

# **United States of America**

**Submission to the United Nations Human Rights Council  
as Part of its Universal Periodic Review  
Regarding the Extrajudicial Involuntary Deportations of  
Immigrant Patients by U.S. Hospitals**

Ninth Session of the Working Group on the UPR  
Human Rights Council  
22 November – 3 December 2010

**Submitted by:**  
Seton Hall University School of Law Center for Social Justice  
New York Lawyers for the Public Interest

**Summary:** United States laws and policies that severely restrict immigrant eligibility for publicly supported health care have resulted in hospitals engaging in extrajudicial medical repatriations of seriously ill or injured indigent immigrant patients to countries lacking adequate medical care. This practice violates the United States' (U.S.) obligations under the Universal Declaration of Human Rights, the International Convention on Civil and Political Rights, the Convention on the Elimination of all forms of Racial Discrimination, the United Nations Convention on the Rights of Persons with Disabilities, as well as the United States Constitution.

## I. INTRODUCTION

1. This submission focuses on extrajudicial medical repatriations, or the practice of hospitals privately deporting immigrant patients. Even though U.S. law requires that hospitals have "appropriate discharge plans" for all patients who are likely to suffer adverse health consequences upon discharge,<sup>1</sup> regardless of immigration status, before releasing them, discharge plans for immigrants have often amounted to little more than contracts with private companies to remove patients to countries that lack appropriate treatment facilities. These extrajudicial deportations occur often without consent of the patient or their guardian and outside any government oversight. Hospitals, government agencies and NGOs have reported more than 100 such extrajudicial removals resulting in serious, adverse health consequences and even death. With approximately 25 million immigrants restricted from non-emergency federal health care coverage,<sup>2</sup> extrajudicial medical repatriations require serious attention to protect immigrants' rights under U.S. and international law.
2. The seriousness of this problem is illustrated by the case of Luis Alberto Jiménez. In February of 2000, Mr. Jiménez, an undocumented immigrant in Florida, suffered devastating brain damage and other physical injuries as a result of a car crash caused by a drunk driver.<sup>3</sup> Mr. Jimenez was rushed to Martin Memorial Medical Center, where he received care for four months before being transferred to a nursing home in June of 2000.<sup>4</sup> By January of 2001, Mr. Jiménez's health had drastically deteriorated and he was readmitted to Martin Memorial and stabilized.<sup>5</sup> Due to his undocumented status, however, Mr. Jiménez was unable to qualify for federal funding for the long-term rehabilitative care he required. Unable to discharge Mr. Jimenez to an appropriate U.S. facility, the hospital sought a court order authorizing it to repatriate him to Guatemala.<sup>6</sup> Although Mr. Jimenez's guardian was contesting the lower court order, the hospital nonetheless contracted with a private company to lease an air ambulance and forcibly repatriate him to Guatemala.<sup>7</sup> The national hospital in Guatemala, however, was unable to provide the care Mr. Jimenez required and discharged him to his elderly mother's hill-top one-room house in the remote Cuchumatán Mountains where he remains bed-ridden, frequently suffering from seizures, and not within easy access of emergency care.<sup>8</sup>
3. The U.S.'s failure to (a) enforce federal requirements for medical discharges; (b) adopt measures prohibiting hospitals from engaging in deportations (a responsibility reserved for the federal government); and (c) provide immigrants access to health benefits,<sup>9</sup> has resulted in a growing number of extrajudicial medical repatriations. These acts and omissions place the U.S. in violation of the rights of due process and liberty, the right to life and health of all persons

regardless of their immigration status, and the right of all persons to be free of discrimination, as protected by U.S. and international law.

4. We recommend the swift implementation of reforms by the U.S. government to end the unlawful practice of private deportations by hospitals and to bring the U.S. into compliance with its human rights obligations.

## II. BACKGROUND AND FRAMEWORK FOR PROTECTION OF MIGRANTS' RIGHTS

### A. Medical Repatriations: Scope of the Problem

5. There have been more than 100 documented extrajudicial medical repatriations in the U.S.<sup>10</sup> However, no reliable data exists on exactly how many patients are unwillingly deported by U.S. hospitals because these extrajudicial repatriations take place in the shadows and there are no federal or state agencies monitoring medical repatriations as they occur. In fact, the United States Department of Health and Human Services (HHS) Office of Inspector General has reported only one case of a hospital being sanctioned for privately deporting a patient to Mexico.<sup>11</sup> Following are some known examples of medical repatriations:

- Two forced medical repatriations in New York in 2009.<sup>12</sup>
- Five incidents of medical repatriation or attempted medical repatriation in New Jersey.<sup>13</sup>
- St. Joseph's Hospital in Phoenix repatriates about 96 patients a year.<sup>14</sup>
- In 2009, Atlanta's Grady Hospital repatriated 10 to 13 dialysis patients to Mexico, four of whom died after their transfer.<sup>15</sup>
- Tucson's University Medical Center repatriates an average of two to three undocumented patients a month.<sup>16</sup>
- Hospitals in Chicago reportedly repatriated ten patients since 2007.<sup>17</sup>
- Broward General Medical Center in Florida has repatriated six to eight patients.<sup>18</sup>
- In 2007, a Texas hospital failed to stabilize a patient before sending her to a hospital in Mexico.<sup>19</sup>

### B. United States Constitutional and Legislative Framework

#### 1. Immigration Law

6. The power to regulate admission, exclusion, and deportation lies exclusively with the federal government.<sup>20</sup> Congress has delegated to the Secretary of Homeland Security and the United States Attorney General the exclusive authority to deport persons.<sup>21</sup> Because Congress has set forth the procedure by which a person is to be deported, state legislatures, courts and private actors such as hospitals have no legal authority to repatriate people against their will and are completely preempted from altering that mandate.<sup>22</sup>
7. Additionally, immigrants subject to removal have a right to due process and fair deportation hearings.<sup>23</sup> These rights afford immigrants the opportunity to apply for various remedies from deportation.<sup>24</sup>

## 2. Health Law:

8. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricts publicly supported health care for lawfully admitted immigrants within five years of their arrival.<sup>25</sup> Undocumented immigrants have severely limited access to Medicaid and the State Children's Health Insurance Program (SCHIP).<sup>26</sup> Moreover, as undocumented immigrants are disproportionately represented in the low-wage workforce, they generally do not receive health insurance through their employers and often cannot afford to pay for health insurance.<sup>27</sup> Further, the 2010 Patient Protection and Affordable Care Act (PPACA) prohibits undocumented immigrants from participating in the new health insurance exchanges.<sup>28</sup> As a result, there is no domestic framework to ensure long term access to health care for undocumented immigrants.
9. Pursuant to the Emergency Medical Treatment and Leave Act (EMTALA), all hospitals receiving federal Medicare are required to provide emergency care to all patients, regardless of immigration status or ability to pay.<sup>29</sup> EMTALA, however, only requires hospitals to stabilize an emergency medical condition and ensure that the transfer will not cause any further deterioration in the patient's condition.<sup>30</sup> Hospitals in violation of EMTALA are subject to penalties, including civil monetary penalties, and license revocation.<sup>31</sup> However, studies have shown that while patient dumping has increased, HHS enforcement of EMTALA violations has been "lax."<sup>32</sup>
10. The Federal Medicare statute requires that hospitals provide discharge planning by evaluating patients' post-discharge needs and make "*appropriate* arrangements for post-hospital care ... before discharge" for all patients who may suffer adverse consequences upon discharge.<sup>33</sup> If a hospital chooses to transfer a patient to another facility, it must comply with the Centers for Medicaid and Medicare Services Conditions of Participation relating to patient discharges, which defines "appropriate" facility to mean a facility that can meet the patient's medical needs.<sup>34</sup> Hospitals are also required to continually review whether discharge plans are responsive to patients' discharge needs following discharge.<sup>35</sup>

## III. Promotion and Protection of Human Rights

### A. Violations of International Human Rights Norms

11. Medical repatriations violate several international human rights obligations:<sup>36</sup>
  - Universal Declaration of Human Rights ("UDHR"): Arts. 2 and 7 (right to non-discrimination), Art. 3 (right to life), Art. 8 (right to an effective remedy), Art. 10 (right to a hearing), and Art. 25 (right to health).<sup>37</sup>
  - International Covenant on Civil and Political Rights ("ICCPR"), (ratified by the U.S.): Arts. 2, 26 (right to non discrimination), Art. 6 (right to life), Art. 13 (due process in expulsion proceedings), Art. 17 (right to privacy).<sup>38</sup>
  - International Convention on the Elimination of all forms of Racial Discrimination ("ICERD") (ratified by the U.S.): Arts. 1, 2 and 5.<sup>39</sup>
  - United Nations Convention on the Rights of Persons with Disabilities ("UN Disabilities Convention") (signed by the U.S.): Art. 11 (mandating state parties to take "all necessary

measures to ensure the protection and safety of persons with disabilities in situations of risk, including...humanitarian emergencies”), Art. 10 (right to life); Art. 14 (right to liberty and security), Art. 25 (right to health).<sup>40</sup>

### **1. Right to Liberty and Due Process**

12. Extrajudicial medical repatriations violate immigrants’ rights to Due Process and judicial protection because the deportations are lacking the basic requisite safeguards guaranteed under the Fifth and the Fourteenth Amendments of the U.S. Constitution<sup>41</sup> and protected by the ICCPR and UDHR.<sup>42</sup> When hospitals deport undocumented immigrants without proceeding through immigration hearings, they circumvent the law and foreclose the right to a fair hearing by preventing access to possible domestic remedies and denying immigrants’ their right to defend themselves.

### **2. Rights against arbitrary deprivation of liberty**

13. Extrajudicial medical repatriations violate the UDHR’s guarantee to “the right to life, liberty and security of person.”<sup>43</sup> They further violate the ICCPR prohibition against arbitrary deprivation of liberty except by procedures established by law.<sup>44</sup>

### **3. Right to Life and Health Care**

14. Medical repatriations deprive undocumented persons of their right to life and health in violation of article 3 of the UDHR, as well as article 6 of the ICCPR and article 5 of ICERD, both of which are binding on the U.S and articles 10, 11 and 25 of the UN Disabilities Convention, to which the U.S. is a signatory.<sup>45</sup> Not only are patients denied access to healthcare in the U.S., they are frequently transferred to countries that cannot provide the required level of care.<sup>46</sup> Moreover, the denial and restriction of immigrants from funding for long-term health care services violates article 25 of the UDHR and article 5 of ICERD.<sup>47</sup> As one U.S. Court has held, the right to continued medical care is “implicit in the concept of ordered liberty,” such that if the government were to deny this right, “neither liberty nor justice would exist if they were sacrificed.”<sup>48</sup> Like all human rights, the right to health imposes a duty on the state to respect, protect and fulfill. The duty to respect requires the state to refrain from denying or limiting equal access to health services for all persons, including undocumented immigrants.<sup>49</sup> The duty to fulfill requires states to adopt appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of the right to health. The duty to protect requires states to take measures to prevent third parties from interfering with this right.<sup>50</sup> The U.S. is in breach of all these duties. It has created a financial and legislative system that encourages hospitals to engage in extrajudicial deportations. It has failed to adequately enforce existing laws regarding discharge plans. It has failed to implement adequate safeguards to ensure informed consent to transfers. Finally, it has failed to protect immigrants and ensure that transfers occur only to countries with capacity to provide appropriate care.

#### 4. Right to Non Discrimination

15. Extrajudicial medical repatriations deprive immigrants of their right to be free from discrimination by withholding crucial health care services to immigrants that would otherwise be available to them but for their immigration status in violation of articles 2 and 7 of the UDHR,<sup>51</sup> articles 2 and 26 of the ICCPR,<sup>52</sup> and article 5 of ICERD.<sup>53</sup> Discrimination means any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms, including the right to health.<sup>54</sup> States have an obligation to both proactively prohibit and eliminate discrimination on all grounds and ensure equality to all. ICERD explicitly underscores that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.<sup>55</sup> Discrimination leads to marginalization of specific groups and makes these groups more vulnerable to poverty and ill-health.<sup>56</sup> The United States is in direct violation of these obligations because it affirmatively denies immigrants access to health care on the basis of immigration status.

#### IV. RECOMMENDATIONS

1. **Prohibition of Extrajudicial Repatriation:** The U.S. Department of Health and Human Services (“HHS”) should promulgate Federal health care regulations prohibiting involuntary extrajudicial deportation.
2. **Increased Enforcement and Sanctions for EMTALA violations:** HHS should adopt an active role in the investigation and prosecution of EMTALA violations by auditing hospital discharge and transfer records and initiating investigations into suspicious transfers.
3. **Enforcement of Medicare Discharge Laws:** To ensure that Hospitals are in compliance with the Medicare Discharge laws, HHS should require that before transferring any patient outside of the U.S. for post-discharge care, hospitals submit the discharge and post-assessment care plan to HHS for approval. In all international patient transfers, HHS should ensure that the receiving facility is appropriate for the patients needs and meets the federal and international standards of care.
4. **Transparency and Reporting Requirements:** HHS should impose more stringent reporting requirements that require hospitals to immediately report any adverse consequences to patients following discharge. The HHS Inspector General has recommended that “steps be taken to encourage hospitals to report suspected cases of patient dumping, including making reporting of suspected cases of dumping a condition of participating in the Medicare program,”<sup>57</sup> and recommended that hospitals be required to “clearly identify transferred patients.”<sup>58</sup>
5. **Universal Health Care:** In keeping with its obligations under international human rights law, the U.S. should provide universal health care, regardless of immigration status. In addition, Congress should repeal all restrictions on immigrants’ access to healthcare.

## Appendix – Reports Highlighting Medical Repatriation Incidents in the United States

- A. Kevin Sack, *For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES, December 31, 2009.
- B. Paul Harasim, *Sending patients home: Hospitals find paying travel costs beats giving free care*, LAS VEGAS REVIEW-JOURNAL, August 29, 2009.
- C. Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, August 3, 2008.
- D. Marcus Baram, *Uninsured Immigrant Facing Forced Removal to Home Country*, ABC NEWS, May 22, 2008.

---

<sup>1</sup> 42 U.S.C. § 1395dd; 42 U.S.C. § 1395x; 42 C.F.R. § 482.43.

<sup>2</sup> Randy Capps, Marc R. Rosenblum & Michael Fix, *Immigrants and Health Care Reform: What's Really at Stake*, MIGRATION POLICY INST., Oct. 2009, at 11.

<sup>3</sup> *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 874 So.2d 654 (Fla. 4th DCA 2004).

<sup>4</sup> *Id.* at 656.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> *Montejo v. Martin Mem'l Med. Ctr., Inc.*, 935 So. 2d 1266, 1268 (Fla. 4th DCA. 2006).

<sup>8</sup> Debra Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, August 3, 2008 at A1 [hereinafter Sontag, *Deported by U.S. Hospitals*].

<sup>9</sup> See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1601 *et seq.* (1996) [hereinafter PRWORA]. In enacting PRWORA the U.S. implemented a discriminatory regime whereby a large group of immigrants, documented and undocumented, are denied access to necessary health care.

<sup>10</sup> Sontag, *Deported by U.S. Hospitals*, *supra* note 8, at A1. In August 2008, the New York Times reported that “some 96 patients a year [are] repatriated by St. Joseph’s Hospital in Phoenix; 6 to 8 patients a year [are] flown to their homelands from Broward General Medical Center in Fort Lauderdale, Florida; 10 [have been] returned to Honduras from Chicago hospitals since early 2007.” *Id.* The article reported that the Mexican Consulate in San Diego handled 87 medical cases involving Mexican immigrants in the U.S. and 265 cases of people crossing the border in San Diego in 2007. A Mexican consulate in Phoenix reported his office had worked with area hospitals in 80 medical repatriations in 2007. Debra Sontag, *Deported in Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 8, 2008. See also Judith Graham, *Sending sick undocumented immigrants back home*, CHI. TRIB., Aug. 20, 2008, available at <http://newsblogs.chicagotribune.com/triage/2008/08/sending-sick-un.html> (last visited Apr. 16, 2010). Chicago hospitals have returned 10 patients to Honduras since 2007 and also send patients to Lithuania, Poland, Guatemala, and Mexico. Sontag, *Deported by U.S. Hospitals*.

<sup>11</sup> OFFICE OF THE INSPECTOR GEN. (OIG), DEP’T OF HEALTH & HUMAN SERVS. (HHS), THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: PATIENT DUMPING ARCHIVE, available at [http://oig.hhs.gov/fraud/enforcement/cmp/patient\\_dumping\\_archive.asp](http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping_archive.asp) (last visited Apr. 16, 2010) [hereinafter OIG ARCHIVE].

<sup>12</sup> Nisha Agarwal and Liane Aronchick, “A Matter of Life and Death: Advocates in New York Respond to Medical Repatriation,” 46 Harv. C.R.-C.L. L. Rev. Amicus \_\_\_\_ (2010) (forthcoming).

<sup>13</sup> Seton Hall Center for Social Justice (CSJ) Interviews with Caryn Maxim, advocate with Grupo Cajola, (Dec. 2009 and Apr. 2010); State of New Jersey, Department of the Public Advocate, *Undocumented Immigrants in New Jersey’s State & County Psychiatric Hospitals*, Mar. 2009; Univision Online, *Diagnóstico: Deportación Parte III*, Nov. 24, 2008, available at <http://www.univision.com/content/content.jhtml?cid=1747832#p> (last visited Apr. 18, 2010); Ralph Ortega, *Immigrant patient says he got care and a threat: Man, 23, allegedly feared deportation*, THE STAR LEDGER, May 17, 2006.

<sup>14</sup> Sontag, *Deported by U.S. Hospitals*, *supra* note 8; Marcus Baram, *Uninsured Immigrant Facing Forced Removal to Home Country*, ABC NEWS, May 22, 2008, available at <http://abcnews.go.com/Health/story?id=4903138&page=1>; Paul Harasim, *Sending patients home: Hospitals find paying travel costs beats giving free care*, LAS VEGAS REVIEW-JOURNAL, Aug. 29, 2009, available at <http://www.lvrj.com/news/54286002.html>.

<sup>15</sup> Kevin Sack, *For Sick Illegal Immigrants, No Relief Back Home*, N.Y. TIMES, Dec. 31, 2009; Matthew Cardinale, *US State Department Reviewing Grady Dialysis Crisis*, The Atlanta Progressive News, Feb. 18, 2010.

<sup>16</sup> Tim Vanderpool, *Extraordinary Deportations*, TUSCON WEEKLY, Aug. 14, 2008, available at <http://www.tucsonweekly.com/tucson/extraordinary-deportations/Content?oid=1092131>.

---

<sup>17</sup> Sontag, *Deported by U.S. Hospitals*, *supra* note 8.

<sup>18</sup> *Id.*

<sup>19</sup> OIG ARCHIVE, *supra* note 11.

<sup>20</sup> See *DeCanas v. Bica*, 424 U.S. 351, 354 (1976).

<sup>21</sup> 8 U.S.C. § 1103(a)(1) (“The Secretary of Homeland Security shall be charged with the administration and enforcement of this chapter and all other laws relating to the immigration and naturalization of aliens.”).

<sup>22</sup> See *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).

<sup>23</sup> *Japanese Immigrant Case*, 189 U.S. 86, 101 (U.S. 1903) (“[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.”). See also U.S. CONST. AMEND. V.

<sup>24</sup> See, e.g., *United States v. Mendoza-Lopez*, 481 U.S. 828, 835 n.9, 840 (1987); *United States v. Ubaldo-Figueroa*, 364 F.3d 1042, 1047 (9th Cir. 2004); *United States v. Copeland*, 376 F.3d 61 (2d Cir. 2004).

<sup>25</sup> PRWORA, *supra* note 9, § 1613.

<sup>26</sup> *Id.*

<sup>27</sup> John Graves and Sharon Long, “Why Do People Lack Health Insurance?,” Urban Institute, May 2006. See also Cory S. Bagby, *The Nexus Between Immigrant Eligibility and Access: An Analysis of the Economic, Social, and Linguistic Barriers to Health Care*, 17 ANNALS OF HEALTH L. 293, 294 (2008) (“Employer-based health insurance coverage is frequently unavailable to immigrants because they tend to work in low-wage jobs and in industries that do not traditionally offer health insurance to their employees. In 2003, the median annual salary for a full-time, non-citizen employee was \$23,140. Nearly 40% of this group had incomes below \$20,000 per year.”).

<sup>28</sup> See Jill Jackson and John Nolen, *Health Care Reform Bill Summary: A Look At What's in the Bill*, CBSNEWS.COM, Mar. 22, 2010, available at [http://www.cbsnews.com/8301-503544\\_162-20000846-503544.html](http://www.cbsnews.com/8301-503544_162-20000846-503544.html) (last visited April 18, 2010).

<sup>29</sup> 42 U.S.C. § 1395dd. See also Brietta R. Clark, *The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System*, 17 ANN. HEALTH L. 229, 238 (2008).

<sup>30</sup> 42 U.S.C. § 1395dd(c), dd(e)(3)(A); 42 C.F.R. § 482.43.

<sup>31</sup> 42 U.S.C. § 1395dd(d).

<sup>32</sup> Thomas A. Gionis, *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment Act (EMTALA)*, 52 Am. U. L. Rev. 173, 200 (2002). See also Office of the Inspector General, Dep't of Health and Human Services, *The Emergency Medical Treatment and Labor Act: Survey of Hospital Emergency Departments* 18 (Jan. 2001); Dana E. Schaffner, *EMTALA: All Bark and No Bite*, 2005 U. Ill. L. Rev. 1021, 1026 (2005).

<sup>33</sup> 42 U.S.C. § 1395x(ee). The requirement to have a discharge planning process is a condition of hospitals' participation in the Medicare program, but it applies to all patients at the hospital regardless of whether they are insured through Medicare or not. See 42 C.F.R. § 482.43.

<sup>34</sup> 42 C.F.R. § 482.43; 59 Fed. Reg. 64149.

<sup>35</sup> *Id.*

<sup>36</sup> The United Nations Special Rapporteur on Health has also underscored that undocumented immigrants occupy one of the most vulnerable segments of society and that states must not deny their human right to medical care. See Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Fact Sheet No. 31 on the Right to Health [hereinafter *Right to Health*]; Comm. On Economic Social and Cultural Rights, General Comment 14, *The Right to The Highest Attainable Standard of Health* (Nov. 8, 2000) [hereinafter “General Comment 14”] (“States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”).

<sup>37</sup> Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GOAOR, 3d Sess., 1<sup>st</sup> plen. Mtg., U.N. Doc A/810 at 71 (1948) [hereinafter UDHR].

<sup>38</sup> International Convention on Civil and Political Rights G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) art. 13. [hereinafter ICCPR]. The Human Rights Committee has made clear that Article 13 applies to immigrants in deportation proceedings challenging a deportation order. Human Rights Committee General Comment No. 15 (11/04/1986): *The Position of Aliens under the Covenant* (“An alien must be given full facilities for pursuing his remedy against expulsion so that this right will in all the circumstances of his case be an effective one.”).

<sup>39</sup> International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force Jan. 4, 1969 [hereinafter



---

ICERD] (It should be noted that art. 1, ¶ 2 specifically permits a party to differentiate between citizens and non-citizens, but with limitations). See Committee on the Elimination of Racial Discrimination, General Recommendation 30 at ¶ 2, Discrimination against Non-citizens (Sixty-fourth session, 2004), U.N. Doc. CERD/C/64/Misc.11/rev.3 (2004) (noting that “Under the Convention, differential treatment based on citizenship or immigration status will constitute discrimination if the criteria for such differentiation, judged in the light of the objectives and purposes of the Convention, are not applied pursuant to a legitimate aim, and are not proportional to the achievement of this aim.”).

<sup>40</sup> Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008 [hereinafter “UN Disabilities Convention”].

<sup>41</sup> *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 territory and thus, entitled to Due Process rights.); 42 C.F.R. § 482.43(c)(1),(3) (4), 42 C.F.R. § 482.21(b)(2).

<sup>42</sup> See ICCPR, *supra* note 38, arts. 10, 11, 14-16; UDHR *supra* note 37, art. 10 (“Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.”).

<sup>43</sup> UDHR, *supra* note 37, art. 3.

<sup>44</sup> ICCPR, *supra* note 38, art. 9, ¶ 1.

<sup>45</sup> UDHR, *supra* note 37, art. 3; ICCPR, *supra* note 38, art. 9; ICERD, *supra* note 39 art. 5; UN Disabilities Convention, *supra* note 42, arts. 10, 11 and 25.

<sup>46</sup> Dr. Steven Larson a migrants health expert described repatriation as “pretty much a death sentence in some of these cases ... I’ve seen patients bundled onto the plane and out of the country, and once that person is out of sight, he’s out of mind.” Sontag, *Deported in Coma*. There have been a number of documented reports of individuals dying or facing serious health deterioration upon their return to their country of origin following extrajudicial hospital deportations. See, e.g., Paul Harasim, *Sending patients home: Hospitals find paying travel costs beats giving free care*, LAS VEGAS REVIEW-JOURNAL, Aug. 29, 2009, available at <http://www.lvrj.com/news/54286002.html> (describing an 18 year old patient with a “highly curable form of leukemia” who died after an Arizona hospital’s transfer to a Mexican hospital); OIG ARCHIVE, available at [http://oig.hhs.gov/fraud/enforcement/cmp/patient\\_dumping\\_archive.asp](http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping_archive.asp). ; Sack, *For Sick Illegal Immigrants, No Relief Back Home*.

<sup>47</sup> ICERD, *supra* note 39, art. 5; UDHR, *supra* note 37, art. 25(1) (“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”)

<sup>48</sup> *Abigail Alliance v. Von Eschenbach*, 496 F.3d 695, 711 (D.C. Cir. 2007) (citing *Washington v. Glucksberg*, 521 U.S. 702, at 720-721).

<sup>49</sup> Comm. On Economic Social and Cultural Rights, General Comment 14, The Right to The Highest Attainable Standard of Health (Nov. 8, 2000) [hereinafter “General Comment 14”].

<sup>50</sup> *Id.*

<sup>51</sup> Equality and non-discrimination are reiterated in many provisions of the Declaration, See, for example, UDHR, *supra* note 37, art. 1 (“All human beings are born free and equal in dignity and rights.”), art. 6 (“everyone has the right to recognition everywhere as a person before the law.”), art. 10 (“Everyone is entitled in full equality to a fair and public hearing . . .”). The United Nations High Commissioner for Human Rights has made clear that “[s]tates must avoid different standards of treatment with regard to citizens and non-citizens that might lead to the unequal enjoyment of economic, social and cultural rights. Governments shall take progressive measures to the extent of their available resources to protect the rights of everyone—regardless of citizenship—to ... the enjoyment of the highest attainable standard of physical and mental health; and education.” The Office of the High Commissioner for Human Rights, “The Rights of Non-Citizens,” p. 25.

<sup>52</sup> ICCPR, *supra* note 38, art. 2 (noting that every party must ensure the rights in the convention “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”), art. 26 (noting that “Everyone shall have the right to recognition everywhere as a person before the law”).

<sup>53</sup> ICERD, *supra* note 39 art. 5.

<sup>54</sup> See *Rights to Health* *supra* note 36 at 7.

<sup>55</sup> ICERD, *supra* note 39, art. 5.

<sup>56</sup> See *generally Right to Health*, *supra* note 36, at 18-20.

<sup>57</sup> OFFICE OF THE INSPECTOR GEN. (OIG), DEP’T OF HEALTH & HUMAN SERVS. (HHS), “PATIENT DUMPING AFTER COBRA: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSE TO COMPLAINTS” (November 1988), available at: <http://oig.hhs.gov/oei/reports/oai-12-88-00831.pdf>.

<sup>58</sup> *Id.*

## **APPENDIX A**

The New York Times

PRINTER-FRIENDLY FORMAT  
SPONSORED BY



This copy is for your personal, noncommercial use only. You can order presentation-ready copies for distribution to your colleagues, clients or customers here or use the "Reprints" tool that appears next to any article. Visit [www.nytreprints.com](http://www.nytreprints.com) for samples and additional information. Order a reprint of this article now.

January 1, 2010

THE BREAKING POINT

## For Sick Illegal Immigrants, No Relief Back Home

By [KEVIN SACK](#)

EJIDO MODELO, Mexico — On the two-hour bus rides from her village on Lake Chapala to a [dialysis](#) clinic in Guadalajara, Monica Chavarria's thoughts would inevitably turn to the husband and son she left behind in Georgia.

A decade after crossing illegally into the United States, Ms. Chavarria returned home in September after learning that Grady Memorial Hospital in Atlanta was closing the clinic that had provided her with dialysis, at taxpayer expense, for more than a year.

Grady, a struggling charity hospital, had been absorbing multimillion-dollar losses for years because the dialysis clinic primarily [served illegal immigrants](#) who were not eligible for government insurance programs.

Hospital officials decided the losses were threatening Grady's broader mission of serving the region's indigent population. But before [closing the clinic](#) on Oct. 4, they offered to pay to relocate patients to their home countries or other states, and to provide dialysis for three transitional months.

Ms. Chavarria, 34, left quickly with her 8-year-old son, Jose Andres, an American citizen who had never been to [Mexico](#). But she has not found a solution there. Her free treatments have run out, and she can now afford dialysis only by poaching the savings her family has set aside for a transplant.

Her husband, Roberto Barajas, 37, and their 14-year-old son, Eduardo, remained in Georgia so Mr. Barajas could keep working and wire money home for her care.

In separate interviews, one in the farming village of Ejido Modelo, the other in the Atlanta suburb of East Point, Ms. Chavarria and Mr. Barajas each wept while describing their separation after 15 years of marriage.

"I think about them all the time," said Ms. Chavarria, whose raven hair falls past her waist. "It was the hardest thing to leave without them."

Mr. Barajas, a stocky road paver, shielded his eyes with his hand. "You don't know if you'll be able to see each other again," he said. "We had always been together, the four of us, and then suddenly they had to go."

Like other patients repatriated by Grady this fall, Ms. Chavarria gambled that her chances would be better at home. The costs of dialysis and a possible [kidney transplant](#) would be considerably lower in Mexico, and she had three siblings there willing to donate an organ.

But it has not worked out that way.

On Dec. 22, she exhausted the 30 free dialysis sessions that Grady had provided at a gleaming private clinic in

Guadalajara. On her doctor's advice, she had been stretching out the treatments, which filter toxins from the blood, by going two times a week instead of the recommended three. Going without dialysis can prove fatal in as little as two weeks, and the twice-a-week regimen has at times left her weak.

Now Ms. Chavarria is dipping into money that Mr. Barajas and other relatives have raised in East Point, which has long been a destination for migrants from Ejido Modelo. They have held raffles and charity soccer tournaments, and placed gold-wrapped donation boxes at taquerias and stores.

The fund-raising proceeds — about \$11,000, according to Mr. Barajas — had been earmarked to defray the \$20,000 cost of a transplant. So it is a setback each time Ms. Chavarria has to withdraw \$100 for a dialysis treatment.

Everywhere, it seems, there are roadblocks to affordable care. The dialysis unit at Guadalajara's public hospital, which offers heavily discounted prices to the uninsured, has a waiting list that extends for months. Ms. Chavarria is not eligible for the insurance plan known here as Social Security, which is limited to salaried workers. The country's five-year-old health program for the uninsured, Seguro Popular, does not cover end-stage renal disease.

On top of the cost, the preparations for a kidney transplant can take months. Ms. Chavarria's brother, Roberto, her first volunteer, recently learned that his own kidneys might not be functioning properly, possibly ruling him out.

When Grady officials decided last summer to close the dialysis clinic for budgetary reasons, the board chairman, A. D. Correll, declared that "people are not going to die on the street because of these actions." But that pledge may ignore the conditions that await patients who return to Latin America.

Two Grady dialysis patients have died in Mexico since the clinic's closing, along with one exceedingly ill patient in Atlanta, according to the hospital. A Grady spokesman said the deaths resulted from severe kidney disease and not from insufficient dialysis.

But one of the Grady patients who died in Mexico, Adriana Ríos Fernández, was receiving dialysis only twice a week because her family could not afford a third treatment that might have helped clear her lungs of fluid, her father said. And recent research has found that dialysis patients in Ms. Chavarria's state of Jalisco, where half of the residents are uninsured, are three times more likely to die than Hispanic dialysis patients in the United States.

"To have end-stage renal disease in Mexico is a tragedy," said Dr. Guillermo Garcia-Garcia, the lead author of the study. "If you don't have Social Security, if you don't have private insurance, you are condemned to die."

The health care dichotomy in Mexico is stark. At Guadalajara's Hospital Civil, the teeming public hospital where Dr. Garcia is chief of nephrology, the dialysis unit runs eight stations around the clock, and meets barely half the demand. Doctors there said they see uninsured patients die every week for lack of dialysis. By contrast, the private clinic for the insured where Ms. Chavarria received her Grady-sponsored treatments is operating at one-fourth of its capacity.

During her journeys for dialysis, and her three-and-a-half hours in the chair, Ms. Chavarria daydreams that her family might some day reunite. "I hope it's soon, while things are all right," she said, as the bus rolled past fields of cactus and maize.

But it is difficult to block out the grim realities. She knows that she may never be strong enough to cross the border again and that her continued treatment may depend on her husband's ability to earn \$11 an hour in Georgia, rather than \$12 a day here as a farmhand.

There are an estimated seven million illegal immigrants in the United States who have no medical coverage. New research shows there may be 5,500 with end-stage renal disease alone. The health care bills in Congress do not address the problem, leaving public hospitals like Grady to treat the immigrants with an ever-fraying safety net.

Most of the 66 immigrants who were dislodged by the Grady clinic's closing have stayed in Atlanta to take advantage of the hospital's offer of three months of treatment. They have signed documents stating that they understand that Grady's financial assistance will end on Sunday, although the hospital's contract with a commercial dialysis provider lasts until September.

Ten to 13 of the patients appear to have returned to Mexico, with varying success. Pastor Chavez, 37, said his aunt had managed to buy insurance for him. Patricia Pichardo, 36, a mother of three, said she was borrowing from friends to afford her twice-weekly dialysis.

Antonio Camron, 20, said he did not know what he would do after his Grady-sponsored treatments ended in late December. "I have very little time left," he said.

The repatriation of most of the patients was carried out by MexCare, a California company hired by Grady. As an additional inducement, MexCare offered many patients a year of health insurance to follow their three months of paid dialysis.

But six patients interviewed in Mexico this month said they knew of no steps being taken to obtain meaningful health insurance. One of MexCare's principals, George Ochoa, said in a brief interview that the company's offer was to pay for a year of Seguro Popular. That program does not cover dialysis or kidney transplants, according to its national commissioner, Salomón Chertorivski Woldenberg.

Matt Gove, a senior vice president at Grady, said the hospital had not been aware that MexCare was promising patients insurance coverage.

Residents of this farming village on the south shore of Mexico's largest lake began seeking work in the suburbs near Atlanta's airport in the mid-1970s. Relatives then summoned relatives until the apartment complexes filled with immigrants. On their days off from construction and landscaping, they reconstituted their social circles and soccer teams as if they had never left home.

During the holidays, when the population of Ejido Modelo swells with homecoming immigrants, the rutted, unpaved streets are dotted with cars bearing Fulton County, Ga., license plates.

Mr. Barajas's family came in waves. He said he made the first of his three illegal crossings at age 17 in 1989, shortly after meeting Ms. Chavarria at the soccer field in Ejido Modelo. They courted by telephone and mail, and he returned to marry her in the whitewashed village church. After Eduardo was born, she followed him back to East Point.

Their American dream was to save enough to build a three-bedroom house in Ejido Modelo, and then return home. But in February 2008, while working at an auto parts plant near Atlanta, Ms. Chavarria began having trouble breathing. Doctors at Grady diagnosed her kidney failure and placed her on dialysis. She and her husband were astonished there was no charge.

When it came time to leave, the family made the heartbreaking decision that Eduardo would remain in Georgia because he wanted to stay in American schools. Jose Andres, they decided, was too young to leave his mother (and unlike his brother had the advantage of American citizenship). He is struggling in school in Mexico, according to

his parents, because he had never learned to write in Spanish.

Mr. Barajas and Ms. Chavarria said their tearful farewells at a McDonald's restaurant at Grady, where her MexCare escort had suggested they meet. Mr. Barajas's sister has moved in to their apartment to help care for Eduardo, but the emptiness remains.

"It's hard to get home from work or some other place and not see her here," Mr. Barajas said.

Ms. Chavarria is living with her 64-year-old mother, who welcomes each morning by baking tortillas over a wood fire. Other family members live in a compound of small brick houses surrounding a communal courtyard that is planted with citrus and poinsettias. Ms. Chavarria said she was happy to be with her extended family, but was "missing my own."

She seems fatalistic about the chances for a reunion, in the house they have all but finished.

"I would want good things to happen," Ms. Chavarria said, "but destiny is not in our hands."

*David Agren in Mexico and Catrin Einhorn in New York contributed reporting.*


---

Copyright 2010 The New York Times Company

[Privacy Policy](#) | [Terms of Service](#) | [Search](#) | [Corrections](#) | [RSS](#) | [First Look](#) | [Help](#) | [Contact Us](#) | [Work for Us](#) | [Site Map](#)

---

## **APPENDIX B**

 [Click to Print](#)[SAVE THIS](#) | [EMAIL THIS](#) | [Close](#)

Aug. 23, 2009  
Copyright © Las Vegas Review-Journal

## **ILLEGAL IMMIGRANTS: Sending patients home**

### **Hospitals find paying travel costs beats giving free care**

By PAUL HARASIM  
LAS VEGAS REVIEW-JOURNAL

As Marta Berrera received emergency dialysis treatment recently at University Medical Center, the 34-year-old illegal immigrant said she wouldn't want to be sent home to Mexico for treatment.

Las Vegas is now home for her and her four school-age children, she said through an interpreter.

"I like it here. People are so nice. I am so thankful to this hospital for doing this for someone who is not a citizen."

Weary from her two-year battle with failing kidneys -- a fight she wages by receiving costly treatment through the UMC emergency room two or three times a week -- Berrera says she has never thought about returning to her homeland for health care to keep her alive.

But as health care costs spiral out of control in the United States, many Americans think illegal immigrants like Berrera should not only think about repatriation, they should be forced to leave.

Hospitals in other states, including Arizona and Florida, have sent patients back to their home countries despite objections of either the patients or their families.

In 2008, St. Joseph's Hospital and Medical Center in Phoenix sent an average of seven patients a month to their native countries for treatment, according to Sister Margaret McBride, an administrator there.

"We always try to get their agreement, but sometimes we can't," she said.

The cost to arrange medical transport of an illegal immigrant back to a home country ranges from \$35,000 on the low end up to \$200,000. That's not cheap, but it's far less than the \$1 million per patient the nonprofit Phoenix hospital estimated it was spending for ongoing dialysis treatment.

The transportation costs can include providing equipment, such as ventilators, if they are not available in the patient's native country.

A medical vehicle is chartered, and medical personnel sometimes is needed to accompany a patient.

And although Arizona sees the vast majority of its illegal immigrants coming from Mexico, repatriation can be to anywhere. One patient was flown to South Korea, McBride said.

In Florida, in what legal experts believe was the first case of its kind, a jury found that a hospital there did not act unreasonably when it chartered a plane six years ago to fly a brain-injured



Guatemalan patient home for care.

The hospital had provided Luis Alberto Jimenez \$1.5 million in long-term care for several years until forcing his repatriation in 2003.

After learning that cash-strapped UMC had provided more than \$20 million in dialysis services for uninsured illegal immigrants in the current fiscal year, Clark County Commissioner Steve Sisolak said more effort must be made to send foreign nationals back to their home countries for treatment.

But Sisolak did not advocate forced repatriation, suggesting instead that the hospital work more closely with the Mexican consul of Las Vegas, Mariano Lemus Gas, to come up with a solid voluntary plan. Gas said he is contacting authorities in Mexico to see if he can have them help pay for repatriation.

Brian Brannman, UMC's chief financial officer, said he is aware of four cases in which the hospital was able to convince illegal immigrants to receive continuing care in their country of origin. That's more likely to happen when the extended family is in the home country, Brannman said.

Last Sunday, the Review-Journal reported that UMC is treating 80 illegal immigrants who require costly and repeated emergency dialysis. Hospital officials say the majority of those patients are Mexican, though they note a wide array of nationalities, from Canadians to Pakistanis, have received care.

Under federal law, anyone who shows up at an emergency room for a medical condition must be given an appropriate medical screening to determine whether there is an emergency. If there is, treatment must be provided regardless of a patient's ability to pay or citizenship.

Dialysis, which must be done two or three times a week on patients, is almost four times more costly when done through the emergency room than through the usual doctor-guided treatment at a dialysis center.

Emergency room treatment would normally be billed out at up to \$18,000 per visit, in part because of required testing and costly in-patient critical care to keep someone alive.

Dr. Dale Carrison, head of emergency services at UMC, said illegal immigrants with failing kidneys have figured out doctors will treat them if they go to the emergency room in bad enough shape.

"They don't have insurance and they can't get Medicare because they're illegal, so all they can do is use the emergency room to stay alive," Carrison said.

UMC, which provides the vast majority of health care for illegal immigrants in the Las Vegas Valley, does not engage in repatriation, spokesman Rick Plummer said.

Health care professionals want to help people, not be an arm of immigration enforcement, he said.

"We don't have the appetite to force people to leave. That's not what health care workers want to do. They go into their profession wanting to help people. ... Immigration authorities know where these people are all across the country."

### **Legal battles**

Plummer noted that litigation costs for hospitals in forced repatriation cases could wipe out the initial savings realized by shipping someone to a country of origin.

He also said some believe forced repatriation constitutes kidnapping.

The Florida legal case involving Jimenez lasted more than five years. The hospital, Martin Memorial Medical Center, has not disclosed how much its legal costs were to defend its actions in a civil lawsuit brought by his family.

Though a Florida appeals court ultimately ruled that Jimenez had been unlawfully detained and deprived of his liberty, that ruling came too late for Jimenez, who already had been sent back to Guatemala.

Despite the Florida jury's initial finding, Sonal Ambegaokar, a health policy attorney at the National Immigration Law Center in California, predicted more lawsuits will be filed against hospitals engaging in forced repatriation.

She said in most cases it is doubtful hospitals are providing a safe discharge for patients.

"In many cases, the hospitals can't guarantee that the proper level of care is continued," Ambegaokar said. "Basically we think these hospitals are acting as a government agency without proper (due process) procedures in place."

When hospitals force an individual to leave family in the United States, Ambegaokar said, an argument can be made that constitutes a kidnapping which tears at the family's emotional fabric.

But McBride said St. Joseph's is breaking no laws when it arranges with health care professionals or facilities in other countries to provide continuing care for a patient. She said the hospital's legal responsibility, regardless of what the patient's family wants, is simply to provide a safe discharge. About seven other hospitals in the Phoenix area also repatriate, she said.

Suzanne Pfister, a spokeswoman for St. Joseph's, acknowledges the hospital's discharges have drawn criticism. In 2008, the Arizona Republic newspaper reported that an 18-year-old who was sent back to a hospital in Mexico died there of a highly curable form of leukemia.

Pfister wouldn't talk about specific cases.

"These are heart-wrenching cases," McBride said, adding that the hospital must make difficult decisions to stay financially solvent.

"We do everything we can to work with families and consulates. But it is something that we must do in order to be able to continue to offer care."

St. Joseph's is a trauma center which treats people who have been in serious accidents. Many who are stabilized at a cost of hundreds of thousands of dollars need long-term care that the hospital cannot provide for financial or licensing reasons, she said.

For-profit institutions, which are licensed for long-term rehabilitation in Phoenix, generally refuse to take patients without insurance, McBride said.

Plummer said there have been trauma cases involving illegal immigrants that have cost UMC hundreds of thousands of dollars.

"We're basically warehousing them for months," he said. "For-profit rehab centers don't want to take them."

The four cases in which illegal immigrants willingly returned to their homelands involved patients who needed long-term continuing care, Brannman said.

"We'll spring for the plane ticket. It's a lot cheaper than running up a bill for hundreds of thousands of dollars."

Brannman said UMC social workers continually work with patients to explain their options. He hopes that building a closer relationship with foreign consuls also can help convince patients that they're better off where they were born.

Gas, the Mexican consul, said he wants to help UMC and does not want to encourage illegal immigrants to come to or stay in Las Vegas.

But, he said, "many of these people don't want to go back to a place that they no longer know very well. Much of their family is here, and it is very emotional."

### Many factors to blame

What is happening to health care in Las Vegas and around the nation isn't surprising to Mark Krikorian, executive director of the Center for Immigration Studies, a nonpartisan research group that supports immigration reform.

He said it's sad that hospital officials are put in a position where they must deport someone because immigration authorities and politicians don't have the will to enforce the law.

"This is what happens that society faces when it doesn't enforce immigration laws adequately," he said. "American hospitals can't give costly medical care to everybody in the world."

Jan Emerson, a spokeswoman for the California Hospital Association, cautioned people not to put too much blame on illegal immigrants for health care problems in the United States.

Emerson said she often hears from "people that don't care about facts" who say treatment of illegal immigrants has been responsible for the closing of 70 hospitals in that state since 1996.

"That's just not true," she said. "They contribute to the problem, but they're not the main reason."

Emerson said about 10 percent of the \$11.3 billion in uncompensated care provided by California hospitals in 2008 is related to illegal immigrants.

She said underfunding of Medicare and Medicaid programs is responsible for nearly three quarters of the uncompensated care, which hurts hospitals' bottom lines.

"There is so much emotion on this topic, and too many people don't want the facts to get in the way," she said.

Still, Emerson agrees that the question of health care reform in the United States can't be addressed without a discussion of illegal immigrants.

Ten percent of the problem is not insignificant, she noted.


After the Florida jury found that Martin Memorial was justified in shipping Jimenez back to Guatemala, hospital CEO Mark E. Robitaille noted that none of the proposed national health care reform bills being debated in Congress address illegal immigrants.

"That means there are still cases like Luis Jimenez's in hospitals across the country, Robitaille said. "And there will continue to be cases like Luis Jimenez's."

Contact reporter Paul Harasim at [pharasim@reviewjournal.com](mailto:pharasim@reviewjournal.com) or 702-387-2908.

#### Find this article at:

<http://www.reviewjournal.com/news/54286002.html>

 **Click to Print**

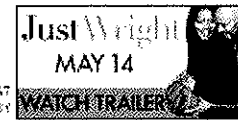
[SAVE THIS](#) | [EMAIL THIS](#) | [Close](#)

Check the box to include the list of links referenced in the article.

## **APPENDIX C**

This copy is for your personal, noncommercial use only. You can order presentation-ready copies for distribution to your colleagues, clients or customers here or use the "Reprints" tool that appears next to any article. Visit [www.nytreprints.com](http://www.nytreprints.com) for samples and additional information. Order a reprint of this article now.

PRINTER-FRIENDLY FORMAT  
SPONSORED BY



August 3, 2008

## Immigrants Facing Deportation by U.S. Hospitals

By DEBORAH SONTAG

JOLOMCÚ, Guatemala — High in the hills of Guatemala, shut inside the one-room house where he spends day and night on a twin bed beneath a seriously outdated calendar, Luis Alberto Jiménez has no idea of the legal battle that swirls around him in the lowlands of Florida.

Shooing away flies and beaming at the tiny, toothless elderly mother who is his sole caregiver, Mr. Jiménez, a knit cap pulled tightly on his head, remains cheerily oblivious that he has come to represent the collision of two deeply flawed American systems, immigration and health care.

Eight years ago, Mr. Jiménez, 35, an illegal immigrant working as a gardener in Stuart, Fla., suffered devastating injuries in a car crash with a drunken Floridian. A community hospital saved his life, twice, and, after failing to find a rehabilitation center willing to accept an uninsured patient, kept him as a ward for years at a cost of \$1.5 million.

What happened next set the stage for a continuing legal battle with nationwide repercussions: Mr. Jiménez was deported — not by the federal government but by the hospital, Martin Memorial. After winning a state court order that would later be declared invalid, Martin Memorial leased an air ambulance for \$30,000 and “forcibly returned him to his home country,” as one hospital administrator described it.

Since being hoisted in his wheelchair up a steep slope to his remote home, Mr. Jiménez, who sustained a severe traumatic brain injury, has received no medical care or medication — just Alka-Seltzer and prayer, his 72-year-old mother said. Over the last year, his condition has deteriorated with routine violent seizures, each characterized by a fall, protracted convulsions, a loud gurgling, the vomiting of blood and, finally, a collapse into unconsciousness.

“Every time, he loses a little more of himself,” his mother, Petrona Gervacio Gaspar, said in Kanjobal, the Indian dialect that she speaks with an otherworldly squeak.

Mr. Jiménez’s benchmark case exposes a little-known but apparently widespread practice. Many American hospitals are taking it upon themselves to repatriate seriously injured or ill immigrants because they cannot find nursing homes willing to accept them without insurance. Medicaid does not cover long-term care for illegal immigrants, or for newly arrived legal immigrants, creating a quandary for hospitals, which are obligated by federal regulation to arrange post-hospital care for patients who need it.

American immigration authorities play no role in these private repatriations, carried out by [nytimes.com/2008/08/.../03deport.html](http://nytimes.com/2008/08/.../03deport.html)...

ambulance, air ambulance and commercial plane. Most hospitals say that they do not conduct cross-border transfers until patients are medically stable and that they arrange to deliver them into a physician's care in their homeland. But the hospitals are operating in a void, without governmental assistance or oversight, leaving ample room for legal and ethical transgressions on both sides of the border.

Indeed, some advocates for immigrants see these repatriations as a kind of international patient dumping, with ambulances taking patients in the wrong direction, away from first-world hospitals to less-adequate care, if any.

"Repatriation is pretty much a death sentence in some of these cases," said Dr. Steven Larson, an expert on migrant health and an emergency room physician at the Hospital of the University of Pennsylvania. "I've seen patients bundled onto the plane and out of the country, and once that person is out of sight, he's out of mind."

Hospital administrators view these cases as costly, burdensome patient transfers that force them to shoulder responsibility for the dysfunctional immigration and health-care systems. In many cases, they say, the only alternative to repatriations is keeping patients indefinitely in acute-care hospitals.

"What that does for us, it puts a strain on our system, where we're unable to provide adequate care for our own citizens," said Alan B. Kelly, vice president of Scottsdale Healthcare in Arizona. "A full bed is a full bed."

Medical repatriations are happening with varying frequency, and varying degrees of patient consent, from state to state and hospital to hospital. No government agency or advocacy group keeps track of these cases, and it is difficult to quantify them.

A few hospitals and consulates offered statistics that provide snapshots of the phenomenon: some 96 immigrants a year repatriated by St. Joseph's Hospital in Phoenix; 6 to 8 patients a year flown to their homelands from Broward General Medical Center in Fort Lauderdale, Fla.; 10 returned to Honduras from Chicago hospitals since early 2007; some 87 medical cases involving Mexican immigrants — and 265 involving people injured crossing the border — handled by the Mexican consulate in San Diego last year, most but not all of which ended in repatriation.

Over all, there is enough traffic to sustain at least one repatriation company, founded six years ago to service this niche — MexCare, based in California but operating nationwide with a "network of 28 hospitals and treatment centers" in Latin America. It bills itself as "an alternative choice for the care of the unfunded Latin American nationals," promising "significant saving to U.S. hospitals" seeking "to alleviate the financial burden of unpaid services."

Many hospitals engage in repatriations of seriously injured and ill immigrants only as a last resort. "We've done flights to Lithuania, Poland, Honduras, Guatemala and Mexico," said Cara Pacione, director of social work at Mount Sinai Hospital in Chicago. "But out of about a dozen

cases a year, we probably fly only a couple back.”

Other hospitals are more aggressive, routinely sending uninsured immigrants, both legal and illegal, back to their homelands. One Tucson hospital even tried to fly an American citizen, a sick baby whose parents were illegal immigrants, to Mexico last year; the police, summoned by a lawyer to the airport, blocked the flight. “It was horrendous,” the mother said.

Sister Margaret McBride, vice president for mission services at St. Joseph’s in Phoenix, which is part of Catholic Healthcare West, said families were rarely happy about the hospital’s decision to repatriate their relatives. But, she added, “We don’t require consent from the family.”

In a case this spring that outraged Phoenix’s Hispanic community, St. Joseph’s planned to send a comatose, uninsured legal immigrant back to Honduras, until community leaders got lawyers involved. While they were negotiating with the hospital, the patient, Sonia del Cid Iscoa, 34, who has been in the United States for half her life and has seven American-born children, came out of her coma. She is now back in her Phoenix home.

“I can think of three different scenarios that would have led to a fatal outcome if they had moved her,” John M. Curtin, her lawyer, said. “The good outcome today is due to the treatment that the hospital provided — reluctantly, and, sadly enough, only in response to legal and public pressure.”

Unlike Ms. Iscoa and Mr. Jiménez, most uninsured immigrant patients in repatriation cases do not have advocates fighting for them, and they are quietly returned to their home countries. Sometimes, their families accept that fate because they are told they have no options; sometimes they are grateful to the hospital for paying their fare home, given that other hospitals leave it to relatives or consulates to assume responsibility for the patients.

Mr. Jiménez’s case is apparently the first to test the legality of cross-border patient transfers that are undertaken without the consent of the patients or their guardians — and the liability of the hospitals who undertake them.

“We’re the rhesus monkey on this issue,” said Scott Samples, a spokesman for Martin Memorial.

### A Life-Changing Accident

Mr. Jiménez’s journey north was propelled by the usual migrant’s dreams. When he pledged thousands of dollars to pay the smuggler who delivered him to the United States, he envisioned years of labor on the lawns of affluent America and then a payoff: the means to buy land of his own, to cultivate his own garden, back in Guatemala.

But fate — in the person of Donald Flewellen, a pipe welder with a drug problem and a long criminal record — intervened. At lunchtime on Feb. 28, 2000, Mr. Flewellen was loitering in the parking lot of a Publix supermarket in Palm Beach Gardens, Fla., when the employees of an irrigation company ran inside, leaving the keys in their van. Seizing the moment, Mr. Flewellen,

a thorn in the side of local prosecutors with at least 14 arrests, jumped into the van and drove off.

In the next few hours, Mr. Flewellen consumed enough alcohol to produce a blood-alcohol level four times higher than the legal limit. But drive he did, along the back roads that connect the affluent Treasure Coast to the agricultural interior where Guatemalan Mayan immigrants have settled in a place, coincidentally, called Indiantown.

About 4 p.m., Mr. Flewellen was heading east on a rural road just as Mr. Jiménez and three compatriots were returning home from a day of landscaping. His stolen van and their 1988 Chevrolet Beretta crashed head-on, instantly killing two of the Guatemalans and severely injuring the driver and Mr. Jiménez, a back-seat passenger.

Identified first as John Doe, Mr. Jiménez arrived by ambulance at Martin Memorial, a not-for-profit hospital on the banks of the St. Lucie River in Stuart. He was unconscious and in shock from extensive bleeding, with two broken thigh bones, a broken arm, multiple internal injuries, a terribly lacerated face and a severe head injury. A doctor noted his prognosis as “poor.”

But Mr. Jiménez, after intensive surgical and medical intervention, survived. “He was no longer Luis; he was another person,” Montejo Gaspar Montejo, his cousin by marriage, said, describing a previously husky and industrious laborer who was also a soccer enthusiast. “He didn’t talk. He didn’t understand anything. He stayed curled up in a ball. But he was alive.”

During that time, Martin Memorial asked Michael R. Banks, a local lawyer who specializes in estate planning, to set up a guardianship for Mr. Jiménez. “I said, ‘Sure, what can come of such a case?’ ” Mr. Banks said. “Then it took on a life of its own. They probably regret they ever called me.”

Mr. Jiménez, whose common-law wife and two children remained in Guatemala, had been living for just under a year with Mr. Gaspar’s family. Mr. Gaspar, who works in golf-course maintenance, agreed to serve as guardian.

At first, things were amicable. In the summer of 2000, Mr. Jiménez was transferred to a nursing home in Stuart, which may have accepted him because an insurance payout was possible.

Mr. Flewellen, who eventually pleaded guilty to D.U.I. manslaughter, D.U.I. injury and grand theft auto, was not insured. But the Guatemalan families sought to hold the irrigation company liable since its employees left the keys in the car. Their lawsuit ultimately failed.

In the nursing home, Mr. Jiménez began wasting away. His relatives grew anxious. Then, Robert L. Lord Jr., Martin Memorial’s vice president of legal services, said, “Mr. Jiménez was put back on our doorstep.”

He arrived by ambulance, this time emaciated and suffering from ulcerous bed sores so deep that the tendons behind his knees were exposed. With infection raging, “the question to be



answered is if the patient's condition is terminal," a doctor wrote in his file.

Again, Martin Memorial's doctors provided life-saving care. Hospitals are mandated to treat and stabilize anyone suffering from an emergency medical condition, and the federal government does provide emergency Medicaid coverage for illegal and new immigrants.

But hospitals say that emergency Medicaid covers only a small fraction of those expenses: \$80,000 in Mr. Jiménez's case, according to court papers.

Mr. Jiménez remained in a vegetative state, coiled in a fetal position, for "one year, two months and 15 days," Mr. Gaspar said with precision.

Stunning his relatives and medical officials, though, Mr. Jiménez gradually woke up and started interacting with the world. "One day," Mr. Gaspar said in Spanish, "we arrived for a visit, and he said to me, 'You are Montejo.' "

Not long afterward, the battle began between Martin Memorial and Mr. Gaspar, a reserved man whose Indiantown living room is decorated with a "We Love America" clock, a beach towel from the ancient city of Tikal and a hammered metal image of the Virgin Mary.

### A Hospital's Dilemma

The average stay at Martin Memorial, a relatively tranquil hospital which features a palm frond design in its gleaming lobby floor and white-coiffed volunteers in its gift shop, is 4.1 days and costs \$8,188. Patients rarely linger.

Those like Mr. Jiménez who outstay their welcome are an oddity but not an anomaly. Mr. Jiménez had a roommate from Jamaica, a diabetic who lost both legs. Martin Memorial eventually flew him back to his native country, too.

In addition to trauma patients, there are uninsured immigrants with serious health problems. "In our emergency room, we don't turn anyone away," said Carol Plato Nicosia, the director of corporate business services. "The real problem is if we find an underlying problem, and now we have six of them — six patients who showed up in renal failure and that we are now seeing three times a week for dialysis."

One of the six, she said, voluntarily returned to Guatemala after receiving a poor prognosis. But she showed up at Martin Memorial again after her relatives insisted that she undertake the trek over the borders a second time because she could not get treatment in Guatemala, Ms. Plato Nicosia said.

"I don't want to sound heartless," Ms. Plato Nicosia said. "A community hospital is going to give care. But is it the right thing? We have a lot of American citizens who need our help. We only make about 3 percent over our bottom line if we're lucky. We need to make capital improvements and do things for our community."

Martin Memorial reported a total margin of 3.6 percent over its bottom line last year and 6

percent in 2006. According to the most recent statewide data, the nonprofit medical center also reported assets of \$270.6 million in 2006, with its senior executives earning more than \$4 million in salaries and benefits.

Tax-exempt hospitals are expected to dedicate an unspecified part of their services to charity cases, and Martin Memorial devoted \$23.9 million in 2006, about 3 percent, which was average for Florida, according to state data.

Mr. Jiménez was a very expensive charity case. In cases like his, where patients need long-term care, hospitals are not allowed to discharge them to the streets. Federal regulations require them — if they receive Medicare payments, and most hospitals do — to transfer or refer patients to “appropriate” post-hospital care.

But in most states, the government does not finance post-hospital care for illegal immigrants, for temporary legal immigrants or for legal residents with less than five years in the United States. (California and New York City are notable exceptions; Medi-Cal, the state’s Medicaid program, spends \$20 million a year on long-term care for illegal immigrants, as does the Health and Hospitals Corporation of New York City.)

Martin Memorial’s lawyer, Mr. Lord, said hospitals should not be forced to assume financial and legal responsibility for these cases. “It should be a governmental burden,” he said, “or the government should step in and otherwise exercise its authority for deportation or whatever it wants to do.”

In Mr. Jiménez’s case, the hospital’s doctors determined that appropriate post-hospital care meant traumatic brain injury rehabilitation. Much to the surprise of the hospital staff, Mr. Jiménez had regained cognitive function to about the level of a fourth-grade child.

Hospital discharge planners searched to no avail for a rehabilitation program or nursing home. “Unable to take patient” was the response to many queries, as noted in Mr. Jiménez’s files, which also state: “At this time, patient remains a disposition problem.”

Representing Mr. Jiménez’s guardian, Mr. Banks took the position that the hospital had a responsibility to provide Mr. Jiménez with the rehabilitation he needed — even if it meant paying a rehabilitation center to provide it. That, he noted, could have benefited both the hospital and the patient.

“It would have been more cost-effective for them,” Mr. Banks said, given that daily patient costs in long-term care are far lower than in acute-care hospitals. “And if the rehab worked, then Luis might have become a functional person and nobody’s charge.”

But the hospital declined, as Mr. Lord put it, “to take out our checkbook” and subsidize his care at another institution.

“Once you take that step, for how long are you going to do that — a year, 10 years, 50 years?” Mr. Lord, the lawyer, asked.

At that point, the hospital intensified its efforts to involve the Guatemalan government in the case. In a memorandum obtained by The New York Times, a consular official wrote that the hospital “informed us of how expensive it was becoming to care for Luis given that there was no insurance and that he is illegal and that the state won’t assume responsibility for his charges.”

Eventually, the Guatemalan health minister wrote a letter assuring Martin Memorial that his country was prepared to care for Mr. Jiménez. Gabriel Orellana, who was foreign minister at the time but did not have direct knowledge of the case, said the Guatemalan government was disposed to assist an American institution. “If a hospital in Florida asks if we can take care of a Guatemalan patient, the tendency is to say yes,” Mr. Orellana said.

Mr. Gaspar was dubious, believing the public health care system in his homeland to be grossly inadequate.

So the guardian and the hospital reached an impasse, and Martin Memorial finally took the matter to court, asking a state judge to compel Mr. Gaspar to cooperate with its repatriation plan. In June 2003, a hearing was held before Circuit Judge John E. Fennelly.

### The Journey Home

In the courthouse in Stuart, a low-key, upscale town that boasts world-class fishing, George F. Bovie III, a lawyer for Martin Memorial, addressed the judge: “This case is not simply a case, as some would try and paint it, of money. This is a case about care for a man in this country illegally who has reached maximum medical improvement at our hospital and is ready to be discharged and whose home government” is prepared to receive and treat him.

Mr. Banks responded: “Your honor, this is a case about a hospital that has failed to do its job properly,” adding that the hospital sought to “have this court legitimize its patient dumping.”

By the time of the hearing, Mr. Jiménez was essentially a boarder at the hospital, wheeling around the hallways and hanging out at the nursing stations. Diana Gregory, a nurse who supervises case management and discharge planning, said in a recent interview that Mr. Jiménez — “I will affectionately call him Louie” — became “like family” to hospital staff members, who bought him birthday cakes, knitted him blankets and gave him toys.

According to hospital records, however, it was not all pastries and presents. Mr. Jiménez grew depressed as he gradually became more cognizant of his situation. He showed signs of regression, too. Emotional and behavioral volatility often follow serious head injuries, and Ms. Gregory said that Mr. Jiménez had developed some disturbing habits, including spitting, yelling out, kicking and defecating on the floor.

In court, his doctor, Walter Gil, testified that Mr. Jiménez would benefit from returning to the intimacy of his family. In his case file, the doctor had noted that Mr. Jiménez had told him, “Estoy triste,” meaning, “I’m sad.”

Dr. Gil said he asked Mr. Jiménez, “Why are you sad when you have basically everything that  
[nytimes.com/2008/08/.../03deport.html...](http://nytimes.com/2008/08/.../03deport.html...)

could be offered to you?" And, he said, Mr. Jiménez replied, "I miss my family and my wife."

Mr. Banks's witnesses challenged what they described as Guatemala's vague offer to care for Mr. Jiménez.

Dr. Miguel Garcés, a prominent Guatemalan physician and public health advocate, said in a deposition that serious rehabilitation "is almost nonexistent" in Guatemala outside private facilities. He predicted that Mr. Jiménez would be taken in and then released from the country's one public rehabilitation hospital within a matter of weeks.

"I don't want him to go home and die," Dr. Garcés said.

"Nobody wants him to go home and die," the hospital's lawyer responded.

A few weeks later, Judge Fennelly ruled. "This Court," he wrote, "sails on uncharted seas." He acknowledged that his decision might provoke dissent but opined, "As Aquinas once stated, 'The good is not the enemy of the perfect,' " inverting and misattributing Voltaire's famous quote, "The perfect is the enemy of the good."

And then he granted the hospital's petition, ordering that Mr. Gaspar stop "frustrating" the hospital's plan to "relocate the ward" back to Guatemala.

Mr. Banks was stunned. He filed a notice of appeal and asked for a stay of the court's order while the appeal was pending. The judge asked the hospital to file a response by 10 a.m. on July 10 before he ruled on the stay.

Four and a half hours before that response was due, shortly before daybreak on July 10, 2003, an ambulance picked up Mr. Jiménez at the hospital and drove him to the St. Lucie County airport, where an air ambulance waited to transport him back to Guatemala. Mr. Gaspar was not apprised.

"We went to see him at the hospital, and his bed was empty," he said.

The hospital's lawyer declined to comment on why the hospital did not wait for the judge to rule on the stay.

Diana Gregory, the nurse, traveled to Guatemala with Mr. Jiménez, bringing a wheelchair, a week's worth of medications, "lunch/snacks/juices/treats," and an emergency passport signed with a fingerprint, according to discharge records. Mr. Jiménez wore a Florida Marlins cap and carried a toy cellphone.

During the flight, the records said, Mr. Jiménez dozed, paged through picture books, pushed the window shade up and down and pointed outside, saying, "Look, look!" When he arrived in Guatemala, an ambulance took him to the National Hospital for Orthopedics and Rehabilitation, which occupies the converted stables of an old villa in the historic center of the capital city.

Ms. Gregory accompanied him there, turned over his records and toured the hospital. In a

recent interview, Ms. Gregory said she was impressed by the place and especially by the staff's pride in it, despite equipment that looked "like it could have been donated to the Smithsonian." She added, "That facility could have taken care of me any day."

While Ms. Gregory was taking her tour, Mr. Jiménez was holding court, according to her notes in his file, "telling everyone that he was from Miami, Florida, and showing them his toy cat." At her request, a physician told Mr. Jiménez in Spanish "that he would be staying with his new friends in Guatemala and that I was leaving." His response, according to her notes: "O.K., O.K., adiós."

Glad that she had helped reunite Mr. Jiménez with his homeland, she said, "I left Guatemala quiet in my heart."

### Care in Guatemala

Immaculately clean but dilapidated, Guatemala's National Hospital for Orthopedics and Rehabilitation operates on a shoestring budget of approximately \$400,000 a year, according to Dr. Harold Von Ahn, who was director when Mr. Jiménez arrived.

Half the hospital is devoted to orthopedic care and the other half serves as an "asylum" for profoundly disabled Guatemalans. Although it is the only public rehabilitation hospital in the country, it dedicates just 32 beds to rehabilitation and does not offer the specialized brain injury treatment that Mr. Jiménez needed.

The Guatemalan foreign ministry said that it knew of 53 repatriations by American hospitals in the last five years. During a visit by The Times to the National Hospital in June, the most recent arrival was an 18-year-old, Diana Paola Miguel, transported there by the University Medical Center in Tucson nine days after a van accident crushed her pelvis, which the Arizona hospital repaired. Supine on a gurney, she Ms. Paola was too tremblingly upset to talk.

Dr. Von Ahn said he believed that American hospitals were dumping patients that should be their responsibility. "It's the same as the classic fall on the stairs, right?" he said. "You go to my home, you fall on my stairs and then you sue me. I am responsible."

Shortly after Mr. Jiménez arrived, the Guatemalan hospital contacted his common-law wife, Fabiana Domingo Laureano, who lived in the city of Antigua with their two young sons, and asked her to come get him. Ms. Domingo, who was 27 at the time, was shocked to learn that her husband was back and terrified by the request. Then as now, she was eking out a living, selling traditional woven clothing in a marketplace while sharing a spare, concrete room with her sons in her parents' humble home.

"I was already living from hand to mouth," she said in an interview in Antigua, where her sons now supplement her income by selling cigarettes after school. "How could I possibly have given him what he needs?"

The couple met as teenagers in the highland village of Soloma. In the mid-1990s, Mr. Jiménez

migrated with his wife's family to Antigua, a volcano-ringed colonial city where tourism sustains the local economy. While she sold clothing, Mr. Jiménez worked as a bus driver's assistant. Together, they earned about \$6 a day, which was not enough to support their family, so Mr. Jiménez, with his wife's brother, Francisco Gaspar, decided to follow a well-traveled path to the north. That is when he changed his name from Gervacio Gaspar to Luis Jiménez, which is how he is now known, even by his family.

After pledging to pay a coyote, or smuggler, about \$2,000 each to ferry them into the United States, they crossed into California under cover of darkness and made their way to Encinitas, where Mr. Jiménez's older brother lived, Mr. Gaspar said.

After the two men failed to find regular work, Mr. Gaspar began suffering panic attacks and returned to Guatemala; Mr. Jiménez decided to try his luck in Florida.

"Lamentably," Mr. Gaspar said, "luck eluded him."

After the hospital contacted Ms. Domingo, Telemundo, the Spanish-language network, called Ms. Domingo and offered to take her to Guatemala City. Shortly thereafter, the network showed her reunion with her husband.

"You are Maria by chance?" Mr. Jiménez said to his wife as the television cameras rolled.

"Fabiana," she replied. Their two sons stood by her side, wide-eyed.

A few weeks later, Dr. Von Ahn said, the hospital discharged Mr. Jiménez "because we needed the bed," transferring him to another public hospital, San Juan de Dios. That is where Mr. Jiménez's brother, Enrique Lucas Gervacio, found him when he made his way down from the mountains by bus.

"He was lying in the hallway on a stretcher, covered in his own excrement," Mr. Lucas said. "So we cleaned him up and we brought him home."

In Favor of Jiménez

In May, 2004, a Florida appeals court overruled Judge Fennelly.

The Fourth District Court of Appeal found that the Florida state judge had overstepped his bounds because deportation is the prerogative of the federal government. The court also declared that no evidence supported the hospital's assertion that Mr. Jiménez would receive appropriate care in Guatemala; the discharge plan, the ruling said, was not detailed enough to satisfy federal requirements or the hospital's own rules.

The appeals court voided the judge's order although, given that Mr. Jiménez was already back in Guatemala, that action came too late for him.

It might affect others, though. The decision has become what is known legally as a case of first impression on the issue of hospital repatriations.

John DeLeon, a lawyer who advises the consulates of Mexico, Honduras and Guatemala in Miami, said he now referred to it when he received calls from hospitals looking to discharge seriously injured or ill immigrants.

“I now write I call my Montejo Gaspar letter,” he said. “It’s a letter that says, ‘Listen, don’t take action to dump this individual because you’ll be risking legal action. The law is now that hospitals can’t dump immigrant patients without securing appropriate after-care. If somebody has a serious illness and needs continuing care, a hospital can’t simply discharge them onto the street, much less put them on a plane.’ ”

Mr. DeLeon said that he was “bombarded by such cases,” adding that he was investigating another medical repatriation by Martin Memorial, which took place two weeks ago “behind the back of the Mexican government.”

Martin Memorial confirmed that on July 16 they flew Neptali Díaz, a severely brain-injured patient to Mexico. A court order authorized Mr. Diaz’s transfer to an unspecified Mexican hospital, ending the man’s 859-day, \$2 million stay at Martin Memorial.

After the ruling in Mr. Jiménez’s favor, Martin Memorial did not appeal. But the case did not go away. The appeals court ruling set the stage for a personal injury lawsuit, taken on by Searcy, Denney, Scarola, Barnhart & Shipley in West Palm Beach.

With that established firm behind him, Mr. Gaspar initiated a false imprisonment action claiming that his cousin was essentially kidnapped by the hospital and smuggled out of the country in a kind of medical rendition. Since then, appeals judges have again ruled in Mr. Jiménez’s favor, stating the hospital can be sued for punitive damages as well as for the cost of his medical care.

This infuriates Ms. Plato Nicosia, the hospital administrator, who said it was Mr. Jiménez’s family who owes the hospital money and not vice versa. “Should they win, we would like them to take those damages and pay his hospital bill,” she said.

Jack Scarola, representing Mr. Jiménez’s guardian, said that he empathized with the hospital’s “significant economic burden” but said that it was the “quid pro quo” of accepting Medicare and Medicaid funds to help finance the hospital’s services. (About 45 percent of Martin Memorial’s net operating revenues came from Medicare and Medicaid last year, based on state data.)

“Also,” he continued, “they chose the wrong way to deal with it. The right way would have been through the Legislature. There is no program in place to appropriately distribute care to undocumented persons who are catastrophically injured, and there should be. But you don’t stick a brain-injured immigrant on a private plane and spirit him out of the country in the predawn hours.”

#### Weighing Quality of Life

The journey to Jolomecú is an arduous one, as Mr. Jiménez’s new legal team discovered when [nytimes.com/2008/08/.../03deport.html...](http://nytimes.com/2008/08/.../03deport.html...)

several members — a lawyer, a paralegal, a priest and a bioethicist — first traveled there to meet him.

After a five-hour drive north from Guatemala City to Huehuetenango and then a winding trip, filled with hairpin turns on cliff-hugging roads up and over the Cuchumatán Mountains, they arrived at the provincial city of Soloma.

From there, the road to Mr. Jiménez's hamlet only goes so far, and the trip must be completed on foot, up and down a rutted dirt path through goat-strewn meadows. The Americans arrived at the top panting. There, awaiting them, in an idyllically situated one-room brick house, was Mr. Jiménez, a broad grin lighting up his face.

"The first striking thing was his disposition: He was very, very happy," said the Rev. Frank O'Loughlin, who pastored migrant workers in South Florida for decades. "Then, the second thing, he was well cared for. What I did was I got down over him and hugged him but also smelled. And there were no bedsores. Nothing was malodorous."

As they drove back to Huehuetenango, Marnie R. Poncy, a nurse-lawyer who runs a bioethics law project in Palm Beach County, offered her view: "I said, 'His quality of life is better than it would be in an American nursing home.'"

"But I hazarded a guess that his longevity of existence was probably severely curtailed," she said.

Still, the team reached a conclusion that surprised them: "There was no real compelling reason to think of bringing him back to Florida," Father O'Loughlin said. "We needed to focus on getting help to him or him to help in Guatemala."

Help has been slow in arriving.

When The Times took the trek to visit him in late June, Mr. Jiménez had not budged from his hilltop home since returning there and no medical professional had visited him, either. With his mother too frail to move him into his wheelchair, his life had shrunken to the confines of his bed, across from his mother's.

During the visit, Mr. Jiménez, wearing a nubby Adidas hat and a ski jacket, sat wrapped in a Guatemalan blanket; his mother, who wore a traditional woven skirt, with a floral scarf braided through her long gray hair, stood by his side. She patted his head; he reached out to pick lint from her sweater.

A few days prior, he had suffered a particularly violent seizure.

"He was almost dead," his mother, Mrs. Gervacio, said in Kanjobal, which was translated into Spanish by a school principal serving as interpreter. "For many years, I am caring for him like he is a baby, changing his diaper, washing him. But this is worse. I am worried to leave him alone at all."



She is right to worry, said physicians consulted for this article. Patients suffering seizure disorders run the risk of injuring themselves — and of increasing their brain damage.

Still, Mrs. Gervacio does leave from time to time, she said, to go to Mass, shutting the door behind her and hoping for the best.

“It scares me a lot when you leave, Mama!” Mr. Jiménez blurted out, revealing that he was intently following the conversation that at first took place as if he were not there.

Given that Mr. Jiménez’s mother’s health is failing, the family worries about the future, too. And Mr. Jiménez shares their concern. “The day my mother is no longer, what’s going to happen to me?” he said. “This is what I have on my mind.”

Mr. Jiménez, whose memory is patchy, said he remembered nothing about his time in the United States — not Indiantown, not his job as a gardener, not the accident and not the hospital.

He does, remember the dreams that propelled his migration, and he expressed them eloquently: “I headed north like a peasant with a heavy bundle on his back, bent over, determined to better himself,” he said. “Other people had things so I thought, ‘Why not me?’ But now I regret it. Maybe God was punishing me for my illusions.”

“No, Luis,” the interpreter interjected, “it was just chance, an accident, a car accident.”

In Guatemala City, Dr. Garcés, the public health advocate, said that he was not surprised that, as he had predicted, Mr. Jiménez never received further medical care. “That’s the usual story of patients that are released from the National Orthopedic Hospital,” he said.

Dr. Garcés called Mr. Jiménez’s repatriation “inhumane.”

“In cases like that, if you cut the medical care, you’re hurting that person,” Dr. Garcés said. “You’re doing just the opposite of what the medical system should do. That goes against every international convention of human rights and health. To send him to Guatemala was to send him to very poor living and health conditions and probably he will die because of that, and that’s not fair.”

Without evaluation, doctors cannot know what potential for rehabilitation — or survival — Mr. Jiménez possesses.

If Mr. Jiménez’s guardian were to prevail in the lawsuit, “it would be possible to set up a good health care arrangement for him because in private practice we have all types of specialties that he needs,” Dr. Garcés said. “And transportation could be arranged.” But the case could drag on for years.

On the day of The Times’s visit, before Mr. Jiménez ate a lunch of eggs, tortillas and sugar water, Mr. Banks, the lawyer, gave him a present from his cousins in Florida — a plastic bag bulging with tube socks, undershirts and oversize sweatpants. Mr. Jiménez fingered the clothing

4/19/2010

Immigrants Facing Deportation by U.S....

with little interest but when a reporter began to read him the accompanying letter in Spanish, he snatched it excitedly from her hands.

Much to the surprise of his visitors, Mr. Jiménez, despite his brain injury, could read. He smoothed out the yellow legal paper from Mr. Gaspar and began: "I am sending you some little things. Luis, I hope that you like them."

At first, Mr. Jiménez read haltingly, then more fluidly. Later, when all his visitors had gone outside, he read the ending aloud again to himself.

"I want to tell you," he read, "that we miss you and love you a lot. May God continue to bless you."

Mr. Jiménez smiled, and repeated, softly, "May God continue to bless you."

*Pilar Conci contributed reporting.*

Copyright 2009 The New York Times Company

[Privacy Policy](#) | [Search](#) | [Corrections](#) | [RSS](#) | [First Look](#) | [Help](#) | [Contact Us](#) | [Work for Us](#) | [Site Map](#)

---

## **APPENDIX D**



## Uninsured Immigrant Patients Sent Home for Care Against Their Will

Woman in Coma the Latest Example of Arizona Uninsured Immigrant Facing Forced Removal to Home Country

By **MARCUS BARAM**

May 22, 2008 —

Hundreds of legal and illegal immigrants in Arizona are being sent back to their home countries, sometimes against their will, for medical treatment because they lack insurance.

In some cases, the FBI and police, responding to allegations of kidnapping, have been called in to halt such forcible removals, according to patients' lawyers. In one recent case, a sick baby who is a U.S. citizen born to an illegal immigrant was being transferred by helicopter to a waiting air ambulance for a flight to a hospital in Mexico when Tucson police intervened and brought the child back to the hospital.

The forcible removals are the result of federal and state law mandating that only U.S. citizens and legal residents are eligible for Medicaid. As a result, state hospitals are pressured to transport noncitizens, even if they're legally in the U.S., at the hospitals' expense, back to their home countries, at a cost of up to \$100,000.

The alarming scenario has come to light in recent weeks with the dramatic case of Sonia Iscoa Del Cid, a house cleaner in the country legally under temporary protected status, who woke up from a coma last week only to realize that she was going to be forced back to her native Honduras because she lacked insurance for long-term care. The case galvanized the immigrant community in Phoenix.

On May 9, hours away from being flown to a small hospital in Honduras, where Del Cid no longer has any family or friends except for an elderly father, her lawyer filed a temporary restraining order preventing the move. Family and friends raised money through car washes, and received significant financial assistance from dozens of trial lawyers in Arizona, to pay the \$20,000 bond ordered by a local judge.

This morning, the story seems to have produced a happy ending. Because of Del Cid's remarkable recovery - [ ] she is talking and has been taken off dialysis - [ ] she likely won't require further treatment, and the hospital will no longer need to transport her.

"We reached an accommodation with the hospital," said attorney John Curtin. "Sonia has improved markedly. It's been a week without dialysis and she's starting to eat softer foods, and she's talking. So the hospital is not contemplating moving her to Honduras."

The hospital declined to discuss Del Cid's particular situation because of medical privacy laws but clarified its policy on transporting uninsured patients.

"About eight times a month, we make arrangements to transfer patients to their country of origin," said Sister Margaret McBride, vice president for mission services at St. Joseph's Hospital and Medical Center in Phoenix. "We've had transfers to Asia and Africa by air ambulance, and we pay for transportation, which starts out at about \$25,000 up to \$100,000."

She said that the hospital is an acute-care facility, and it is obligated to plan for a safe discharge to the next level of care, which may involve months and years of treatment. Most long-term care facilities in the state want a year's payment upfront, which is a hardship for many of the uninsured who are not U.S. citizens..

"It's hard on us to make that decision," Sister McBride said, adding that the hospital would fight for changes in the law. "We don't feel good about this because we're caught in the middle, and we don't have any recourse. ... We've talked to legislative folks and told them that we're stuck in the middle."

Del Cid, who has been in the United States for 17 years and has a valid work visa, fell into a coma after an emergency Caesarean section and hysterectomy April 20. Her newborn daughter, Juliani Milagros Mitchel, who was delivered prematurely, remains stable in the hospital's pediatric intensive care unit.

Soon after the hospital told Del Cid's family that she would be flown to Hospital Escuela in Tegucigalpa, Honduras, family friend Maria Adame called Curtin and his law partner, Joel Robbins, to stop the transfer. A spokesman for Hospital Escuela told the Arizona Republic that its intensive care unit has only four beds and lacks a dialysis unit.

"She doesn't want to go back," Adame said. "Sonia's lived here for half her life, and she has seven kids, all born here in Phoenix. And she works legally - she has her license to clean houses and she worked for a furniture company."

The scenario was not unfamiliar to Fernando Gaxiola, an attorney who said he has prevented three attempted forcible removals of uninsured clients.

"One was a baby born in Arizona and because the parents couldn't pay and they were Mexican, University Medical Center in Tucson tried to fly the child to a hospital in Mexico," he said. "They were waiting to move the child from the helicopter to an air ambulance when the police intervened."

In another case, Gaxiola said one of his clients visiting the country on a tourist visa was transported from Tucson to a small town on the Mexican border.

"I called the FBI and the police," he said. "When the ambulance got to the border, the border patrol agent asked to speak to the passenger in the vehicle, who said he didn't want to be transported. The police responded, and he got back to Tucson."

A spokesman for University Medical Center, Katie Riley, declined to discuss specific cases but explained that the hospital has transported hundreds of patients back to their home countries.

"There are certainly some who are not happy," she said. "In most cases, long-term care [facilities] won't take people if they don't pay. And we have no choice."