Futility on the Border

Miguel is an eighteen-year-old male transferred to Alamo Hospital for anti-venom treatment after a rattlesnake bite while sleeping on railroad tracks. His “coyote,” an individual who guides undocumented people across the U.S. border from Mexico, dropped him off at a clinic. By the time Miguel was transferred from the clinic to Alamo, he was in complete paralysis and at risk for heart failure, requiring ventilator support to breathe. A person who receives treatment for a snake bite within one to two hours has a 99 percent chance of recovery, but for Miguel, at least fifteen hours had already passed.

A hospital ethicist at Alamo contacted the Mexican consulate, and together they arranged for Miguel’s father to come to Alamo and make decisions for him. His physicians have determined that he is in a persistent vegetative state and can no longer benefit from hospital treatment. However, no long-term care facility will accept him. Miguel is undocumented and unfunded.

Miguel’s father wishes to take his son home, but the cost of transporting him is high, and their home state in Mexico has no ventilator available for him and no consistent supply of electricity to run it. What should the hospital do?

The second issue is more pragmatic. How can we provide care for these individuals? My experience as a clinical ethicist gives me a deeply ingrained moral injunction: We ought to provide care for those people in medical need. The challenge comes when there are limited resources and someone has to pay the bills. One consulting company, MGT of America, estimates that for U.S. border counties, uncompensated emergency care accounts for $190 million. The Texas Comptroller has said that medical care for the undocumented costs that one state $1.3 billion per year.

One solution to which hospitals are increasingly frequently resorting is medical repatriation. The hospital sends critically injured or ill immigrants back to their native country, even without their consent. In a report issued last year, Discharge, Deportation, and Dangerous Journeys, the Center for Social Justice and New York Lawyers for the Public Interest documented over eight hundred cases during a six-year period. In Miguel’s case, then, the choices are grim: (a) remove his ventilator and feeding tube support and provide comfort care only, (b) keep him in the ICU at U.S. taxpayer expense, (c) find a long-term care facility that accepts ventilator-dependent patients who lack any private or public means of support, or (d) try to repatriate him to his home country. His father rejects (a), and (b) and (c) are not viable.

Mark Kuczewski has written that medical repatriation may be ethically acceptable if it meets three criteria: it is in the patient’s best interest, medical due diligence is followed, and the patient (or the patient’s legal surrogate) gives informed consent. In Miguel’s case, being close to his family, who can then visit him and provide some caregiving, is a clear benefit of repatriation. However, Miguel is dependent on a ventilator, and such a device is not available in his home state, nor is the electrical supply there dependable. Also, we do not know that he will receive an equivalent level of medical care.

One solution would be for the hospital to donate a ventilator to Miguel, along with a generator so as to ensure a steady electrical supply. A ventilator costs about $30,000, a generator about...
Kuczewski's last criterion is that repatriation can be done only with consent. Miguel's father would need to understand the risks and benefits and be able to provide the consistent electrical supply his son's ventilator needs. In addition, his decision would need to be uncoerced. In this case, if Miguel's family and the hospital agree, medical repatriation may not only be ethical, but also the best choice.

Under the terms of the statute, Alamo need not prove that further treatment is "futile," but only that it is "inappropriate." There is therefore no legal need to engage in a debate over the meaning of medical futility. Indeed, it would be difficult for Alamo to prove futility under any generally accepted legal meaning. For Miguel, continued treatment, including ventilation, is not "futile" in the sense of the often-used analogy that giving antibiotics to a patient with a viral infection would be futile because antibiotics have no medical effect at all on viruses. Nor is it "futile" in the more general sense that it requires the impossible.

In this sense of the word, punching the wrong personal identification number into an ATM is futile because it is impossible that the machine will dispense cash. Without the treatment Alamo is providing, Miguel will die. Providing treatment may be an inappropriate use of medical resources, but it is not futile.

If Miguel is stable, Alamo must allow Miguel's family to transfer him back to Mexico before withdrawing life sustaining treatment. It can fund this transfer if it chooses, but it does not have to. Alamo probably retains a legal obligation to ensure Miguel does not undergo undue suffering. If the team believes that a transfer to Mexico would cause such suffering, then the hospital could petition the court to have a guardian appointed to review the transfer decision. However, if the hospital is not willing to sustain Miguel on the ventilator, and if he can be moved without undue suffering, it is hard to predict whether a judge would block the transfer.

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By Jennifer S. Bard

Alamo Hospital is unlikely to face civil or criminal legal liability if it releases Miguel to his father's custody so he can be transported to what may well be a less capable hospital in Mexico. This is because Alamo has already evaluated Miguel, stabilized him, and come to the conclusion that it is no longer willing to provide medical treatment because he can no longer benefit from it. Although Alamo has to assist in a transfer if there is a facility willing to take Miguel, it has no obligation to fund the transfer. If Miguel's family cannot afford the transfer to Mexico, Alamo could withdraw Miguel's ventilator support against his father's objections. It cannot, however, participate in causing greater suffering than would be caused by being extubated in the hospital. It cannot, for example, participate in a transfer that essentially leaves him gasping for air in a van on the way to the airport. No surrogate decision-maker has unfettered authority to make a decision that increases a patient's suffering.

But assuming the transfer does not substantially increase Miguel's risk of suffering, then under general principles of common law and some existing statutes, hospitals and physicians in most states would have strong legal protection if they allow the transfer, even if Miguel died in transit or shortly afterwards. Since Alamo is located in Texas, however, it has the added advantage of being able to rely on the only statute in the country setting out a series of procedures that, if followed, insulate the hospital from liability for withdrawing treatment. Under the Texas Advanced Directives Act (Health and Safety Code §166.046), if Alamo no longer believes Miguel would benefit from care, then it can stop treatment over his family's objections as long as it follows the statute's requirements, which include giving his family forty-eight hours' notice, arranging an internal consultation using the hospital's own ethics procedures, and trying to arrange a transfer. If no transfer proves possible, the law immunizes the hospital and the physicians from civil or criminal liability for withdrawing care. The patient, or his decision-maker, has no right of appeal to a court.

There were many attempts in the 2013 legislative session to change or repeal the law, but the law will remain in place for the next two years. Although the statute has no data collection requirements, anecdotal evidence suggests that it is invoked only in the rare situations in which the family adamantly refuses to acquiesce to medical advice and transfer is impossible.

If Miguel were a citizen of the United States, a skilled nursing facility would probably accept him even if he lacked insurance because he would eventually qualify for Medicare and Medicaid. This is an artifact of the rules of the payment system: a person in a coma can become eligible for public assistance when his assets run out, but the same person who has an urgent need for an organ transplant or chemotherapy would not. If Miguel were a citizen of another U.S. state, Alamo could not involuntarily transport him to that state. U.S. citizens are protected by three principles of constitutional law that, in broad generality, prohibit treating residents of one state differently than residents of another. Hospitals like Alamo can and do engage in "Greyhound" therapy by giving a patient who is expensive to treat a bus ticket to another state, but they cannot forcibly relocate such a patient.

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