THE PRACTICE OF MEDICAL REPATRIATION: THE PRIVATIZATION OF IMMIGRATION ENFORCEMENT AND DENIAL OF HUMAN RIGHTS

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In February 2000, Luis Alberto Jiménez was returning home from a day's work as a landscaper in Florida when the car he was riding in was struck by a drunk driver with a blood alcohol level four times the legal limit. While the drunk driver was a U.S. citizen with a significant criminal history, Luis Jiménez was a 35 year old undocumented gardener that had left his family behind in Guatemala two years ago and immigrated to the United States in pursuit of his dream of working hard, earning significantly more money, and ultimately being able to buy land and cultivate his own garden back home to support his family.[1] As a result of the head-on crash, Mr. Jiménez was catastrophically injured and two of his fellow immigrant landscapers in the car with him died

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1. *See* Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1. For a practical discussion of the Jiménez case and medical repatriation see Lori A. Nessel, Lori A. Nessel on the Legality and Ethics of Medical Repatriation, LEXIS, 2009 Emerging Issues 4404 (Oct. 6, 2009), *available at* http://www.lexisnexis.com/Community/emergingissues/blogs/emergingissuescommentary/archive/2009/10/07/Lori-A.-Nessel-on-the-Legality-and-Ethics-of-Medical-Repatriation.aspx (last visited August 2, 2010).

instantly.[2] Mr. Jiménez was rushed to Martin Memorial Medical Center (a not for profit hospital) and was diagnosed as having sustained traumatic brain damage and severe physical injuries, with his prognosis described as "poor."[3] Mr. Jiménez was treated and remained hospitalized at Martin Memorial for approximately four months. In June 2000, Martin Memorial transferred Mr. Jiménez to a nursing home for ongoing care and rehabilitation.[4] Because the accident left Mr. Jiménez incapacitated, both physically and mentally, a court appointed Mr. Jiménez's cousin, Montejo Gaspar Montejo, as his legal guardian.[5]

While at the nursing home, Mr. Jiménez's health deteriorated dramatically, resulting in his readmission to Martin Memorial Medical Center for emergency treatment in January 2001.[6] At the time that Mr. Jiménez was re-admitted, he was "emaciated and suffering from ulcerous bed sores so deep that the tendons behind his knees were exposed."[7] Mr. Jiménez's infection was so severe that doctors questioned whether the condition might be terminal.[8]

Martin Memorial treated Mr. Jiménez and he remained in a vegetative state for over a year but then improved.[9] In November 2001, Mr. Montejo filed a guardianship plan seeking ongoing care for Mr. Jiménez at a hospital or nursing home.[10] When Martin Memorial could not find a long-term care facility that would accept Mr. Jiménez, it intervened to seek a court order authorizing it to unilaterally return him to his native Guatemala.[11]

On June 27, 2003, over the objections of Mr. Jiménez and his guardian Mr. Montejo, the state circuit court granted the order allowing Martin Memorial to charter a private plane and medical attendant to forcibly return Mr. Jiménez to Guatemala.[12] Mr. Jiménez moved for rehearing but it was denied on July ninth. On that same day, Mr. Montejo filed a notice of appeal along with an emergency motion for a stay pending appeal. However, the very next morning, before the court even had an opportunity to rule on the emergency stay, Martin Memorial

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2. Sontag, *supra* note 1, at A1.

3. Montejo v. Martin Memorial Medical Center, Inc., 874 So.2d 654 (Fla. Dist. Ct. App. 2004); Sontag, *supra* note 1, at A3.

4. *Montejo*, 874 So.2d at 656.

5. *Id.*

6. *Id.*

7. Sontag, *supra* note 1, at A3.

8. *Id.*

9. *Id.*

10. *Montejo*, 874 So.2d at 656.

11. *Id.*

12. *Id.*

forcibly ushered Mr. Jiménez (via private plane) to a hospital in Guatemala that could not treat brain injuries, and which subsequently discharged him to his elderly mother's house in a mountainous region of Guatemala where he remains to date.[13] A New York Times reporter who visited Mr. Jiménez in the summer of 2008 found him largely confined to his bed and suffering from routine seizures.[14] He had not received medical care for over five years.

This Article focuses on nonconsensual medical repatriations like the one Mr. Jiménez endured. In this context, the practice of "medical repatriation" refers to the forced or coerced extrajudicial deportation of an undocumented poor and seriously ill or injured individual to his or her native country.[15] It occurs when undocumented immigrants are at their most vulnerable, and appears to be an increasingly pervasive practice.[16] When undocumented immigrants face a medical crisis, they find themselves at the intersection of two harsh regimes that are urgently in need of reform: immigration and health care.[17] Although hospitals are

13. Montejo v. Martin Mem'l Med. Ctr., Inc., 935 So.2d. 1266, 1268 (Fla. Dist. Ct. App. 2006). According to *Montejo*, notwithstanding the circuit court's order that the hospital file a response to the motion for a stay by 10:00 am the following day, the hospital proceeded to remove Jiménez to Guatemala at 7:00 am that day. *Id.*

14. Deborah Sontag, *Jury Rules for Hospital that Deported Patient*, N.Y. TIMES, July 27, 2009, at A10.

15. This Article does not address situations in which medical repatriations are requested by the patient and carried out voluntarily to fulfill the patient's wishes to return to his or her native country for medical treatment. It is also important to note that many immigrants in lawful status, including lawful permanent residents, are also at risk of medical repatriation because, under federal law, they are prohibited from accessing social services, including Medicaid with limited exceptions, for at least five years after obtaining permanent residency. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA or "1996 Welfare Act"), Pub. L. No. 104-193, 110 Stat. 2105 (1996).

16. *See* Sontag, *supra* note 1. While it is difficult to gather precise statistics on medical repatriations, Sontag provides compelling evidence of the "little-known but apparently widespread practice" including: St. Joseph's Hospital in Phoenix, Arizona repatriates approximately ninety-six immigrants a year; Broward General Medical Center in Fort Lauderdale, Florida repatriates about six to eight patients a year; and Chicago has repatriated about ten patients a year to Honduras since early 2007. *Id.* In addition, the Mexican Consulate reported being involved in eighty-seven medical cases involving Mexican nationals and 265 cases involving immigrants injured while crossing the border, most of which ended in repatriations. *Id.*

17. Although President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010, it fails to provide for any new funding or benefits for undocumented immigrants. *See* H.R. 3590 (2010); National Immigration Law Center, *How are Immigrants Included in Health Care Reform? Patient Protection and Affordable Care Act [H.R. 3590], available at* http://www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf (last visited June 12, 2010) (Pursuant to the new law, undocumented immigrants are precluded from purchasing private insurance through

required to provide emergency care to all patients, regardless of immigration status,[18] once patients are "stabilized," hospitals are no longer required or funded to treat undocumented patients and rehabilitative or long-term care facilities, to which such patients would otherwise be released, are not required to accept them.[19] In addition, while hospitals must have appropriate discharge plans for these patients,[20] they increasingly amount to little more than partnering with

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newly created purchasing pools and are not eligible for premium tax credits or cost-sharing reductions. Furthermore, undocumented immigrants are not eligible for Medicare, nonemergency Medicaid, or Children's Health Insurance Program, although they do remain eligible for emergency Medicaid and nonemergency health services at community health centers or safety-net hospitals). The new health care reform bill also left intact the restriction on Medicaid coverage for most lawful permanent residents for at least five years *Id. See also* Juliana Barbassa, *Health Care Reform Promise Explicitly Excludes Millions of Illegal Immigrants,* BUSINESS NEWS, April 4, 2010, *available at* http://blog.taragana.com/business/2010/04/04/health-care-reform-promise-explicitly-excludes-millions-of-illegal-immigrants-47802/ (explaining that the notion of extending coverage to undocumented immigrants was so politically contentious that the new legislation goes as far as to prohibit them from purchasing health insurance in the newly created exchanges, even with their own money). While President Obama stated that comprehensive immigration reform was still a priority, until recently there has been little movement in this area. *See* Ginger Thompson & Marc Lacey, *Obama Sets Immigration Changes for 2010,* N.Y. TIMES, Aug. 10, 2009, *available at* http://www.nytimes.-com/2009/08/11/world/americas/11prexy.html ("[President Obama] reiterated his commitment to pursuing comprehensive immigration reform, despite his packed political agenda and the staunch opposition such an initiative is likely to face."); President Barack Obama, State of the Union Address (Jan. 27, 2009), *available at* http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address. The State of the Union included only one line about immigration reform: "[a]nd we should continue the work of fixing our broken immigration system—to secure our borders, enforce our laws, and ensure that everyone who plays by the rules can contribute to our economy and enrich our nation." *Id.* However, on March 18, 2010, Senators Charles E. Schumer (D - N.Y.) and Lindsey Graham (R - S.C.) unveiled a comprehensive immigration reform proposal that could require undocumented immigrants to admit they violated the law before being able to gain lawful immigration status and require all U.S. workers to carry biometric identification proving eligibility for employment under immigration laws. *See* Julia Preston, *2 Senators Offer Immigration Overhaul,* N.Y. TIMES, March 18, 2010, at A11; Washington [Reuters], *Obama Vows to Press Ahead on Big Challenges,* WASHINGTON POST, March 30, 2010, *available at* http://www.reuters.com-/article/idUSTRE62T1UD20100330 ("The president said specifically that it was important for Congress to move ahead with legislation on energy and immigration policy as well as financial regulatory reform.").

18. *See* Emergency Medical Treatment and Leave Act [hereinafter EMTALA], 42 U.S.C.A. § 1396(b)(v) (West 2010).

19. *Id.*

20. 42 C.F.R. § 482.43 (2010).

private companies to deport undocumented patients to their native countries.[21]

This Article examines the growing trend in medical repatriations through the perspectives of both domestic and international human rights. Utilizing the recent conflicting rulings in the *Jimenez* case, this Article analyzes inconsistencies in existing health care and immigration laws and the lack of regulatory oversight that has given rise to extrajudicial deportations.

Under current law, hospitals that receive medicare funding are required to provide emergency treatment to all patients regardless of immigration status or insurance coverage. Once stabilized, hospitals must comply with federal and state regulations to insure that any subsequent discharge or transfer is "appropriate," and that adequate follow-up care will be provided. However, long-term rehabilitative or nursing care facilities are not required to accept patients that are uninsured or undocumented. In order to ensure that all patients requiring emergency treatment receive it, hospitals are prohibited from reporting undocumented patients to the Department of Homeland Security for removal. Thus, hospitals find themselves with an ethical and statutory duty to provide care and to follow up with appropriate discharge plans. However, with no concomitant duties imposed on long-term care facilities to accept such patients, hospitals are left with exorbitant costs, no federal funding and no decent options. This gulf between the need for medical treatment and funding is rived with legal and moral issues including: the moral and human rights based-duty to provide medical care to all that are in need; a regulatory duty not to "dump" patients that cannot afford to pay; a public health, moral, and in some states, statutory duty not to report undocumented patients to immigration authorities; and an international-human right to health care, life, dignity and due process in expulsion proceedings.

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21. The largest private transfer company engaging in medical repatriations to Latin America is MexCare. As per its website, MexCare describes itself as the 'liaison' between the American and the Latin American healthcare systems, explaining that it "safely, professionally and effectively manages the transfer and care of patients to Latin American hospitals." MexCare, http://www.mexcare.com (follow "services" hyperlink; then follow "procedure" hyperlink) (last visited June 12, 2010). As advertised on Mexcare's site, "[w]ith a network of over 30 hospitals and treatment centers, MexCare reduces cost per discharge for U.S. hospitals seeking to alleviate the financial burden of unpaid services." MexCare, *available at* http://www.mexcare.com (follow "locations" hyperlink) (last visited June 12, 2010). "Any hospital seeking to defray un-reimbursed medical expenses can contact MexCare. We accept acute and sub-acute patients who are in stable condition." MexCare, http://www.mexcare.com (follow "services" hyperlink; then follow "how we do it" hyperlink; then follow "Candidates for MexCare") (last visited June 12, 2010).

The private medical transfer companies that are stepping up to fill this void advertise "high quality medical care for unfunded Latin American nationals . . . resulting in significant savings to U.S. hospitals."[22] Such private companies agree to obtain patient consent and arrange for private planes to return undocumented patients back to their native countries. Initially, patients are usually admitted to a private hospital run by the transfer company. After that point, patients have reported a lack of follow-up or oversight.[23]

In this Article, I argue that the interests at stake are too significant to be delegated or left to private companies. Because the right to life, to health, and to due process are core fundamental human rights, the United States is obligated to respect them and hospitals cannot repatriate seriously ill immigrants against their will or with consent that was obtained without advising the patient of the immigration consequences. By examining issues with informed consent, immigration consequences of repatriations, federal authority over immigration regulation, and the human right to health care and due process, I conclude that there is an urgent need for reform of the health care and immigration regimes and that the U.S. must care for those within our country that are in need of medical treatment.

I. THE MIXED MESSAGES SENT BY THE JIMÉNEZ RULING

Notwithstanding his "deportation" by the hospital, Mr. Jiménez's guardian, Montejo, continued to challenge both the lower court's order that had authorized the forced repatriation and its finding that the hospital was not an "interested party" in the guardianship proceedings.[24] On May 5, 2004, the Florida District Court of Appeals ruled that, in light of the financial burden at stake, the hospital was "affected by the outcome of the proceeding" and, therefore, an interested party to the guardianship proceedings.[25] The hospital asserted that Mr. Jiménez's discharge to Guatemala had rendered the appeal moot, particularly because any decision as to his return would be preempted by federal

22. Mexcare, http://www.mexcare.com (last vistited Apr. 7, 2010). Mexcare is the largest private transfer company involved in medical repatriations. *Id.*

23. See for example the discussion of Grady Hospital in Atlanta at notes 64-83 and accompanying text. The immigrant dialysis patients have brought a human rights complaint alleging, inter alia, that they did not receive the promised level of care after signing contracts with a private transport company that was assisting the hospital in repatriations.

24. Montejo v. Mem'l Med. Ctr., Inc., 874 So.2d 656, 656 (Fla. Dist. Ct. App. 2004).

25. *Id.* The hospital asserted that it spent over $1 million on Jiménez's care, only $80,000 of which was reimbursed by Medicaid. *Id.*

immigration law.[26] The court held that the appeal was not moot, both because of the hospital's role in removing Jiménez before the court had an opportunity to resolve the legal issues, and the important issue at stake and the potential for repetition.[27] The court overturned the lower court's order that had authorized the hospital to repatriate Jiménez. The court held that the order was invalid as the state court was preempted by federal law regulating immigration. Finally, the Florida District Court of Appeals ruled that there was no competent substantial evidence to support the hospital's discharge of Mr. Jiménez to Guatemala.[28]

Approximately four months after the Florida District Court of Appeals reversed the lower court, Mr. Jiménez's guardian instituted a personal injury lawsuit for monetary damages, alleging that the hospital's action in confining Jiménez in the ambulance and private airplane constituted false imprisonment under Florida law. The trial court dismissed the false imprisonment claim with prejudice and Mr. Montejo appealed. On appeal, the hospital asserted that it should be shielded from liability because it acted to repatriate Jiménez pursuant to a court order that was lawful at the time, even if subsequently overturned. According to the hospital, the fact that it had acted pursuant to a then-valid court order also signified that its actions were not "unreasonable and unwarranted."[29]

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26. *Id.*

27. *Id.* at 657.

28. *Id.* at 658. At the evidentiary hearing that was required in order for the hospital to be able to discharge Jiménez, the hospital was obligated to show that Jiménez would be discharged to an "appropriate facility," one that in this case could provide the traumatic brain injury rehabilitation needed for Jiménez. There were appropriate facilities in Florida, but they refused to accept Jiménez because he did not qualify for Medicaid funding. The trial court found that Jiménez had reached a "therapeutic plateau" and that Montejo was not acting in Jiménez's best interests by advocating for his stay in a hospital that "as an acute care facility, cannot provide for the long-term therapy needs" of Jiménez. *Montejo*, 874 So.2d at 657. In order to satisfy its obligations for appropriate discharge under both its internal regulations and federal law, the hospital relied upon a letter from the vice minister of public health in Guatemala attesting to Guatemala's willingness to find an appropriate no-cost facility for Mr. Jiménez. *Id.* The Florida District Court of Appeals held that this letter was inadmissible hearsay and even if admissible, lacked the specificity required by both federal regulations and the hospitals procedures for discharge. *Id.* at 658. According to the Florida Court of Appeals, the only admissible evidence was testimony from an expert on the Guatemalan public healthcare system who testified that facilities providing traumatic brain injury rehabilitation in Guatemala did not exist. *Id.*

29. The elements of a false imprisonment cause of action under Florida law include: the unlawful detention and deprivation of liberty of a person; against that person's will; without legal authority or "color of authority;" which is unreasonable and unwarranted under the circumstances. *Montejo*, 935 So.2d at 1268.

On August 23, 2006, the Florida District Court of Appeals reversed the trial court, finding that the hospital was not entitled to absolute immunity as it did not act in furtherance of a court order.[30] The Court also found that the hospital was not entitled to qualified immunity because it was not a state actor and was motivated primarily by a private interest.[31]

Even though the Florida District Court of Appeals had ruled that the hospital acted without legal authority, the matter was remanded for a factual determination as to whether Martin Memorial Hospital's actions were unreasonable and unwarranted under the circumstances, and if so, what damages were due. On July 27, 2009, the trial judge instructed the jury that, as a matter of law, the Florida Court of Appeals had already ruled that Mr. Jiménez had been (1) unlawfully detained, (2) without legal authority, and (3) against his guardian's will, thereby satisfying three of the four elements for false imprisonment under Florida law.

However, in this highly publicized and politicized case, the jury ultimately decided that the hospital did not owe any monetary damages to Mr. Jiménez. The jury's verdict was based on its finding that the hospital's actions toward Mr. Jiménez were not "unreasonable and unwarranted under the circumstances," the final element required for false imprisonment under Florida law.[32]

Thus two distinct and conflicting messages, which illustrate the need for reform of our immigration and health care regimes, emerged from the case: on the one hand, the jury did not find any monetary liability for Martin Memorial Hospital, seeming to signal a green light to similarly situated hospitals debating whether to forcibly repatriate uninsured immigrants. However, the Florida District Court of Appeals also ruled that the hospital repatriation was unlawful as it was preempted by federal law from immigration regulation and thus lacked subject matter jurisdiction to rule on what was, at its heart, an immigration matter. Moreover, the Florida District Court of Appeals ruled that the hospital was not protected by the doctrine of qualified immunity as it was acting to further a private interest. Based on these aspects of the court of

30. *Id.* at 1270.

31. *Id.* at 1271.

32. According to the New York Times coverage, the court room was filled with hospital supporters throughout the trial and the jury lacked any Hispanic members. *See* Sontag, *supra* note 16, at A10. For an analysis of the Jimenez decision, see Nessel, Lori A. Nessel on the Legality and Ethics of Medical Repatriation, LEXIS, 2009 Emerging Issues 4404 (Oct. 6, 2009), *available at* http://www.lexisnexis.com/Community-/emergingissues/blogs/emergingissuescommentary/archive/2009/10/07/Lori-A.-Nessel-on-the-Legality-and-Ethics-of-Medical-Repatriation.aspx (last visited August 2, 2010).

appeals ruling, hospitals considering following suit might well face liability in the future.

II. "INFORMED" CONSENT AND "VOLUNTARY" REPATRIATIONS

Mr. Jiménez's story is also representative of a much larger problem. There are estimated to be approximately twelve million undocumented persons living within the United States.[33] Undocumented immigrants by and large perform the most dangerous work for the lowest pay.[34] Furthermore, undocumented workers are largely without health insurance.[35] In addition to the undocumented population, a strikingly high proportion of lawful permanent resident immigrants are also uninsured.[36] In the cities with the largest immigrant populations, the numbers of uninsured immigrants are dramatic.[37]

As noted, hospitals are required by federal law to provide medical treatment and to stabilize all patients that require emergency treatment regardless of their immigration status or possession of health insurance.[38] However, once patients have been stabilized, obligations become murkier. As long as hospitals have appropriate discharge or transfer plans, they are permitted to discharge or transfer patients to other facilities.[39] In order to effectuate such a transfer, hospitals must either

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33. According to the Pew Hispanic Center, there were approximately 11.9 million undocumented immigrants in the United States as of March 2008. *See* Aaron Terrazas & Jeanne Batalova, *Frequently Requested Statistics on Immigrants and Immigration in the United States*, MIGRATION POLICY INSTITUTE, Oct. 2009, *available at* http://www.migrationinformation.org/USFocus/display.cfm?ID=747.

34. *See* Lori A. Nessel, *Undocumented Immigrants in the Workplace: The Fallacy of Labor Protection and the Need for Reform*, 36 HARV. C.R.-C.L. L .REV. 345, 347 (2001).

35. According to recent MPI estimates, immigrants accounted for 29 percent of the 46.6 million working-age adults and children under 18 with no health insurance in 2008. Of these 13.4 million uninsured immigrants, about half (6.8 million) were unauthorized immigrants, almost a third (4.2 million) were lawful permanent residents (LPRs), and another 17 percent (2.3 million) were naturalized citizens. Terrazas & Batalova, *supra* note 33.

36. Of the roughly 12 million lawful permanent residents in the United States, 4.2 million are uninsured. *See* Randy Capps, Marc R. Rosenblum & Michael Fix, *Immigrants and Health Care Reform: What's Really At Stake*, MIGRATION POLICY INSTITUTE, Oct. 2009, *available at* http://www.migrationpolicy.org/pubs/healthcare-Oct09.pdf.

37. For example, in New York State, a recent study found that nearly thirty percent of the state's 2.3 million uninsured persons are noncitizens and noncitizens are three times as likely as citizens to be uninsured. *See* Danielle Holahan & Allison Cook, United Hospital Fund, Characteristics and Health Coverage of New York's Noncitizens (2009), *available at* http://www.medicaidinstitute.org/assets/651.

38. EMTALA, *supra* note 18.

39. 42 C.F.R. § 482.43 (2010). In order for a transfer plan to be deemed appropriate, it must ensure that the patient will be received at a facility that has adequate space, has

obtain the patient or guardian's consent or seek a court order if the patient or guardian opposes the transfer or discharge.

In cases involving consent, the question is whether the patient or guardian has been advised as to the consequences of such a discharge such that the consent is meaningful. If the discharge or transfer involves agreeing to leave the United States, there can be significant immigration consequences. For example, if the patient were in the United States unlawfully for a period greater than six months but less than one year and agreed to leave, she would be barred from re-entering the U.S. for three years.[40] If the patient were in the U.S. unlawfully for a year or more and agreed to leave, she would be barred from re-entering the U.S. for ten years.[41] The patient might also be basing consent to repatriation upon an understanding that there are no rehabilitative services available to her in the U.S. Again, this determination would depend on whether there were possible ways for the patient to obtain lawful immigration status.

For example, prior to the Welfare Reform Law of 1996, federal health care benefits, including rehabilitative and nursing home services, were available to both lawful permanent residents and a broad class of person considered to be permanently residing under color of law, or PRUCOL.[42] Although the 1996 Welfare Reform Law eliminated the PRUCOL category entirely as a basis for federal public benefits, certain states have retained PRUCOL as a basis for state benefit eligibility.[43] Therefore, seriously ill or injured immigrants who are facing repatriation by the hospital might actually be eligible for rehabilitative or nursing

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agreed to provide necessary medical services, and where any risks to the patient's health will be minimized. 42 U.S.C.A. § 1395dd (West 2010).

40. *See* Immigration and Nationality Act, INA § 212(a)(9)(B)(i)(I), 8 U.S.C.A. § 1182 (West 2010) (providing that any alien that is unlawfully present for more than 180 days but less than one year and voluntarily departs prior to the commencement of removal proceedings is inadmissible for three years).

41. I.N.A § 212 (a)(9)(B)(i)(II), 8 U.S.C.A. § 1182 (providing a ten-year bar to admissibility for an alien that is unlawfully present in the U.S. for one year or more before voluntarily departing).

42. PRUCOL "applies to [immigrants] 'under statutory authority and those effectively allowed to remain in the United States under administrative discretion.' Examples of PRUCOL [status] include: those granted indefinite voluntary departure; those residing in the U.S. under orders of supervision; . . . [those] granted stays or suspension of deportation, [temporary protected status], and aliens whose departure [ICE] does contemplate enforcing." Randall Chun & Danyell Punelli LeMire, Minn. H.R. Research Dep't, Eligibility of Noncitizens for Health Care and Cash Assistance Programs 12 (2006), *available at* http://www.house.leg.state.mn.us/hrd/pubs/ncitzhhs.pdf.

43. See National Immigration Law Center, Medical Assistance Programs for Immigrants in Various States, *available at* http://www.nilc.org/pubs/guideupdates/med-services-for-imms-in-states-2010-02-24.pdf (last visited June 12, 2010) for a comprehensive state-by-state-table of immigrant eligibility for benefits.

home services in their state. To give just one example, an undocumented Haitian immigrant in need of ongoing care in New York might qualify for state benefits if the hospital assisted him in seeking temporary protected status.[44]

Similarly, a person that suffers from a chronic medical or mental health condition and is facing repatriation to a country that does not provide adequate treatment might have a claim to protection from removal under the refugee protection regime. [45] For example, a person that shows that persons with mental disabilities are persecuted in a country that fails to provide adequate protection might qualify for political asylum.[46] A patient that needs a particular medical treatment regime to survive might be able to show that repatriation to a country that will not provide such treatment would rise to a level of torture and warrant protection under the United Nations Convention against Torture.[47]

If undocumented patients have been in the United States for at least ten years continuously, and can show that deportation would result in

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44. On January 21, 2010, the secretary of homeland security designated Haiti for temporary protected status (TPS). 75 Fed. Reg. 3476-3479 (January 21, 2010). Under section 244(b)(1) of the INA, the secretary is authorized to designate a foreign state, or part of a foreign state, for TPS upon a finding that such state is experiencing ongoing armed conflict, a natural disaster or "extraordinary and temporary conditions." Thus, Haiti was designated for TPS based on the devastating earthquake that ravaged the nation on January 12, 2010. Pursuant to TPS, Haitian nationals that can prove that they were already present in the U.S. when the earthquake struck Haiti are provided with lawful temporary immigration status for 18 months.

45. *See* 8 C.F.R. § 208.16(c) (2010) (withholding of removal pursuant to the Convention against Torture); I.N.A. § 208, 8 U.S.C.A. § 1208 (asylum procedures). *See* Kendra Stead, *Critical Condition: Using Asylum Law to Contest Forced Medical Repatriation of Undocumented Immigrants*, March 13, 2009, *available at* www.ssrn.com (id=1392576).

46. *See, e.g.,* Tchoukhrova v. Gonzales, 4040 F.3d 1181 (9th Cir. 2005) (recognizing, for asylum protection purposes, a social group comprised of "parents of children born with severe disabilities" and granting asylum to a mother so that she would not be returned to a country that had forcibly institutionalized, abused and denied care to her disabled son).

47. *See, e.g.,* Jean-Pierre v. U.S. Att'y Gen., 500 F.3d 1315 (11th Cir. 2007) (vacating and remanding to determine whether returning a man with late-stage AIDS and mental illness to mandatory imprisonment and physical abuse without medication constitutes torture under the Convention); Matter of P-C-, (BIA Apr. 30, 2010) (unpublished decision on file with author) (holding that deportation of Haitian criminal with psychiatric disorders to face indefinite imprisonment without medication constitutes torture under the Convention). But see, Pierre V. Att'y Gen. of U.S., 528 F.3d 180 (3rd Cir. 2008) (en banc) (holding that grave harm that would likely befall Haitian criminal deportee with feeding tube and need for medical care is insufficient to constitute torture absent a showing of specific intent).

extreme and exceptionally unusual hardship to a U.S. citizen or lawful permanent resident family member, the immigrant might have a defense to deportation known as cancellation of removal.[48] Depending upon the country of nationality, there may be other remedies available such as temporary protected status.[49] Finally, if the injury at issue was sustained incident to a violent crime and the injured immigrant is willing to assist the government in prosecuting the perpetrator, she might qualify for special U visas for victims of violent crime.[50]

Given the complexities of immigration law, and the harsh consequences that apply to voluntary repatriation, patients should be advised as to the immigration consequences prior to consenting to repatriation. On the one hand, this highlights why hospitals or private transfer companies should not be repatriating patients as they are ill equipped to navigate the complex labyrinth of immigration options and consequences, and are not authorized to do so under federal law. Even in situations in which a patient consents, given the magnitude of what is at stake, consent should not be considered as "informed" if the patient has not been advised as to the immigration consequences of repatriation.

In the criminal law context, the Federal Rules of Criminal Procedure specify that judges must ensure that pleas are knowingly and voluntarily entered into before they can be accepted. Before accepting a guilty plea or a nolo contendere plea, the court is required to determine whether the plea is being entered into voluntarily and absent force, threats or promises.[51] As the Supreme Court has noted, "[i]gnorance, incomprehension, coercion, terror, inducements, subtle or blatant threats might be a perfect cover-up of unconstitutionality."[52]

However, the Supreme Court jurisprudence overall has held that deportation is part of a civil regulatory scheme rather than a punishment.[53] Because deportation is not viewed as punishment, and deportation proceedings are deemed to be civil, rather than criminal, many constitutional rights do not apply such as the right to free counsel for indigent defendants or protection afforded by the ex post facto clause.

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48. I.N.A. § 240A(b).

49. *See* I.N.A. § 244; 8 C.F.R. § 244.

50. I.N.A. § 101(a)(15)(U), 8 U.S.C.A. § 1101(a)(15)(u) (West 2010).

51. FED. R. CRIM. P. 11(b)(2).

52. Boykin v. Alabama, 395 U.S. 238, 243 (1969).

53. See e.g. *Reno v. Am.-Arab Anti-Discrimination Comm.*, 525 U.S. 471, 491 (1999) (explaining that deportation is not punishment because the noncitizen is "merely being held to the terms under which he was admitted."); *I.N.S. v. Lopez-Mendoza*, 468 U.S. 1032, 1038 (1984), (holding that deportation is a "purely civil action" and refusing to apply the exclusionary rule to such proceedings).

Until recently, federal law has not required judges, prosecutors, or defense attorneys to advise a noncitizen defendant as to the immigration consequences of entering into a criminal plea agreement, although approximately twenty-one states require either the sentencing judge or the defense attorney to advise the noncitizen defendant that a conviction might jeopardize her immigration status. [54]

The debate as to whether a noncitizen defendant must be advised as to the immigration consequences of a guilty plea had centered largely on whether deportation was viewed as a collateral or direct consequence of the guilty plea. Because of the large number of collateral consequences that can result from a guilty plea—ranging from losing the ability to vote to being disqualified for certain types of employment—many courts held that it would be impractical to require criminal defense attorneys to advise their clients of all of them.[55]

However, individual justices on the Supreme Court have long noted the severity of deportation and have passionately analogized deportation to "banishment,"[56] noting its potential to deprive immigrant defendants "of all that makes life worth living."[57] As articulated by the Supreme Court, "[p]reserving the client's right to remain in the United States may be more important to the client than any potential jail sentence."[58]

Most recently, in a ground-breaking decision, the Supreme Court held that criminal defense attorneys that fail to advise noncitizen criminal defendants as to the immigration consequences before accepting a plea may be found to be constitutionally deficient under the Sixth Amendment. Writing for the majority in *Padilla v. Kentucky*, Justice Stevens noted that, "the importance of accurate legal advice for noncitizens accused of crimes has never been more important. Deportation is an integral part—indeed, sometimes the most important part—of the penalty that may be imposed on noncitizen defendants who plead guilty to specified crimes."[59] The Court rejected the direct versus collateral consequence paradigm as "ill-suited" when noncitizen defendants face deportation as a result of a plea agreement. In this context, the Court noted that "deportation is uniquely difficult to classify

54. STEPHEN H. LEGOMSKY & CRISTINA M. RODRIGUEZ, IMMIGRATION AND REFUGEE LAW AND POLICY 557 (5th ed. 2009).

55. *See, e.g.*, State of Maryland v. Denisyuk, No. 1819, 2008 term (Court of Special Appeals, Maryland, March 29, 2010) (summarizing the "unbroken phalanx of federal authority" holding that deportation is a collateral, rather than direct consequence of a criminal plea).

56. Fong Haw Tan v. Phelan, 333 U.S. 6, 10 (1948).

57. Ng Fung Ho v. White, 259 U.S. 276, 284 (1922) (Brandeis, J.).

58. I.N.S v. St. Cyr, 533 U.S. 289, 323 (2001).

59. Padilla v. Kentucky, 130 S. Ct. 1473, 1475 (2010).

as either a direct or collateral consequence." Therefore, the Court held that "advice regarding deportation is not categorically removed from the ambit of the Sixth Amendment right to counsel."[60]

In keeping with the reasoning in *Padilla*, the increasing criminalization of immigration law and status has led a number of scholars to call for a re-examination of the premise that deportation is not punishment.[61] Just as the severity of deportation needs to be taken into account in the criminal context when advising defendants as to whether to accept particular plea bargains, the severe consequences of deportation should give rise to a heightened standard for informed consent when medical repatriation is at issue.

Informed consent in the medical repatriation context should draw upon these principles. At a minimum, before consent to repatriation can be considered "voluntary," hospitals should be required to fully explain options for treatment and the availability of free or low cost medical care in the United States. Such information is essential for patients to weigh their options. This information also needs to be communicated in the patient's best language, free from coercion or threats. Finally, patients must be advised as to the immigration consequences of agreeing to repatriation.

However, because medical repatriations are being carried out insulated from judicial oversight or accountability, there are no requirements for informing the patient as to the immigration consequences of repatriation, and there is no way to ensure that interpreters are being used or that options are being fully explored. For example, immigration status or consequences are not even considered on the frequently asked questions section of the Mexcare site.

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60. *Id.* at 9.

61. *See, e.g.*, Angela Banks, *Proportional Deportation*, 55 WAYNE L. REV. (forthcoming 2010); Peter L. Markowitz, *Straddling the Civil-Criminal Divide: A Bifurcated Approach to Understanding the Nature of Immigration Removal Proceedings*, 43 Harv. C.R.-C.L. L. Rev. 289 (2008) (concluding that "[r]emoval proceedings straddle the civil-criminal divide, with exclusion falling on the civil side and expulsion on the criminal side."); Lea McDermid, *Deportation Is Different: Noncitizens and Ineffective Assistance of Counsel*, 89 CAL. L. REV. 741, 762 (2001) (arguing that even if deportation were considered a collateral consequence in the past, the Congressional overhaul of the immigration regime in 1996 made the threat of deportation a direct consequence for those facing removal for aggravated felony convictions); Robert Pauw, *A New Look at Deportation as Punishment: Why at least some of the Constitution's Criminal Procedure Protections Must Apply*, 52 ADMIN. L. REV. 305 (2000) (arguing that, notwithstanding the civil/criminal distinction, additional constitutional protections must apply in civil contexts such as removal proceedings in which governmental sanctions may be deemed punitive).

Based on accounts from the media, it appears that coercion and lack of translation are serious concerns. For example, in Arizona, an undocumented mother who almost had her newborn U.S. citizen baby repatriated to Mexico after he was born with Down syndrome and a heart defect reports that, "we were so scared. [The hospital officials] 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 15 minutes with a lady. It was ugly. We contacted the Mexican consulate. They got us a lawyer."[62] The hospital claimed that the mother had consented and then equivocated, while the mother states that she wasn't able to express herself clearly or the hospital misunderstood her.[63]

The current situation at Grady Memorial Hospital in Atlanta also illustrates the interplay of immigration status and health care policies and the impact on undocumented patients in need of dialysis treatment. The situation further illustrates the murkiness of "consent" to repatriation when carried out by a private company.

Under federal and most state laws, undocumented immigrants are ineligible for medical treatment, except in emergency situations. Although dialysis is required to sustain life for persons with kidney failure, there are no national standards for dialysis provision for undocumented patients.[64] Therefore, the only option for many immigrant patients in need of dialysis has been public hospitals with charity care, such as Grady Memorial Hospital in Atlanta. However, on August 14, 2009, Grady Memorial Hospital informed its mostly immigrant patients that its outpatient dialysis unit would soon be closed and no further treatment would be provided.[65] Six days later, however, Grady Memorial Hospital entered into a contractual agreement with various private dialysis companies to provide dialysis treatment for one year to all of Grady's current patients.[66] Even though Grady had entered into a contractual agreement by which dialysis would be provided to all of its

62. Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at 5.

63. *Id.*; *See infra* note 110 and accompanying text for further discussion of this incident.

64. Hurley, L. et al., *Care of Undocumented Individuals with ESRD: A National Survey of US Nephrologists*, AM. J. KIDNEY DISEASE (June 2009), *available at* http://www.ncbi.nlm.nih.gov/pubmed/19327878?dopt=Abstract.

65. See the allegations contained in the Request for Precautionary Measures on behalf of Reina Andrade and Anabel Quintanilla, submitted to the Inter-American Commission on Human Rights in December 2009 (on file with author) [hereinafter "Request for Precautionary Measures"].

66. *Id.* at para. 4.

end renal-stage dialysis patients, it did not inform the patients that such treatment was available.[67] Instead, hospital representatives told patients that they would need to leave the state or repatriate to their native countries.[68] After substantial media attention, the hospital agreed to pay for three months of dialysis at private clinics for approximately 50 impacted immigrant patients.[69] The immigrant patients, still uniformed as to their contractual rights to receive a year's worth of treatments, had to sign contracts stating that they understood that Grady's dialysis treatments would end in three months.[70] When the three months expired and immigrants still found themselves in Atlanta and in desperate need of dialysis, Grady Hospital agreed to extend the treatments for one more month.

Grady then contracted with Mexcare to repatriate those immigrants who consented. The vast majority of Grady's immigrant patients have remained in Atlanta, fearful that they would be left to die if they returned to their native countries; a fear borne out by two former Grady dialysis patients that died once returned to Mexico.[71] In order to obtain consent to repatriation, Mexcare offered patients three months of funded dialysis plus an additional year of health insurance.[72] However, the insurance offered by Mexcare does not include dialysis or kidney transplant services.[73] Moreover, a senior vice president of Grady Hospital has stated that he was unaware that Mexcare was promising health insurance to its patients.[74]

In a desperate attempt to save their lives, a group of Grady immigrant patients have brought suit in state court under a breach of contract theory based on their contractual rights to treatment for a year as third party beneficiaries to the contract between Grady and dialysis treatment providers. The immigrants have also sought an emergency injunction from the Inter American Commission on Human Rights, alleging that the State's violations of their basic human rights to health care are endangering their lives.[75]

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67. *Id.*

68. *Id.*

69. Kevin Sack, *The Breaking Point: Reprieve Eases Medical Crisis for Illegal Immigrants*, N.Y. TIMES, Jan. 6, 2010, at A12.

70. Request for Precautionary Measures, *supra* note 65.

71. Kevin Sack, *The Breaking Point: For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES, Jan. 1, 2010, at A1.

72. *Id.*

73. *Id.*

74. *Id.*

75. *See* Request for Precautionary Measures, *supra* note 65. On January 29, 2010, the Inter-American Commission on Human Rights granted precautionary measures, asking

As illustrated by the tragedy at Grady, there is reason to be concerned as to whether the repatriations are truly consensual. Those that consented did so based on representations that they would receive three months of dialysis and a year of health insurance. The immigrant patients were not informed that the insurance would exclude treatment for kidney failure, and the hospital that had treated them in Atlanta and contracted with Mexcare for the repatriation services was not even aware that such a promise was being made as an inducement to repatriation.

The situation at Grady also highlights the significance of understanding the immigration consequences of agreeing to repatriation. Monica Chavarria is one of the Grady patients that consented to repatriation to Mexico via Mexcare.[76] She had resided in the United States for ten years and agreed to repatriate to Mexico with her eight year-old son, a United States citizen, who had never before been to Mexico.[77] When Ms. Chavarria consented to repatriation, she left behind her husband of fifteen years and their fourteen year old son so that her husband could work and send money to Mexico for treatment and their son could continue his studies.[78] Given Ms. Chavarria's decade-long residence in the United States, her failing health, her family ties (including a son that is a citizen of the United States), she might have qualified for discretionary relief from removal that would result in permanent residency status in the United States.[79]

Moreover, Ms. Chavarria's failing health and ties to the United States, including her husband and son that she left behind, might mean that she would need to return to the United States. Newspaper accounts report that both Ms. Chavarria and her husband are devastated by their separation.[80] The dialysis treatments that Grady paid for are now over,

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"the United States to instruct the competent authorities to take the urgent measures necessary to ensure that the beneficiaries have access to the medical treatment that may be required for their condition, and to inform the IACHR about compliance with these measures within 10 days, and thereafter on a periodic basis." *See* Inter-American Comm'n on Human Rights, *Precautionary Measrues Granted by the Commission During 2010*, PM 385-09, *available at* http://www.cidh.oas.org/medidas/2010.eng.htm (last visited June 13, 2010).

76. *Id.*

77. *Id.*

78. *Id.*

79. Pursuant to 8 U.S.C.A. § 1229b(b)(1) (West 2010), cancellation of removal is a discretionary defense to removal for undocumented immigrants that have resided continuously in the United States for ten years without being placed in removal proceedings, are of good moral character, and can demonstrate that their removal would cause exceptional and extremely unusual hardship to a United States citizen or lawful permanent resident child or spouse.

80. Sacks, *supra* note 69.

even with Ms. Chavarria stretching them out by undergoing treatment only twice a week rather than the prescribed three times a week regimen.[81] Ms. Chavarria is now paying for dialysis with the money that her family had been saving for a kidney transplant.[82] However, because Ms. Chavarria voluntarily departed from the United States after being out of status for over a year, she will be barred from re-entering for ten years, even if she were to find a lawful way to obtain a visa.[83]

III. CAN STATE COURTS ORDER REPATRIATIONS WHEN PATIENTS WILL NOT CONSENT?

As in the Jiménez case, when an undocumented patient or his/her guardian refuses to consent to a medical repatriation plan, hospitals have sought and secured court orders authorizing nonconsensual repatriations. However, as the appellate court subsequently ruled in the Jiménez case, state courts are preempted from regulating immigration and therefore lack jurisdiction to order forced medical repatriations. Indeed, when a hospital acts to forcibly return an immigrant to his/her native country, it is essentially engaging in a deportation absent any federal oversight or accountability."[84]

Pursuant to the plenary power doctrine,[85] the Supreme Court has long held that the power to regulate immigration is vested with the federal government.[86] More specifically, this power is situated with the legislative and executive branches.[87] For this reason, the Supreme Court has historically afforded Congress extreme deference when immigration

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81. *Id.*

82. *Id.*

83. I.N.A. § 212(a)(9)(B), 8 U.S.C.A. § 1189(a)(9)(B) (West 2010)

84. According to Black's Law Dictionary, deportation entails "[t]he act . . . of removing a person to another country; esp[ecially] the expulsion or transfer of an alien from a country." *See* BLACK'S LAW DICTIONARY (8th ed. 2004).

85. This doctrine dates back to the 1880's and is based on deeply held notions of sovereignty and nation-states inherent authority to admit and exclude foreigners, as well as to set forth regulations upon which to determine admissibility and deportability. *See* e.g., Ekiu v. United States, 142 U.S. 651, 659 (1892). In Chae Chan Ping v. United States (The Chinese Exclusion Case), 130 U.S. 581, 609 (1889), the Supreme Court held that the authority to admit and exclude foreigners is "an incident of sovereignty belonging to the government of the United States."

86. *See, e.g.,* Fong Yue Ting v. United States, 149 U.S. 698 (1893) (noting that the U.S. Constitution lodges the power to deport with the federal government).

87. *See, e.g.,* Harisiades v. Shaughnessy, 342 U.S. 580 (1952) ("[S]uch matters are so exclusively entrusted to the political branches of government as to be largely immune from judicial inquiry.").

regulation is at issue.[88] The Supreme Court has also emphasized that immigration regulation is inextricably intertwined with other political functions and that Congress's broad authority is essential for uniform regulation of foreign policy, national defense, international trade, and maintenance of a republican form of government.[89]

As the Supreme Court has explained, "the power to regulate immigration is unquestionably exclusively a federal power."[90] Congress has exercised its extensive power by delegating to the secretary of homeland security and the U.S. attorney general the authority to deport persons.[91] As articulated by the Supreme Court, the federal power over immigration, naturalization and deportation is absolute.[92] Because Congress has set forth procedures by which a person is to be deported, state courts are preempted from altering that mandate.

Similar issues have arisen when state or federal courts have ordered deportations as part of a criminal sentencing package. For example, in *United States v. Castillo-Burgos*,[93] the district court's sentencing order included a mandate that the noncitizen defendant be deported upon

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88. However, the Court has carved out certain instances in which it will review Congressional actions involving the regulation of immigration. For example, in *Zadvydas v. Davis*. 533 U.S. 678, 695 (2001), the Court suggested that a federal statute that would permit the indefinite detention of immigrants in removal proceedings would be unconstitutional, explaining that Congress' plenary power is "subject to important constitutional limitations." *Id.*; *see also* I.N.S. v. Chadha, 462 U.S. 919, 941–42 (1983) ("The plenary authority of Congress over aliens . . . is not open to question, but what is [able to be challenged] is whether Congress has chosen a constitutionally permissible means of implementing that power."); *Fiallo*, 430 U.S. at 793 n.5 (1977) (stating there is a "limited judicial responsibility under the Constitution even with respect to the power of Congress to regulate the admission and exclusion of aliens").

89. *See, e.g.*, *Harisiades*, 342 U.S. at 588–89; *Ekiu*, 142 U.S. at 659; Head-Money Cases, 112 U.S. at 591–95 (1884).

90. DeCanas v. Bica, 424 U.S. 351, 354 (1976). The United States Supreme Court has repeatedly held that "[t]he authority to control immigration . . . is vested solely in the Federal government." Truax v. Raich, 239 U.S. 33, 42 (1915). The formulation of "[p]olicies pertaining to the entry of aliens and their right to remain here . . . is entrusted exclusively to Congress," Galvan v. Press, 347 U.S. 522, 531 (1954).

91. 8 U.S.C.A. § 1103 (2006). Specifically:

> An immigration judge [who receives authority under regulation of the Attorney General] shall conduct the proceedings for deciding . . . the deportability of an alien . . . . [and] [u]nless otherwise specified in this chapter, a proceeding under this section shall be the sole and exclusive procedure for determining whether an alien may be admitted to the United States or, if the alien has been so admitted, removed from the United States.

8 U.S.C.A. § 1229a(a) (West 2006).

92. *See* Hines v. Davidowitz, 312 U.S. 52, 62 (1941).

93. 501 F.2d 217 (9th Cir. 1974), *cert. denied*, 419 U.S. 1010 (1974).

completion of his confinement.[94] On appeal, the Ninth Circuit held that the district court exceeded its authority in ordering the defendant to be deported, explaining, "Congress has enacted laws governing the admission, expulsion, and deportation of aliens. Those laws delegate authority to order deportation to the Attorney General and not to the judiciary." [95]

Similarly, in *United States v. Abushaar*,[96] the Third Circuit Court of Appeals held that a district court lacked the authority to order a criminal noncitizen defendant to serve his probationary period outside of the United States. The Third Circuit explained that:

> [A]liens may be deported only in accordance with the carefully designed federal statutory and regulatory scheme. . . . The no-return condition [of the probation order] would short-circuit Congress's scheme and assume unwarranted exercise of the Attorney General's authority just as effectively as if the sentence had contained a direct order of deportation and exclusion. . . . Whether and how to initiate deportation procedures is exclusively the province of the Attorney General[.] [97]

In the infamous Elian Gonzales case, the Florida state court recognized that it was unable to grant the petition of the noncitizen-child's uncle—a United States citizen—for custody of the child, who the federal immigration authorities had ordered to be returned to his father in

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94. *Id.* at 218.

95. *Id.* at 219 (citations omitted).

96. 761 F.2d 954 (3d Cir. 1985).

97. *Id.* at 960-61; *see also* United States v. Hernandez, 588 F.2d 346, 350 (2d Cir. 1978) (reversing the district court sentencing order that required a lengthy period of unsupervised parole to be served outside the United States). The Second Circuit agreed with the defendant's argument that the sentence was "tantamount to a judicial order of deportation and exclusion, and accordingly beyond the power of the district court to impose." *Id.* at 350. The Second Circuit explained:

> Nowhere in [the federal] statutory scheme is there a provision for a court to deport aliens sua sponte. True, the sentence here did not explicitly order appellant deported. But a no-return condition in lieu of a direct order of deportation is at best a distinction without a difference. The no-return condition would short-circuit Congress's scheme and assume an unwarranted exercise of the Attorney General's authority just as effectively as if the sentence had contained a direct order of deportation and exclusion. . . . Congress might have given the courts a role in determining deportability. It chose not to, and courts have long recognized the Attorney General's exclusive power to admit or expel aliens.

Id. at 351.

Cuba.[98] The court recognized that it lacked subject matter jurisdiction, noting that:

> The state court cannot, by deciding with whom [Elian's] custody should lie, subvert the decision to return him to his father and his home in Cuba . . . . The remedy sought in this court is custody of the child. While the court recognizes the many, many authorities that establish that domestic relations, family law, is an area reserved to the state courts, *Petitioner fails to recognize the fundamental nature of his case—it is an immigration case, not a family case.*[99]

Similarly, a forced or coerced medical repatriation is essentially a deportation, a matter clearly within the realm of immigration law and therefore reserved for the federal government, rather than a state court.

IV. SHOULD HOSPITALS REPORT UNDOCUMENTED STATUS TO DHS?

In light of the fact that only the executive branch Immigration Courts have the jurisdiction to order deportations, the logical question is whether hospitals can or should refer undocumented patients to immigration authorities to commence deportation proceedings. At least one scholar has advocated such a plan as a way to save money for hospitals and ensure that immigrant patients facing repatriation be afforded the same level of due process that is afforded all immigrants in removal proceedings.[100]

It is true that the Constitution guarantees all persons the due process protections of the Fifth and Fourteenth Amendments.[101] The Supreme Court has long held that a person facing deportation from within our

98. *In re Gonzalez*, No. 00-00479-FC-28, 2000 WL 492102 (Fla. Cir. Ct. Apr. 13, 2000).

99. *Id.* at *4, *6 (emphasis added).

100. *See* Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CIN. L. REV. 657 (2010). Johnson advocates a new federal repatriation program for the medically needy. *Id.*at 692. She proposes that hospitals be able to voluntarily report suspected undocumented migrants that need long-term medical care. *Id.* at 693. Once reported by hospitals, Johnson's plan calls for ICE to place the seriously ill patient in expedited removal proceedings and proceed via video conferencing at the hospital. *Id.* at 695.

101. *See* Plyer v. Doe, 457 U.S. 202, 215 (1982). ("That a person's initial entry into a State, or into the United States, was unlawful, and that he may for that reason be expelled, cannot negate the simple fact of his presence within the State's territorial perimeter" and, thus, entitled to due process rights.) *Id.*

country must be provided with a hearing in which the issue of deportability is formally adjudicated:

> [I]t is not competent . . . to cause an alien who has entered the country, and has become subject in all respects to its jurisdiction, and a part of its population, although alleged to be illegally here, to be taken into custody and deported without giving him all opportunity to be heard upon the questions involving his right to be and remain in the United States. No such arbitrary power can exist where the principles involved in due process of law are recognized.[102]

In removal proceedings, the government has the burden to prove deportability by clear, unequivocal, and convincing evidence, unless the government establishes that the alien came to the United States illegally, in which case the burden shifts to the alien to establish his entitlement to remain in the country.[103] Importantly, an immigration judge must inform an alien in removal proceedings of certain relief from deportation for which he or she may be eligible. This requirement has been called mandatory and a failure to do so would be a denial of due process.[104]

Arguably, placing seriously ill immigrants in removal proceedings would provide greater process and safeguards than the current practice of hospitals and private transfer companies engaging in covert repatriations. An immigration judge would be in the best position to advise the ill immigrant as to potential avenues for obtaining legal status or relief from removal. The immigration judge would also be best situated to advise the immigrant patient as to the immigration consequences that would attach to repatriation, whether engaged in voluntarily or via a court-ordered removal. The decision by the immigration judge would also be subject to review by the Board of Immigration Appeals and, potentially, the federal courts.

However, there are significant problems associated with such a proposal. First, some states and municipalities have passed ordinances that prohibit hospitals from reporting a patient's immigration status to the Department of Homeland Security. For example, in New York City, city employees are prohibited from inquiring as to a person's immigration

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102. Kaoru Yamataya v. Fisher, 189 U.S. 86, 101–02 (1903).

103. 8 C.F.R. § 1240.8(a), (c) (2010).

104. *See* United States v. Muro-Inclan, 249 F.3d 1180, 1183 (9th Cir. 2001); 8 C.F.R. § 1240.49(a) (2010).

status absent certain special circumstances.[105] Similarly, San Francisco prohibits city and county employees from requesting information about immigration status.[106] Even in cities or states that do not prohibit reporting of immigration status, a policy of reporting undocumented immigrant patients to immigration authorities is ill advised and dangerous.[107] As Diane Rowland, Executive Director of the Commission on Medicaid and the Uninsured at the Henry J. Kaiser Family Foundation has cautioned, "[t]he H1N1 flu doesn't know about immigration status when it attacks."[108]

There is also a substantial body of scholarly commentary critiquing the local enforcement of immigration laws.[109] Allowing local police

105. New York City Exec. Order No. 41, City-Wide Privacy Policy and Amendment of Executive Order No. 34 Relating to City Policy Concerning Immigration Access to City Services at 2 (Sept. 17, 2003), *available at* http://www.nyc.gov/html-/imm/html/executive/eo41.shtml. See also Open Letter from Alan D. Aviles, President, N.Y. City Health & Hosp. Corp., & Guillermor Linares, Comm'r, Mayor's Office on Immigration Affairs, to Immigrant New Yorkers, *available at* http://www.nyc.gov/html/hhc/html/community/letter-to-immigrants.shtml (last visited June 13, 2010) for a joint open letter from the President of New York City's Health and Hospitals Corporation and the Commissioner for Immigrant Affairs reassuring immigrants that, "the Health and Hospitals Corporation (HHC) runs the public hospitals in New York City. We respect you and want to help you. People who work in a public hospital will not tell the Immigration Service or other law enforcement agencies your immigration status. We will not tell anyone." *Id.*

106. *See* SAN FRANCISCO ADMIN. CODE § 12H.2(c), *available at* http://www.bayswan.org/sftraffick/SFcityrefuge.html (last visited May 30, 2010).

107. Many scholars have warned of the dangers posed by legislative attempts to require hospital reporting of immigration status. *See e.g.*, Huyen Pham, *The Private Enforcement of Immigration Laws*, 96 GEO. L.J. 777 (2008) (noting that health care workers and administrators were successful in defeating the Bush Administration's proposed rules that would have required hospitals seeking federal reimbursement to provide information on the immigration status of patients. Pham points out that the National Association of Public Hospitals and Health Systems criticized these proposed rules as endangering the undocumented population as well as posing a public health threat to the entire community). *See also* Huyen Pham, *The Constitutional Right Not to Cooperate*, 74 U. Cin. L. Rev. 1373, 1400 (2006) ("Another reason frequently advanced by local governments for passing local laws is to protect their communities' public health. Immigrants with serious health problems may refuse to seek medical care if they believe that hospital workers will report them or their family members to federal immigration authorities. Not only are the immigrants themselves at risk, but their family members, neighbors, co-workers, and others in the community are also at risk if the health problem is contagious.").

108. Julia Preston, *Health Care Debate Revives Immigration Battle*, N.Y. TIMES, Sept. 5, 2009, at A22.

109. *See, e.g.*, Huyen Pham, *The Inherent Flaws in the Inherent Authority Position: Why Inviting Local Enforcement of the Immigration Laws Violates the Constitution*, 31 FLORIDA ST. U. L. REV. 965 (2004); Michael Wishnie, *State and Local Police Enforcement of Immigration Laws*, 6 U. PA. J. CONST. L. 1084 (2004).

officers to enforce immigration laws has had a chilling effect on the willingness of undocumented crime victims and witnesses to come forward.[110] Similarly, allowing for hospital reporting of immigration status would have a chilling effect on the ability of undocumented persons to receive treatment, thereby posing a threat to the broader community.

In the context of medical repatriations, immigrants are facing punitive deportation without any access to due process. They are not advised as to the immigration consequences of accepting repatriation, and not advised as to any potential ways to obtain lawful status to remain in the country. In fact, hospitals have moved to forcibly repatriate United States citizen children against the wishes of their parents.[111]

Although encouraging hospitals to report the immigration status of patients seems ill-advised, the question is how hospitals can be expected to advise immigrant patients of their rights and the immigration consequences of repatriation at the same time that they are being faulted for engaging in immigration regulation. In other words, if hospitals should not be permitted to repatriate patients, how can they be required to advise patients as to the immigration consequences of repatriation?

One way to mitigate this tension would be through regulatory or statutory change to allow for issuance of special humanitarian visas or deferred enforced departure for severely ill or injured immigrants. In recognition of the ethical duty not to endanger persons' lives by repatriating them to countries in which treatment would not be available, immigration status could be afforded in extreme situations. If there were

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110. As Michael Wishnie has noted, the federal effort to enlist state and local police in routine immigration enforcement has been criticized by diverse groups ranging from law enforcement officials to civil and immigrants' rights advocates. Wishnie, *supra* note 109. Law enforcement officials have objected that enforcing immigration laws will deter crime reporting by noncitizens and divert resources from local policing priorities, as well as potentially exposing local police to liability for wrongful arrest. *Id.* Civil rights and immigration policy organizations have condemned such local enforcement for its likelihood of resulting in increased racial profiling by state and local police, and as undermining social unity by deterring immigrants from availing themselves of the protection offered by the police, fire, hospital, school, and other local services. *Id.*

111. *See, e.g.,* Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 8, 2008 (describing a Tucson hospital's actions to send a United States citizen baby with Down syndrome and a heart defect to Mexico two days after his birth, notwithstanding his American citizenship or his parents' desire that he remain in the United States and be treated. The hospital had already placed the baby in an ambulance en route to the airport when the parents' attorney sought police intervention, and ultimately got the hospital to bring the baby back. *Id.* The hospital then sought a court order to repatriate the baby without parental consent, threatening to sue the family for medical reimbursement. *Id.* Ultimately, the state Medicaid system approved coverage for the U.S. citizen baby and the hospital ceased its efforts at repatriation or litigation). *Id.*

an affirmative discretionary relief available, hospitals and patients could partner to seek such relief before United States Citizenship and Immigration Services. This would transform the adversarial relationship in which seriously ill or injured immigrant patients and hospitals currently find themselves.

An alternate approach could be modeled on the existing U visa paradigm that allows for lawful immigration status in exchange for assisting the government in criminal investigation or prosecution. [112] Because hospitals that receive federal funding are prohibited, under EMTALA, from "patient dumping" and are required to have appropriate discharge plans, the Department of Health and Human Services could certify U visas for immigrants that seek to challenge forced repatriations and assist the government in prosecuting the hospital for EMTALA violations. While the temporary lawful immigration status would not allow for health benefits under federal law, it would allow for PRUCOL status and benefits under many state programs.

V. HUMAN RIGHTS NORMS PROHIBIT FORCED OR COERCED MEDICAL REPATRIATIONS

Private entities such as hospitals are engaging in deportation absent any due process as guaranteed by international human rights instruments that the U.S. has ratified or signed, such as the International Covenant on Civil and Political Rights (ICCPR)[113] and the American Convention on Human Rights.[114]

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112. Congress has already established a U visa category for victims of violent crimes that are willing to assist the government in criminal investigation and/or prosecution of the perpetrator in exchange for temporary lawful immigration status. *See* 8 U.S.C.A. § 1101; I.N.A. § 101 (a)(15)(U). While initially the certification that an immigrant was willing and needed to assist in an investigation or prosecution had to come from a criminal law enforcement agency, the U.S. Department of Labor has recently announced that it will begin certifying U nonimmigrant visas starting this summer. According to Tyler Moran, policy director of the National Immigrant Law Center, it is now up to Congress to "provide the Department of Labor with additional tools to enforce the law by supporting the expansion of U visas to the many immigrant workers who experience egregious violations of civil labor and employment laws—including wage theft." The U visa process could be broadened to include the Department of Health or Health and Human Services to certify that an immigrant patient were willing and necessary to assist in a prosecution for a violation of EMTALA's adequate discharge procedures.

113. *See, e.g.*, International Covenant on Civil and Political Rights, art. 13, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 (signed by the United States Oct. 5, 1977) (guaranteeing that "aliens lawfully in the territory" may be expelled "only in pursuance of a decision reached in accordance with law and shall . . . be allowed to submit the reasons against his expulsion and to have his case reviewed by, and be represented for the purpose before, the competent authority or a person or persons especially designated by

Medical repatriations also violate the internationally recognized right to health, as guaranteed by the Universal Declaration of Human Rights,[115] the International Covenant on Economic, Social and Cultural Rights,[116] and the Convention on the Rights of the Child.[117] Furthermore, President Obama has recently signed the United Nations Convention on the Rights of Persons with Disabilities. Among other provisions, this convention mandates that state parties, such as the United States, take all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including . . . humanitarian emergencies."[118] The Special Rapporteur on Health has also stressed that undocumented immigrants occupy one of the most vulnerable segments of society and must not be denied their human right to medical care.[119]

Framing the issue as one implicating basic internationally recognized human rights shifts the focus away from the immigration status of the patient. Instead, the question is what role the United States should play in ensuring that human rights are respected. It is the United States' acting, or failing to act, that must be analyzed to determine whether repatriating seriously ill immigrants violates the duty to ensure that persons' human rights are respected (such as the right to life, right to health care, or right to due process). In the Jiménez case, the hospital that engaged in the repatriation was a public hospital, and its forced repatriation was in

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the competent authority.") The Human Rights Committee, charged with interpreting the ICCPR, has clarified that "lawfully in the territory" includes noncitizens who wish to challenge the validity of a deportation order. According to the Human Rights Committee "if the legality of an alien's entry or stay is in dispute, any decision on this point leading to his expulsion or deportation ought to be taken in accordance with Article 13." *Id.*

114. American Convention on Human Rights, art. 8., Nov. 22 1969, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123. The U.S. signed the American Convention on Human Rights in 1977. Pursuant to Article 8, paragraph 1 "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 . . . for the determination of his rights and obligations . . . . "For a more complete discussion of the international human rights instruments that mandate the right to due process before expulsion, see UNGA, Human Rights Council, *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Rights to Development, Report of the Special Rapporteur on the Human Rights of Migrants, Mission to the United States of America* (Mar. 5, 2008).

115. *See* The Universal Declaration of Human Rights, G.A. Res. 217A, art. 25, at 76, U.N. GAOR, 3d Sess., 1st Plen. Mtg., U.N. Doc A/810 (Dec. 10, 1948).

116. G.A. Res. 2200A (XXI), at 49, UN Doc. A/6316 (Dec. 16, 1966).

117. G.A. Res. 44/25, at 167, U.N. Doc. A/44/49 (Nov. 20, 1989).

118. G.A. Res. 63/192, art. 11, U.N. Doc A/Res/63/192 (Feb. 24, 2009), *available at* http://www.unhcr.org/refworld/docid/49b8c9f30.html.

119. UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31, The Right to Health*, June 2008, *available at* http://www.unhcr.org/refworld-/docid/48625a742.html.

violation of its federal obligations to ensure that discharges are appropriate.[120] However, even where private hospitals are involved, one can argue that the United States should be held accountable if it is established that it has knowledge of the widespread practice of medical repatriations and extralegal deportations and is not taking any action to prevent such violations of law.

However, absent Congressional action to reform the health care system so as to include all persons, regardless of immigration status, in the right to medical treatment in circumstances beyond emergency care, there will be no funding to treat such immigrant patients. Thus, hospitals and private companies will continue to pursue repatriations that are cost-effective, but illegal.

VI. NEED FOR CONGRESSIONAL REFORM

The practice of medical repatriation points out the urgent need for reform of our immigration and health care systems. If there were comprehensive immigration reform, a large portion of the undocumented population might be able to regularize their immigration status and then qualify for insurance. Similarly, if the health care system were reformed to include coverage for undocumented immigrants, hospitals would be free to devise appropriate discharge plans and would not have an incentive to repatriate the gravely ill. Absent such reform, or findings of liability by the courts, the murkiness will continue, and along with it, the unethical practice of medical repatriations.

Unfortunately, given the current climate, comprehensive immigration reform seems illusive and the health care reform that recently passed failed to provide any health benefits to the undocumented population. If there were comprehensive immigration reform, some percentage of undocumented individuals would be able to come out of the shadows and legalize their status. However, most of the proposals that have gained any traction in recent years have limited that pool to immigrants that have already been in the United States for several years. This means that immigrants like Mr. Jiménez, who was critically injured in the United States by a U.S. citizen operating a stolen vehicle while intoxicated in violation of various state laws in the United States, would be unable to regularize his immigration status because he was only in the country for less than two years when injured.[121]

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120. *Montejo*, 874 So.2d at 656.

121. For example, if enacted, the Comprehensive Immigration Reform Act of 2006, sponsored by Senator Arlen Specter (D-Pa.), would have required continuous presence for five years (to attain earned legalization) or for two years (to attain deferred mandatory

Furthermore, the federal welfare reform legislation enacted in 1996 has disqualified even lawful permanent residents from access to most public benefits for a five-year period.[122] This means that even if comprehensive immigration reform were enacted, those undocumented immigrants that obtained lawful permanent residency would still be ineligible for benefits for five years under the current access to health care laws.

The case of Antonio Torres highlights this dilemma. Antonio Torres was a nineteen year-old lawful permanent resident living in Arizona with his lawful permanent parents and family when he was critically injured in a car accident.[123] He was admitted to the hospital's intensive care unit

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departure) along with evidence of employment for three to five years respectively. Comprehensive Immigration Reform Act of 2006, S. 2611, 109th Cong. (2006), *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN02611:@@@L&summ2=m. In 2007, Senator Edward M. Kennedy (D-Mass.) introduced S. 1639, A Bill to Provide for Comprehensive Immigration Reform and for other Purposes, S. 1639, 110th Cong. (2007), *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN01639:. If enacted, the legislation would have required continuous presence since the year of enactment in addition to evidence of employment for three of the previous five years. However, Representative Solomon Ortiz (D-Tex.) introduced the Comprehensive Immigration Reform As Soon As Possible Act of 2009. CIR ASAP Act of 2009, H.R. 4321, 111th Cong. (2009), *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d111:h.r.04321:. If enacted, this legislation would require continuous physical presence solely from the date of enactment, in addition to requiring attestation as to employment, education, military or community service (with exemptions permitted). *See* Migration Policy Institute, Side-by-Side Comparison of 2006 and 2007 Senate Legislation and 2009 CIR ASAP Bill, Dec. 2009, *available at* http://www.migrationpolicy.org/pubs/CIRASAPsidebyside.pdf (last visited June 12, 2010).

122. In enacting the PRWORA in 1996, Congress rendered most lawfully residing immigrant permanent residents ineligible for SSI and food stamps and imposed a five year waiting period for lawfully residing immigrants to receive Temporary Assistance for Needy Families (TANF) and non-emergency Medicaid. *See generally* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1997) (codified in scattered sections of 7, 8, 21 and 42 U.S.C.A. (West 2010). *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 402(a), 110 Stat. 2105 (codified at 8 U.S.C.A § 1612(a)(1)-(3) (West 2010)) (barring many lawfully residing immigrants from SSI); *See id.* at § 403 (barring many lawfully residing immigrants from Federal Means-Tested Public Benefits including TANF, Medicaid, and CHIP). Since 1996, Congress has enacted several pieces of legislation that have restored benefits to many of the immigrants that were initially excluded. However, the five-year wait period for non-emergency Medicaid still applies to most lawful permanent residents. *See* Migration Policy Inst., *supra* note 118. Notwithstanding the federal limitations on Medicaid for immigrants, as of 2006, twenty-two states provided Medicaid to at least some post-enactment qualified immigrants who are ineligible for federal benefits. *See* National Conference of State Legislatures, *Immigrant Eligibility for Health Benefits: Federal Action and State Laws in 2005-2006*, Jan. 2007, *available at* http://www.ncsl.org/default.aspx?tabid=13144.

123. Sontag, *Deported in a Coma, Saved Back in U.S.*, *supra* note 62, at 8-13.

with traumatic brain injuries, bruised lungs and abdominal injuries.[124] The social worker at the hospital advised the parents to disconnect Antionio from the ventilator.[125] When the parents refused, she informed them that the hospital would need to discharge Antonio and could no longer treat him.[126] Although he was a lawful permanent resident, he did not qualify for Medicaid in Arizona because he had been a lawful permanent resident for less than five years.[127] The hospital repatriated Antonio to Mexico while comatose and with a severe infection.[128] Ultimately, the parents were able to bring Antonio back to the United States for treatment in a California hospital, based on differences between California and Arizona's state Medicaid funding schemes.[129] Antonio crossed the border back to the United States comatose and with potentially fatal septic shock caused by the raging infection.[130] However, 18 days after being admitted to the hospital in California, Antonio awoke from his coma, was transferred to an intensive rehabilitation center and ultimately discharged to his family.[131]

Thus, in addition to comprehensive immigration reform, health care reform is needed to amend the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and restore access to health care benefits to lawful permanent residents.[132] Congress's action in removing health care benefits for lawful permanent residents for their first five years has dramatically increased the fiscal burden on states with large immigrant populations. Hospitals in states with large immigrant populations are in an impossible situation with an unfunded mandate to provide care and an ethical duty not to send patients to known death in their native countries. The very fact that medical repatriations are occurring signals the need for reform and for re-thinking our immigration and health care laws and policies.

Unfortunately, the health care reform bill President Obama signed did not provide for access to health insurance for undocumented immigrants.[133] In fact, just the notion that undocumented immigrants be

124. *Id.*
125. *Id.*
126. *Id.*
127. *See supra* note 122.
128. Sontag, Deported in a Coma, *supra* note 62, at 8-13.
129. *Id.*
130. *Id.*
131. *Id.*
132. It is estimated that the decision as to whether to retain the five-year wait period for Medicaid eligibility or to apply it to new insurance subsidies could impact more than one million lawful permanent residents. *See* Migration Policy Institute, *supra* note 36.
133. *Id.*

allowed to purchase insurance with their own money was extremely controversial and quickly abandoned. Therefore, the recent health care legislation has not changed the legal landscape for the undocumented or lessened the pressures on hospitals

Given the barriers to accessing health care for the undocumented and the shortcoming in the proposed immigration reform laws, it is worth exploring whether the billions of dollars in tax revenue from undocumented workers could be reallocated to cover the costs of medical care for the undocumented.[134] Undocumented immigrants that rely on false social security numbers in order to work contribute billions of dollars in taxes to a system that offers them no safety net in return. As of 2005, The New York Times reported that undocumented workers were paying approximately seven billion dollars a year in social security taxes.[135] One option then would be to utilize this money to fund treatment for undocumented workers that need medical care. Dean Johnson spoke about the need for recognition that it is labor that pushes and pulls immigrants to this country and the need for a more just and humane system. As long as we allow 12 million people to remain in the shadows, living and working, but with no safety net or protections, they will remain vulnerable to exploitation, working and paying into a system that offers them no protection when they are seriously sick or injured.

The recent debate as to who should pay for the treatment of airlifted Haitian earthquake victims, with planes and lives on hold on the tarmac, illustrates the tension between the moral and human rights-based obligations to help those in need and to treat the ill and the lack of

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134. See e.g. Marguerite Angelari, *Access to Health Care for Elderly Immigrants*, 17 ANNALS HEALTH LAW 279, 282 (2008) (noting that "annually undocumented immigrants pay 7 billion dollars in Social Security taxes and 1.5 billion dollars in Medicare taxes." These contributions are held in an Earnings Suspense File by the Social Security Administration.); Laura Fernandez Feitl, *Caring for the Elderly Undocumented Workers in the United States: Discretionary Reality or Undeniable Duty?* 13 ELDER L.J. 227 (2005) (analyzing the impact of the undocumented on the Earnings Suspense File and arguing for changes in laws so that the elderly undocumented population can access the money that has been withheld in taxes during their working years in the U.S.).

135. Eduardo Porter, *Illegal Immigrants Are Bolstering Social Security With Billions*, N.Y. TIMES, Apr. 5, 2005, *available at* http://www.nytimes.com/2005/04/05-/business/05immigration.html. According to Porter, contributions by undocumented workers into the social security system accounted for 10% of the surplus in 2004. *Id.* In 2002 alone, nine million W-2's with incorrect Social Security numbers ended up in the suspense file, accounting for $56 million in earnings, or approximately 1.5% of total reported wages. *Id.*; *see also* Editorial, *How Immigrants Saved Social Security*, N.Y. TIMES, Apr. 2, 2008, *available at* http://www.nytimes.com/2008/04/02-/opinion/02wed3.html (noting that "the taxes paid by other-than-legal immigrants will close 15 percent of the system's projected long-term deficit. That's equivalent to raising the payroll tax by 0.3 percentage points, starting today.").

funding to do so.[136] I have suggested elsewhere that intertwined histories between nations (whether due to colonialism, slavery, or economic exploitation) should give rise to a heightened duty to protect refugees from certain countries.[137] Similarly, I suggest here that there is a moral duty to aid and protect those living amongst us, whether documented or not, when they have become sick or injured. Indeed, the California Medical Association has taken the position that forced medical repatriations are never morally justifiable and the issue is also presently under consideration by the American Medical Association.[138]

In setting forth the contours of a moral duty to rescue those who are "nearby" and in need, Richard Miller states that, "[o]rdinary moral thinking about aid to needy strangers discriminates in favor of the political closeness of compatriots and the literal closeness of people in peril who are close at hand."[139] According to Miller, there is a duty to aid someone encountered close by "who is currently in danger of severe harm and whom one can help to rescue with means at hand, if the sacrifice of rescue does not itself involve a grave risk of harm of similar seriousness or of serious physical harm..."[140]

Our immigration regime has always been motivated in part by a desire to protect those who are vulnerable and in need of safety—whether from persecutors, torturers, traffickers, perpetrators of violent crimes, or perpetrators of domestic violence. Our country also depends on immigrant labor and we have an obligation to care for members of our community when they are hurt. The debatable question is whether the sacrifice involved in rescuing seriously ill immigrants within our borders

136. In the aftermath of the devastating January 12, 2010 earthquake that killed approximately 200,000 Haitians and left as many injured, the U.S. began medical evacuations in order to rescue people and provide treatment at U.S. hospitals. However, all emergency medical evacuation flights were suspended after Florida officials asserted that their hospitals were overwhelmed and unable to accept additional evacuees absent federal reimbursement for medical costs. *See* Peter Baker & Joseph Berger, *U.S. to Resume Airlift of Injured Haitians*, N.Y. TIMES, Feb. 1, 2010, at A1. After five days of negotiations, the federal government agreed to reimburse American hospitals who treat Haitian earthquake victims with life-threatening injuries and the evacuations proceeded. Peter Baker and Joseph Berger, *U.S. Will Reimburse Hospitals That Treat Haitians,* N.Y. TIMES, February 1, 2010, *available at* http://www.nytimes.com/2010/02/02-/world/americas/02airlift.html?pagewanted=1.

137. *See* Lori A. Nessel, *Externalized Borders and the Invisible Refugee*, 40 COLUM. HUM. RTS. L. REV. 625, 697-98 (2009).

138. *See Doctors Study Repatriation of Uninsured*, N.Y. TIMES, Nov. 10, 2008, at A18.

139. Virginia Mantouvalou, *N. v. UK: No Duty to Rescue the Nearby Needy?*, MOD. L. REV. (forthcoming 2009) (draft on file with author) (citing R. Miller, *Moral Closeness and the World Community*, THE ETHICS OF ASSISTANCE—MORALITY AND THE DISTANT NEEDY 101 (D.K. Chatteriee ed. 2004)).

140. *Id.* at 115.

involves "a grave risk of harm of similar seriousness."[141] Certainly there are real economic costs associated with providing medical care to immigrants that lack permission to be within the country and resource allocation issues if treating ill or injured immigrants diverts scarce resources away from serving others. But, as viewed through the eyes of the immigrant patients at risk of losing life-sustaining dialysis treatments in the United States, "if somebody holds your hand to support you and then stops, you're going to fall . . . they have a moral duty to help us . . . they cannot let us die."[142]

141. *Id.*
142. Sack, *supra* note 69