. See, e.g., *Matter of Tomas*, 19 I&N Dec. 464 (BIA Aug. 6, 1987).

¹³⁰ See *Hines v. Davidowitz*, 312 U.S. 52, 66 (1941) (holding that “...where the federal government, in the exercise of its superior authority in this field, has enacted a complete scheme of regulation, states cannot, inconsistently with the purpose of Congress, conflict or interfere with, curtail or complement, the federal law, or enforce additional or auxiliary regulations).

time, and varies among members of a household.¹³¹ Immigrants who currently lack legal status may be in the process of acquiring legal status¹³² or may not be subject to deportation pursuant to U.S. policies. In certain circumstances, even immigrants who are present in the U.S. without formal permission are eligible to adjust their immigration status or apply for a visa.¹³³ Due process safeguards ensure an accurate determination of immigration status before an individual is forced to leave the country. Without a federal immigration hearing, immigrants are at risk of being repatriated without being advised about the potential ways to obtain lawful immigration status as well as the immigration consequences associated with voluntarily departing from the U.S. after a period of undocumented status. Additionally, as the cases documented in this report illustrate, hospitals have repatriated immigrants who were lawfully present or eligible for immigration relief, or even held U.S. citizenship status.

Elliot

While two-day-old U.S. citizen Elliot slept in the neonatal intensive care unit of a hospital in Arizona, the hospital began making arrangements to transfer him to a hospital in Mexico. Born with down syndrome as well as a heart problem, Elliot was in need of continuing care, but the hospital stated that its policy was to transfer patients to their “community of residence” when they had such needs. It was irrelevant, according to the hospital, that Elliot was a U.S. citizen.

When Elliot was two weeks old, the hospital informed his mother that they were moving Elliot to Hermosillo, Mexico. Terrified, Elliot’s mother contacted the Mexican consulate, who in turn put her in touch with a local lawyer, Fernando Gaxiola. Mr. Gaxiola called the hospital asking them to delay the transfer while he sought a court order of protection, but an attorney for the hospital stated it was too late. Elliot was already en route to the airport.

With time running out, Mr. Gaxiola had Elliot’s parents transfer custody to him, at

¹³¹See e.g., *Drax v. Reno*, 338 F.3d 98, 99 (2d Cir. 2003) (describing “the labyrinthine character of modern immigration law” as “a maze of hyper-technical statutes and regulations”).

¹³²See e.g., 8 U.S.C. §§ 1255 (i) (allowing immigrants to adjust status to lawful permanent residence), 1158 (authorizing asylum to refugees fleeing persecution abroad), 1229b (b) (providing relief from deportation to certain persons otherwise subject to removal); 8 C.F.R. § 244.2 (granting certain immigrants temporary protected status).

¹³³See generally Nessel, *supra* note 17. These remedies can result in postponement of removal, cancellation of removal, or even adjustment of status to that of lawful permanent resident. See 8 U.S.C. §§ 1229a (c)(4), 1229b. See also 8 U.S.C. §§ 1158, 1254a (protection from removal for fear of persecution or ongoing armed conflict in home country), 1182 (d)(5)(A) (parole for “urgent humanitarian reasons or significant public benefit”), 1227 (a)(1)(E)(iii) (waiver of a ground of deportability for purposes of family unity). An immigrant who has suffered past persecution is eligible for a discretionary grant of asylum on humanitarian grounds if he has established a reasonable possibility that he may suffer other serious harm upon removal to that country, unrelated to the past persecution. 8 C.F.R. § 1208.13 (b)(1)(iii).

which point he called 9-1-1 and informed the police that a kidnapping was occurring. He subsequently called the hospital to inform them that his consent was required to move Elliot. The police arrived at the airport in time to stop the flight, and Elliot was returned to the hospital.

As a citizen, Elliot was eventually approved by the Arizona Medicaid system for coverage. Mr. Gaxiola pointed out that the “medical pretext for the transfer disappeared once they found the money.”¹³⁴

RIGHT TO LIFE AND PRESERVATION OF HEALTH AND WELL-BEING

When critically ill or catastrophically injured immigrant patients are transferred to facilities abroad that cannot adequately provide the care they require, their health, and in some instances their lives, are put in jeopardy. Accordingly, these patients’ rights to life and preservation of health and well-being are undermined. These rights are protected by the ICCPR, the American Convention, and the American Declaration, and the ICESCR. However, the U.S. current legislative scheme fails to protect immigrant patients’ rights to life and the preservation of health.

International Human Rights Law

The U.S. is bound by the ICCPR, which it has signed and ratified, to protect the right to life. Article 6 of the ICCPR provides that “[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.”¹³⁵ The UN Committee on Human Rights—the monitoring body of the ICCPR—has explained that the right to life under Article 6 “should not be interpreted narrowly,”¹³⁶ and in order to sufficiently protect the right, countries should adopt positive measures to ensure the protection of this right.¹³⁷

Within the Inter-American system, there are also significant protections for the right to life. Article 4 of the American Convention guarantees the right to life using the same language contained in Article 6 of the ICCPR. Article I of the American Declaration also provides that

¹³⁴ Tim Vanderpool, *Baby on Board*, Tucson Weekly, Sept. 4, 2008, <http://www.tucsonweekly.com/tucson/baby-on-board/Content?oid=1092330>.

¹³⁵ ICCPR, *supra* note 104, at Art. 6.

¹³⁶ Human Rights Comm., General Comment No. 6: The Right to Life (Article 6), UN Doc. HRI/GEN/1/Rev.9 (Vol.I), ¶ 1 (Apr. 30, 1982) available at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument).

¹³⁷ *Id.* at ¶ 5.

“[e]very human being has the right to life, liberty, and the security of his person.”¹³⁸ The Inter-American Court has found that Article I does not just encompass protection from death, but also speaks to the right to live a dignified life. In the *Street Children* case, petitioners brought action against Guatemala for its failure to protect the lives of five children from abuses and killings by the security forces. The Court announced that:

The right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning. Owing to the fundamental nature of the right to life, restrictive approaches to it are inadmissible. In essence, the fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. [Countries] have the obligation to guarantee the creation of the conditions required in order that violations of this basic right do not occur. . . .¹³⁹

Furthermore, a violation of this right occurs when the country had knowledge of a threat to the right to life and did not reasonably act within the scope of its authority to prevent it.¹⁴⁰

Additionally, the IACHR has found that forcible repatriations may constitute a deprivation of life resulting in a violation of Article I.¹⁴¹ For example, in the *Haitian Centre for Human Rights et al. v. United States* case, petitioners alleged that the U.S. practice of interdicting and forcibly returning Haitian refugees placed them in great danger and violated their guaranteed right to life. The Commission declared the right to life includes “a person’s legal and uninterrupted enjoyment of his life, his limbs, his body, his health and his reputation.”¹⁴² The IACHR found that this right was violated when the U.S. “interdict[ed] Haitians on the high seas, place[d] them in vessels under their jurisdiction, return[ed] them to Haiti, and [left] them exposed to acts of brutality by the Haitian military and its supporters.”¹⁴³

¹³⁸ American Declaration, *supra* note 106, at 17.

¹³⁹ Villagrán-Morales et al. v. Guatemala (“Street Children”), Judgment, Inter. Am. Ct. H.R. (Ser. C) No. 63, ¶ 144 (Nov. 19, 1999).

¹⁴⁰ Sawhoyamaya Indigenous Community v. Paraguay, Judgment, Inter. Am. Ct. H.R. (Ser. C) No. 146, ¶ 155 (Mar. 29, 2006); *see also*, Yakyé Axa Indigenous Community v. Paraguay, Judgment, Inter. Am. Ct. H.R., (Ser. C) No. 125, ¶ 162 (June 17, 2005) (“[T]he State has the duty to take positive, concrete measures geared toward fulfillment of the right to a decent life, especially in the case of persons who are vulnerable and at risk”). *See also* Ximenes-Lopes v. Brazil, Judgment, Inter. Am. Ct. H.R. (Ser. C) No. 149 ¶ 125, (July 4, 2006).

¹⁴¹ The Haitian Centre for Human Rights et al. v. United States, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 10.675 (Mar. 13, 1997).

¹⁴² *Id.* at ¶ 170.

¹⁴³ *Id.* at ¶ 171.

This obligation extends to U.S. regulation and supervision of hospitals, whose engagement in medical repatriation amounts to *de facto* deportation and inevitably infringes upon immigrants' right to life. When patients are repatriated to inadequate facilities abroad or repatriated without transfer to another medical facility,¹⁴⁴ this deprivation of vital care often results in significant deterioration of the patients' health, or in death, in violation of the right to life. These consequences are inherent risks of forced or coerced medical repatriation due to the hasty nature of the transfers abroad and the lack of continuity in medical care. By failing to act to prevent forced or coerced medical repatriations from occurring, the U.S. is interfering with the right to life guaranteed under international law.

Antonio

Antonio was taken to the emergency room of a Las Vegas hospital in 2009 after being hit by a car. He was diagnosed with severe spinal injuries and given preliminary treatment. However, after learning that Antonio lacked insurance, hospital administrators decided to transfer Antonio. The hospital asked his guardian and family members for permission to transfer Antonio to Guatemala. The family refused the hospital's request.

Not heeding the family's objections, the hospital hired a plane and repatriated Antonio to Guatemala, leaving him on the tarmac where his family met him after travelling over two hours from their home in San Marcos. Since the hospital had made no arrangements for Antonio's medical care once he arrived in Guatemala, his family hired a taxi cab to drive them from hospital to hospital throughout Guatemala City in search of one that would accept him. Each hospital refused to take him because they claimed that they were at capacity. Left with no other option, Antonio's family paid an ambulance to drive him from Guatemala City to their home in San Marcos. Within weeks of his repatriation, Antonio contracted an infection and died.¹⁴⁵

The right to life is intrinsically linked to the right to the preservation of health and well-being contained in Article XI of the American Declaration. This Article provides that “[e]very person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and *medical care*, to the extent permitted by public and community resources.”¹⁴⁶ Moreover, under the Universal Declaration of Human Rights and the

¹⁴⁴ Case of Antonio, documented by the CSJ.

¹⁴⁵ Case of Antonio., documented by the CSJ; CSJ email correspondence with Ubaldo Villatoro, advisor to the National Council of Migrant Care in Guatemala (CONAMIGUA), August 7, 2010; CSJ Telephone Interview with family member of Antonio, July 22, 2010, and email August 8, 2010 (family member wishes to remain anonymous).

¹⁴⁶ See American Declaration, *supra* note 106, at Art. XI

ICESCR, the U.S. is also committed to protecting the right to health. Specifically, the Universal Declaration of Human Rights states, “[e]veryone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and *medical care* and necessary social services.”¹⁴⁷ Article 23 of the ICESCR provides that “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁴⁸ The UN Committee on Economic, Social and Cultural Rights has recognized that countries have minimum core obligations to assure that health care is accessible without discrimination, with particular emphasis on “the most vulnerable or marginalized sections of the population.”¹⁴⁹ The Committee has further affirmed that all migrants deserve to enjoy the right to health, asserting that countries “are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”¹⁵⁰ By allowing for undocumented immigrants who are in need of medical treatment to be repatriated against their will, the U.S. is violating the right to health established under international law.

THE DUTY OF DUE DILIGENCE UNDER INTERNATIONAL HUMAN RIGHTS LAW

International human rights law mandates that countries exercise due diligence in order to protect individuals within its borders from human rights violations. Specifically, countries have a duty to prevent, investigate, and punish violations of human rights and, when possible, ensure adequate compensation to victims as warranted for damages resulting from these violations. Under this standard of due diligence, even when the violation of a human right is not the result of any governmental action, responsibility for violations of that right can be imputed to the country when it fails to fulfill its duties. The obligation to exercise due diligence is found in a number of

¹⁴⁷ Cf. Universal Declaration of Human Rights, G.A. Res. 217A (III), UN GOAOR, 3d Sess., 1st plen. Mtg., UN Doc A/810, Art 25(1) (1948) [hereinafter UDHR].

¹⁴⁸ Cf. International Covenant on Economic, Social and Cultural Rights, 993 U.N.T.S. 3, Art. 12. (entered into force Jan. 3, 1976).

¹⁴⁹ Cf. Comm. On Econ., Soc. & Cultural Rights, General Comment No. 14: Article 12, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, ¶ 12 (Nov. 8, 2000).

¹⁵⁰ *Special Rapporteur On The Right Of Everyone To The Enjoyment Of The Highest Attainable Standard Of Physical And Mental Health*, OHCHR, <http://www2.ohchr.org/english/issues/health/right/> (last visited Dec. 7, 2011).

treaties to which the U.S. is a signatory or party, namely the American Convention, ICCPR, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

For instance, the IACHR has interpreted Article 1(1) of the American Convention¹⁵¹ to require that countries exercise due diligence to prevent human rights violations and thus has held countries responsible for human rights violations committed by private actors.¹⁵² In the seminal case of *Velasquez Rodriguez v. Honduras*,¹⁵³ the Inter-American Court held that a country is responsible for the actions of private parties when a violation of an individual's rights occurs "with the support or acquiescence of the government, or when the [country] has allowed the act to take place without taking measures to prevent it or punish those responsible."¹⁵⁴

Similar to the American Convention, the ICCPR, to which the U.S. is a party, mandates that countries act with due diligence to protect individuals, investigate harms, punish violators, and redress the victims.¹⁵⁵ Article 2 Section 1¹⁵⁶ of the ICCPR dictates that each country must ensure that "all individuals within its territory and subject to its jurisdiction" are equally afforded the rights laid out in the ICCPR, regardless of their immigration status. The United Nations Human Rights Committee comment to this Section clarifies that, under Section 1, each country is obligated to exercise due diligence for actions committed by both governmental and non-governmental actors.¹⁵⁷

¹⁵¹ American Convention on Human Rights, Art. 1(1), <http://www.oas.org/juridico/english/treaties/b-32.html>. "The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition."

¹⁵² *Velásquez Rodríguez v. Honduras*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 4, ¶ 178 (July 29, 1988).

¹⁵³ *Id.* at ¶ 174.

¹⁵⁴ See *Velásquez Rodríguez*, Inter-Am. Ct. H.R. (ser. C) No. 12.562, at ¶ 178.

¹⁵⁵ Human Rights Comm., General Comment No. 31 [80]: The Nature of the General Legal Obligation Imposed on State Parties to the Covenant, UN Doc. CCPR/C/21/Rev.1/Add.13 ¶ 11 (May 26, 2004) [hereinafter General Comment 31], *available at*

<http://www.unhchr.ch/tbs/doc.nsf/0/58f5d4646e861359c1256ff600533f5f?Opendocument>.

¹⁵⁶ ICCPR, *supra* note 104 at Art. 2 (1). "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

¹⁵⁷ See General Comment 31, *supra* note 155, ¶ 11. "However the positive obligations on States Parties to ensure Covenant rights will only be fully discharged if individuals are protected by the State, not just against violations of Covenant rights by its agents, but also against acts committed by private persons or entities that would impair the enjoyment of Covenant rights in so far as they are amenable to application between private persons or entities. There

Likewise, the Committee against Torture, the monitoring body for CAT, stated:

...where [governmental] authorities or others acting in official capacity or under color of law, know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-[governmental] officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-[governmental] officials or private actors consistently with this Convention, the [country] bears responsibility and its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts.¹⁵⁸

In the context of medical repatriation, the U.S. government is responsible for the ensuing human rights violations because it is aware of the ongoing practice of medical repatriations and is turning a blind eye. A recent *New York Times* article quoted Kelly Nantel, a spokeswoman for ICE, as saying that ICE “does not get involved in repatriations undertaken by hospitals.”¹⁵⁹ Additionally, in April 2010, CSJ submitted a report detailing medical repatriations to the United Nations Human Rights Council as part of the Human Rights Council Universal Periodic Review of U.S. compliance with international human rights norms.¹⁶⁰ The report was cited in the Office of the High Commissioner on Human Rights (OHCHR) Summary of stakeholders’ information that includes “credible and reliable information” submitted by other relevant stakeholders.¹⁶¹ To date, the U.S. government has not responded to this submission nor addressed the practice of medical repatriations by hospitals that are directly funded by the federal government and deporting immigrants under the color of law.

To make matters worse, in some cases, the U.S. government not only acquiesces, but also actively supports hospitals that engage in this practice. Pursuant to the Western Hemisphere

may be circumstances in which a failure to ensure Covenant rights as required by article 2 would give rise to violations by States Parties of those rights, as a result of States Parties’ permitting or failing to take appropriate measures or to *exercise due diligence to prevent, punish, investigate or redress the harm caused by such acts by private persons or entities*” (emphasis added).

¹⁵⁸ See UN Comm. Against Torture, General Comment No. 2: Implementation of article 2 by States Parties, UN Doc. CAT/C/GC/2/CRP. 1/Rev.4 (Nov. 23, 2007), available at http://www1.umn.edu/humanrts/cat/general_comments/cat-gencom2.html.

¹⁵⁹ See Sontag, *Deported*, *supra* note 15.

¹⁶⁰ CSJ and NYLPI, *Submission to the United Nations Human Rights Council as Part of its Universal Periodic Review Regarding the Extrajudicial Involuntary Deportations of Immigrant Patients by U.S. Hospitals*, Ninth Session of the Working Group on the UPR, Human Rights Council, available at http://lib.ohchr.org/HRBodies/UPR/Documents/session9/US/SHUSL_SetonHallUniversitySchool.pdf.

¹⁶¹ See Office of the High Commissioner for Human Rights, *Summary prepared by the Office of the High Commissioner for Human Rights in accordance with paragraph 15 (c) of the annex to Human Rights Council resolution 5/1*, Ninth Session of the Working Group on the UPR, Human Rights Council, available at http://lib.ohchr.org/HRBodies/UPR/Documents/session9/US/A_HRC_WG.6_9_USA_3.pdf.

Travel Initiative (WHTI), hospitals seeking to repatriate patients who do not have a passport or other identity documents must first obtain an official travel document from the Consulate establishing the patient's identity and nationality.¹⁶² Consulates report that U.S. government officials have pressured them to release the travel documents for patients who have not consented to their transfer.¹⁶³ For instance, a consular official recalled one case in which she refused to issue travel documents for a patient because of his medical condition. The hospital responded by contacting a U.S. Senator who admonished her for her refusal.¹⁶⁴ In another instance, an advocate reported that a U.S. Congressman contacted a Guatemalan consular officer in Chicago on behalf of a hospital in Michigan. According to the advocate, although the patient at issue was unable to communicate and his family had refused to consent to repatriation, the Congressman nevertheless put pressure on the Consulate to arrange for his return to Guatemala.¹⁶⁵ Similarly, an attorney who represents many Mexican and Guatemalan Consulates reports that U.S. government officials from the Department of Homeland Security and members of Congress have pressured his clients to release the travel documents required for the

¹⁶² See Western Hemisphere Travel Initiative (WHTI), 8 C.F.R. §§ 212, 235 (2006). (requires all air travelers departing the United States to present a passport or other accepted document that establishes the bearer's identity and nationality). A travel document can be issued in the form of a traditional passport or on consular letterhead. *Id.* See also AEROMEXICO, *Documentation Requirements for Departure by Air from the United States*, <http://www.aeromexico.com/us/TravelInformation/BeforeYouPurchase/RegulationsAndPolicies/AMRegulationsPolicies.html> (last visited Aug. 15, 2011).

¹⁶³ Sontag, *Deported*, *supra* note 15. (“Hospitals need consulates’ assistance in finding relatives and health care options in patients’ homelands as well as in obtaining travel documents. The relationship is complicated and often contentious.”). Consular officials have also expressed frustration with hospitals bypassing the Consulate in attempted repatriations that could jeopardize immigrants’ health. See, e.g., Judith Graham & Deane Williams-Harris, *Undocumented Immigrant in Coma Set To Be Returned To Mexico*, CHI. TRIB., August 20, 2008, http://articles.chicagotribune.com/2008-08-20/news/0808190878_1_national-immigrant-law-center-long-term-care-chronic-care (noting frustrations of Mexican Consulate with University of Illinois Medical Center at Chicago because the hospital failed to inform the consulate of plans to repatriate Francisco Pantelon). According to Ioana Navarrete, chief of protection at the Mexican Consulate in Chicago, hospitals contact the Consulate “on a regular basis.” Sean Cooley, *The Immovable Man*, MEDILL REP.: CHICAGO, Nov 04, 2009, available at <http://news.medill.northwestern.edu/chicago/news.aspx?id=144591>. Hospital officials throughout the country have said that their ability to repatriate patients depends on their relationships with local consulates. According to Mike Leston, a spokesperson at Tucson Medical Center, how quickly undocumented patients leave for their home countries depend on the hospital's relationship with that country. Heidi Rowley, *Feds To End Funding of ER Care For Migrants*, TUCSON CITIZEN, August 28, 2008, available at <http://tucsoncitizen.com/morgue/2008/08/28/95093-feds-to-end-funding-of-er-care-for-migrants>. Barbara Felix, an international patient services coordinator at University Medical Center in Arizona, stated that her relationship with consulates makes it easier to get permission to transport a patient.

¹⁶⁴ CSJ interview with Consulate General, July 26, 2010.

¹⁶⁵ CSJ interview with Caryn Maxim.

repatriation of patients who have not consented to and who, upon further investigation, were not stable enough for transfer.¹⁶⁶

Fernando

In June 2010, Fernando suffered serious head injuries after an accident and was admitted to a hospital in Greensborough, NC. Fernando was comatose and could not communicate. The hospital immediately contacted Fernando's family, requesting their permission to transfer him to Guatemala. Fernando's family refused, fearing that he would not receive proper treatment in Guatemala. Despite their objections, the hospital contacted the Guatemalan Consulate to request travel documents, informing the officer that Fernando was stable even though he remained in a vegetative state.

The Consulate initially refused to issue travel documents until it had secured care for Fernando in Guatemala. However, U.S. officials contacted the Consulate on the hospital's behalf to urge the immediate issuance of travel documents. After pressure from the hospital and the U.S. officials, the family consented to the repatriation and the Consulate provided the hospital with the necessary travel documents.

In addition, the U.S. has failed to provide an adequate process through which immigrant patients who are unlawfully repatriated may seek redress, as required under the standard of due diligence. While there are some documented cases in which the hospital admits that no consent for transfer abroad was obtained from the patient,¹⁶⁷ an undocumented patient will have no redress for his or her wrongful deportation in most instances. For example, if a patient was unlawfully present in the U.S. for more than a year and is considered to have voluntarily departed, he or she is *barred* from re-entry for ten years, regardless of whether s/he had a legal basis for immigration relief that would have allowed him or her to remain within U.S. borders.¹⁶⁸ Although the INA establishes some form of recourse for immigrants ordered deported, these avenues are only available when a removal *order* exists. When a patient is repatriated by a hospital, no such order has been made.

By failing to enact laws and policies that sufficiently protect these patients' human rights and by inadequately enforcing the limited laws that do exist, the U.S. has created an environment in which medical repatriations occur with impunity. The U.S. is therefore responsible for the

¹⁶⁶ Interview with John de Leon, Esq. with the Law Offices of Chavez & De Leon, P.A.

¹⁶⁷ See Sontag, *Deported*, *supra* note 15.

¹⁶⁸ INA § 212 (a)(9)(B)(i)(II), 8 U.S.C § 1182 (a)(9)(B)(i)(II) (2011). Although it is possible to seek a waiver of the 3- and 10-year admissibility bars, it requires a showing of extreme hardship to a US citizen or lawful permanent resident spouse or parent. See INA § 212(a)(9)(B)(v) (2011).



resulting violations of rights enshrined in the American Declaration, the American Convention, CAT, and the ICCPR, namely the rights to life, health and well-being, humane treatment, and due process.

CONCLUSION

The practice of forced or coerced medical repatriation violates U.S. and international law and must be curtailed. The federal government has failed to remedy serious deficiencies in its overall legislative scheme, particularly with respect to the rights to due process, life, and the preservation of health and well-being. By restricting immigrants' access to public health programs, limiting hospitals' ability to seek reimbursement for the care they provide to immigrant patients, inadequately enforcing existing protections regarding patient dumping and federal discharge laws, and failing to create a relevant regulatory framework concerning informed consent, the federal government has created an environment in which hospitals engage in medical repatriation with little to no oversight—working to the detriment of immigrant patients in need of serious medical care. Additionally, medical repatriation violates immigrant patients' rights to due process under international human rights law and the U.S. Constitution. Under the standard of due diligence, the U.S. has a duty to take measures to prevent these human rights violations from occurring and to create accountability measures for hospitals that engage in this practice.

RECOMMENDATIONS

To the U.S. Congress:

- Convene hearings to investigate the practice of unlawful medical repatriations by private hospitals under international and domestic law.
- Repeal all laws that impose bars to Medicaid benefits based upon immigration status.

To the Department of Health and Human Services:

- Immediately promulgate regulations that prohibit and impose sanctions on any hospital that performs an involuntary repatriation.
- Develop a process by which hospitals must document and report international patient transfers.
- Develop an auditing process through which the department can monitor compliance with such rules and regulations.

To the Department of State:

- Engage in a dialogue with foreign consulates within the U.S. and implement a formal procedure for international medical transfers, so that transfers can be verified with receiving hospitals prior to travel documents being issued.

To Hospitals:

- In the absence of state or federal regulations, establish protocols to ensure that consent to unlawful, international transfers is *informed* through disclosures of potential immigration consequences.
- Confirm (in cooperation with foreign consulates) that destination hospitals can provide the necessary long-term care before a transfer is deemed viable.
- Train hospital social workers and advocates on the special issues of working with immigrants, both documented and undocumented.

To States:

- Repeal any bars to funding for means-tested and long-term medical care based on immigration status.
- Establish a fund for long-term care for catastrophically injured immigrants.
- Amend legislation to allow for broader basis for PRUCOL eligibility for Medicaid.

To State Courts:

- Acknowledge federal preemption limitation on jurisdiction when discharge proceedings involve *de facto* deportations.
- Stay any orders of international discharge until determinations of immigration status, removability, and potential relief have been rendered by an Immigration Court.
- Direct any appointed guardians to consider immigration consequences when acting on behalf of the patient and seek independent assessment of the patient's situation

To Community Groups and Advocates:

- Document cases of actual or threatened medical repatriation.
- Raise awareness concerning discharge and language access rights and Emergency Medicaid.
- Create a rapid response working group to assist undocumented immigrants at risk of medical repatriation.

GLOSSARY OF TERMS

American Convention on Human Rights (American Convention)

Adopted in 1969, the American Convention obliges signatories to uphold and protect the human rights of all people under their jurisdiction. As per the preamble, the purpose of the Convention is “to consolidate in this hemisphere, within the framework of democratic institutions, a system of personal liberty and social justice based on respect for the essential rights of man.”

American Declaration of the Rights and Duties of Man (American Declaration)

Adopted in 1948, the Declaration was the first international human rights instrument of a general nature. The Declaration sets forth aspirational standards for human rights and is a source of international obligations for members of the Organization of American States.

Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT)

Adopted by the UN General Assembly in 1984, CAT defines torture and affirms countries’ commitment to its prohibition. The U.S. implemented the language of CAT into federal law with reservations and understandings in 1998.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA is a federal law enacted in 1986 to prohibit the practice of “patient-dumping” by hospitals. EMTALA requires federally funded hospitals with emergency rooms to accept all emergency patients and stabilize them or otherwise transfer patients to an “appropriate” facility.

Inter-American Commission on Human Rights (IACHR)

Established in 1959, the IACHR receives, analyzes, and investigates individual petitions alleging violations of specific human rights protected by the American Convention and American Declaration. It also monitors the general human rights situation in the OAS countries and, when necessary, prepares and publishes country-specific human rights reports.

International Covenant on Civil and Political Rights (ICCPR)

Adopted by the UN General Assembly in 1966; parties of the treaty agree to uphold and respect individual civil and political rights. The U.S. has ratified the ICCPR.

Immigration and Customs Enforcement (ICE)

ICE is a federal law enforcement agency within the U.S. Department of Homeland Security that is charged with investigation and enforcement of federal immigration laws.

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Adopted by the UN General Assembly in 1966, the parties of the treaty agree to recognize and uphold certain economic, social, and cultural rights, including the right to health. The U.S. has signed but not ratified the ICESCR.

Lawful Permanent Resident (LPR)

An LPR is a non-citizen in the U.S. who has been officially granted the right to residence and

employment within the country and, after fulfilling statutorily defined requirements, may apply for citizenship.

Medicaid

Medicaid is a federal- and state-funded health insurance program administered by the states for low-income and disabled individuals.

Medical repatriation

In the context of this report, the term is used to refer to the practice of U.S. medical facilities transporting ill or injured non-citizens, or those perceived to be non-citizens, to medical facilities abroad without due process and frequently without proper consent.

Medicare

Medicare is a federally funded health insurance program for the elderly and disabled. Medical facilities that accept Medicare insurance are bound by Medicare's conditions of participation in the Medicare Modernization and Prescription Drug Act, which includes the requirement of patient discharge planning.

Medicare Modernization Act of 2003 (MMA)

MMA is the largest re-vamping of Medicare since its creation in the 1960s and added prescription drug and preventative health care benefits to the Medicare program. It provides for reimbursement to hospitals that treat undocumented, uninsured immigrants pursuant to EMTALA.

Patient Protection and Affordable Care Act (PPACA) of 2010

PPACA is the legislative overhaul to the U.S. health care system that expanded the health insurance market by requiring LPRs and U.S. citizens to be insured while present in the U.S. and providing subsidies to reduce health care costs. Undocumented immigrants are explicitly excluded from this mandate.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996

PRWORA is a federal law that reformed the U.S. welfare system. PRWORA prohibited LPRs who have resided in the U.S. for less than five year and undocumented immigrants from receiving federal funding for health care, except for emergency care.

State Children's Health Insurance Program (SCHIP)

SCHIP is a federal- and state-funded health insurance program for children, intended to cover those who do not qualify for low-income Medicaid.

T visa

T visas provide legal status to victims of human trafficking and their immediate family members who would suffer extreme hardship if removed from the U.S. and are willing to cooperate with law enforcement in the investigation and prosecution of their trafficking perpetrators. They grant permission to remain and work in the U.S. for up to four years, and allow beneficiaries to eventually apply for permanent resident status after three years. Victims of trafficking in persons are also eligible for U visas.

U visa

U visas provide legal status to victims of certain serious crimes who have suffered substantial physical or mental harm and can document cooperation with law enforcement. They grant permission to remain and work in the U.S. for up to four years, and allow beneficiaries to eventually apply for permanent resident status.