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ETHICS CASE

How Should Clinicians Treat Patients Who Might Be Undocumented?

Commentary by Jeff Sconyers, JD, and Tyler Tate, MD

Dr. Connelly, who recently finished her residency program, has now worked as a partner in a private primary care practice for a year. She shares the practice with an older physician who is considering retirement, taking on fewer responsibilities, and reducing his hours. The practice is part of a large hospital network and serves a diverse community in a large city. Dr. Connelly loves the prospect of owning the practice but is unsure whether she wants to assume sole responsibility for managing the business when her partner retires. She acknowledges that her training was medical and her business-oriented expertise is limited.

One day, the clerk at the front desk of the practice is welcoming one of the new patients, Ms. Nunez, and notices that the identification (ID) she presents lacks the holograms and graphics on IDs typically issued in the state. Unsure what to do, the clerk instructs Ms. Nunez to complete the usual forms and shows her ID to the fellow clinic staff members, some of whom suspect it to be false. One of the nurses, Kim, holds strong beliefs about illegal immigration and, based on Ms. Nunez's ethnicity and language preferences marked on her forms, assumes that she is an undocumented immigrant.

Kim approaches Dr. Connelly and demands that someone from their office report Ms. Nunez to the appropriate federal authorities. Taken by surprise and pressed for time, Dr. Connelly asks Kim to wait to discuss the matter as she enters another patient's room to try not to get further behind in her appointment schedule. By the time Dr. Connelly invites Kim to talk more about Ms. Nunez's ID, she learns that Kim has mobilized other members of the office and nursing staff, who agree upon their responsibility to report Ms. Nunez.

Dr. Connelly is reluctant to join them, as she is not convinced that a patient's immigration or political status should be a factor in determining who receives care. She considers seeking legal advice and wonders whether she does indeed have a legal obligation to report a patient suspected of not being a legal resident. But she also wonders whether Ms. Nunez, who may have presented a false ID, would give accurate clinically relevant information, given that she might not feel comfortable telling the whole truth.

Commentary

If Dr. Connelly had quick, easy access to a lawyer, she might ask several questions: "What am I required to do in this situation? What am I permitted to do? What am I prohibited from doing?" A lawyer could advise Dr. Connelly about any controlling legal authority, and, if asked, could express a personal view about the right thing to do, as well. Ultimately, however, it will be up to the client—Dr. Connelly—to decide what to do in the event.

Legal Considerations

Some of Dr. Connelly's nurse colleagues and other staff believe they have a responsibility to call the immigration authorities. There is a common misconception among nonlawyers that there is a general duty to report illegal activity. There isn't. In the same way that the First Amendment to the US Constitution protects the right of free speech, it also protects the right not to speak. There is no general obligation to report a crime, even if one witnesses the crime directly. (Here, the office staff members assume Ms. Nunez is an undocumented individual; they have no actual knowledge that she has committed any illegal act.) While there are some exceptions to the rule that create a duty to report, none apply here [1].

Although Dr. Connelly has no obligation to report Ms. Nunez, she also has no obligation to see her or take her on as a patient. A duty to treat arises because a doctor has a pre-existing relationship with a patient or because in the circumstances the patient reasonably relies on the doctor's help, such as when a doctor provides medical advice, even in a social situation, when asked directly for it [2].

Whatever moral obligations may attach when encountering someone who needs care, whether routine or emergent, the doctor is generally under no legal obligation to provide it [3]. Most doctors are familiar with the so-called "Good Samaritan" laws, which protect doctors who voluntarily, and without compensation, decide to provide care to an individual in need. These laws protect doctors who choose to act altruistically, so if a doctor chooses to volunteer, she should not bill for the services; Good Samaritan rules don't apply when payment occurs. Doctors, like other citizens, are permitted to refuse service for any legal reason or for no reason at all.

Here, Dr. Connelly is concerned that Ms. Nunez might not tell the truth about her medical condition or other clinically relevant details. If Dr. Connelly reasonably concludes that she will be unable to treat Ms. Nunez safely because the patient is likely to withhold or misrepresent important information, she can decline to enter into the doctor-patient relationship from the start. What Dr. Connelly can't do, however, is choose not to care for Ms. Nunez on the basis of her membership in a legally protected category—for example, race, religion, national origin, color, sex/gender/gender identity/sexual orientation, veteran status, or disability. State laws vary on what categories are considered

protected, and the intersection of state and federal laws in this area can be confusing. A good lawyer would tell Dr. Connelly not to discriminate, and which categories are protected in her state and under federal law.

Presumably, Ms. Nunez has come into the clinic and given her personal information to Dr. Connelly's staff for the purposes of obtaining health care. As a result, all the information she has provided—her name, her address, and any other data such as her health history and current complaint—is protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA) [4] and its implementing regulations [5]. To oversimplify an extremely complex set of rules, under HIPAA no one at the clinic with access to Ms. Nunez's personal information may disclose that information except (1) for purposes of providing her with health care services, obtaining payment, and conducting clinic operations (2) as and to the extent she authorizes disclosure in advance, or (3) in certain very limited circumstances without her prior authorization.

There is no general exception for reporting criminal activity, only an exception for "criminal conduct that occurred on the premises" of the clinic [6], which does not apply here. As already noted, no one has actual knowledge that Ms. Nunez is using a false ID; and even if she were, it is not generally a crime to use a name other than your own legal name [7]. Using a false name to obtain benefits to which that the person is not entitled (e.g., Medicaid coverage, a student loan, or preferential employment treatment) *is* almost always a crime, but no crime has yet occurred because Dr. Connelly's staff has acted before she has made any claim for benefits. As a result, neither Dr. Connelly nor the clinic may provide any information about Ms. Nunez to immigration or law enforcement authorities, and they must affirmatively protect her privacy—all the information collected from her for purposes of providing her with care—from disclosure.

What about Kim, the vigilante nurse? He is bound by the requirements of HIPAA just as much as are Dr. Connelly and the clinic. In the case, Kim has apparently not yet contacted the authorities; if he had contacted the authorities about Ms. Nunez, there would be several results. HIPAA breach notification rules require notice to the secretary of the Department of Health and Human Services in many circumstances [8]; a breach can lead to substantial fines and penalties. Dr. Connelly and her partner would need to consult a lawyer about the requirements of the breach notification rules, and if they concluded that notification is necessary, how to give it in keeping with the rules. At a minimum, the clinic owners would need to let Ms. Nunez know about any such disclosure by Kim or another member of the staff; they should recognize that Ms. Nunez might, in that case, have a claim for damages for violation of her privacy, and they might contact their insurer for advice on how to proceed.

In addition, under these circumstances, a difficult choice would confront Dr. Connelly and her partner: whether to discipline Kim for violating Ms. Nunez's privacy rights. Depending

on what Dr. Connelly and her partner concluded about Kim's knowledge of his confidentiality obligations, they would want to consider whether he would benefit from additional education because he was unaware of his confidentiality obligations, or whether his actions were deliberate in spite of adequate training and education and therefore suggest his possible suspension or even termination.

One final note on legal requirements: although Dr. Connelly has no obligation to report Ms. Nunez, or to take on her care, she does have an obligation to make sure any bills she submits for services are accurate. The clinic should have in place a process to verify that the information it provides to insurers for billing is correct. Private insurers like Aetna and Blue Cross can establish their own rules to drop or otherwise punish providers who bill them incorrectly, including requirements for verification of identity or coverage; providers need to check the rules of these payers and follow them. The state and federal governments, in the form of the Medicaid and Medicare programs, go further and impose severe penalties for bills submitted with inaccurate, false, or misleading information [9]. Medicare and Medicaid expect that clinics and other providers will have processes in place to verify all the information they submit, including reasonable steps in the circumstances to verify identity. With regard to Ms. Nunez, the clinic appears to be on notice that she may not be who she says she is: the ID she presents doesn't appear authentic. Before submitting a bill to any payer, but especially if the payer is Medicaid or Medicare, clinic staff should do more to determine whether her ID is genuine. Whether she receives services for her visit today, the clinic should not submit a bill until it is satisfied she is who she says she is.

Ethical Considerations

In terms of the ethical analysis of this case, there is no better place to start than the Hippocratic Oath. While the oath never explicitly states *primum non nocere* (first do no harm), a phrase it is often assumed to contain, it does give us the informative statement "Into whatever homes I go, I will enter them for the benefit of the sick…whether they are free men or slaves" [10]. The normative claim implicit here is that it is the duty of the physician to take care of anyone who comes to him or her for care, regardless of that person's societal status. This claim is intimately related to the principle of beneficence, which is a broad concept encompassing acts of mercy, kindness, charity, altruism, love, humanity, and a deep concern for the promotion of the good of others [11]. At times, the demands of beneficence can conflict with an agent's desire for a comfortable life; this conflict will influence Dr. Connelly's analysis of a relationship with Ms. Nunez.

We believe that if a patient has an acute life-threatening condition (for example, a stroke, respiratory distress, or ongoing blood loss), it is the physician's moral obligation to treat him or her, except under rare and extenuating circumstances—such as certain risk of dangerous exposure, injury, or death from attempting treatment. (This moral obligation is different from the legal rules outlined above.) If a patient is *in extremis*, a physician

must attempt to treat. However, these clear obligations need not apply in less acute scenarios like that of Dr. Connelly and Ms. Nunez.

Moreover, it is not Dr. Connelly's moral obligation as a physician to work for free. If Ms. Nunez does not have insurance, Dr. Connelly would likely not be reimbursed for her medical care (unless she paid in cash). This is where Dr. Connelly's interpretation of beneficence plays a critical role in her decision making. Although Dr. Connelly could decide, as a rule, to give free medical care to patients without insurance, or to work within a barter system (or within the framework of any legal and feasible system), most bioethicists would consider these acts to be supererogatory (above the normal call of duty). Whereas many would argue that being a physician does in fact require some degree of "self-effacement" [12], we believe that working for free has moved beyond duty, and while it may be morally praiseworthy, it is not required.

The physician does, however, have a professional obligation to leave prejudices at home when he or she enters the clinic or hospital. As Pellegrino and Thomasma argue in *For the Patient's Good*, "it is necessary to establish that persons within the [patient-doctor] relationship are bound by specific ethical obligations not necessarily binding for the rest of the population or for the same persons outside of that relationship" [12]. We believe that health care professionals cannot in good conscience narrow the category of patients who deserve their time, attention, and care based upon gender, race, ethnicity, sexual orientation, disease process, socioeconomic status, or any other factors, including immigration status. This opinion is also codified by the American Medical Association [13]. The oath physicians take is real and binding; just as elected officials must act for the good of the public without discrimination, we believe physicians and other health care professionals must act for the good of all of their patients, irrespective of their category memberships. Of course, at times it can be difficult to know what the "good" actually is. However, we are confident that it is not limiting care to patients who fit within a certain class, framework, or demographic.

Would Dr. Connelly's obligations change if she *were* legally bound to report patients with suspicious immigration status? We would argue no—the demands of beneficence and the weight of the patient-doctor relationship can transcend the law, and Dr. Connelly would be morally justified if she chose not to report.

It is also important to consider this case within a historical framework—one of physicians acting as an arm of law enforcement. Jeremy Spevick does an excellent job of describing the sordid history of physicians acting unethically as "agents of the state" [14]. He highlights the human rights violations and macabre practices of experimentation, eugenics, and euthanasia performed by many German physicians in Nazi Germany at the government's request. He also identifies some more acceptable practices, however, such as mandatory reporting of patients with communicable

diseases or the administration of vaccines to school-aged children to fulfill legal mandates. These later practices are rooted in a utilitarian health-promoting ethic: some degrees of inconvenience, or loss of freedom, are ethically acceptable if the practices clearly benefit the community. Ultimately, though, we believe that physicians are morally justified in "conscientiously objecting" to any law that requires them to act in contradiction to their professional duties to patients.

Conclusion

It is Dr. Connelly's prerogative to decide to what extent she wants to investigate Ms. Nunez's immigration status. She has no legal obligation to call a lawyer, let alone law enforcement. However, she does have a moral obligation to (1) assess Ms. Nunez and treat her if she is acutely ill (in extremis), (2) accept her as a patient regardless of her background or status as a citizen of the United States, and (3) respect Ms. Nunez's confidentiality as she would that of any other patient. This argument is rooted in beneficence, which we believe is an integral part of the vocation of health care.

References

1. Some important exceptions to the rule include the duty of a conspirator who plans a crime but backs out of committing it to notify law enforcement about other conspirators and their plans; and the duty to answer truthfully (or assert Fifth Amendment rights against self-incrimination) when providing information to law enforcement.
2. The right answer in such cases is almost always "I would be glad to see you at the office—call for an appointment and I'll make sure you get in quickly."
3. If Dr. Connelly is staffing a hospital emergency room when Ms. Nunez presents for care, a different rule applies. The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires hospitals that participate in the Medicare or Medicaid programs and, by extension, their employed physician staff, to provide a medically appropriate screening exam and any medically necessary stabilizing treatment for any patient who presents at the hospital's emergency department. In this limited setting, there is in fact an obligation to provide care—but only until the patient's emergency condition is stabilized or the patient is transferred to another facility. See 42 USC sec1395dd (2016).
4. Health Insurance Portability and Accountability Act of 1996, Pub L No. 104-191, 110 Stat 1936.
5. 45 CFR sec 160, 164 (2016).
6. 45 CFR sec 164.512(f)(5) (2016).
7. Kushner JS. The right to control one's name. *UCLA Law Rev*. 2009;313:324-329.
8. US Department of Health and Human Services. Breach notifcation rule. http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/. Accessed December 8, 2015. A single breach of HIPAA confidentiality rules does not usually require immediate notice, but Dr. Connelly will need to assess the

scope of the breach and how many other breaches may have occurred in deciding when and what she is required to report.
9. The False Claims Act, 31 USC sec 3729 (2016), imposes a penalty under federal law of up to $10,000 plus 3 times actual damages for every false claim for services under the Medicare program. Similar laws apply at the state level. For example, Title 74, section 74.66.020 of the *Revised Code of Washington* imposes a penalty of up to $11,000 plus 3 times actual damages for every false claim under the state's Medicaid program.
10. National Library of Medicine. The Hippocratic Oath. North M, trans. 2002. https://www.nlm.nih.gov/hmd/greek/greek_oath.html. Accessed December 15, 2015.
11. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York, NY: Oxford University Press; 2013:ch 6.
12. Pellegrino ED, Thomasma DC. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York, NY: Oxford University Press; 1988:27.
13. American Medical Association. Opinion 9.121 Racial and ethnic health care disparities. *Code of Medical Ethics*. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9121.page. Accessed January 20, 2016.
14. Spevick J. Physicians as agents of the state. *Virtual Mentor*. 2002;4(12). http://journalofethics.ama-assn.org/2002/12/medu1-0212.html. Accessed January 27, 2016.

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