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Ethical Legal Feature

Undocumented Patients and Rehabilitation Services

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Introduction

Limited options for undocumented patients can create ethical dilemmas and moral distress for health care providers working in rehabilitation. Compared with other low-income patients, patients who are undocumented have less access to financial, social, and medical services. For example, uninsured patients who are citizens or permanent residents may be eligible for public aid, charity care, or have access to philanthropic resources. For most undocumented patients, this is not the case, although some states and local communities have made provisions. Furthermore, the U.S. safety-net health care system is geared towards emergency and acute inpatient services. The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, requires that any patient who comes to an emergency department must be screened and, if needed, stabilized. They cannot be turned away from the emergency department based on inability to pay. There is no such requirement for rehabilitation providers, although patients with various conditions and injuries initially treated in emergency departments and acute care hospitals could often benefit from rehabilitation.

As a clinical medical ethics fellow from 2000 to 2002, I attended case conferences in which we discussed and analyzed the details of cases—medical indications, patient preferences, quality of life and contextual factors [1]. We debated the complexities, options, and recommendations. Often, when issues of social justice were brought up, a faculty member cautioned that resource allocation or justice issues should not be adjudicated at the bedside. I understood the caution—clinicians and clinical ethicists should work with the facts that they can gather and know and make decisions based on the best set of options practically available to them. Yet, as a bicultural daughter of immigrants, keenly aware of social justice issues from my training in clinical/community psychology and affinity with disability rights, I struggled with how we balance and address the principle of social justice in practice. I continue to struggle with this tension. This column is one attempt to explore social justice and rehabilitation using a current issue.

In this column, we will explore the controversies and complexities of providing rehabilitation services for undocumented patients. The ethical issues have been explored in other venues, most notably by a working group at the bioethics think tank The Hasting Center in a project entitled, "Undocumented Patients: Human Rights, Access to Health Care & the Ethics of the Safety Net" [2]. This topic of health care for undocumented patients certainly is timely. It became heated when the Affordable Care Act was being debated, came to the forefront during our recent U.S. presidential election, and has been raised again in the first weeks of the current administration. Is health care a right or a privilege? How should payer status impact rehabilitation services received? Do we have a responsibility to treat patients regardless of immigration status? And beyond our personal or political leanings, what do we do at the bedside when a patient who is undocumented needs our services?

I have asked 4 columnists to share their perspectives. Michelle Gittler, MD, Medical Director, Chairperson of PM&R and Residency Program Director at Schwab Rehabilitation Hospital in Chicago, uses 2 different rehabilitation cases to address the utility of rehabilitation, reminding us that the medical indications are in fact, very relevant. Our second columnist, Judy L. Thomas, MD, a clinical assistant professor in the department of PM&R at UT Health Houston Medical School, and the Chief of PM&R at LBJ General Hospital, describes her practice in Texas, serving a large population of undocumented patients. Michael Bozza, an immigration lawyer practicing in Boston, describes his experiences with undocumented clients and reminds us that many patients who need our services will never try

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to access them. Finally, Nancy Berlinger, research scholar at The Hastings Center, based in Garrison, New York, explores the ethical issues raised by occupational injuries and the role of charity care in providing services.

As always, I welcome your reactions and ideas for columns. As of March 25th, I can be reached at dmukherjee@sralab.org (formerly ric.org).

References

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2. Berlinger N, Gusmano MK. Undocumented Patients: Undocumented Immigrants & Access to Healthcare. Executive Summary. Available at http://undocumentedpatients.org/executive-summary/. Accessed February 27, 2017.

Postacute Care for Uninsurable Persons

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It is estimated that in 2016 there were more than 5 million undocumented immigrants in the United States who are uninsured [1]. There is a fairly strong likelihood that some of these individuals will sustain disabling conditions that require rehabilitation services. Although the EMTALA requires that individuals are treated in emergency departments regardless of their ability to pay, there is no requirement for the provision of postacute care. I will present 2 cases of undocumented, uninsured individuals that illustrate some of the complexities of this issue.

José

José (pseudonym) is a 27-year-old, soon-to-be new father, who sustained a midthoracic spinal cord injury during a carjacking. While delivering food in an unfamiliar neighborhood, he was pulled out of his car, robbed of his money, and he was shot and left down. He was taken to a local trauma unit, where he was found to have intra-abdominal injuries that required emergent laparotomy with primary repair of bowel injuries. He had complete paraplegia and was evaluated by neurosurgery and did not require surgical intervention. He also had a neurogenic bowel and bladder, and, all of the other potential secondary risk factors, attendant to a spinal cord injury. Rehabilitation medicine was consulted, and recommendations were made to prevent secondary complications. His wife, who was 9 months pregnant, was at the bedside daily. We had multiple meetings with the patient and family. It was clear he needed interdisciplinary rehabilitation to learn how to manage his spinal cord injury and all of the secondary conditions; however, he was uninsurable secondary to being undocumented. His wife was a U.S. citizen, and the family planned to stay in the United States and raise their children. They lived in a second-floor apartment.

We agreed that we would engage in a short, intensive inpatient rehabilitation program at the rehabilitation hospital within the health system. The patient was taught clean catheterization techniques, and all red rubber catheters that were used during his rehabilitation stay were collected in anticipation of discharge. The patient and wife were taught to clean the catheters with soap and water and to store each catheter in a baggie with a few drops of rubbing alcohol (or to microwave them for several minutes). We were able to obtain a secondhand wheelchair for him and taught him transfers including in and out of a car. Family and friends were taught how to get him up and down stairs in his wheelchair, and, he was also taught how to bump up and down stairs. He was discharged home successfully after 2 weeks of inpatient rehabilitation. Although the rehabilitation hospital was not reimbursed, the cost savings to the acute care hospital was estimated at 60,000 dollars, an approximation for staying on the medical-surgical unit for 3-4 weeks with limited therapies. In addition, this individual did not require emergency department or rehospitalization services for 2 years after discharge from the rehabilitation setting.

Juan

Juan (pseudonym) is a 40- or 50-year-old individual who was found down outside of the boarding house in which he shared a room with multiple other people. He was found to have massive subarachnoid and intraventricular bleed necessitating craniectomy, with implantation of the skull in his abdomen, to keep it nourished for when it would be reimplanted. Although he did appear to have identification (documents), it was later determined that these were fake. The individuals in the rooming house were unaware of his family name or where he was from. He was reported to speak Spanish, although we could not prove his country of origin. He remained unresponsive. A tracheostomy and a gastrostomy tube were placed. He was weaned successfully from a ventilator. After 6 months, a guardian from the state was appointed.

When it came time to plan for the next level of care, there was heated debate between physicians from the rehabilitation hospital and administrators at the acute care hospital. The physiatrists noted Juan's limited rehabilitation goals and were concerned that this was an inappropriate transfer. Furthermore, there was no discharge plan in place after rehabilitation. Juan