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Medical Repatriations by Hospitals Provide Controversial Remedy for Difficult Discharges

Medical repatriation, in which hospitals send undocumented alien patients back to their countries of origin when there appears to be no other option for discharge, is a small but growing practice that raises controversial ethical and legal issues for hospitals, experts told BNA.

Undocumented aliens are a subset of a class of individuals known as ''difficult-to-discharge patients,'' according to Elisabeth Belmont, corporate counsel at MaineHealth in Portland, Me. These patients no longer require a hospital's acute care services, but need more care than they can provide for themselves.

Usually, such patients are discharged to step-down facilities, such as nursing homes and rehabilitation centers. But hospitals are caught in a bind when, as often happens with undocumented aliens, there is no facility willing to accept the patient, and the hospital must continue to provide care.

In most cases, the cost of this care will be uncompensated, according to Lori A. Nessel, professor of law and director of the Center for Social Justice at Seton Hall Law School in Newark, N.J. Cuts to disproportionate share hospital (DSH) payments under Medicare have reduced funds available to hospitals that provide charity care. Additionally, under federal law, states cannot use federal funds to provide Medicaid coverage for illegal immigrants or for legal immigrants who have been in the United States fewer than five years.

Even the recent health reform law will not help to resolve the problem, Nessel said. Undocumented aliens expressly are barred from seeking coverage under federal and state insurance exchanges set up pursuant to the Affordable Care Act.

As a result, the hospital is caught in a difficult spot: continue providing uncompensated care that can run into the millions of dollars or find another way to discharge the patient. Some hospitals have seen medical repatriation as the answer with respect to undocumented alien patients. Belmont told BNA she was aware of the practice, although she personally never has participated in a medical repatriation.

Marie Watteau, director of media relations for the American Hospital Association told BNA that ''AHA does not have a policy'' regarding medical repatriation. ''Each hospital handles these situations on a case by case basis. On those occasions when patients are moved to a different care setting (including being returned to his or her nation of origin), it is a decision made by the patient, the care team and the family, when appropriate.''

Numbers Unknown. In a December 2012 study written in conjunction with New York Lawyers for the Public Interest (NYPLI), *Discharge, Deportation, and Dangerous Journeys: A Study on the Practice of Medical Repatriation*, Nessel cited over 800 known cases of attempted or actual medical repatriation, although she said the true number is not known.

Many of these cases have been reported in the popular media, including that of a repatriated patient who died after being left on an airport tarmac in his country of origin. There also are cases, she said, where hospitals have tried to repatriate legal resident aliens and U.S. citizens—the latter being children of undocumented aliens, who were born in the United States.

''Hospitals see no real downside to medical repatriation''

THOMAS J. DUFF, DUFF LAW FIRM PLC, DES MOINES

Nessel conceded that hospitals are placed in a ''very difficult situation,'' but argued that medical repatriation places a ''vulnerable population'' at risk. ''Lives are placed in danger by this process,'' she said. And faced with possible forced deportation, many undocumented aliens will not seek out needed medical care, she said. It is a ''complete recipe for loss of life.''

Many undocumented individuals are compelled to seek emergency care. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), hospitals must provide that care regardless of the patient's status or ability to pay. That obligation, however, ends once the patient has been screened, treated, transferred, and/or admitted. Step-down facilities, like nursing homes and rehabilitation centers, are not subject to EMTALA.

Nessel told BNA she is troubled by the idea of ''de facto'' deportation. Repatriation against a person's will or without their consent should be actionable, she said, but patients have failed to prevail in the few cases to have tested hospital actions.

Legal Liability Lacking. Thomas J. Duff, of the Duff Law Firm PLC in Des Moines, told BNA that he believes ''medical repatriations occur a lot more than people realize.''

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This is due, at least in part, to the fact that hospitals are unlikely to incur legal liability for this conduct, assuming the patient is medically stable and the hospital's EMTALA duties are satisfied. ''Hospitals see no real downside to medical repatriation,'' he said. ''The victims of this conduct do not speak English, do not think they have any rights, and most are not able to find anyone to advocate for them.''

''These are the facts that hospitals know, understand, and are willing to exploit,'' Duff said. ''It is a huge cost-saving measure for the hospitals, and in all likelihood the victim will never complain.''

Duff represented two individuals in an unsuccessful false imprisonment claim against a hospital in Iowa. His clients, Jacinto Rodriguez Cruz and Jose Rodriguez-Saldana, suffered severe head trauma in an automobile accident. They were taken to Iowa Methodist Medical Center, a facility operated by Central Iowa Hospital Corp., where they were treated and their conditions stabilized.

Due to the severity of their injuries, both men needed long-term rehabilitation services after their discharge, according to an opinion in the case. The hospital, however, was unable to locate a facility that would accept the men due to their undocumented status, even though both had health insurance.

Subsequently, the court said, the hospital arranged for the men's return to Mexico. Both were unconscious, although in stable condition, during the flight. They were admitted to a hospital in Vera Cruz, Mexico, and remained there for about one month, after which they were released to the care of their families.

An Iowa trial court dismissed Cruz's and Saldana's claims, a decision affirmed by the Iowa Court of Appeals in *Cruz v. Central Iowa Hospital Corp.*, 826 N.W.2d 516 (Iowa Ct. App. 2012) [2012 BL 327119] (21 HLR 1770, 12/20/12). The appeals court found that the plaintiffs had failed to established a central element of their false imprisonment claim, namely, that they were confined without their consent or that of their families. Additionally, because the men were unconscious during the flight to Mexico, they were unaware of their alleged imprisonment and suffered no injury as a result of the confinement, the court said.

Attorneys for the defendant hospital did not respond to BNA's request for comment.

Florida Hospital Escapes Liability. Duff's case was only the second known reported decision dealing with medical repatriation.

The first case had a complicated procedural history. In 2000, Luis Alberto Jimenez, an undocumented native of Guatemala, sustained brain damage and severe physical injuries in a car crash. He was treated at Martin Memorial Medical Center in Stuart, Fla., for nearly six months before being transferred to a skilled nursing facility. In January 2001, Jimenez was readmitted to Martin Memorial on an emergency basis. He remained there until June 2003.

Montejo Gaspar Montejo filed a guardianship plan for Jimenez in late 2001. Martin Memorial intervened, arguing that Montejo had failed to ensure that Jimenez was in the best facility to meet his medical needs. The hospital sought the Florida court's permission to discharge Jimenez and have him transported to Guatemala for further care. The trial court granted the hospital's petition. Montejo appealed but, before the appeal could be heard, the hospital took Jimenez to the airport and had him flown to Guatemala.

The Florida District Court of Appeal for the Fourth District reversed the order that had authorized Martin Memorial to transport Jimenez to Guatemala, *Montejo v. Martin Memorial Medical Center Inc.*, 874 So. 2d 654 (Fla. Dist. Ct. App. 2004)(13 HLR 720, 5/13/04). It held that the trial court lacked subject matter jurisdiction to authorize Jimenez's transportation because deportation issues are within the exclusive jurisdiction of the federal government.

Montejo then filed a false imprisonment suit on Jimenez's behalf. The trial court initially dismissed the claim because the hospital discharged and transported Jimenez pursuant to a then-valid court order. The Florida appeals court reversed, holding that the hospital was not entitled to immunity from the false imprisonment claim for actions taken in reliance on an order later determined to be invalid, *Montejo v. Martin Memorial Medical Center Inc.*, 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006).

The case went to trial, but ended in a jury verdict for the hospital, Jack Scarola, an attorney for Montejo, confirmed for BNA. Montejo moved for a new trial (18 HLR 1093, 8/13/09), and filed a second appeal. According to Scarola, the case was resolved while the appeal was pending, but he declined to give details of the settlement. Scarola and Jack P. Hill, of Searcy Denney Scarola Barnhart & Shipley PA, West Palm Beach, Fla., represented Montejo. Attorneys for the hospital did not respond to BNA's request for comment.

Movement to Limit, End Practice. There may be little that can be done, legally, to end the practice of medical repatriation—or at least to curb perceived abuses—but it is being discouraged by at least one health industry player.

Hospitals should ''take forced medical repatriation off the table.''

Dr. Mark Kuczewski, Neiswanger Institute for Bioethics, Loyola University of Chicago

In a 2012 report entitled *Physician Responsibilities for Safe Patient Discharge from Health Care Facilities*, the American Medical Association's Council on Ethical and Judicial Affairs (CEJA) stated that a physician's ethical duties include the obligation to develop a safe discharge plan without regard to the patient's socioeconomic status, immigration status, or other nonmedical considerations. ''Physicians should not discharge a patient to an environment in which the patient's health could reasonably be expected to deteriorate due solely to inadequate resources at the intended destination,'' the report stated.

The report advised physicians to consider the concerns of potential caretakers and the preferences of noncitizen patients, just as they would when planning the discharge of a citizen patient. ''The physician should consider the caretakers' and patient's understanding of the standards of care in their country of citizenship and the social attachments . . . that the patient may have in the U.S.''

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''Forcing an immigrant to leave the U.S. is prerogative of the federal government, and should only occur following due process,'' the report concluded ''Physicians should decline to authorize a discharge that would result in the patient's involuntary repatriation, except pursuant to legal process.''

Hospital Best Practices. The AMA's comments echoed those of medical ethicists. Dr. Mark Kuczewski, director of the Neiswanger Institute for Bioethics at Loyola University of Chicago, told BNA that the first thing a hospital caring for an undocumented immigrant should do is ''take forced medical repatriation off the table.''

From a public health point of view, forced repatriation ''undermines the hospital's mission,'' Kuczewski said. If members of a local immigrant community are aware of the practice, they may be reluctant to seek health care unless it is absolutely necessary.

Hospitals that do not engage in repatriation also may find themselves at a competitive disadvantage, he said, since those hospitals may have to charge more in order to spread out the costs of caring for difficult-to-discharge patients. Ending forced repatriation would help level the playing field.

Kuczewski, who teaches medical ethics, said that a hospital instead should look at all of its options and choose the one that best suits the needs of the patient, just as it would for any other patient. Repatriation may be the best option in a particular case, he said. But that conclusion should be reached only after a hospital has explored other possibilities and researched whether a repatriated patient would receive the level of care needed in his or her home country, he said.

Many immigrants come to the United States to work, Kuczewski said. They may have no family or other social support system here to help care for them if they are ill or injured. If they have a good social support system in their home country, and can receive the necessary care there, they may want to return home. The hospital's role at that point is to ensure the repatriation is voluntary and that the patient's reasonable medical needs can be met.

The voluntariness of the repatriation can be difficult to ensure, Kuczewski admitted. He suggested that the hospital have an interpreter who is comfortable explaining to the patient, or the patient's family, his or her medical needs, diagnosis, and prognosis if he or she should return to his or her home country. The hospital should be able to give the patient ''a good fix on their day-to-day situation'' should he or she agree to repatriation.

This also imposes on the hospital the need to research the conditions in the patient's country and determine whether his or her medical needs reasonably can be met there. The hospital needs to ''take the time,'' just as it would with other discharges, to determine whether repatriation would be in the patient's best interest, Kuczewski said.

Kuczewski advised that hospitals begin by determining the extent of the patient's social support systems both here and abroad. Are there community centers or houses of worship that would provide the patient with support while recovering from an illness or injury? Does the patient have family in the United States capable of providing care?

The hospital also should try to identify the best and worst patient outcomes in both countries, Kuczewski said. Are there medical facilities in the country of origin that can provide, to a reasonable degree, the medical care the patient needs? Would it be better—i.e., cheaper—in the long run, for the hospital to pay for the patient's stay in a long-term care facility in the United States? The last thing a hospital should do, Kuczewski said, is to make a decision solely based on financial concerns. At that point, hospitals ''stop being creative,'' he said.

Policy Changes Needed. Nessel maintained that medical repatriation is unethical, immoral, contrary to federal immigration policy, and violates international human rights law. Yet, repatriated individuals have little recourse against hospitals, she said.

It is a ''self-perpetuating problem,'' she said. Once repatriated, most individuals would not be eligible to return to the United States for several years due to U.S. immigration laws. And for some individuals, repatriation is essentially a death sentence, since facilities in their native countries are inadequate to provide for their needs.

Nessel suggested that there are several things that could be done to stop medical repatriation, beginning with changing government policies to enable hospitals to receive reimbursement from Medicare and Medicaid for immigrant patients' care. Making access to health insurance for aliens a priority, as the reform law has for citizens, also would be helpful, she said.

Removing 'Cloak of Secrecy.' Government regulation of medical repatriation practices could stop some of the abuses that have been noted, Nessel said. For example, there are stories of patients being taken out of hospitals through loading docks and laundry rooms, to be secretly loaded onto airplanes bound for foreign countries. Regulations requiring hospitals to remove patients openly and to be more transparent about repatriation practices, thereby removing the ''cloak of secrecy,'' could stop such alleged behavior, Nessel said.

At the very least, Nessel said, government regulations could require that hospitals obtain knowing consent from patients or the families of patients who are being repatriated. In this case, ''knowing'' consent would require a full explanation of the consequences of being removed from the country, made in the patient's native tongue, she said.

Pressure also could be placed on nursing homes and long-term care facilities to accept undocumented individuals. According to Nessel, imposing EMTALA-like obligations on step-down facilities is a possibility.

Most of all, hospitals should play ''an active role'' in lobbying for changes in federal law that would allow them to avoid the huge financial strain of caring for these patients, Nessel said.

She suggested that hospitals be strong agents in pressing for reforms that would allow them to avoid making the decision of whether to remove an undocumented alien from their facilities. Sending a patient back to his or her country of origin, knowing the patient is unlikely to receive adequate medical care, must be a ''difficult'' and even ''painful'' decision for a hospital and its workers, she said.

BY MARY ANNE PAZANOWSKI

The Seton Hall/NYLPI study is at http://www.nylpi.org/images/FE/chain234siteType8/site203/client/FINAL%20MED%20REPAT%20REPORT%20FOR%

20WEBSITE.pdf. The AMA report is at http:// www.ama-assn.org/resources/doc/ethics/ceja-5a12.pdf.

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