

PEER-REVIEWED CME ARTICLE

How Medicine May Save the Life of US Immigration Policy: From Clinical and Educational Encounters to Ethical Public Policy

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Abstract

Medicine has a conceptual contribution to make to the immigration debate. Our nation has been unable to move forward with meaningful immigration reform because many citizens seem to assume that immigrants are in the United States to access benefits to which they are not entitled. In contrast, when medicine encounters undocumented immigrants in the health care or medical education setting, it is obvious that their contributions to our health care system are denied by exclusionary laws. When the system is amended to be inclusive, immigrants become contributors to the systems that they access. I illustrate this thesis concerning the benefits of inclusion through an examination of the issues of forced medical repatriation, access to health insurance, and the access of undocumented students to medical education.

Introduction

For better or worse, virtually every person needs to access medical care at some time, and this means that there is no social problem that will not enter the health care system and need to be addressed in some way by clinicians. When policymakers refuse to address particular social issues, e.g., poverty, hunger, homelessness (and immigration), health care facilities may have to address the problems as they manifest on a case-by-case basis. In short, the burden of addressing such issues may be transferred to an already stressed health care system. This generally means that individual physicians and other health care professionals, their clinics and hospitals, and their communities must work creatively to address the needs of these patients. In some cases, reasonable options for patients afflicted by these issues may be few or none, as adequate resources may not be available. In such instances, it would also seem to be the responsibility of health care professionals to advocate for needed policy changes. In the United States,

our immigration system has been the focus of needed reform for several decades, but little progress has been made. As a result, the problems created by the immigration system's inadequacies have impacted health care and require policy interventions. This may require that medicine attempt to inform the nation's perspective on immigrants.

Context and the Life of Ethics

Fortunately, medicine and medical ethics are up to the task. The late, renowned philosopher Stephen Toulmin described in 1982 how medicine had saved the life of ethics [1]. Ethics had lapsed into relativism paradoxically because it took universal principles as its starting point. These principles are abstracted from all particular content in a quest for certitude. But once such content is removed, the basis for deciding among choices is also nullified. Thus all positions become equal. Toulmin argued that medical ethics, a.k.a., bioethics, made progress during this period when philosophical ethics was barren because the problems medicine posed are within a rich context that can be analyzed and mined to assist in the solution. In particular, medical ethics starts by looking at cases in a broad sense, i.e., common situations. Within such situations, stakeholders have interests that are somewhat objective. Included in those interests are role-specific responsibilities within institutions that have been forged over time.

Toulmin's approach is similar to that of social philosophers such as Michael Walzer [2] in asserting that socially established institutions such as those that serve health care contain an internal logic, values, and wisdom that address the needs of the community. Solutions to problems that preserve these professional enterprises and serve the community present themselves as ethically and morally choice worthy. This methodology, which became best known as the revival of casuistry (i.e., case-based reasoning) in its further development with the venerable bioethicist, Albert Jonsen [3], takes historical context and embedded wisdom seriously. It is an inductive method that can build outward to higher levels of generality and elucidate our communal "forms of life" [1]. That is, we can harvest the lessons we learn in the medical sphere of endeavor to shed light on other aspects of our shared life [3].

Where Immigration-Related Challenges (and Opportunities) Present to Medicine

Three immigration-related issues are virtually unavoidable in the clinical setting for medicine and for intimately related enterprises such as medical education. They simply present within medical and medical education facilities and require a response. First, clinicians have occasionally found themselves confronting the phenomenon of potentially forcing "medical repatriation" of an immigrant patient. Some of these cases have captured media attention, and a small medical and legal literature has developed [4, 5]. Such cases usually involve an undocumented immigrant in need of long-term care. The patient lacks any means of financing the care. His or her immigration status pre-empts most of the usually available ways by which low-wage workers might secure insurance, either through private purchase or through the provision of [Medicaid](#). Thus,

the health care institution seeks to discharge the patient to the only place that will accept him, i.e., the country of his birth. Closely related is the more general relationship between immigration status and health insurance. The exclusion of undocumented immigrants from the reforms occasioned by the Affordable Care Act not only poses problems when a patient cannot be discharged, but also frustrates the goals of the health care system. Finally, young undocumented immigrants, a.k.a. "DREAMers," have sought and, to a very limited degree, matriculated in medical schools. The needs of the physician workforce should prompt us to advocate for equality in the admissions and access to federal financial aid for this population.

Medicine confronts and responds to these issues each day in the best ad hoc manner available within the situation and inductively develops approaches and best practices that make use of the values and experience available within health care institutions because these situations demand a response. My conclusion from an analysis of these issues from that developing health care perspective reveals that public policy regarding undocumented immigrants and health care has been made from a mistaken paradigm. This paradigm starts with a universal rule that breaking laws is wrong and lawbreakers must not be rewarded for doing so. In attempting to apply the rule, every good is viewed through the lens of a potential reinforcement to the undocumented immigrant (i.e., the lawbreaker) that must be denied. This view uncritically comes to see access to health care and education as benefits to the individual and rightfully only available to citizens. In this presumptive worldview, citizen-contributors are pitted against those who come to the US illicitly to take such "benefits."

This rigid and mistaken framing of issues concerning immigrants has developed over several decades and was first made explicit in the debate concerning "welfare reform." As a result, the welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and a related act that specifically applied to immigrants called the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 restricted access to a wide variety of "benefits" for authorized immigrants and undocumented immigrants, including health care [6, 7]. And, of course, this exclusion has continued in the Affordable Care Act [8, 9] and financing for higher education, such as student loans, by limiting such access to citizens [10]. These policies restricted access to benefits because policymakers believed that immigrants were being attracted to the metaphorical US "welfare magnet" [11, 12]. Thus, significant amounts of policy toward immigrants are premised on the image of immigrants as in pursuit of benefits being given to them [13]. This line of reasoning was translated and updated into the vernacular four years ago by then-presidential candidate Mitt Romney, who espoused a theory of "makers versus takers" at a private fundraiser [14], and he also suggested in public debates that, as takers, undocumented immigrants would "self-deport" if they were not able to access benefits [15]. While much has happened in four years, similar thinking

underlies a significant amount of the current public policy dialogue, and illicit “taking” is put forward in more virulent and noxious forms, e.g., “rapists,” “bringing drugs” [16, 17].

Makers, Takers, and Health Care

Medicine implicitly understands the artificiality of this maker-versus-taker dichotomy. Medicine historically starts within the context of a one-on-one relationship of physicians to patients that operates within health care institutions and systems. These institutions are party to an implicit social contract and professional ethos of caring for patients and for the public health in a humane and efficient way [18]. In what follows, we will apply the procedure of medical ethics as it has evolved from Jonsen and Toulmin and other practical ethicists in order to provide recommendations that address the ethical issues that sometimes arise in the encounters between medicine and undocumented immigrants. We will see that a certain pattern emerges. Namely, the problems arise in the clinical or educational setting because undocumented immigrants are excluded from the common ways that such issues are addressed with citizens. We will see that policies that exclude undocumented immigrants from full participation in society actually serve to turn them into “takers” from the health care system. The obvious conclusion will be that developing inclusive social policies toward this population will ameliorate the issues by allowing undocumented immigrants to contribute to the solutions to these problems. Such a finding undermines the maker-versus-taker distinction and thereby helps to reframe the larger social policy debate.

The View from Health Care

Rejecting forced medical repatriation. [Forced medical repatriation](#) is perhaps the most dramatic encounter involving unauthorized immigrants within our medical system. And a quick analysis of this issue shows how leaving particular health care facilities to address the needs of undocumented patients in an ad hoc manner threatens much of what medicine and the public value. These episodes begin with an injured patient, oftentimes a construction worker or other laborer, whose injury is so severe that the patient’s rehabilitation and care needs will continue for a significant period after the acute phase, perhaps for the remainder of the patient’s life. Acute care hospitals wish to discharge patients to the next appropriate level of care when it becomes feasible for obvious reasons, e.g., lower levels of care are less costly and patients are vulnerable to hospital-acquired infections when they remain as inpatients. But discharge to another facility requires a method of payment. The hospital opens its doors to all who need emergent care under the Emergency Medical Treatment and Active Labor Act (EMTALA) [19], which requires that patients presenting be examined and stabilized when they present to an emergency room. However, other facilities, such as a rehabilitation hospital or a skilled nursing facility, do not need to accept transfers of such patients when they have been effectively stabilized. In paradigmatic instances of medical repatriation, the worker lacks insurance because his employer does not provide it and, being undocumented, he will not qualify for Medicaid, which would commonly be the insurer covering long-term care in a

similar case involving a US citizen. So the hospital lacks the usual discharge options [20]. Deportation of the patient seems the obvious way to end the situation, and some hospitals have engaged in this practice over the objections of the patients or their families.

The literature on this topic reflects a consensus against forced medical repatriation, i.e., medical repatriation against the will of the patient [21, 22]. Forcing medical repatriation essentially risks making a health care facility into an arm of the immigration enforcement apparatus. It is a dramatic and high-profile activity. In overriding the will of the patient and family, it brings a kind of violence to the healing relationship. Immigrant communities can learn of such unfortunate practices, adding to the general fear that encountering public institutions and authorities can place one at risk. These fears extend beyond persons who are undocumented, as many families are of mixed status and those with an authorized immigration status can still fear placing their families at risk by interacting with the institutions. Furthermore, these practices that are based on lack of a lawful immigration status contribute to the perception by members of immigrant communities that they are treated with suspicion and should fear interactions with health care institutions [23]. Widespread mistrust can mean that large numbers of persons will not voluntarily present at the health care institution or will only present at a point of desperation.

The practice of forced medical repatriation undermines our health care institutions by eroding some of their fundamental values and aims. Our health care institutions, especially those designated as nonprofit entities, are supposed to be caring institutions where anyone in the community can present when in distress. We have noted that, as a society, we have codified this premise in EMTALA, which opens the door to the hospital to all in emergent situations [19]. While we can claim that this law is based on fundamental human rights, it also represents the settled intuition in our society that we do not want people dying in the streets. The hospital is a place where they are welcome to present. And if people believe they are unwelcome, this belief will undermine the ability of the institution to respond efficiently to their needs. Patients will present later in the course of their illness when they are sicker, and it will require more resources to treat [24, 25]. This will also mean that should they bear a communicable disease, they will place the community at additional risk by delaying treatment of it. So, forced medical repatriation has been rejected as ethically untenable, as it undermines the key value of the institution of medicine, that of caring for patients and the community.

For the time being, hospitals and health systems must act creatively to provide care for such patients without resorting to forced medical repatriation. But preservation of the values and functions of our health care institutions obviously would be better facilitated by the extension of the usual health insurance options to this population. Being insured would enable these patients to be transferred to a lower, more appropriate, level of care

with the same efficiency as any other patient. Thus, health insurance certainly benefits the patient, but it is an even greater benefit to the health care system. Inclusion within the system enables the system to fulfill its functions and live up to its values rather than introducing the distortion of the patient being eligible only for care at a fairly high level of care, i.e., emergency care, on the care continuum.

Rethinking health insurance and immigration. Health insurance from this vantage point of its implicit medical ethic is a way of enabling an undocumented patient to contribute to the system in advance. One can continue to deny access to insurance but to do so means that when these patients present, the financing of their care will need to be entirely absorbed by others. If they are enabled to buy insurance, they contribute by prepaying into the risk pool of the community. The community benefits in addition to any benefit the purchasers utilize. Some progressive organizations such as the American College of Physicians (ACP) have recognized this point and argued that undocumented immigrants should be able to purchase private insurance on the new insurance exchanges, as it seems foolhardy not to accept prepayment for care that will be utilized [26]. However, the ACP statement then falls prey to the conventional misunderstanding regarding who benefits whom by asserting that undocumented immigrants should remain ineligible for any of the sliding scale subsidies the government provides to enable persons of lower and lower-middle incomes to afford the purchase. While one can easily fall into the trap of seeing the subsidies as benefits to the purchaser and therefore deny them, the subsidies enable the purchase. If the potential purchaser does not buy insurance because of the lack of a subsidy, the person is denied the ability to make the contribution to the system that he or she can and again becomes a free rider should he or she need health care [27, 28].

At this point, we see that health insurance parallels other progressive practices in regard to undocumented immigrants [29]. In particular, sanctuary cities apply this same type of reasoning to “benefits” such as access to law enforcement. Enabling undocumented persons to call the police without fear that their immigration status will be challenged benefits the community by not allowing criminal activity to go unchecked [30]. Similarly, many states will issue drivers licenses regardless of immigration status [31]. Ensuring that all drivers on the road have received proper training and are identifiable benefits all who are on that same road. Of course, all of these measures have secondary benefits to the undocumented persons. Drivers’ licenses make increased economic activity realistic for the bearers. Being able to call police officers when in danger or victimized by criminals makes life safer for them as well. And being able to visit health care facilities when ill helps one to maintain one’s health and quality of life. Inclusion increases the degree to which an undocumented resident is a contributor to rather than a taker from the system. This forms a virtuous circle in which undocumented persons increasingly contribute to the community and the community increasingly benefits the undocumented person [29]. This virtuous circle, in which benefits to the society and inclusion of persons who are

immigrants reinforce each other, can be even more clearly seen in the issue of undocumented doctors.

Dreamer MDs. In the fall of 2012, the Loyola University Chicago Stritch School of Medicine became the first medical school in the United States to amend its admissions criteria to explicitly note that a specified group of undocumented immigrants is eligible to apply for admission [32]. These young people have been known as DREAMers, which is an acronym formed from the never-passed piece of legislation called the Development, Relief, and Education for Alien Minors (DREAM) Act [33], which would have provided them with a path to citizenship. (They are increasingly rejecting this acronym for separating them from solidarity with the larger undocumented immigrant community [32].) This population consists of undocumented immigrants who were brought to the United States before the age of 16 by their parents and have been raised and educated in the United States for a substantial period of their development.

When these students who had outstanding undergraduate academic qualifications began asking in the first decade of the twenty-first century if they could apply to medical schools, it was obvious to the leadership of the Stritch School of Medicine that it would be highly desirable to entertain these applications [34]. In addition to the usual academic qualifications, these applicants bring a variety of qualifications that are highly desirable in terms of the mission of medical schools to produce a physician workforce that meets the needs of society. For instance, such applicants are typically bilingual and bicultural. While they have grown up in the United States—with the result that in most respects they are not especially different from their citizen-peers—they also have a firsthand acquaintance with the experience of immigrants in the United States. Thus, when they successfully compete for admission on their merits, they also bring all the well-recognized benefits of diversity to their class [35]. They enrich the educational experience of their peers and their demographic profiles indicate that they are more likely to understand and choose to serve underserved communities similar to those in which they grew up [35].

As undocumented immigrants, DREAMers were excluded from working lawfully in the United States until the creation of a new status, Deferred Action for Childhood Arrivals (DACA), by the executive branch on June 15, 2012 [36]. With conferral of such status, one receives an Employment Authorization Document (EAD), also known as a work permit, and can apply for a social security number. However, they are still barred from receiving any federal financial aid, as that would seem to be a federal “benefit” [37]. Aside from the financial aid difficulty, there are few reasons for medical schools to reject the utilization of this talent pool. With the possibilities made possible by DACA, this talent pool should be stewarded for the benefit of the ends of the medical profession. For instance, their talents often include specific abilities such as linguistic skills and cultural knowledge that will enable them to meet particular needs of various segments of our

communities. They do not pose the usual concerns of international students that they might be likely to take their education and go back to a country of origin, thereby not benefiting the communities that help to support medical education in the United States. In this sense, these students are from here, from our communities [37].

The case of DREAMers shows that communities are once again best served by enabling the full participation of those present rather than artificially restricting that participation. It is difficult to see why they should be prevented from using their talents to benefit patients in need. Again, we see the self-fulfilling nature of the maker-versus-taker distinction. If the conditions of inclusion exist, these people become contributors. If they are excluded from participation in the mainstream life of the community, they are limited in the kinds of contributions that they may make. As we noted earlier, DREAMers in medical school cannot secure federal student loans because our system does not wish to give a “benefit” to an undocumented immigrant [37]. But we must again recall why student loans are provided to medical students and students in higher education at all. Such loans have been historically seen as helpful to overall economic development and enhancing the quality of life and security of the nation [38]. And medical student loans have enabled the expansion and diversification of the physician workforce to comprise a group better able to address a growing and diversifying population [39]. Of course, a student who can become a doctor is benefitted. But that benefit is ancillary to meeting the need for a talented and qualified physician workforce.

Ethics, Policy, and the Community

The conclusion from our overview is simple. Our health care institutions are undermined when clinicians are forced to treat some patients and potential colleagues differently simply because of immigration status. These institutions and clinicians are forced to act contrary to their values and to discriminate in ways contrary to the established norms of medicine and health care for nonmedical reasons that are extrinsic to the profession.

This conclusion also seems to yield a corollary: namely, the degree to which undocumented persons contribute to our institutions is largely determined by the degree to which systems enable and accept their contributions. Seeking to exclude their participation from health insurance or health care professions as punishment for unlawful entry or overstaying a visa limits their contributions. Of course, as people who are motivated to leave their homeland and immigrate to the United States often possess great determination, they sometimes find ways to overcome these barriers despite the intended obstacles. Such considerations call into question the prudence and practicality of exclusionary policies. Is the absolutizing of laws regarding authorized immigration worth undermining our cherished values and institutions and denying our communities the contributions of undocumented immigrants? Toulmin reminds us that morality is to a large extent that which preserves and furthers our institutions and forms of life rather than undermines them [1].

Conclusion

Our survey of the ways in which undocumented immigrants interact with the health care system illustrates that the common way of framing issues related to undocumented immigrants is highly artificial. That is, the maker-versus-taker focus abstracts a particular individual from the social and institutional context and does not consider the person as part of larger communities and human ecology. As a result, such artificial thinking makes prescriptions that damage the community and its institutions. Medicine starts from cases within institutions and asks for policy solutions that preserve the goods that we value within our institutions and communities.

The conclusion that our health care institutions are undermined when clinicians are forced to treat some patients and potential colleagues differently simply because of immigration status and that policies inclusive of this population benefit our institutions seems to have immigration policy implications as it underscores the self-reinforcing nature of public policy. That is, undocumented immigrants who have lived, studied, and worked within a community participate within that community. The community functions best when that participation is not truncated but fosters inclusion. That is in the community's interest. And as the undocumented immigrant contributes to the community, he or she becomes still more a part of that community by developing a kind of equity interest in these social institutions and their values. Reciprocally, with the passage of time, the community gains an equity interest in the individual whose good it also has at least tacitly fostered.

Medicine and its ethics contribute to our thinking about the treatment of undocumented immigrants who live and work within our borders. We must treat such people in accordance with the inclusive norms of our institutions—institutions that promote the good of the community. But can medicine and its ethics tell us exactly how to alter our immigration policies such that we know exactly how many people and who they are that should be given entry visas? Of course not. But it provides a starting point and a methodology. We must begin from within the ecology of our institutions and relationships rather than begin with an empty and negative characterization of immigrants.

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