6. One study indicated that 14.3% of women aged 18-25 years with one lifetime sex partner, 22.3% with two lifetime sex partners, and 31.5% with more than three lifetime partners (33) had HPV infection. Id. at 3.

7. Id.


9. When it comes to vaccine policy, the Advisory Committee on Immunization Practices (ACIP) sets the agenda. Congress established the group to advise the Centers for Disease Control and Prevention (CDC). Based on the ACIP’s advice, the CDC recommends vaccine policy to the states. Although the CDC’s recommendations are not binding, nearly all states choose to follow them. Id.


15. See Jordan, supra note 12.

16. Id.

17. Id.


19. See Campagne Francaise de Navigatation a Vapeur v. Louisiana State Board of Health, 186 U.S. 380, 385 (1902), the Supreme Court held that the Louisiana Board of Health had the authority under statute, to "exclude healthy persons from a locality infested with a contagious or infectious disease, and that this power was intended to apply as well to persons seeking to enter the infected place, whether they came from without or from within the state" and that this statute was consistent with the United States Constitution. Id.

20. See Jacobson v. Commonwealth of Massachusetts, 197 U.S. 11, 25 (1905). The Supreme Court held that mandatory vaccination was necessary and reasonable. Although the Supreme Court specified that this ruling applied only to the specific question of whether the smallpox vaccine could be mandated, the case has been used to support a wide range of public health measures.


23. J. D. Blum and N. Talib, "Balancing Individual Rights v. Collective Good in Public Health Enforcement," Medicine and Law 25 (2006): 273. Following the Jacobson formula, the viability of mandatory childhood vaccine programs would depend on whether such efforts would be seen by courts as necessary, reasonable, proportional, and safe for the participants. Id.


25. Id.


27. See National Conference of State Legislatures, supra note 9. The CDC announced that the HPV vaccine is available through the Federal Vaccines for Children (VFC) program in all 50 states. Chicago, New York, Philadelphia, San Antonio and Washington DC. VFC provides vaccines for children ages nine to 18 who are covered by Medicaid, Alaskan-Native or Native American children, and some underinsured or uninsured children.

28. See CDC, supra note 4, at 15.

29. See Jacobs, supra note 20. "[I]t might be that an acknowledged power of a local community to protect itself against an epidemic threatening the safety of all might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons."

30. See Adams, supra note 22, at 822. The Supreme Court in Adams justified requiring different testing standards for cows outside of Milwaukee and those inside the city saying, "The requirements are not unreasonable; they are properly adaptive to the conditions. They are not discriminatory; they have proper relation to the purpose to be accomplished."

31. Where there is an indication that a certain group of citizens poses a great threat to public health, it may be appropriate to apply vaccine mandates to that group. Although you could argue that a class of immigrants is not similarly situated (as explained in Jacobson) to citizens, for the purpose of the HPV vaccine, unless some justification can be advanced for requiring the vaccine for immigrants and not for citizens, it appears arbitrary or, worse, discriminatory.


Medical Repatriation of Alien Patients

Joseph Wolpin

Transferring uninsured alien patients with significant long-term care needs to facilities abroad, a practice known as medical repatriation, has been characterized as an economic necessity by hospital administrators and as unethical international patient dumping by immigrant advocates. No state or federal governmental agencies track medical repatriations, so it is difficult to gauge their frequency nationwide; a recent New York Times investigation suggests that hundreds of cases occur each year, with the majority of patients repatriated to South America. Despite such numbers, current federal and state laws do not directly address repatriations. Instead, immigration and Medicaid reforms over the past decade have created a de facto regulatory framework in which repatriation has become an attractive solution for hospitals faced with increasing costs of uncompensated medical care for uninsured non-citizens. What is currently lacking, though, is a set of legal or regulatory protections that would ensure that these transfers protect patients’ interests.

Although empirical confirmation is lacking, anecdotal evidence suggests that most medical repatriations result from cases when uninsured aliens present at emergency rooms with catastrophic injury or significant acute care needs that
require long-term care. There is substantial evidence indicating that the uninsured generally and uninsured aliens in particular wait until symptoms and illnesses have progressed substantially before seeking medical care, most often in emergency rooms. When hospitals are unable to find a charity or relatives who can provide for the alien's long-term care needs, hospitals may then consider repatriating the patient. Transferring a patient to a facility abroad can offer significant benefits to hospitals because it allows them to reduce uncompensated care costs and free space for other patients. If it works well, repatriation may also allow non-citizens to move closer to relatives and a familiar culture while they recover. However, dangers arise when patients are forced, pressured, or unwittingly consent to return to foreign facilities that prove to be inadequate for their medical needs.

On October 6, 2008, the California Medical Association (CMA) House of Delegates passed Resolution 105a-08, entitled “Forced Deportation of Patients” in an attempt to address these concerns. The resolution contained two brief declarations: “CMA oppose[s] forced deportation of patients” and proposes “that this [issue] be referred for national action.” The original draft resolution submitted by Dr. Robert J. Margolin contained a more detailed formulation, calling for medical repatriations to “be done only with the full consent of the patient and their families and to foreign facilities that can provide adequate long-term care.” Although that language was ultimately rejected, the CMA’s resolution represents the first time a state medical association has officially addressed the legally, economically, and ethically complex issue of hospital-sponsored repatriations of uninsured aliens.

One month after the CMA resolution’s passage, the American Medical Association (AMA) House of Delegates considered the issue at its 2008 Interim Meeting. The California delegation, prompted again by Dr. Margolin, submitted a draft resolution calling on the AMA to oppose forced medical deportations. The resolution was debated in the AMA’s Reference Committee on Amendments to Constitution and Bylaws; testimony “was divided, but witnesses generally concurred that repatriation poses significant professional challenges for physicians.” Although AMA members could not reach a consensus on the issue, the House of Delegates voted to commission a study to examine the practice and return to the debate at its 2009 Interim Meeting.

Immigration and Medicaid reforms over the past decade have created a de facto regulatory framework in which repatriation has become an attractive solution for hospitals faced with increasing costs of uncompensated medical care for uninsured non-citizens. What is currently lacking, though, is a set of legal or regulatory protections that would ensure that these transfers protect patients’ interests.

The CMA’s resolution and upcoming AMA study on medical repatriations mark important first steps in the development of the medical community’s position on the issue. Because the House of Delegates is the principal policy-making body of the AMA, any future pronouncement on medical repatriations could indicate the organization’s intentions to lobby state and federal lawmakers for reform.

Defining “Forced” In evaluating future policy regarding medical repatriations, a distinction will need to be made between non-consensual medical repatriations and those that occur following patient or guardian consent. Both the CMA resolution and the AMA have focused on “forced” repatriations without defining the word “forced.” One possible definition would be physically removing patients from the U.S. against their wishes, which may raise issues of liability for false imprisonment. Issues of force may also arise in cases in which a legal guardianship has been established, such as for a comatose patient or a child. For example, can a hospital intervene in a guardianship hearing to argue that an uninsured alien ward’s best interests are served by repatriation to the home country for treatment, even over the guardian’s wishes? The legal and ethical boundaries for proceeding with a medical repatriation for a patient unable to personally consent have not been fully resolved by either statutory or common law; the current lack of guidance from the CMA resolution and the AMA means that the issue remains an important and open one that highlights the additional complexities of medical repatriations when patients are unable to make decisions for themselves.

Perhaps more significantly, the CMA resolution and AMA also have yet to address the requirements of informed consent to repatriation, whether that consent is granted by the patient or a guardian. Future studies of medical repatriations may show that consensual transfers prove to be the rule rather than the exception; one company that arranges medical repatriations, California-based Mexcare, claims “all of MexCare’s transfers have been done with a signed consent of the patient or their Legal Guardian and with extensive communication with their family.” Requiring consent before effecting a repatriation would offer alien patients some pro-
tection, but how much will depend on the contours of the consent. One particularly relevant safeguard might be to inform patients of the possible immigration consequences of leaving the country before agreeing to the repatriation. This process would be similar to statutory protections in some states that require trial courts to inform non-citizen defendants that adverse immigration consequences may result from a plea agreement or plea of guilty. This pre-repatriation protection is particularly important for non-citizen patients because once outside the country, they will face significant logistical obstacles to obtaining legal remedies in U.S. courts and will be unable to challenge any part of their repatriation.

Despite leaving such issues unresolved, the CMA and AMA's latest actions have added important new voices in the discussion of the ethical, legal, and economic consequences of medical repatriation. Jack Scarola, the lead attorney in a current civil case related to the repatriation of a Guatemalan citizen, believes states or the federal government need to develop better rules to govern the practice of repatriations: "The problem clearly cries out for a legislative solution; however, until such a solution is crafted, we cannot permit the continued victimization of undocumented persons through international patient dumping." Hospitals may disagree with that characterization of repatriations, but they surely find the economic strains of uninsured alien care frustrating. "It should be a governmental burden," said one hospital administrator in an interview in the New York Times. Yet even that solution appears incomplete; countries with universal health care also have been forced to confront the dilemmas that medical repatriations present.

In March 2008, for example, a Ghanaian woman died of cancer shortly after being deported from the United Kingdom following the expiration of her visa. The Lancet, the leading medical journal in the U.K., called her deportation an "atrocious barbarism," reacting to the fact that British immigration officials ordered the woman's removal despite knowing she was unable to afford continued treatment in Ghana. Uninsured Alien Patients: Legal Restrictions and Hospital Responses

In the U.S., uninsured aliens seeking medical care face significant barriers to treatment. Undocumented aliens have long been banned from receiving most federal benefits, a rule most recently restated in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. However, the PRWORA's more controversial provisions made even most legal immigrants ineligible for Medicaid and the State Children's Health Insurance Program (SCHIP) for five years after entering the U.S.

In addition, although the PRWORA restrictions end after five years, immigrants who are required to submit Affidavits of Support when applying for permanent residency (for example, all family-based immigrants) often cannot obtain benefits for an additional five years. Affidavits of Support are guarantees by a U.S. citizen or permanent resident sponsor that the incoming immigrant will not become a public charge for ten years following admission to the U.S. Until 1996, affidavits were treated as moral promises, but the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 made them legally binding on the sponsors. Immigration rules further provide that a sponsor's income must be included when determining an immigrant's eligibility for federal means-tested benefits until the immigrant attains citizenship or completes 40 quarters of qualifying work. These federal rules severely limit new legal immigrants' access to Medicaid, making most ineligible for ten years. And although some states provide replacement coverage for these individuals, eligibility and coverage vary greatly depending on the state.

While restrictions on Medicare eligibility make non-citizens' situations more acute, medical repatriations can be conceptualized as a subset of the broader problem of discharge regulations. All aliens, regardless of legal status, qualify for the emergency screening and stabilization protections of the 1996 Emergency Medical Treatment and Active Labor Act (EMTALA). Under EMTALA, hospitals must stabilize emergency patients and provide treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility." Despite EMTALA's prohibitions on "patient dumping," hospitals face difficult choices when deciding how and when to discharge uninsured patients who need extensive follow-up care after being stabilized. Under current law, hospitals have a discharge option for non-citizens unavailable for U.S. citizen patients: repatriation.

If a hospital chooses to transfer a patient to another facility, it must comply with Centers for Medicaid and Medicare Services (CMS) Conditions of Participation (CoPs) relating to patient discharges. Among these requirements are that the patient be transferred only to an "appropriate facility," interpretive guidelines suggest such a facility is one "that can meet the patient's medical needs on a post-discharge basis." In Montejo v. Martin Memorial Medical Center, Inc., one of the few reported cases concerning a challenge to a medical repatriation, a Florida Court of Appeals found that the hospital failed to meet CMS discharge requirements when it did not demonstrate that the foreign facility suggested for transfer could meet the patient's medical needs. If other courts follow this precedent, then Medicaid-participating hospitals will need to be particularly careful in investigating the quality and capacity of foreign medical facilities before repatriating patients to them.

Implications for Health Care Reform

If changing the regulatory structure surrounding medical repatriations will require significant alterations to current federal Medicaid law and
guidelines, reformers may face a difficult political battle. In addition, some of the legal and ethical issues implicated by medical repatriations apply to all uninsured patients; during the AMA House of Delegates debate regarding the proposed resolution censoring medical repatriations, one speaker concluded that “the overarching concern in this matter involved inappropriate discharge of patients more than immigration status specifically.” Dr. Margolin, the physician who proposed the CMA resolution against medical repatriations, also sees broader themes underlying the issue: “Unfunded mandates are bad in medicine. Either we create federal Medicaid minimum standards for acute illness that cover everyone, or we at least make sure that if we send someone abroad, there is no question that the foreign facility can properly take care of them. After all, we doctors all took an oath to ‘First, do no harm.’”

References
1. The terms “medical deportation” and “medical repatriation” often have been used interchangeably by the press and public when discussing this issue. Because “deportation” carries specific immigration law connotations, I use “repatriation,” a more neutral word denoting a return to the country of origin. Also, I use “alien” and “non-citizen” interchangeably to refer generally to non-U.S. citizens and “immigrant” to those holding U.S. permanent residency.


3. Id.


5. See Sontag, supra note 2.

6. Id. (describing the personal stories of several immigrants whose medical condition deteriorated rapidly after being repatriated to their native countries in South America).

7. CMA House of Delegates Res. 105-08a (October 6, 2008).


12. See supra notes 7, 9, and 10.

13. See Montejano v. Martin Memorial Medical Center, Inc., 874 So. 2d 1266 (Fla. Dist. Ct. App. 2006); the case has been remanded and a jury trial on the false imprisonment action is likely to occur in spring 2009. Personal communication from Jack Scarola to author, November 25, 2008.


16. For instance, threatening undocumented patients of notifying immigration authorities if they do not consent to repatriation.

17. Among the many possible immigration consequences that could follow a medical repatriation, permanent residents might find themselves unable to re-enter the U.S. after leaving its borders under certain circumstances. See U.S.C. §101(a)(15)(C) (1993).

18. See INS v. St. Cyr 533 U.S. 329, 322 (citing state statutes with these requirements).

19. Personal communication from Jack Scarola (lead attorney in Montejano case) to supra note 13 to author November 25, 2008.

20. See Sontag, supra note 2 (noting that un-reimbursed care for uninsured alien patients can cost hospitals millions.


25. See 8 CFR §213a.2; family-based immigrants represent the largest group requiring the affidavits of support, however, other smaller classes of immigrants must provide them as well.


27. Costich, supra note 9 at 1049.


31. See 42 CFR §482.43.

32. 42 CFR §82.43(d).


34. See 574 So. 2d 654, supra note 14 (holding that a letter from a doctor in the foreign facility promising to provide adequate care was inadmissible hearsay evidence).

35. See AMA House of Delegates, supra note 10.

36. Personal communication from Dr. Robert J. Margolin to author, November 25, 2008.

Proposal 2: Michigan Voters End 30-Year Ban on the Destruction of Human Embryos for Stem Cell Research

Elisha Baron

On November 4, 2008, Michigan voters approved by a slim 53 percent margin a citizen-initiated amendment (Proposal 2) to the state constitution to allow research on surplus human embryos originally created for fertility treatments. Proposal 2 overturns a 30-year Michigan ban on human embryo research which allegedly discouraged life sciences research and investment in the state. The new law came into effect on December 19, 2008.

Background
Prior to the November ballot, Michigan was among the small minority of states which explicitly banned non-therapeutic research which threatened the “life or health” of a human embryo, fetus, or neonate. Michigan researchers could only conduct research using adult stem cells or already-extracted cell lines from other states and foreign countries because the creation of embryonic stem cell lines involves the destruction of embryos. With the passage of Proposal 2, research will also be permitted on embryonic stem cell lines created within Michigan.