



SHOULD WE SEND ILLEGAL IMMIGRANTS BACK HOME WHEN THEY SEEK MEDICAL CARE?

CASE FOR DISCUSSION

Maria Tomas, a native of Mexico, has been living in Syracuse as an illegal immigrant for five years. For most of that time Mrs. Tomas has worked in fast-food restaurants and cleaning rooms in hotels, low-paying jobs that do not provide health insurance. She supports herself and her 8-year-old daughter and is able to send money to her family in Mexico. For the past three months her asthma has worsened, but she has avoided seeking medical attention because she lacks health insurance and feels intimidated by the area medical facilities. This morning, after a night of struggling to breathe, she went to a hospital emergency department frightened and in respiratory distress. While Mrs. Tomas is waiting for the physician, an employee observes that she probably is an illegal immigrant and wonders whether she should be reported to the authorities and perhaps denied treatment.

Discussions about whether illegal immigrants should be included in a health insurance plan are part of the current health care debate. High profile cases like that of Luis Jimenez, who was flown back to Guatemala from Florida in 2003 after a long, expensive hospitalization (<http://www.nytimes.com/2009/07/28/us/28deport.html>), serve as examples of the injustices of our current health system and of health care expenditures on people who do not qualify. Recently, an exchange of letters to the editor in the Syracuse *Post-Standard*, initiated under the headline "Why not nab illegals when they seek care?" (September 1, 2009) has invigorated the dialogue here in Central New York.



PATIENTS IN NEED

Ethical traditions of medicine and health care focus on a patient in need and do not qualify who that patient is. For example, the oath taken by physicians who graduated from Upstate Medical University last May, which is similar to the commitments by physicians, nurses, and health care professionals everywhere, includes the following: *"The health of my patient will be my first consideration; may I never see in the patient anything but a fellow human in need. I will treat all patients with compassion, no matter how much they differ from me. I will respect the secrets patients confide in me."*

There is nothing in the oath about excluding illegal immigrants or people without insurance, nor does the oath enjoin physicians and other health care providers to act as agents of the state to report illegal immigrants.

The following comes from The Association of Bioethics Program Directors, representing the leadership of 60 academic bioethics programs across North America and is reprinted from their website with permission.

THREE MYTHS ABOUT THE ETHICS OF HEALTH CARE REFORM

The Association of Bioethics Program Directors (ABPD) represents the leadership of 60 academic bioethics programs across North America. At this critical juncture in the national debate about health care reform in the United States, our membership wishes to send a clear message about some myths that challenge the ethics of reform proposals.

MYTH #1: Health care reform will mean giving up control of my own health care decisions.

FACT: The field of bioethics has long championed the rights of individual patients to make their own health care decisions in consultation with their physicians. If we thought the major proposals being considered posed a serious threat to these rights, we would be the first to speak out. But that is NOT the case. The right of individuals to make decisions about their health care is engrained in the ethics of American medical practice and that won't change under any of the approaches to health care reform currently under discussion.

MYTH #2: Health care reform will control health care costs by depriving patients of important, but costly, medical treatments.

FACT: This is also untrue. If anything, the provisions in current health care proposals will increase the likelihood that patients will get quality medical

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IN BRIEF

CENTER FOR BIOETHICS AND HUMANITIES

Bioethics in Brief is a newsletter of the Center for Bioethics and Humanities.

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Immigrants

TOO MANY UNKNOWNNS

Although blogs about health care reform are full of dire warnings and negative opinions, attempts to quantify the health care expenditures of illegal immigrants are confounded by inaccurate estimates of their numbers and failure to distinguish illegal immigrants when they engage the health care system. The Emergency Department of University Hospital asks for basic information from all patients, but they do not ascertain citizenship or visa status. All patients are accepted for evaluation and treatment, a process that seems standard across the country.

The number of illegal immigrants currently living in the U.S. is estimated to be about 12 million, which is derived by subtracting the number of foreign-born people who are legally in the U.S. from the census estimate of the total foreign-born population. According to Reuters, September 8, 2009 (<http://www.reuters.com/article/press>

Release/idUS53536+08-Sep-2009+PRN20090908), in 2007 there were an estimated 6.6 million illegal immigrants without health insurance who had incomes below 400 per cent of poverty, a threshold in some proposed legislation. (About 40 percent of illegal immigrants do have health insurance and less than 1 percent have incomes above 400 percent of poverty.) Reuters estimates that the current cost of treating uninsured illegal immigrants is \$4.3 billion per year, primarily at emergency rooms and free clinics. To insure all uninsured illegal immigrants could cost as much as \$30 billion, which is about 1 percent of current health care expenditures in the U.S. However, whether actual costs would be that high is debatable because an insured population eventually should be healthier and thus ultimately should incur less

costs, and uninsured illegal immigrants may use less health care than others without health insurance because they tend to be younger.

With regard to the health characteristics of uninsured illegal immigrants, they presumably are similar to those of the 48 million people in our country without health insurance. According to a 2002 Kaiser report, the uninsured receive less preventive care, are diagnosed at more advanced stages of disease, when diagnosed tend to receive less medical and surgical treatment, and have higher mortality.

"...NOR DOES THE OATH ENJOIN PHYSICIANS AND OTHER HEALTH CARE PROVIDERS TO ACT AS AGENTS OF THE STATE TO REPORT ILLEGAL IMMIGRANTS."

Let us return now to Mrs. Tomas and the hospital employee who wonders whether she should report her. **First** and fundamental, our commitment to our ethical principles requires that any patient who is sick deserves treatment, regardless of their personal characteristics or legal status. **Second**, the determination of whether a person is an illegal immigrant is not the business of

health care. It would require documents that many legal citizens would find difficult to locate and it would place an inappropriate burden on the health care facility. **Third**, if we used our health care system to police illegal immigrants, it would undermine the trust between patient and physician, and by extension the health system, and would make such patients even more reluctant to seek health care services. This could worsen their own health and, in some situations, such as patients with communicable diseases, could be harmful to others. **Finally**, if there is a problem to be addressed regarding illegal immigrants, it should be resolved through appropriate debate and development of consistent policies and laws, not through the health care system.

— Gregory L. Eastwood

MONTANA SET TO DECIDE IF STATE CONSTITUTION SUPPORTS A RIGHT TO ASSISTED SUICIDE

The Montana Supreme Court is reviewing a case being closely watched across the US. In *Baxter v. Montana*, the court will decide whether a lower court correctly found that the Montana Constitution provides a terminally ill patient with the right to a physician's aid in dying.

For several decades, courts have wrestled with a person's right to make medical end-of-life decisions, and to what extent the government may interfere with the right. Since *Quinlan* in 1976, a right to refuse life-sustaining treatment is generally accepted. More recently, the US Supreme Court addressed physician-assisted suicide in a

series of cases, ultimately holding that the US Constitution does not give a person the right to assisted suicide. However, in one of the decisions, *Vacco v. Quill*, Justice O'Connor opened the door to a state-level process that strikes a balance between a state's right to preserve human life and an individual's right to die in a dignified manner.

Some states have put the issue of physician-assisted suicide in the hands of citizens. In 1997, Oregon enacted the Oregon Death with Dignity Act (ODWDA), which provides terminally ill people with a legal process to die with a physician's assistance. The ODWDA, while subject to a great deal of scrutiny, appears to have found the "balance" Justice O'Connor mentioned, due in large part to its restrictive terms: only terminally ill people diagnosed with six months or less to live qualify; a

mandatory 15 day waiting period applies to all; and a person is encouraged to opt out throughout the process. In fact, only 401 people, the majority with terminal cancer, have died using the ODWDA since it passed 15 years ago. In 2008, Washington passed a law almost identical to the ODWDA.

The *Baxter* case is noteworthy as it presents a "court first" approach, and finds within a state constitution a right to assisted suicide. Yet, in keeping with the OR and WA legislative approaches, the lower court explicitly recognized the next step would involve passing a law to balance the right with the state's interest in preserving human life. A decision by the Montana Supreme Court is still pending (as of October 14, 2009).

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Myths

care and decrease the likelihood of medical errors that kill thousands of patients every year. There are unethical ways to control costs, including refusing to treat the uninsured or those who have insurance but cannot afford the exorbitant out-of-pocket costs of expensive treatments—that is the status quo. Health care reform offers a more coherent approach to delivery of health care that aims to control costs while maintaining the quality Americans have come to expect and deserve.

MYTH #3: Health care reform will deny older Americans medical treatments at the end of life.

FACT: This may be the most pernicious myth of all. In proposed approaches to reform, there is a provision that supports the rights of individuals and their families to make decisions at the end of life by institutionalizing a process for patients and families to express their desires to their physicians and other health care professionals. This right is part of the culture of American medicine, defended since the beginnings of the field of bioethics, and



supported by case law going back over 50 years. Some opponents of health care reform have twisted both the intent and effect of this provision, making unsupported claims about how it will push older Americans into hospice against their will, and even euthanasia. Nothing could be further from the truth.

Straightforward conversations about end of life are critical to quality health care, with decisions continuing to be made by individuals and their families in ways that are consistent with their values and in consultation with their physicians.

Here is the real bottom line: The current state of health care is unethical. It is neither just nor fair. There is no morally defensible reason why some Americans get excellent medical care at costs they can afford and other Americans lose their homes or go into bankruptcy attempting to secure treatment for a seriously ill loved one. The current proposals being debated in Congress all go a long way toward making health care in America more just. At the same time, there is nothing in the current proposals that

threatens a patient's right to choose, a critical feature of an ethically acceptable health care system.

We commend efforts to reform the health care delivery system with commitments to cover all Americans while protecting choice and maintaining the high quality care that our fellow citizens deserve. We stand ready to aid however we can in this vital effort.

This statement is issued by the ABPD Board of Directors on behalf of its members.

PAYING PHYSICIANS TO TALK ABOUT END-OF-LIFE DECISIONS

“DEATH PANEL” MYTH

Should physicians talk with their patients about decisions near the end of life? Absolutely. And patients should be informed why it matters that they make their wishes for future care known before they lose capacity to make contemporaneous decisions, and of the right and opportunity to sign a health care proxy or other form of advance directive. The importance of planning ahead for our care when serious, life-threatening illness robs us of decisional capacity is widely accepted, especially in New York where the law governing surrogate decisions regarding life-sustaining treatment is restrictive.

Yet, most of us do not exercise this right. As a result, the burdens of decision for families and health care providers are too often complicated by uncertainty about the patient’s wishes and values. Nationally, only about 20 percent of us put our wishes in writing. Among the reasons advance care planning does not occur as often as it should are the difficulties of confronting these issues, physician discomfort in engaging patients in this dialogue, and lack of reimbursement for physicians’ time in discussing advance directives.

HR 3200 INCENTIVE

One of the health care reform bills (HR 3200) would reimburse physicians for engaging in end-of-life discussions with their patients. In effect, an end-of-life

conversation with your physician would become a health care benefit under Medicare and some insurance policies. If enacted, the bill would strongly encourage physicians, nurse practitioners or physician assistants with authority to write end-of-life orders to conduct advance care planning consultations with patients at least every five years, more often if the patient’s condition (e.g., colon cancer) warrants. Key features of an advance care planning consultation would be to:

- Explain advance directives, such as health care proxies and living wills.
- Explain the role and responsibilities of a health care proxy.
- Provide a list of national and state-specific resources.
- Explain the services and support available, including palliative care and hospice.
- Facilitate informed decisions about life-sustaining treatment, including both refusal of and consent to medical interventions.

Under the bill, advance-care planning consultations must also take into account state law and practice. In New York this should certainly include explanation, and sometimes completion, of a MOLST form (Medical Orders for Life Sustaining Treatment) available from the New York Department of Health.

This short section of a more than 1000 page bill has received disproportionate attention in the health care reform

debate. A handful of opponents of reform have erroneously charged that the Democrats’ reform proposals would create “death panels” to decide when people should die. They have also claimed that with these panels the federal government would be deciding “when grandma dies.” This political rhetoric distorts and misrepresents the purpose and meaning of the advance care planning proposal. *Under our well-established national ethical and legal consensus, decisional authority for health care decisions, including end-of-life decisions, firmly rests within the patient-family-physician relationship.* Ultimately, the right to refuse treatment means that decisions to withhold or withdraw respirators, feeding tubes or other medical interventions are based on the adult patient’s statements, wishes and values. These decisions are not made by a committee or by physicians or hospitals. Nothing in HR 3200 or any other proposal in Congress would change these fundamental principles. To the contrary, the goal is to enhance and strengthen these patient-centered principles and laws by encouraging patients to document their wishes for end-of-life care, and by providing financial incentives for doctors, nurses and physician assistants to talk to their patients about advance care planning.

—Robert S. Olick, Joel Potash,
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