PATIENTS WITHOUT BORDERS: EXTRALEGAL DEPORTATION BY HOSPITALS

By Kit Johnson‡

I. INTRODUCTION

II. THE PROBLEM OF LONG-TERM MEDICAL CARE FOR UNDOCUMENTED MIGRANTS
   A. THE NEED FOR MEDICAL CARE
   B. CARE BY THE NUMBERS
   C. REPATRIATION: THE HOSPITAL RESPONSE
   D. THE CASE OF LUIS ALBERTO JIMÉNEZ

III. AN ANALYSIS OF THE LEGALITY OF HOSPITAL REPATRIATIONS
   A. FEDERAL PREEMPTION
      1. REPATRIATION BY STATE AND LOCAL HOSPITALS AS PREEMPTED LAWMAKING
      2. THE PROBLEM OF PRIVATE HOSPITALS
   B. THE FOURTEENTH AMENDMENT
      1. HOSPITALS AS STATE ACTORS
      2. DUE PROCESS
         A. SUBSTANTIVE DUE PROCESS
            I. REPATRIATION IMPLICATES THE CONSTITUTIONAL RIGHT TO LIFE “LIFE” AS A FUNDAMENTAL INTEREST
            II. REPATRIATION IMPLICATES FUNDAMENTAL LIBERTY INTERESTS
            III. REPATRIATION DOES NOT WITHSTAND STRICT SCRUTINY
         B. PROCEDURAL DUE PROCESS
            I. EMTALA ESTABLISHES A PROPERTY INTEREST IN MEDICAL CARE
            II. REPATRIATION PROCEDURES DO NOT SATISFY DUE PROCESS
               (A). THE PROCESS IN DEPORTATION PROCEEDINGS
               (B). A LESSER FORM OF PROCESS
            3. EQUAL PROTECTION
   C. FALSE IMPRISONMENT
   D. KIDNAPPING
   E. RICO
   F. EMTALA

‡ Visiting Assistant Professor at the University of North Dakota School of Law, J.D. 2000, University of California at Berkeley, Boalt Hall School of Law. I am very grateful to Eric E. Johnson for his helpful comments regarding this paper, Jan Stone for her assistance, Amy Oster and Kiara Kraus-Parr for their insights, and, finally, Tamara Adams and Cassie Olson, without whose help I would never have completed this project. © 2009 Kit Johnson.

DRAFT – PUBLICATION FORTHCOMING, UNIVERSITY OF CINCINNATI LAW REVIEW, VOLUME 78, ISSUE 2
IV. A NEW PROPOSAL
   A. THE NEED FOR A UNIFORM PUBLIC SOLUTION
   B. FEDERAL REPATRIATION
      1. STEP ONE: HOSPITAL REPORTING
      2. STEP TWO: REMOVAL

V. CONCLUSION
I. INTRODUCTION

Put yourself in the place of an undocumented migrant who is driving home with co-workers after a long day of gardening and landscaping. A drunk driver hits your vehicle, killing two of your friends and leaving you severely injured. You are rushed to the hospital where doctors labor to save your life. You live, but you have severe brain damage that will require long-term rehabilitation. You have no insurance, nor savings to pay the astronomical hospital bills. Unable to find a long-term care facility to take you, and prohibited by federal law from discharging you to the street, the hospital seize upon your immigration status as a way to get rid of you. In the early hours of the morning, they drive you to a private airfield, load you into a chartered plane, and have you transported to the door of a dilapidated third-world hospital that can do little more than warehouse you. As you were rushed out of America, you never saw a single immigration official. In fact, none were notified.

Now imagine you are the head administrator of the not-for-profit hospital that provided the life-saving emergency care to the accident victim. You receive no money from the government for the long-term care of undocumented migrant patients. You will have to absorb your losses with no prospect of reimbursement. Allowing the patient to stay indefinitely will involve a loss of millions of dollars and take away a bed from other patients seeking care. Paying for long-term rehabilitation in another facility would free up the bed, but little if any of the funds. And it would set a dangerous precedent. So you call the consulate of the patient’s home country and talk to doctors there to develop a new plan of care. For the price of medical transport, your hospital will be able to stop
hemorrhaging cash, and the patient, no longer able to work in the United States, will be back with his family.

This scenario is not hypothetical. It is the story of Luis Alberto Jiménez, a Guatemalan migrant, and Martin Memorial Medical Center, a hospital near Port St. Lucie, Florida. Moreover, the saga highlights a very real and very significant problem facing U.S. hospitals. Federal law requires hospitals to treat patients in need of emergency medical care regardless of whether or not they are lawfully present in the United States. And hospitals are prohibited from discharging those patients unless and until there is an assurance that their continuing medical needs will be met by another facility. Yet federal law does not dictate what can and should be done with undocumented migrants after their need for emergency care has passed but their need for ongoing medical care lingers. Nor is there federal funding for long-term care for undocumented migrants, unlike the Medicaid system’s reimbursements for citizens.

Several hospitals have made the decision to repatriate undocumented patients needing long-term medical care at the hospitals’ expense. That is, the hospitals hire transport to return these medically needy individuals to the care and custody of their native countries. Yet there is no legal authority for hospitals to enforce federal immigration law in this way. The fact that hospitals have not yet been subject to widespread litigation arising from their repatriation efforts in no way indicates that their conduct is above reproach. To the contrary, this paper addresses a range of potential legal challenges to private repatriation, including constitutional and non-constitutional claims.
There is no question that hospitals face significant problems in treating undocumented migrants with long-term medical needs. The answer, however, cannot be private action that is nothing more than institutionalized vigilantism. There must be a public solution. I propose a new administrative process whereby hospitals can call upon the Department of Homeland Security to initiate the expedited removal and transfer of medically needy undocumented migrants.

The importance of process cannot be overemphasized. As Justice Bleckley of the Supreme Court of Georgia stated more than 140 years ago, “Matter without form is chaos; power without form is anarchy. The state, were it to disregard forms, would not be a government, but a mob. Its action would not be administration but violence.” Only when repatriation follows a new process, one that satisfies the stringent requirements of our Constitution, will it properly be considered administration and not mob violence.

II. THE PROBLEM OF LONG-TERM MEDICAL CARE FOR UNDOCUMENTED MIGRANTS

A. The Need For Medical Care

Undocumented migrants include those non-citizens who have entered the United States surreptitiously as well as those non-citizens admitted to the country with valid documents that have since expired. The exact number of undocumented migrants presently in the United States is unknown but was estimated to be approximately 11.3 million as of March 2007.

---

2 Such migrants are often referred to as “illegal aliens.”
4 Steven A. Camarota, Immigrants in the United States, 2007: A Profile of America’s Foreign-Born Population, Backgrounder, Center for Immigration Studies (Nov. 2007),
Any number of events can lead undocumented migrants to seek medical care at U.S. hospitals. Some migrants are injured in their attempts to enter the United States without inspection. Dr. Raul Coimbra, Chief of the Division of Trauma / Surgical Critical Care / Burns at the University of California San Diego Trauma Center, counted 200 people arriving at his emergency room between 2000 and 2006 seeking care after falling from the fence that demarks the border between Mexico and the United States. He has seen those figures rise (along with the height of the border fence) and is now treating about two migrants a week for fall-related injuries. These patients “require complex orthopedic reconstructive procedures” and hospital stays from a week to two weeks.

Undocumented migrants are also injured in workplace accidents, automobile accidents, and other mishaps. In addition, they also fall victim to the same debilitating illnesses suffered by the general U.S. population, including stroke and kidney failure.


6 Id.

7 Id.

8 See, e.g., Design Kitchen & Baths v. Lagos, 882 A.2d 817 (Md. 2005) (addressing workers-compensation claims made by Diego E. Lagos, an undocumented migrant who suffered a hand injury while operating a saw during his employment with Design Kitchen & Bath. The injury required immediate medical attention, including multiple surgeries.).


10 See, e.g., Deborah Sontag, Deported in Coma, Saved Back in U.S., N.Y. TIMES, Nov. 9, 2008, at A1 (hereinafter “Sontag II”) (reporting story of Kong Fong Yu, an undocumented migrant from China who suffered a stroke in May 2007, and whose long-term care has been the subject of debate at New York Downtown Hospital).
While such patients may arrive at U.S. hospitals seeking immediate treatment on an emergency basis, they often require long-term medical care following their initial hospital stays.  

**B. Care by the Numbers**  

The Emergency Medical Treatment and Active Labor Act (“EMTALA”) is a federal law that requires all hospitals participating in the federal Medicare program\(^\text{13}\) to treat patients in need of emergency medical care regardless of whether they are lawfully present in the United States.\(^\text{14}\) Specifically, EMTALA requires hospitals to assess whether “any individual” seeking emergency care has an emergency medical condition\(^\text{15}\) and further requires that patients with emergency medical conditions be stabilized before transfer or discharge.\(^\text{16}\) The interpretation of the term “any individual” to include

---

\(^{11}\) See Alan Zarembo and Anna Gorman, *Dialysis dilemma: Who gets free care? In California, officials say not treating illegal migrants has high cost*, L.A. TIMES, Oct. 29, 2008 (reporting story of Marguerita Toribio, an undocumented migrant from Mexico who has received life-saving dialysis treatment at a U.S. hospital roughly 2,000 times over the last 17 years); *Ibid.* (undocumented migrants account for about 1,350 of the 61,000 people on dialysis in California and 52 of the 1,912 kidney transplants conducted in California during 2007); Sontag I, *supra* note 9 (reporting that six patients who arrived at Martin Memorial Hospital in Florida with renal failure are now being treated with ongoing dialysis).

\(^{12}\) See Zarembo and Gorman, *supra* note 11 (“[D]ialysis stands out because it is often a lifetime commitment. The investment in a single patient over time can easily top $1 million.”)

\(^{13}\) “[A]s a practical matter … since all hospitals must accept federal and state sponsored health insurance programs to sustain financial viability … EMTALA becomes a requirement for all hospitals with an emergency department[.]” Svetlana Lebedinski, *EMTALA: Treatment Of Undocumented Aliens And The Financial Burden It Places On Hospitals*, 7 J.L SOC’y 146, 161 (2005).

\(^{14}\) 42 U.S.C. § 1395dd(a) (emergency medical treatment must be provided to “any individual”).

\(^{15}\) *Ibid.*

undocumented migrants is compelled by the provisions of EMTALA that provide Medicaid coverage for emergency treatment of undocumented migrants.\(^\text{17}\)

Complementing EMTALA, Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 at one time provided “Federal reimbursement of emergency health services furnished to undocumented aliens.”\(^\text{18}\)

However, that statutory provision expired in October 2008.\(^\text{19}\)

Even before Section 1011 funding dried up, hospitals argued that the monies were wholly inadequate for the treatment of undocumented migrants.\(^\text{20}\) For example, the average cost – not the charge – for treating a patient at the University of California San Diego Trauma Center for falls off of the border fence is $18,000.\(^\text{21}\) Yet the hospital receives an average of $4,000 in reimbursement from the federal government – less than 25 percent of what it spends.\(^\text{22}\)

While the federal government provides inadequate reimbursement for emergency care of undocumented migrants, it provides no reimbursement at all for the long-term medical care of undocumented migrants.\(^\text{23}\) Yet federal regulations prevent hospitals from discharging undocumented migrants after their emergency conditions, required to be

\(^{17}\) 42 U.S.C. § 1396b(v) (“Medical assistance to aliens not lawfully admitted for permanent residence”).


\(^{21}\) Id.

\(^{22}\) Id.

\(^{23}\) 42 U.S.C. § 1320b-7(a)(1), (d), (f).
treated under EMTALA, are stabilized. Federal regulations obligate hospitals to “transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.”24 The phrase “appropriate facilities” has been held to mean “facilities that can meet the patient’s medical needs on a post-discharge basis.”25 In addition to federal regulations, hospitals may also have their own discharge policies and procedures that require identification of appropriate post-hospital care.26

Some states and local governments have stepped in to finance long-term care for undocumented migrants. California provides Medi-Cal coverage for undocumented migrants and spends millions each year on their long-term medical care.27 The Health and Hospitals Corporation of New York City also provides long-term medical coverage for medically needy undocumented migrants.28 Other cities and states provide coverage for certain long-term treatments, such as dialysis.29

24 42 C.F.R. § 482.43(d).
26 See Montejo v. Martin Memorial Med. Ctr., Inc., 874 So.2d 654, 657 ( Fla. Dist. Ct. App. 2004) ("Montejo I") (noting a hospital’s requirement that “the discharge plan identify the next appropriate level of care required by the patient, identify by name and address the receiving facility, provide the name of the supervising medical doctor who will take responsibility for the patient's care at the receiving facility, and confirm that the doctor will provide the patient with the identified appropriate level of care”).
27 See Sontag I, supra note 9 (reporting expenditures of $20 million a year by California for the long-term care of undocumented migrants); see also Zarembo and Gorman, supra note 11 (reporting California paid some $51 million for the dialysis treatment of 1,350 undocumented migrants in the year 2007).
28 See Sontag I, supra note 9.
29 See Zarembo and Gorman, supra note 11 (noting that in Houston “the public hospital district uses local taxes to pay for routine dialysis even though the state Medicaid program does not.”)
Supplemental state and local coverage is the exception and not the rule. Most hospitals must eat the cost of treating undocumented migrants with long-term medical needs.

C. Repatriation: The Hospital Response

Facing potentially unlimited expenses in the care of undocumented migrants, hospitals have begun a private campaign of repatriating the medically needy. Hospitals are, at their own expense, returning these individuals to the care and custody of their homelands. For the cost of transportation, which can run hundreds of dollars for a commercial bus or plane ticket to tens of thousands of dollars for a private air ambulance, hospitals have found that privately repatriating migrants allows them to avoid unlimited expenses in long-term care, which can run in the millions of dollars.30

There are only spotty statistics as to how many undocumented migrants are returned to their home countries by hospitals each year. The figures that have been disclosed show that a significant number of private repatriations have taken place.

• St. Joseph’s Hospital in Phoenix, Arizona has repatriated some 96 immigrants a year.31
• The Broward General Medical Center in Fort Lauderdale, Florida has returned some six to eight patients a year to their native countries.32
• Dr. Karla Vital, a kidney specialist at University of Texas Medical Branch in Galveston, said her hospital simply encourages Mexican

---

30 Sontag I, supra note 9 (describing a hospital’s purchase of a $30,000 flight on an air ambulance for a patient who had cost the hospital over a million dollars).
31 Sontag I, supra note 9; Sontag II, supra note 10.
32 Sontag I, supra note 9.
nationals to return to Mexico while other hospitals pay for plane tickets back.\textsuperscript{33}

- The Guatemalan foreign ministry has said that some 53 of its citizens have been returned to the country by U.S. hospitals in the last five years.\textsuperscript{34}
- Ten patients have been returned to Honduras from Chicago hospitals since early 2007.\textsuperscript{35}
- In 2007, the Mexican consulate in San Diego handled 87 medical cases – as well as 265 border-crossing injuries – many of which ended in repatriation.\textsuperscript{36}

In many cases, physical return of the patients has been outsourced to medical transport companies. One, MexCare, markets itself as “An Alternative Choice for the Care of the Unfunded Latin American National,” whose “transfer protocols result in significant savings to U.S. hospitals.”\textsuperscript{37} The company spins its role in private repatriations as providing “patients with a choice of location for care delivery, an opportunity to reunite families and guarantee quality of care in a cost-effective manner.”\textsuperscript{38} It emphasizes that “all . . . transfers have been done with a signed consent of the patient or their Legal Guardian and with extensive communication with their family.”\textsuperscript{39}

\textsuperscript{33} Zarembo and Gorman, supra note 11.
\textsuperscript{34} Sontag I, supra note 9.
\textsuperscript{35} Id.
\textsuperscript{36} Id.
\textsuperscript{39} MexCare.com, Transfer Agreement, http://mexcare.com/transfer.html (last visited Feb. 6, 2009).
MexCare not only provides an outsourced method for transporting undocumented-migrant patients, it provides an outsourced method for justifying the transfer. MexCare touts that it has

chosen to use private hospitals where we control the quality of care being provided, as well as the length of stay. The quality of care is validated by our Medical Director and our Case Managers who round on our patients throughout their stay.

Prior to the patient being admitted, the physician from the discharging facility, our Medical Director and the physician at the admitting facility will review the case and determine the care to be provided, as well as the approximate length of stay. This is done to ensure the patient receives the necessary care for the appropriate time.40

MexCare’s quality assurances aside, there is simply no information about how hospitals make the determination that a patient is an undocumented migrant whom it would be appropriate to return to their home country, how or whether the patient’s consent to transfer is obtained, how or if hospitals make the decision that a patient is medically stable for return to their home country, nor how or whether any determination is being made about the adequacy of the health care that will be provided to these patients upon return to their home countries or even if health care will be provided at all.41

Patient consent is, at best, a gray area. Hospital administrators have a strong incentive pressure patients and family to accept repatriation in order to keep hospital

41 MexCare provides only cursory answers to these questions with statements such as “Your discharge will be determined by your condition, the doctor and the services you require.” See Mexcare.com, FAQs, http://mexcare.com/faq.html (last visited Feb. 20, 2009).
costs down. At the same time, patients may be entitled to stay in the United States on claims grounded in, among other things, asylum, temporary protected status, or the Violence Against Women Act. Hospitals administrators are unlikely to be immigration experts, able to gauge whether a given patient might be entitled to stay in the United States, nor would they seem to have any motivation to inform patients of their potential rights. As a result, patient “consent” may simply stem from hospital administrators telling patients that they have no rights and that their best and only alternative is repatriation.

The questions raised about repatriation cannot presently be answered because the practice is taking place without any oversight. Despite the fact that the Secretary of Homeland Security alone is charged with the investigation and removal of

---

42 See, e.g., Sontag II, supra note 10 (quoting one hospital administrator as saying “We’re trying to be good stewards of the resources we have.”).
44 See 8 U.S.C. § 1254a. Temporary Protected Status may be granted to certain individuals who are temporarily unable to safely return to their home country because of ongoing armed conflict, an environmental disaster, or other extraordinary and temporary conditions. See U.S. Citizenship and Immigration Services, Temporary Protected Status http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=609d3591ec04d010VgnVCM1000048f3d6a1RCRD&vgnextchannel=609d3591ec04d010VgnVCM1000048f3d6a1RCRD (last visited Feb. 20, 2009).
45 See 8 U.S.C. § 1229b(b)(2). Congress has created special exemptions to deportation for individuals who have been battered by spouses or parents who are U.S. citizens or lawful permanent residents.
46 Sontag II, supra note 10 (reporting the story of one undocumented mother who was informed by a hospital that neither she nor her U.S. citizen child had any rights and that they would repatriate her medically needy infant “with or without” her).
47 In 1996, the Immigration and Nationality Act was restructured so that “removal” proceedings (a new term) would encompass what was formerly termed “deportation” (removing non-citizens from the United States) and “exclusion” (rejecting the applications of non-citizens seeking entry into the United States). See 8 U.S.C. § 1229a. Despite the shift in statutory language, most continue to use the terms deportation and removal interchangeably. In keeping with that convention, this article uses both terms.
undocumented migrants within the United States, there has been no federal involvement in hospital repatriations. A spokesperson for Immigration and Customs Enforcement has stated that the agency does not assume responsibility for the health care of illegal immigrants unless they are in federal immigration detention and that the agency does not get involved in hospital repatriations.

While the federal government has not stepped in to address the problem of hospital repatriations, the issue is garnering attention from the American Medical Association (“AMA”). In November 2008, the AMA voted to undertake a study regarding repatriation. The AMA has not, however, taken any stand on the issue, pending examination of the “legal, financial and medical issues involved.”

D. The Case of Luis Alberto Jiménez

The hypothetical at the beginning of this paper is based on the story of Luis Alberto Jiménez, who sparked the only judicial opinion in the United States on the legality of repatriation. Mr. Jiménez came to the United States from Guatemala. He entered the country without inspection or documentation to settle in Florida and work as a

48 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[]”); 8 U.S.C. § 1103(a)(5) (“He shall have the power and the duty to control and guard the boundaries and borders of the United States against illegal entry of aliens[]”).
49 Sontag II, supra note 10.
50 Doctors Study Repatriation of Uninsured, N.Y. TIMES, Nov. 11, 2008.
51 Ibid. In contrast, the California Medical Association voted in October 2008 to oppose the forced repatriation of patients. Ibid.
52 Ibid. Notably, the AMA committee report on this issue suggested “that the overarching concern in this matter involved inappropriate discharge of patients more than immigration status specifically.” AMA asks TJC for time on disruptive docs, MEDICAL ETHICS ADVISOR, Jan. 1, 2009.
53 Montejo I, 874 So.2d 654.
54 Sontag I, supra note 9.
On February 28, 2000, he and three friends were driving home from work when they were hit by a drunk driver. Mr. Jiménez was taken to Martin Memorial Hospital, a not-for-profit hospital, where he arrived unconscious and in shock from extensive bleeding. He had two broken thigh bones, a broken arm, multiple internal injuries, a lacerated face and a severe head injury.

Mr. Jiménez survived the accident but only after intensive surgical and medical intervention. In the summer of 2000, he was transferred to a nursing home where he began “wasting away.” He was then transferred back to the hospital where he was treated for ulcerous bed sores that left the tendons behind his knees exposed. The hospital saved Mr. Jiménez, but he remained in a vegetative state for over a year and a half. When Mr. Jiménez unexpectedly awoke, the hospital determined that he needed traumatic brain injury rehabilitation. However, the hospital was unable to find any appropriate rehabilitation center or nursing home willing to care for Mr. Jiménez, who had no funds to pay for such long-term medical care himself.

Legally precluded from simply discharging Mr. Jiménez and unable to secure post-hospital care, Martin Memorial Hospital faced the prospect of providing potentially

---

55 Id.
56 Id.
57 Id.
58 Id.
59 Id.
60 Id.
61 Id.
62 Id.
63 Id.
64 Id.
65 See supra notes 24-26 and accompanying text.
unending long-term care for Mr. Jiménez.\textsuperscript{66} At this point, Martin Memorial contacted the Guatemalan government for assistance, and the health minister for Guatemala agreed to take over care.\textsuperscript{67}

Mr. Jiménez, however, had a guardian in the United States, and that guardian opposed his return to Guatemala, citing concerns about the quality of health care Mr. Jiménez would receive in his homeland. The guardian filed a guardianship plan in state court stating that Mr. Jiménez needed 24-7 nursing care for the next twelve months.\textsuperscript{68} The hospital sought judicial review of the guardianship plan, arguing that it was not in the best interest of Mr. Jiménez and seeking instead to discharge Mr. Jiménez to Guatemala.\textsuperscript{69}

Circuit Judge John E. Fennelly authorized the hospital to relocate Mr. Jiménez to Guatemala, at its own expense, accompanied by “a suitable escort with the necessary medical support for [Mr. Jiménez’s] trip back to Guatemala.”\textsuperscript{70} Mr. Jiménez’s guardian filed a notice of appeal and asked the court to stay execution of its order pending appeal.\textsuperscript{71} The court asked the hospital to file a response.\textsuperscript{72} Hours before that response was due, the hospital returned Mr. Jiménez by air ambulance back to Guatemala.\textsuperscript{73}

\textsuperscript{66} Sontag I, supra note 9.
\textsuperscript{67} Id.; see also Montejo I, 874 So.2d at 657 (quoting the letter received from the public health minister in which he identified a Guatemalan doctor who was “ready to give the necessary care to Mister Luis Alberto Jimenez,” indicated he would “evaluate and transfer him to the most appropriate facility for the treatment of his condition,” and that the “medical treatment to be available will be without any cost to Mister Jimenez.”).
\textsuperscript{68} Montejo I, 874 So.2d at 656.
\textsuperscript{69} Ibid.
\textsuperscript{70} Montejo v. Martin Memorial Medical Center, Inc., 935 So.2d 1266, 1267 & n.1 (Fla. Dist. Ct. App. 2006) (“Montejo II”).
\textsuperscript{71} Id. at 1267-68.
\textsuperscript{72} Id. at 1268.
\textsuperscript{73} Ibid.
flight cost $30,000 and was paid for by Martin Memorial.\textsuperscript{74} It brought to a close the bill for Mr. Jiménez’s care, which totaled some 1.5 million dollars.\textsuperscript{75} For that care, the hospital was reimbursed just $80,000 from the federal government.\textsuperscript{76}

Mr. Jiménez was initially placed at Guatemala’s National Hospital for Orthopedics and Rehabilitation, the country’s only public rehabilitation facility.\textsuperscript{77} After a few weeks, he was discharged to another public hospital.\textsuperscript{78} That is where his brother found him, “lying in the hallway on a stretcher, covered in his own excrement.”\textsuperscript{79} Mr. Jiménez’s family then brought him home to the mountains of Guatemala, where he has received “no medical care or medication – just Alka-Seltzer and prayer.”\textsuperscript{80}

Just under a year after Martin Memorial returned Mr. Jiménez to Guatemala, the District Court of Appeal of Florida reversed the order that had originally cleared his removal to Guatemala.\textsuperscript{81} The court found insufficient evidence that Mr. Jiménez could receive adequate care in Guatemala.\textsuperscript{82} In addition, and with no further elaboration, the court held that “the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala.”\textsuperscript{83}

\begin{footnotes}
\item[74] Sontag I, supra note 9.
\item[75] Ibid.
\item[76] Ibid.
\item[77] Ibid.
\item[78] Ibid.
\item[79] Ibid.
\item[80] Ibid.
\item[81] Montejo I, 874 So.2d 654.
\item[82] Montejo I, 874 So.2d at 658.
\item[83] Ibid. (parenthetical in original).
\end{footnotes}
III. AN ANALYSIS OF THE LEGALITY OF HOSPITAL REPATRIATIONS

In evaluating the return of Mr. Jiménez to Guatemala, the Florida appellate court focused on the quality of Martin Memorial’s decision-making. The court side-stepped larger issues concerning the constitutionality of the hospital’s conduct. In this section, I conclude that principles of due process, equal protection, and federal preemption render hospital repatriations unconstitutional. I also conclude that repatriation can give rise to tort challenges as well as criminal kidnapping or RICO charges.84

A. The Fourteenth Amendment

The Fourteenth Amendment contains two provisions key to analysis of hospital repatriations. The Due Process Clause prohibits states from depriving individuals of “life, liberty or property” without due process of law,85 while the Equal Protection Clause provides that states may not “deny to any person within its jurisdiction the equal protection of the laws.”86

Several courts have held that state, local-government, and public-trust hospitals are state actors subject to the proscriptions of the Fourteenth Amendment.87 Thus, the

---

84 Repatriation may also be the basis for lower-stakes administrative challenges. That is, hospitals and doctors may have to respond to complaints filed with licensing authorities arising out of repatriation efforts. See Sontag II, supra note 10 (reporting that the parents of a legal immigrant who was repatriated from a Phoenix hospital filed a detailed complaint against the hospital with the Arizona Department of Health Services).
85 U.S. Const. amend. XIV, § 1.
86 U.S. Const. amend. XIV, § 1.
87 See McKeensport Hosp. v. Accreditation Council for Graduate Med. Educ., 24 F.3d 519, 528 (3d Cir. 1994) (“Courts commonly hold a state agency, like a county hospital district, for example, is a state actor even though it is not engaged in actions that are traditionally the exclusive province of the state.”); Dunn v. Washington County Hosp., 429 F.3d 689, 692 (7th Cir. 2005) (analyzing county hospital’s actions as if a state actor); Beedle v. Wilson, 422 F.3d 1059, 1070 (10th Cir. 2005) (“Subsequent cases from our court have held, with little fanfare, that public trust and county hospitals are properly deemed state actors for § 1983 purposes.”).
more significant question is whether private hospitals can be state actors for Fourteenth Amendment analysis.

Whether the Fourteenth Amendment has any bearing on private hospital repatriations turns on one important question: Can private hospitals be considered state actors under the Fourteenth Amendment? Only if this question can be answered affirmatively is it necessary to reach the issue of whether hospital repatriations violate Fourteenth Amendment protections.

1. Private Hospitals as State Actors

The majority of courts faced with this issue have held that private hospitals are not generally considered state actors for Fourteenth Amendment purposes even if they receive governmental aid, are subject to governmental regulations, or benefit from a local monopoly.\(^88\) These cases, however, carve out some important exceptions to the general rule.

Courts have held that private hospitals can be considered state actors if their actions “so approximate state action that they may be fairly attributed to the state.”\(^89\) Several tests determine whether a the action of a private hospital can be fairly attributable to the state so as to render the hospitals a “state actor” for purposes of Fourteenth Amendment analysis.\(^90\) These tests are: (1) the public function test; (2) the state

\(^88\) Kottmyer v. Maas, 436 F.3d 684, 688-89 (6th Cir. 2006) (“the mere fact that a hospital is licensed by the state is insufficient to transform it into a state actor for purposes of section 1983.”); Crowder v. Conlan, 740 F.2d 447 (6th Cir. 1984); Ward v. St. Anthony Hospital, 476 F.2d 671 (10th Cir.1973); see also Jackson v. Metro. Edison Co., 419 U.S. 345, 350 (1974) (“State regulation of a private entity, even if it is ‘extensive and detailed,’ is not enough to support a finding of state action.”).

\(^89\) Lansing v. City of Memphis, 202 F.3d 821, 828 (6th Cir. 2000).

\(^90\) Lansing, 202 F.3d at 828.
compulsion test; and (3) the symbiotic relationship/nexus test. If any of one of these three tests are met, a private hospitals can be considered state actors for Fourteenth Amendment analysis.

Under the public function test, actions by private hospitals may be attributed to the state if “the private entity exercise[s] powers which are traditionally exclusively reserved to the state, such as holding elections or eminent domain.” As discussed in Part III.A, repatriation is an exercise of power traditionally and exclusively reserved to the federal government and not states. Thus, if one were to follow the public function test literally, repatriation would not be attributable to the state since it is not a traditional exercise of state power. Yet a literal approach would not do justice to the underlying principle of the test. Private hospitals are undertaking a public function when engaged in repatriating undocumented migrants because they are deputizing themselves to enforce federal law. As such, their conduct falls squarely within the public function test and should render the private hospitals state actors under the Fourteenth Amendment.

Test two, the state compulsion test, evaluates whether the state “exercise[s] such coercive power or provide[s] such significant encouragement, either overt or covert, that in law the choice of the private actor is deemed to be that of the state.” For example, in Kia v. McIntyre, the Second Circuit has held that a private hospital can be considered a state actor when it acts as “reporting and enforcement machinery for [ ] a government  

91 See, e.g., id.; Rockwell v. Cape Cod Hosp., 26 F.3d 254, 257 (1st Cir. 1994); Harvey v. Harvey, 949 F.2d 1127 (11th Cir. 1992).
92 Wolotsky v. Huhn, 960 F.2d 1331, 1335 (6th Cir. 1992); see also Ellison v. Garbarino et al, 48 F.3d 192, 195-96 (6th Cir. 1995) (finding that a private hospital, when it involuntarily committed an individual, was not a state actor).
agency charged with detection and prevention of child abuse and neglect.”94 Kia concerned an infant born in a private hospital. The infant tested positive for methadone, and a hospital social worker, who was mandated under state law to report suspected child abuse, notified the Child Welfare Administration (“CWA”) of the baby’s positive test. The baby was medically cleared for release after testing negative for methadone, but was kept by the hospital until the CWA indicated that it would not seek custody of the child. The Second Circuit found that the hospital was not a state actor until it held the child after receiving medical clearance; at that point, however, the hospital was acting as both a “reporting and enforcement machinery for CWA” and was thus a state actor.

In many ways, repatriation of undocumented migrants by private hospitals is analogous to the conduct at issue in Kia. Repatriation is not a part of providing medical services. To the contrary, with repatriation, hospitals are in effect acting as enforcement machinery for the Immigration and Nationality Act (“INA”)95 despite the fact that such conduct is unauthorized. Yet private hospitals are not compelled to be enforcers of immigration law, which places them in a different position from the mandatory reporters in Kia.

While the Kia analogy is incomplete, it does not render the state compulsion analysis void. There are grounds for arguing that states exercise significant overt power over repatriation by private hospitals. For example, Arizona does not provide Medicaid coverage for legal immigrants who have been present in the United States for less than

---

95 See 8 U.S.C. § 1101 et seq.
five years.\textsuperscript{96} By not reimbursing hospitals for the care of these legal immigrants, Arizona is providing “significant encouragement” to hospitals to find alternative care in the form of repatriation. This analysis is further helped by noting that Arizona has not prosecuted any hospital administrators for crimes arising out of repatriation, such as kidnapping, which is discussed in Part III.D below, despite the involvement of police in thwarting some repatriation efforts.\textsuperscript{97} Under these circumstances, the state compulsion test may be an appropriate means for rendering private hospitals state actors under the Fourteenth Amendment.

The final test – the symbiotic relationship/nexus test has been addressed differently in different courts. The Sixth Circuit has held that the test requires examination of whether there is “a sufficiently close nexus between the state and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the state itself.”\textsuperscript{98} As discussed above, states generally do not have a role in enforcement of immigration law. However, Congress has authorized the Department of Homeland Security to enter into agreements with states pursuant to which state officers can “perform a function of an immigration officer in relation to the investigation, apprehension or detention of aliens in the United States.”\textsuperscript{99} And several states and counties across the United States have taken advantage of this program.\textsuperscript{100}

While these agreements do not extend to the removal of undocumented migrants from the

\textsuperscript{96} Sontag II, \textit{supra} note 10; ARIZ. REV. STAT. ANN. § 35-2903.03(B)(2).
\textsuperscript{97} See Sontag II, \textit{supra} note 10.
\textsuperscript{98} Wolotsky, 960 F.2d at 1335.
\textsuperscript{99} 8 U.S.C. § 1357(g).
\textsuperscript{100} The Workers & Immigrant Rights Clinic of Yale Law School has assembled a large repository of such agreements which is available at http://islandia.law.yale.edu/wirc/287g_foia.html.
United States, if a state or county has entered into such an agreement, the close connection between their function in investigation and apprehension and the private hospital’s action in repatriation might satisfy the nexus analysis.

Other courts analyzing the final state actor test have focused on whether there is a symbiotic relationship between the private hospital and the state. In *Jatoi v. Hurst-Euless-Bedford Hosp. Authority*, the Fifth Circuit found that a private hospital was a state actor because of such a symbiotic relationship.101 The hospital facilities at issue in *Jatoi* were publicly owned and constructed with public funds by a public corporation created by statute to serve a public purpose.102 While the hospital was leased to a private manager, that manager took over a job formerly performed by the state for the public benefit.103 Although the public owner of the hospital was not involved in day-to-day operations, it was informed of the private manager’s decisions and monitored the manager’s activities.104 As a result, the private manager was considered a state actor for purposes of Fourteenth Amendment analysis. While *Jatoi* sets a high bar, its fact-specific analysis may be useful in determining that some apparently-private hospitals can, in fact, be considered state actors due to their close ties to the state.

Having concluded that both public and private hospitals should be considered “state actors,” the question becomes whether repatriation violates any of the protections provided by the Fourteenth Amendment.

---

101 807 F.2d 1214 (5th Cir. 1987).
102 Id. at 1221.
103 Id.
104 Id.
2. Due Process

Undocumented migrants are entitled to due process under the Fourteenth Amendment.105 This guarantee includes substantive and procedural components.

a. Substantive Due Process

Principles of substantive due process forbid state actors from infringing on certain “fundamental” interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.106 But does repatriation by hospitals implicate fundamental interests? And, if so, is the infringement on these interests by hospitals narrowly tailored to serve a compelling state interest?

i. Repatriation Implicates The Constitutional Right To Life

As the story of Luis Alberto Jiménez highlights, repatriation can mean return to a country with highly inadequate medical care or no medical care at all.107 Dr. Steven Larson, an expert on migrant health and an emergency room physician at the Hospital of the University of Pennsylvania, has said, “Repatriation is 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.”108

---

105 *Plyler v. Doe*, 457 U.S. 202, 211-212 (1982) (The provisions of the Fourteenth Amendment “‘are universal in their application, to all persons within the territorial jurisdiction ...’”) (*quoting Yick Wo v. Hopkins*, 118 U.S. 356, 369 (1886)); *Cf. Kwong Hai Chew v. Colding*, 344 U.S. 590, 596 n.5 (1953) (“The Bill of Rights is a futile authority for the alien seeking admission for the first time to these shores. But once an alien lawfully enters and resides in this country he becomes invested with the rights guaranteed by the Constitution to all people within our borders”) (*quoting Bridges v. Wixon*, 326 U.S. 135, 161 (1945) (concurring opinion)).


107 *See, supra, Part II.D*

108 *Sontag I*, supra note 9.
If repatriation is in effect a “death sentence,” then it would effect a person’s interest in his own life, which the Supreme Court has already held to be a “fundamental interest.”\footnote{109} The Constitution itself is unambiguous: States cannot “deprive any person of life … without due process of law.”\footnote{110} Following this precedent, it seems clear that at least some repatriations would effect a fundamental interest in life and trigger substantive due process analysis. But a recent \textit{en banc} decision from the D.C. Circuit, \textit{Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach}, suggests that there are limits to the constitutional protection of life that might render a different conclusion.\footnote{111}

The focus of \textit{Abigail Alliance} was an effort to enjoin the Food and Drug Administration (FDA) from continuing to enforce its policy barring sale to terminally ill patients of experimental drugs not yet approved for public use.\footnote{112} The dissent sought to characterize plaintiffs’ claims as the right “to try to save one’s life,” with a “textual anchor in the [constitutional] right to life.”\footnote{113} The majority rejected this approach.\footnote{114} Citing the Supreme Court’s decision in \textit{Washington v. Glucksberg},\footnote{115} the D.C. Circuit cautioned against such a “broad generalization” of the rights at issue: “If the asserted

\begin{footnotes}
\item[109] \textit{Tennessee v. Garner}, 471 U.S. 1, 9 (1985) (assessing a Fourth Amendment challenge to the use of deadly force on nonviolent suspects and noting that “The suspect’s fundamental interest in his own life need not be elaborated upon.”).
\item[110] U.S. Const. amend. XIV, § 1.
\item[111] See \textit{Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach}, 495 F.3d 695 (D.C. Cir. 2007) (en banc).
\item[112] \textit{Ibid.}
\item[113] \textit{Id.} at 714-15; \textit{see also id.} at 701 at n.5. The due process claim at issue in the case was rooted in the Fifth Amendment, which applies to the federal government, and not the Fourteenth Amendment discussed herein. But the analysis is the same.
\item[114] \textit{Id.} at 701 n.5
\item[115] 521 U.S. 702, 721 (1997) (finding no fundamental liberty interest in the right to assisted suicide).
\end{footnotes}
right is so broad that it protects a person’s efforts to save his life, it might subject to strict scrutiny any government action that would affect the means by which he sought to do so, no matter how remote the chance of success.” Accordingly, the D.C. Circuit framed the right at issue narrowly as “the right to access experimental and unproven drugs in an attempt to save one’s life.” This right, the Court concluded, was not a fundamental liberty interest protected by the Constitution because it was not “deeply rooted in our Nation’s history and traditions.”

The majority opinion in Abigail Alliance sidestepped the issue of the constitutional protection of life. By focusing on Washington v. Glucksberg, the court transformed the analysis from an examination of the parameters of “depriving any person of life” to an analysis of whether there was a liberty interest at issue. But whether or not the case implicated liberty interests does not answer the question of whether it also implicated “life.”

The Supreme Court has never attempted to define the term “life.” But it has analyzed the term “person,” holding, in Roe v. Wade, that constitutional references to “person” have “application only postnatally.” Whenever the government itself causes the death of any such person – whether by a police shooting, execution of a

---

116 Abigail Alliance, 495 F.3d at 701 n.5
117 Ibid.
118 Ibid.
121 Stated differently, whenever the government or “deprive[s] any person of life.” See U.S. Const. amend. XIV § 1; see also U.S. Const. amend. V.
convicted criminal,\textsuperscript{124} blocked access to life-saving medicine,\textsuperscript{125} or death by deportation – there is deprivation of life which demands due process. Focusing specifically on repatriation, no principled distinction can be made between repatriations that are effectively death sentences and government removal of life support systems without patient consent. It is unquestionable that the latter conduct would implicate the constitutional protection of life.\textsuperscript{126} For the same reasons, repatriation that would result in death must also implicate the constitutional protection of life.\textsuperscript{127}

\textbf{ii. Repatriation Implicates Fundamental Liberty Interests}

The Fourteenth Amendment protects against not only state deprivation of life but also state deprivation of “liberty.”\textsuperscript{128} The Supreme Court has held that among the protected liberty interests is the “right to bodily integrity,” which was found to be violated when government officials forcibly opened a criminal suspect’s mouth and pumped his stomach against his will.\textsuperscript{129} The Supreme Court has also “assumed, and strongly suggested” that the right to refuse unwanted lifesaving medical treatment is a

\textsuperscript{124} While the Constitution specifically recognizes the death penalty, see U.S. Const. amend. V, such “depriv[ation] of life” cannot be accomplished without “due process of law,” \textit{ibid}. See William J. Brennan, Jr., \textit{Constitutional Adjudication and the Death Penalty: A View from the Court}, 100 HARV. L. REV. 313, 324 (1986) (“when and if death is a possible punishment, the defendant shall enjoy certain procedural safeguards”).

\textsuperscript{125} \textit{Abigail Alliance}, 495 F.3d at 714-15.

\textsuperscript{126} See JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW § 13.3 (5th ed. 1995).

\textsuperscript{127} In many cases, however, repatriation may not be a death sentence. It may only lead to a significantly decreased quality of life. The extent to which the constitutional protection of life should extend to these circumstances is an open question.

\textsuperscript{128} U.S. Const. amend. XIV § 1.

fundamental one.\textsuperscript{130} If the right to refuse medical procedures is fundamental, does governmental refusal to provide necessary medical care also implicate fundamental interests?

The first step in answering this question is to create a “‘careful description’ of the asserted fundamental interest.”\textsuperscript{131} The next step, determining whether the asserted interest is “fundamental,” turns on whether the interest is “deeply rooted in our Nation’s history and traditions” and “implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed.”\textsuperscript{132} Of course, the answer to this inquiry depends on what interest or right is being assessed. And framing the right at issue is subject to manipulation. It is possible to view repatriation as concerning “the right to act to save one’s own life,”\textsuperscript{133} “the right to be free from near-certain death,” “the right to continue medical care in the United States in an attempt to save one’s life,” “the right to receive the same medical care as U.S. citizens,” or even “the right of non-citizens to continue to receive medical care in the United States at the cost of citizen taxpayers.”

I view the right at issue to be “the right to continue prescribed medical care.”

And this right, I believe, is fundamental. The United States has a long history of providing medical care to the poor. Indeed, George Washington was only four years old when America’s oldest public hospital, Bellevue Hospital in New York City, was founded.\textsuperscript{134} On the other side of the country, California had one of the most extensive

\textsuperscript{131} Id. at 721.
\textsuperscript{132} Abigail Alliance, 495 F.3d at 711 n.19 (citing Glucksberg, 521 U.S. at 720-21).
\textsuperscript{133} Abigail Alliance, 495 F.3d at 716 (dissent).
public hospitals systems in the nation by the early 1900s.135 Moreover, many of our nation’s earliest immigrants came from countries with long histories of providing medical care to the poor.136 This history suggests that the right to continue prescribed medical care is “deeply rooted in our Nation’s history and traditions.” The right to continue prescribed medical care is also “implicit in the concept of ordered liberty,” such that if the government were to deny this right, “neither liberty nor justice would exist.”137

This conclusion is not hampered by the fact that those affected by repatriation are not U.S. citizens: While the United States has a long history of denying entry to certain medically needy non-citizens,138 there is no equally storied history to support the exporting of undocumented migrants with medical needs. Moreover, immigration status cannot be boot-strapped into the definition of the right at issue because the provisions of the Fourteenth Amendment “are universal in their application.”139

---

135 Deborah Reidy Kelch, Caring for Medically Indigent Adults in California: A History (California HealthCare Foundation June 2005) at 5.
136 See, e.g., HEALTH CARE AND POOR RELIEF IN PROTESTANT EUROPE 1500-1700 (Ole Peter Grell & Andrew Cunningman eds.,1997) (discussing medical care for the poor in Northern Europe including Holland, Belgium, Germany, Denmark, Sweden, Finland, Poland, Scotland, and London).
137 Abigail Alliance, 495 F.3d at 711 n.19 (citing Glucksberg, 521 U.S. at 720-21).
138 In 1882, Congress enacted legislation to bar “Lunatics,” “idiots,” and “any person unable to take care of himself or herself without becoming a public charge” from entry into the United States. Immigration Act of 1882, ch. 376, 22 Stat. 214 (Aug. 3, 1882). In 1891, Congress added “persons suffering from a loathsome or a dangerous or contagious disease” to the list of excludable aliens and also required immigrants to undergo a medical examination as part of the inspection process before they were allowed entry into the United States. Immigration Act of 1891, ch. 551, 26 Stat. 1084 (Mar. 3, 1891). In 1903 “epileptics” were added to the excludable list. Immigration Act of 1903, ch. 1012, 32 Stat. 1213, 1214 (Mar. 3, 1903). In 1917, “persons of constitutional psychopathic inferiority persons with chronic alcoholism,” and persons afflicted with tuberculosis were also excluded. Immigration Act of 1917, ch. 29, 39 Stat. 874 (Feb. 5, 1917). The law today continues to exclude those whom it has been determined “have a communicable disease of public health significance.” 8 U.S.C. § 1182(a)(1)(A)(i).
To the extent the right at issue is seen not as “to continue prescribed medical care” but “to continue prescribed, life-saving medical care,” it is even easier to spot a fundamental liberty interest. As discussed by the dissent in *Abigail Alliance*, our nation has a long history in support of the “duty of self preservation.”¹⁴⁰ Indeed, the Supreme Court has already recognized the right to life-saving medical procedures in holding that a woman has the right to abort a fetus at any stage of a pregnancy if doing so is necessary to preserve her life or health.¹⁴¹ Not only are these rights deeply rooted in our nation’s history, they are “implicit in the concept of ordered liberty” because the right to life and right to personal autonomy are essential to our free society.¹⁴² They are, therefore, fundamental, and they cannot be abridged by state actors unless the infringement is narrowly tailored to serve a compelling state interest.

### iii. Hospital Repatriation Does Not Withstand Strict Scrutiny

It is unclear what “compelling state interest” is served by the repatriation of undocumented migrants. To the extent the interest is in the enforcement of federal immigration law, there is no such state interest. To the extent the interest is in saving state funds, this should not be considered “compelling” when pitted against the life and liberty interests of undocumented migrants.

Moreover, it is doubtful that the current repatriation efforts are “narrowly tailored” to serve state interests. The fact is that it is not presently possible to assess “tailoring” in the absence of information as how hospitals determine whether a patient

---

¹⁴⁰ *Id.* at 717 (dissent).
¹⁴² *Abigail Alliance*, 495 F.3d at 719-21 (dissent).
has the right to stay in the country and/or is a candidate for repatriation. Hospitals appear to be pursuing repatriation on an *ad hoc* basis depending largely on whether they are able to accomplish repatriation. Such policies almost certainly cannot withstand the strict scrutiny required for deprivation of fundamental rights.

**b. Procedural Due Process**

Even if the life and liberty interests affected by repatriation are not “fundamental” such that substantive due process applies, procedural due process requirements still must be met. Moreover, there is a strong argument that repatriation involves not only the deprivation of life and liberty, but the deprivation of property interests without procedural due process as well.

**(i) EMTALA Establishes A Property Interest In Medical Care**

In 1970, the Supreme Court held that expected government entitlements could constitute property whose deprivation must be protected by the government’s obligation of due process.\(^{144}\) The Court focused on the fact that the welfare benefits at issue were “a matter of statutory entitlement for persons qualified to receive them.”\(^{145}\)

Medically needy undocumented migrants have an analogous entitlement to medical care that is grounded in statute. EMTALA was enacted “principally to address the problem of ‘patient dumping.’”\(^{146}\) Congress was concerned about evidence that hospital emergency rooms were denying uninsured patients the same treatment that they

\(^{143}\) Indeed, Deborah Sontag of the New York Times has reported on hospital attempts to “repatriate” medically needy U.S. citizen children of undocumented parents, see Sontag I, *supra* note 9 and Sontag II, *supra* note 10, as well as a *legal* immigrant without health insurance, see Sontag II, *supra* note 10.


\(^{145}\) *Id.* at 262.

were providing to paying patients, “either by refusing care outright or by transferring uninsured patients to other facilities.” EMTALA addressed these concerns by requiring all hospitals participating in the federal Medicare program to: (1) assess whether “any individual” seeking emergency care has an emergency medical condition, and (2) stabilize patients with emergency medical conditions before transfer or discharge. The statute works in conjunction with federal regulations that require discharge or transfer of patients only to “appropriate facilities” that “can meet the patient’s medical needs on a post-discharge basis.”

Read together, EMTALA and the federal regulations provide that medically needy undocumented migrants have the right to emergency care, to have their medical condition stabilized, and to be discharged to appropriate facilities. These are property interests that cannot be taken away without due process.

(ii) Repatriation Procedures Do Not Satisfy Due Process

Whether repatriation affects life, liberty, or property interests (or, as I argue, all three), the government cannot deprive individuals of these interests without due process. Exactly what process is due, however, could be the subject of debate.

---

150 42 C.F.R. § 482.43(d).
152 It is worth noting that EMTALA makes little policy sense. Hospitals are reimbursed only for providing expensive emergency treatment; they receive no funding for less-expensive preventative care. As a result, EMTALA actually contributes to higher health care costs. See Morgan Greenspon, The Emergency medical Treatment and Active Labor Act and Sources of Funding, 17 Annals Health L. 309, 312-3 (2008).
(a) The Process Due In Deportation Proceedings

If repatriation is, in essence, private deportation, then patients subject to repatriation are entitled to the same due process that is required for deportation proceedings.\(^{153}\) The process “due” would be that which is followed by the Department of Homeland Security pursuant to statute,\(^ {154}\) including, among other things: a hearing before an immigration judge\(^ {155}\) at which the government carries “the burden of establishing by clear and convincing evidence that ... the alien is deportable,”\(^ {156}\) notice of the right to appeal the decision,\(^ {157}\) as well as the opportunity to move the immigration judge to reconsider,\(^ {158}\) to seek discretionary relief of removal,\(^ {159}\) and to obtain habeas review of the decision not to consider waiver of deportation.\(^ {160}\) No extra-governmental process would be allowed.\(^ {161}\)

Hospitals might argue that repatriation cannot be analogized to removal proceedings because: (1) hospitals are not making judgments about immigration status but rather securing appropriate post-hospital care for patients; and (2) in many cases, patients consent to repatriation. Neither argument is persuasive. When hospital administrators identify a patient as a potential candidate for repatriation, they are inherently making a decision about that individual’s immigration status and about the

\(^{153}\) See *Yamataya v. Fisher*, 189 U.S. 86, 100-101 (1903) (due process is required for deportation proceedings).


\(^{155}\) 8 U.S.C. § 1229a(a)(1).


\(^{157}\) 8 U.S.C. § 1229a(c)(5).

\(^{158}\) 8 U.S.C. § 1229a(c)(6).

\(^{159}\) 8 U.S.C. § 1229a(c)(3)(4).


\(^{161}\) 8 U.S.C. § 1229a(a)(3) (“… a proceeding under this section shall be the sole and exclusive procedure for determining whether an alien may be .... removed from the United States.”).
propriety of removing that patient from the United States. And any consent obtained from patients is necessarily infected by this improper determination of immigration status.\(^{162}\)

Removal proceedings are the only authorized means for removing individuals from the United States. Since hospitals have acted outside of these procedures, they have violated patients’ procedural due process rights.

(b) A Lesser Form Of Process

It is very clear that the process required for repatriation is that provided by removal proceedings. Nonetheless, it is worth noting that even if one were to conclude that repatriation does not require the stringent process due in removal proceedings, because it affects life, liberty, and property interests, it requires some form of process. At a minimum, there must be a means for patients to contest repatriation before a neutral decision-maker.\(^{163}\)

Repatriation, however, is occurring without any process. Hospitals are acting on an \textit{ad hoc} basis, without established procedures, oversight, or uniformity. There is no evidence about how hospitals are concluding that patients are undocumented, that those patients have no right to remain in the United States, much less whether they should be returned to their country of origin. There is also no evidence about how patients can appeal hospitals’ decision-making. As Montejo I makes clear, the only resort a patient

\[^{162}\] \textit{See, supra} notes 42-46 and accompanying text.

\[^{163}\] \textit{See, e.g.}, \textit{In re Murchison}, 349 U.S. 133, 136 (1955) (“A fair trial in a fair tribunal is a basic requirement of due process.”).
would have to avoid repatriation would be to state courts, yet state courts do not have the authority to determine an alien’s immigration status.\textsuperscript{164}

Since patients do not receive the bare minimum standards of process, repatriation necessarily violates their rights to procedural due process.

3. Equal Protection

In addition to due process protections, undocumented migrants are entitled to equal protection under the Fourteenth Amendment.\textsuperscript{165} Undocumented migrants have not, however, been held to constitute a “suspect class” such that discriminatory laws or state action should trigger strict scrutiny analysis.\textsuperscript{166} Nevertheless, where non-suspect classes raise equal protection challenges that affect fundamental rights, strict scrutiny will apply.\textsuperscript{167} Thus, the analysis parallels the analysis of substantive due process.

As discussed, repatriation affects fundamental interests in life and liberty.\textsuperscript{168} Hospitals are infringing upon these fundamental interests in a classified manner – they are offering different courses of treatment to individuals based upon their perceived immigration status by seeking to deport undocumented migrants and continuing to treat all others.

\textsuperscript{164} Hazelton, 496 F. Supp. 2d at 538; Montejo I, 874 So. 2d at 658.
\textsuperscript{167} Harper v. Virginia Bd. of Elections, 383 U.S. 663, 670 (1966) (“where fundamental rights and liberties are asserted under the Equal Protection Clause, classifications which might invade or restrain them must be closely scrutinized and carefully confined.”).
\textsuperscript{168} See Parts III.A.2.a.i & ii, supra.
\textsuperscript{169} The word “perceived” is important. As discussed in notes 43-45 supra and note 182 infra, and the accompanying text, not all undocumented migrants are subject to deportation.
To survive an equal protection challenge, hospitals must show that differing courses of treatment based upon perceived immigration status are necessary or narrowly tailored to promote a compelling state interest. As discussed above, this standard cannot be met: States have no interest in enforcement of federal immigration law and any there is no indication that repatriation is narrowly tailored to address state fiscal concerns.\textsuperscript{170}

\textbf{B. Federal Preemption}

The supremacy clause of the U.S. Constitution dictates that federal law preempts or overrides state or local legislation that is in conflict with the federal law.\textsuperscript{171} Preemption curtails state and local conduct that would otherwise “stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”\textsuperscript{172} In so going, preemption “avoid[s] conflicting regulation of conduct by various official bodies which might have some authority over the subject matter.”\textsuperscript{173}

There is no question that, with the INA, Congress created a comprehensive scheme for the identification and removal of undocumented migrants. There is also no dispute that this scheme has left no room for a direct state or local role in immigration.\textsuperscript{174}

\begin{footnotes}
\textsuperscript{170} See, supra, Part III.A.2.a.iii.
\textsuperscript{171} U.S. Const. art. VI, cl. 2 (“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof. . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding”); see \textit{McCulloch v. Maryland}, 17 U.S. 316, 436 (1819) (“States have no power … to retard, impede, burden, or in any manner control the operations of the constitutional laws enacted by Congress to carry into execution the power vested in the General Government. This is, we think, the unavoidable consequence of that supremacy which the Constitution has declared.”).

\textsuperscript{172} \textit{Hines v. Davidowitz}, 312 U.S. 52, 67 (1941).


\textsuperscript{174} See Blas Nuñez-Neto et al., Cong. Research Serv., \textit{Enforcing Immigration Law: The Role of State and Local Law Enforcement} 6-7 (2007) (“The civil provisions of the INA have been assumed to constitute a pervasive and preemptive regulatory scheme--leaving

36

\textit{Draft – Publication Forthcoming, University of Cincinnati Law Review, Volume 78, Issue 2}
The unanswered question is whether congressional preemption of the immigration field presents a barrier to hospital repatriation efforts.

By its terms, the Supremacy Clause addresses only “Laws of any State.” This leads to important questions: Can conduct by hospitals run by state or local governments constitute “law” for purposes of constitutional analysis? If so, does repatriation by state or local hospitals run afoul of the Supremacy Clause? Finally, how does the preemption clause apply to the conduct of privately owned hospitals, if at all?

1. Repatriation By State And Local Hospitals As Preempted Lawmaking

There are no state or local laws authorizing hospitals to repatriate undocumented migrants. However, when hospitals run by state or local governments act to repatriate undocumented migrants, their conduct can best be understood as legislating or rulemaking. This is because such hospitals are effectively arms of the state or local governments they serve. When their officers – hospital administrators – decide to repatriate patients, they are making judgments on behalf of state or local governments about the lawfulness of those patients’ continued stays in the United States. Their judgments have the force and effect of law, and these de facto laws should be subject to preemption analysis.

While no federal court has yet dealt with these issues in the context of the Supremacy Clause, courts have determined that state or local hospital action amounts to “State Action” for purposes of Fourteenth Amendment analysis.175 The same analysis

---

175 See supra note 87 and accompanying text.
should be applied in the preemption context with the ultimately conclusion that repatriation by state and local hospitals is de facto lawmaking by the state.

Viewed fairly, the Supreme Court’s preemption analysis in Wisconsin Dept. of Industry, Labor and Human Relations v. Gould Inc., 176 compels this result. Gould concerned a Wisconsin statute forbidding private parties within the state from doing business with certain repeat violators of the National Labor Relations Act (“NLRA”). The state argued that its statutory scheme was a lawful exercise of its spending power.177 The Supreme Court disagreed, finding that the state was exercising its regulatory power by attempting to enforce compliance with the NLRA. The Court emphasized that the purpose of the NLRA was to “entrust[administration] of the labor policy for the Nation to a centralized administrative agency.”179 The Court held that any state interference with the NLRA’s “interrelated federal scheme of law, remedy, and administration” would be preempted.180

While Gould concerned traditional as opposed to de facto lawmaking, the reasoning underlying the case calls for the same result: preemption of the state or local conduct. Hospitals consistently argue that repatriation is financially necessary.181 Thus, repatriation is an exercise in state and local spending, which is the same argument raised by Wisconsin in Gould. But, just as in Gould, the hospitals’ conduct affects more than

177 Gould, 475 U.S. at 287.
178 Id.
179 Id. at 289-90 (citations omitted).
180 Id. at 290.
181 Sontag II, supra note 10 (quoting one hospital administrator as stating “We’re trying to be good stewards of the resources we have … We’re trying to make sure that the acute-care hospital is available for individuals who need acute care. We can’t keep someone forever.”).
spending, it interferes with the federal legislative scheme governing the removal of undocumented migrants.

The issue of interference with the federal immigration scheme was the focus of *Lozano v. City of Hazelton*,, sup{182} in which the District Court for the Middle District of Pennsylvania reversed a city-wide ordinance designed, in part, to prevent landlords from renting to non-citizens. sup{183} In *Hazelton*, the court noted that the federal government permits several classes of people not lawfully present in the United States to nonetheless remain and even work in this country, including: (1) aliens who have completed an application for asylum or withholding of removal; (2) aliens who have filed an application for adjustment of status to that of a lawful permanent resident; (3) aliens who have filed an application for suspension of deportation; (4) aliens paroled into the United States temporarily for emergency reasons or reasons deemed strictly in the public interest; and (5) aliens who are granted deferred action, which is “an act of administrative convenience to the government which gives some cases lower priority[.]” sup{184} Since these non-citizens are permitted to work and, by implication, live in the United States, hospitals necessarily and impermissibly interfere with the federal immigration scheme when they deny patients falling into these categories their right to remain in the country. sup{185}

In another parallel to *Hazelton*, interference with the federal immigration scheme is apparent because the hospitals’ conduct assumes that “a conclusive determination by the federal government that an individual may not remain in the United States can

---

sup{182} 496 F. Supp. 2d 477 (M.D. Pa. 2007).

sup{183} Id. at 530-31.

sup{184} Ibid. (citing 8 C.F.R. § 274a.12(c) ¶¶ 8-11, 14).

sup{185} Compare Ibid.
somehow be obtained outside of a formal removal hearing.” To the contrary, the United States evaluates the lawfulness of a non-citizen’s presence in the United States exclusively through the complex procedures set forth in the INA. Because repatriation ignores INA procedures, it directly conflicts with federal law governing removal of undocumented migrants.

Thus, just as Gould found state interference with the NLRA’s “interrelated federal scheme of law, remedy, and administration” would be preempted, state or local interference with the INA’s “interrelated federal scheme of law, remedy, and administration” must be preempted. It should be irrelevant that the interference occurs through de facto as opposed to direct lawmaking.

2. The Problem of Private Hospitals

“The Supremacy Clause does not require pre-emption of private conduct.” That is because, by its terms, the clause applies only to “Laws of any State.” Thus, if Gould had concerned a private company’s decision not to do business with repeat violators of the NLRA, there would have been no preemption issue for the Court to evaluate; the conduct would have been permissible even though it too would have interfered with the NLRA scheme.

Similarly, repatriation by private hospitals is not generally subject to preemption analysis even if the conduct directly interferes with federal law. But there may be

---

186 Id. at 530.
187 Id. at 532.
188 475 U.S. at 290.
190 U.S. Const. art. VI, cl. 2.
191 Gould, 475 U.S. at 290.
exceptions to this general rule. In analyzing whether private hospitals can be “State Actors” under the Fourteenth Amendment, courts examine factors such as whether the hospitals are undertaking a traditional state function, are compelled to act by the state, or have a symbiotic relationship with the state. ¹⁹² The same considerations could be imported to preemption analysis in order to determine whether conduct by private hospitals could be considered de facto state law.

Even if preemption analysis is unavailable, this does not indicate that repatriation by private entities is lawful. That would lead to absurd results, such as a change in the focus of the citizen-run Minutemen Project from monitoring the border between the United States and Mexico to repatriation. ¹⁹³ As discussed in Parts III.C-F below, repatriation may give rise civil and criminal actions.

C. False Imprisonment

Beyond constitutional challenges to repatriation by hospitals, various common-law tort claims might lie against hospitals and their employees involved in repatriations, including fraud and battery. The most salient, however, is false imprisonment. The legal guardian of Mr. Jiménez ¹⁹⁴ is currently suing Martin Memorial Medical Center for false imprisonment, and a trial has been tentatively scheduled for September 2009. ¹⁹⁵

The common law tort of false imprisonment generally includes the elements of: (a) intent to confine, (b) confinement, (c) consciousness of the confinement or harm

¹⁹² See Part III.A.1, infra.
¹⁹³ Instead of seeking to enforce federal immigration law themselves, members of the Minutemen Project watch the U.S.-Mexican border for people crossing illegally and then pass the location of those migrants on to law enforcement. See, e.g., Matt Gross, Three Miles to Go in New Mexico, N.Y. TIMES (July 18, 2007).
¹⁹⁴ Mr. Jiménez’s story is recounted in Part II.D supra.
¹⁹⁵ Melissa Holsman, Trial Against Martin Memorial might begin in Sept., STUART NEWS, B5 (Feb. 14 2009).
resulting from the confinement).\textsuperscript{196} In hospital repatriation cases, such elements will be easily met when patients are placed into, or confined, in an ambulance or plane.\textsuperscript{197}

The key issue in repatriation cases will revolve around the affirmative defense of consent. Where the hospital has not in fact obtained any consent, then none would be implied in law, and the hospital would be liable.\textsuperscript{198} For those patients who have consented to repatriation,\textsuperscript{199} the question is whether that consent is sufficient to vitiate the underlying claim.\textsuperscript{200} Hospitals should be wary of relying on patient (or family) consent since they are acting outside of the mandated deportation proceedings. Patients could, for example, claim that the consent was obtained under duress\textsuperscript{201} or by misrepresentation about the legal authority for hospital repatriation,\textsuperscript{202} which would render any consent invalid.

In Florida, where the Martin Memorial case is pending, the courts use a doctrinal formulation for false imprisonment that is somewhat unclear and confused, but which is apparently meant to be similar in substance to false imprisonment claims elsewhere. The four elements for false imprisonment in Florida are: (1) the unlawful detention and deprivation of liberty of a person (2) against that person’s will (3) without legal authority

\textsuperscript{196} See Restatement (Second) of Torts, § 35.
\textsuperscript{197} Confinement to a mode of transport counts as confinement. See, e.g., Whittaker v. Sandford, 85 A. 399 (Me. 1912) (confinement on a yacht); Sindel v. New York City Transit Authority, 307 N.E.2d. 245 (N.Y. 1973) (confinement on a school bus).
\textsuperscript{198} See Sontag I, supra note 9, and Sontag II, supra note 10, reporting about patients who did not want to be repatriated.
\textsuperscript{201} See, e.g., Restatement (Second) of Torts, § 40A.
\textsuperscript{202} See, e.g., Restatement (Second) of Torts, § 41.
or “color of authority” and (4) which is unreasonable and unwarranted under the circumstances.\footnote{\textit{Montejo II}, 935 So.2d at 1268.}

In the Jiménez case, the first prong is clearly met. Although the use of “unlawful” is arguably superfluous and the words “detention” and “deprivation of liberty” would seem to be duplicative, hospital repatriation clearly satisfies this element. The “sole and exclusive procedure for determining whether an alien may be … removed from the United States” is the removal procedures established by the Department of Homeland Security.\footnote{8 U.S.C. § 1229a(a)(3).} Since repatriation effects the removal of aliens outside of these established procedures, it is “unlawful.” The requisite “detention” and “deprivation of liberty” are accomplished by the international transportation of patients.

The second element – lack of consent – gets at the same substance as consent as an affirmative defense, albeit apparently shifting the burden of proof to the plaintiff.

The third element – regarding “legal authority” – has already been the subject of litigation by Martin Memorial.\footnote{\textit{Montejo II}, 935 So.2d at 1266.} The hospital moved to dismiss the false imprisonment suit filed by the guardian of Mr. Jiménez on the basis that the hospital was immune from suit because it had authority from the trial court to repatriate Mr. Jimenez.\footnote{\textit{Montejo II}, 935 So.2d at 1270-71. The court also rejected Martin Memorial’s argument that repatriation occurred “during the course of the judicial proceeding” and, as such, should have been protected “by the absolute immunity related to judicial proceedings.” \textit{Id.} at 1269-70. In rejecting this argument, the court noted simply that “Martin Memorial’s actions were taken neither during the course of the judicial proceedings nor in an effort to prosecute or defend its lawsuit.” \textit{Id.} at 1270.} The District Court of Appeal of Florida rejected this argument.\footnote{\textit{Ibid.}} The court emphasized that the trial
court lacked subject matter jurisdiction to authorize the underlying repatriation order.\textsuperscript{208} And, because the hospital was seeking to vindicate a purely private right when it sought judicial approval to deport Mr. Jiménez,\textsuperscript{209} the hospital was not entitled to immunity for acting pursuant to the void order.\textsuperscript{210} Thus, hospitals cannot obtain “legal authority” to repatriate patients; that is a power exclusively reserved to the Department of Homeland Security.\textsuperscript{211}

The final element – unreasonable and unwarranted under the circumstances – is a strange articulation of law, one alien to traditional notions of false imprisonment. Under the common law, private persons are not certainly not privileged to deprive people of personal liberty at will, even when doing so might be objectively reasonable. Nonetheless, the Florida appellate court has identified this issue as one for the upcoming Martin Memorial trial.\textsuperscript{212} Given such an opportunity, Martin Memorial will no doubt argue that repatriation was reasonable and warranted under the circumstances. To this end, the hospital will emphasize that it had, in hand, a court order authorizing the international transfer. The guardian for Mr. Jiménez, in contrast, will likely emphasize the fact that the court had no authority to approve repatriation – indeed the court determined later that it had lacked subject-matter jurisdiction. Moreover, Mr. Jiménez will likely argue that the very way in which the hospital chose to execute the repatriation – hours before the hospital’s response to a request for stay pending appeal was due and

\textsuperscript{208} Montejo I, 874 So.2d at 658.
\textsuperscript{209} That is, the hospital was not in the same position as an agent of the government executing an order of the court. Montejo II, 935 So.2d at 1270-71.
\textsuperscript{210} Id. at 1271; see Montejo I, 874 So.2d at 658 (“the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala”).
\textsuperscript{211} 8 U.S.C. § 1229a(a)(3).
\textsuperscript{212} Montejo II, 935 So.2d at 1272.
“shortly before daybreak”\textsuperscript{213} evidences the fact that the hospital knew full well that the underlying order was unauthorized.

While these are contested factual disputes in the Martin Memorial trial, they are unlikely to arise in other suits against hospitals precisely because of the \textit{Montejo} precedent. Hospitals are now fully on notice that courts cannot authorize repatriation – that is the exclusive province of the Department of Homeland Security. At the same time, if hospitals act to repatriate patients without any legal authority, their conduct is unlikely to be held reasonable under the circumstances.

This analysis indicates that the tort of false imprisonment may be a significant tool for challenging hospital repatriation efforts. Yet there will undoubtedly be challenges to such civil suits. It may be difficult or even impossible for repatriated individuals to find counsel in the United States much less to be involved in such suits from abroad. Moreover, it may make economic sense for hospitals to risk and even lose such civil suits. If a hospital is stuck with a million-dollar verdict, it may nevertheless have saved several millions of dollars in long-term care by accomplishing the repatriation. That said, a conscious choice to pursue a course of improper but profitable conduct would certainly open the door to punitive damages, which may be enough to deter repatriation.

\textbf{D. Kidnapping}

Kidnapping, of course, is the criminal parallel to false imprisonment. Under 18 U.S.C. § 1201, it is a federal crime to “unlawfully seize[] … or carr[y] away and hold[]

\textsuperscript{213} Sontag I, supra, note 9; \textit{Montejo II}, 935 So.2d at 267-68.
for ransom or reward \textit{or otherwise} any person … when the person is willfully transported in interstate or foreign commerce.\textsuperscript{214}

Repatriation by U.S. hospitals meets this definition of kidnapping. The hospitals’ conduct is unlawful: as discussed above, private deportation is not allowed by statute and patient consent is meaningless in the context of repatriation. Repatriation also involves the carrying of individuals across international borders. And it is an act of foreign commerce because the cost of caring for the transported patient is being transferred from the United States to the destination country.

The penalties for federal kidnapping are severe. If applied to repatriation, hospital administrators could face “imprisonment for any term of year or for life and, if the death of any person results, shall be punished by death or life imprisonment,”\textsuperscript{215} for the repatriation of patients over the age of 18. They could face “imprisonment for not less than 20 years”\textsuperscript{216} for the repatriation of patients under the age of 18. Of course, in addition to federal charges, hospitals and involved persons could face state kidnapping charges.

\textbf{E. RICO}

In addition to kidnapping charges, repatriation may open hospital administrators to charges brought under the Racketeer Influenced and Corrupt Organizations Act (“RICO”).\textsuperscript{217} RICO makes it illegal “for any person employed by or associated with any

\footnotesize
\textsuperscript{215} 18 U.S.C. § 1201(a).
\textsuperscript{216} 18 U.S.C. § 1201(g).
\textsuperscript{217} RICO is not only the basis for criminal charges, it expressly provides for civil suits. 18 U.S.C. § 1964(c). Civil RICO actions will have particular appeal for private litigants because the statute authorizes both treble damages and the recovery of attorneys fees. \textit{Ibid.} However, civil RICO claims can only be brought upon a showing of injury to
enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise’s affairs through a pattern of racketeering activity…” 218

One could argue that doctors, hospital administrators, hospitals, and medical transport companies are participants in an enterprise who common purpose is repatriation of medically needy patients.219 The enterprise affects foreign commerce in two ways: (1) the cost of caring for the patient shifts from the United States to the country of repatriation; and (2) the transportation costs themselves affect foreign commerce. Furthermore, the participants accomplish repatriation through “racketeering,” which, by its definition, includes “any act or threat involving… kidnapping.” 220 Because repatriation meets the federal definition of kidnapping, as outlined in Part III.D, RICO’s requisite “pattern” of racketeering could be established by two or more acts of repatriation or attempted repatriation.221 The pattern or racketeering may also be rooted in the hospital administrators’ communications with foreign embassies, hospitals, and patients’ family members: If the administrators fraudulently represent the legal basis for

---

219 The purpose would not be limited to the repatriation of undocumented migrants because hospitals have the same incentives to repatriate uninsured legal aliens. See Sontag II, supra note 10 (discussing repatriation of uninsured legal immigrant).
221 18 U.S.C. § 1961(5) (“pattern of racketeering’ requires at least two acts of racketeering activity… the last of which occurred within ten years … after the commission of a prior act of racketeering activity.”).
repatriation, those communications may amount to mail or wire fraud, which are also
predicate racketeering acts.\textsuperscript{222}

As with kidnapping, severe penalties flow from RICO convictions. The statute
authorizes imprisonment for “not more than 20 years (or for life if the violation is based
on a racketeering activity for which the maximum penalty includes life
imprisonment).”\textsuperscript{223} It also authorizes fines and criminal forfeiture.\textsuperscript{224}

\section*{F. EMTALA}

EMTALA has also created a private cause of action for “[a]ny individual who
suffers personal harm as a direct result of a participating hospital's violation of a
requirement of” the statute.\textsuperscript{225} Individuals may “obtain those damages available for
personal injury under the law of the State in which the hospital is located, an[d] such
equitable relief as is appropriate.”\textsuperscript{226}

The statute is significant in part because it renders hospitals automatically liable
for the conduct of their employees. In contrast to tort law, plaintiffs will not need to
establish that the hospital was responsible for the conduct of its emergency medical
providers either on theory of \textit{respondeat superior} (for employees) or negligent
supervision (for independent contractors).\textsuperscript{227}

\footnotesize
\begin{itemize}
    \item \textsuperscript{222} 18 U.S.C. 1961\$1961(1)(B) (citing 18 U.S.C. \$\$ 1341 (mail fraud), 1343 (wire
        fraud)).
    \item \textsuperscript{223} 18 U.S.C. \$ 1963(a).
    \item \textsuperscript{224} \textit{Id}.\textsuperscript{225}
    \item \textsuperscript{225} 42 U.S.C. \$ 1395dd(d)(2)(A).
    \item \textsuperscript{226} 42 U.S.C. \$ 1395dd(d)(2)(A).
    \item \textsuperscript{227} See Gloria Frank, \textit{EMTALA: An Expert Tells Us What It’s All About}, J. of
        _cdi=6869&_user=2386327&_orig=search&_coverDate=02%2F28%2F2001&_sk=9
\end{itemize}
In addition, some courts have found that EMTALA preempts state hurdles to lawsuits against hospitals.\textsuperscript{228} For example, the Eighth Circuit has held that EMTALA preempted a Missouri statute that provided immunity to state hospital districts.\textsuperscript{229} The Fourth Circuit did not need to reach the issue of preemption when it evaluated the effect of the Maryland Health Care Malpractice Claims Act on EMTALA suits; it found the state statute entirely inapplicable to EMTALA claims.\textsuperscript{230} State limits on damage recovery, however, have been allowed to stand.\textsuperscript{231} Nonetheless, EMTALA itself may provide another significant means for challenging hospital repatriations.

IV. A NEW PROPOSAL

A. The Need For A Uniform Public Solution

The expenses associated with long-term care of undocumented migrants in U.S. hospitals cannot be ignored. If private repatriation is, as I argue, legally flawed, the answer cannot be that hospitals must simply accept the financial losses associated with the care of undocumented migrants. Such a solution would surely lead to the closure of at least some medical facilities. In Los Angeles County alone, some ten hospitals have closed in the last five years, citing losses from treating the uninsured.\textsuperscript{232}

One could argue that the federal government should step in by funding the long-term care of undocumented migrants, following the model of California and New York.

\textsuperscript{228} Ibid.
\textsuperscript{229} Root v. New Liberty Hospital District, 209 F.3d 1068 (8th Cir. 2000).
\textsuperscript{230} Brooks v. Maryland General Hospital, 996 F.2d 708 (4th Cir. 1993).
\textsuperscript{232} Mary Engel, Latinos’ use of health services studied, L.A. TIMES, Nov. 27, 2007.
City. Yet this solution seems highly unlikely and arguably runs contrary to the policy norms implicit in current immigration law.\footnote{The government already has measures in place to avoid needing to pay for the long-term medical care of legal immigrants. For example, medical examinations are required for overseas applicants for immigrant visas, 22 C.F.R. § 42.66, those seeking refugee status, 8 C.F.R. § 207.2, special agricultural workers, 8 C.F.R. § 210.1(d), and applicants in the United States seeking to adjust to permanent resident status, 8 C.F.R. § 245.5.}

I believe that the solution lies in a new, federal repatriation program for the medically needy. Hospitals should be able to contact the Department of Homeland Security when faced with patients they believe could be repatriated. Homeland Security, through Immigration and Customs Enforcement (“ICE”), should, in turn, initiate and complete expedited removal proceedings tailored to address the unique concerns raised by medical repatriation.

In short, the answer is process. Repatriation of the medically needy would not be abhorrent if it were conducted in a uniform manner with the procedural safeguards already put in place for evaluating the removal of undocumented migrants.

In order to implement an effective repatriation process, Congress should first pass legislation making it a federal crime for hospitals to transport (or arrange transport of) undocumented migrants across international borders with or without patient consent. Such a law must be passed in order to achieve uniformity and address the problems posed by: (a) private hospitals who may not considered state actors for constitutional analysis, (b) consent by duress or misrepresentation.

**B. Federal Repatriation**

Establishing a federal process for the repatriation of medically needy undocumented migrants would not be difficult as there is already in place a system for
the removal of non-citizens. The issues unique to the medically needy would be: (a) how to involve hospitals in the process; (b) how to quickly and efficiently determine whether an individual patient is an undocumented migrant subject to removal from the country; and (c) how to appropriately remove the patient.

1. Step One: Hospital Reporting

Hospital administrators should be able to contact a local ICE office when they believe they are providing emergency medical care to undocumented migrants facing long-term medical needs. This initial contact should be voluntary, not mandatory, and should be initiated by the hospital itself and not by independent investigation by ICE officers.

There are two critical reasons for making the initial report discretionary. First, some cities and states have declared themselves to be “sanctuaries” and have accordingly passed laws that would prohibit them from reporting undocumented patients to federal authorities. Second, other hospitals may have overriding public health concerns that will lead them not to seek repatriation assistance from the federal government – for example, some hospitals will not want to report undocumented migrants because it might discourage other undocumented migrants from seeking needed medical care when

---

suffering from diseases with potentially disastrous public health consequences such as avian flu or drug-resistant tuberculosis.\footnote{Former Mayor of New York City Ed Koch noted this concern was one basis for his city’s sanctuary policy. See Ronald Brownstein, ‘Sanctuary' as battleground, L.A. TIMES (Aug. 22, 2007) (quoting Koch on his objection to checking for immigration documentation at emergency rooms: “The effect would be . . . illegal aliens would be . . . contagious and causing disease to spread . . . It's hard to see where there would be any advantage in [that].”).}

Where hospitals decide, for their own reasons, to continue to provide care and to not seek deportation, then, in keeping with the norms of current immigration law, hospitals should not be compelled to serve the role of snitches. Many hospitals, of course, such as Martin Memorial, will welcome the opportunity to report those patients who are undocumented migrants and require long-term, un-reimbursable, medical care. By directing these hospitals to ICE, the law introduces a full measure of due process and an incremental measure of humanity into the dynamic.

2. Step Two: Removal

Once notified, ICE officials should begin the process of evaluating whether there is prima facie evidence that the identified patient is a non-citizen present in the United States in violation of law.\footnote{This is the current standard for determining whether an arrested alien should be issued a Notice to Appear before an immigration judge in removal (deportation) proceedings. See 8 C.F.R. § 287.3(b). Given the immobility of medically needy aliens and the pressing time concerns, I propose conflating the arrest and subsequent notice into a single notice step.} Given the potentially very high costs associated with intensive medical care, legislation or regulations could be instituted to establish prompt deadlines for this first step. For example, ICE might be required to look into a hospital’s request within 48 hours of receiving the initial notice.
Speed in this early stage is sensible because determining whether a patient is a candidate for removal is not typically difficult. Patients may readily admit that they are undocumented and indeed may have already disclosed this fact on hospital admission forms or to a doctor taking the patient’s medical history. Completing this step simply sets the stage for removal proceedings.

Formal removal could be accomplished in many different ways. One means would be simply integrating patients into the traditional removal system with their cases heard in due course. But traditional removal proceedings take several months to complete and, during that time, the costs of caring for the potentially removable patients will continue to rise on a daily basis, making this a very unsatisfying option.

Alternatively, Congress could add medically-needy undocumented patients to the list of individuals subject to “expedited removal” from the United States. Congress has already empowered immigration officers (as opposed to immigration judges) to order the removal of several classes of inadmissible aliens without further hearing or review unless the non-citizen indicates an intent to apply for asylum and has a credible fear of persecution. While this expedited process would address the cost concerns that militate against traditional removal, grouping medically needy undocumented patients

---

237 Those currently subject to expedited removal include: (1) non-citizens attempting to enter the United States without admission documents, who present false documents, or who misrepresent a material fact to obtain a visa or gain admission to the United States, 8 U.S.C. § 1225(b)(1)(A)(i); (2) non-citizens who have not been admitted or paroled into the United States who have not affirmatively shown physical presence in the United States for the past two years, 8 U.S.C. § 1225(b)(1)(A)(iii)(I), see also 67 FR 68,924-5 (Nov. 13, 2002); (3) non-citizens encountered within 100 miles of the U.S. border and who entered the U.S. without inspection less than 14 days before the time they are encountered, 69 FR 48,877-81 (Aug. 11, 2004); and (4) non-citizens deemed inadmissible on security grounds, 8 U.S.C. § 1225(c).

with inadmissible aliens poses significant problems. Because the patients are present in the United States and not seeking entry at our nation’s border, they have due process rights that demand more than adjudication by an immigration officer without judicial review.

Thus, unique issues raised by repatriation of the medically needy call for a middle-of-the-road approach. Removal proceedings must be expedited, to address hospitals’ cost concerns, but patients’ due process rights must also be secured. The Department of Homeland Security already takes such a balanced approach in handling the removal of non-citizens convicted of aggravated felonies.239 Lawful permanent residents convicted of aggravated felonies are subject to ordinary removal procedures,240 but there is a statutory mandate to finalize the removal proceedings before the non-citizen’s release from incarceration for the underlying aggravated felony.241 The scheme accomplishes speed in some instances by use of videoconference technology to hold removal hearings in detention facilities.242

Non-citizens who are not lawful permanent residents are also subject to more abbreviated procedures. Such persons receive an administrative removal order that is subject to judicial review243 or an order of removal by the federal district court presiding over their criminal sentencing.244

243 8 U.S.C. 1228(b).
244 8 U.S.C. § 1228(b), (c), (c).
Congress should fashion a new form of removal for medically needy undocumented migrants modeled on the removal of aggravated felons. New legislation should authorize expedited removal of medically needy non-citizens. As with aggravated felons, those who are not lawful permanent residents could be subject to administrative removal with an opportunity for judicial review. Those who are lawful permanent residents could follow traditional removal proceedings at an expedited pace. Videoconferencing could be used to hold removal hearings in hospitals just as they are currently being held in prisons and detention facilities.

Congress will have to consider how to handle the removal of those non-citizens who are mentally impaired as a result of their medical conditions. Traditionally, non-citizens are only entitled to legal representation in removal proceedings at no expense to the government.\(^\text{245}\) In medical repatriation cases, however, the lack of any representation would work an injustice. Congress should appoint either counsel or a guardian ad litem for affected patients. If Congress chooses the latter option, there is no requirement that the guardian be an attorney. This role could be taken up by a relative or friend of the patient. In the absence of any such individual, a social worker or other appropriate representative should be utilized.

Essential to any new removal procedures will be the implementation of standards to evaluate: (1) whether the patient is medically stable for transport out of the United States and (2) whether the patient will receive medical care in their home country.

Critics might argue that ICE is not equipped to make determinations about a patient’s medical condition, much less the level of care available to that patient in another

country. Yet such expertise could be easily obtained. The United States already evaluates the medical stability of patients for purposes of inter-country travel. The U.S. military makes such determinations about soldiers wounded in Iraq and Afghanistan every day. The model established by the military could be adopted by ICE. A limited number of medical personnel could be hired either on a full-time or consultant basis by ICE to evaluate patients and the available medical treatment in their home countries. Indeed, if all medical repatriation cases were funneled to one set of ICE agents and attorneys, the government could create a group with special expertise in handling these cases. That expertise could be further retained by providing that any contested medical repatriation cases be heard by a specially appointed immigration judge with medical expertise or training.

Specialized attorneys and judges have the potential to benefit not only the removal of undocumented patients with long-term medical needs but the removal of other non-citizens with medical concerns. For example, the Department of Homeland Security came under fire in 2006 when a non-citizen miscarried twins during her physical removal from the United States. Had her removal been handled by attorneys and judges immersed in medical issues, perhaps her removal could have been effected in a way that would have avoided such a tragic result.

Evaluating the availability and adequacy of medical treatment abroad will be much more complex and controversial than evaluating the stability of patients for travel. Centralizing the analysis to a specialized task force within ICE will assure that consistent standards will be followed. Among the issues that should be considered are:

• Is the patient’s home country willing to accept the responsibility of caring for the patient?

• What medical treatment will be available in the home country?

• Will the patient be transferred to the care and custody of a hospital, rehabilitation center, nursing home, or other medical facility?

• How long will the patient receive medical treatment in their home country?

• Will return of the patient to their home country likely be fatal?

Few countries will provide medical treatment equal to that which is available in the United States. This alone should not prevent repatriation efforts. But the government should evaluate whether repatriation would, in fact, be “a death sentence.”\footnote{Sontag I, supra note 9. (“’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.’”).} In those cases, attempts at repatriation should be abandoned. The United States already has a policy of refusing to send migrants home to certain death – one that is codified in our asylum laws\footnote{See 8 U.S.C. § 1101(a)(42); 8 U.S.C. § 1158(b)(1).} and in our adherence to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment\footnote{See 8 C.F.R. §§ 208.16-208.18.} – and death by repatriation should be treated no differently.

If it is determined that repatriation cannot be accomplished due to the patient’s unstable medical condition or an absence of medical care in the home country, the patient
should be paroled into the United States. Regulations could be established to reevaluate the patient’s medical condition and home-country conditions on a periodic basis in order to determine if removal can be accomplished. In the interim, Medicaid should be extended to parolees in order to reimburse hospitals in part for care provided to non-removable patients.

V. CONCLUSION

Providing long-term care to medically needy undocumented migrants is a costly proposition. But the solution cannot be institutionalized vigilantism where hospitals deport undocumented migrants without process or oversight. Immigration is, and should be, regulated solely by the federal government, and thus the federal government must step in to establish uniform procedures for the removal of medically needy undocumented migrants.

250 8 U.S.C. § 1182(d)(5)(A). Non-citizens who enter the United States on parole have not been “admitted” under the INA; they may be subject to expedited removal proceedings if ultimately deemed inadmissible.