

# The Dilemma of Undocumented Immigrants with ESRD

Rudolph A. Rodriguez, MD

The author is associate professor of medicine in the Division of Nephrology at the University of Washington, Seattle.

The National Kidney Foundation (NKF) 2010 Spring Clinical Meetings will take place April 13-17 at the Walt Disney World Swan and Dolphin Hotel in Orlando, Fla. These multi-disciplinary meetings will present opportunities for renal healthcare providers to learn new developments related to all aspects of nephrology, and are designed for nephrologists in the private sector and academia, fellows and residents with a special interest in kidney disease, general internists, pharmacists, physician assistants, nurse practitioners, nurses and technicians, social workers, and renal and clinical dietitians. In a session entitled "Special Issues in Minority Populations," the NKF will provide a forum for discussion of "Dialysis of Undocumented Immigrants," among other topics. The following article presents the viewpoint of Rudy A. Rodriguez, MD, who will be speaking at that session.

The 50th anniversary of the birth of chronic dialysis was celebrated this year in Seattle. On March 9, 1960, Dr. Belding Scribner and his team began treating the first chronic hemodialysis patient using the shunt Dr. Scribner developed. These pioneering health professionals soon faced the dilemma of how to choose suitable candidates for this expensive and scarce technology.

The controversial "Life or Death Committee" received national publicity in a 1962 *Life* magazine article entitled "They Decide Who Lives, Who Dies" and the 1965 NBC documentary "Who Shall Live?" The committee and the selection process were soon criticized for making comparative judgments of social worth.<sup>1</sup> This controversy is credited by some for the birth of bioethics and for the eventual 1972 passage of the landmark legislation establishing the Medicare End-Stage Renal Disease Program.

This program now provides access to treatment for nearly all patients with one notable exception—undocumented immigrants. Due to differing interpretations of federal Medicaid regulations, there is no

uniform policy of dialysis coverage for undocumented immigrants in the U.S. Some states provide coverage and others do not.<sup>2,3</sup> In some states, undocumented immigrants with ESRD have no viable options for treatment. Fifty years after Dr. Scribner's team treated the first dialysis patient, the medical community is once again facing difficult decisions about who shall live.

## Renal Care of Undocumented Immigrants in the U.S.

There are an estimated 11.9 million undocumented immigrants in the U.S., 80% of whom emigrated from Latin America.<sup>4</sup> Given that in 2006, the prevalence of ESRD among Hispanics in the U.S. was 2,326 cases per million population,<sup>5</sup> simple math would predict sizable numbers of undocumented immigrants with ESRD in many of the U.S. cities with large Hispanic immigrant populations.

There is no strong voice in the medical community opposing treatment for these patients. Instead, the hurdle is paying. Since it was established in 1965, Medicaid

has been the main source of health coverage for non-citizens with serious conditions. Over the years, however, the general trend for such treatment has been to restrict Medicaid access by non-citizens. Presently, Medicaid provides undocumented immigrants with coverage for only "emergency medical conditions." This is defined as a medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity that the absence of immediate attention could result in serious impairment to bodily functions, serious dysfunction of any bodily organ, or placing the patient's health in serious jeopardy. Services are limited to those required "after the sudden onset" of a medical condition.<sup>3</sup>

This definition leaves room for various interpretations concerning what is truly an emergency, such as in the case of ESRD. The Centers for Medicare and Medicaid Services (CMS) and the courts have attempted to provide guidance in differentiating chronic dialysis from emergency dialysis for acute indications. To a nephrologist, this distinction is contrary to good sense. Unlike other emergency

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conditions such as trauma or childbirth, after a patient with acute indications for dialysis is stabilized with dialysis and discharged with no plans for chronic dialysis, the patient is only days away from reaching the same acute condition.

Some states have decided to interpret chronic dialysis coverage as an emergency medical condition qualifying for Medicaid coverage, while other states view only acute inpatient dialysis as qualifying. Therefore, an undocumented immigrant in California with ESRD can receive the standard of care—thrice weekly outpatient dialysis—whereas a person in the same situation in Texas will be treated acutely in a hospital

Regrettably, these important institutions are perpetually under-funded and as the current national financial crisis escalates, a few facilities have faced difficult decisions and decided to discontinue offering dialysis to undocumented immigrants. These safety-net hospitals likely used the rationale that discontinuing dialysis in this population would allow for the fair distribution of healthcare resources to the greatest number of vulnerable patients. However, it is not clear why a life-sustaining treatment was chosen over other services in these medical centers. The life-and-death nature of these decisions are hidden by offering alternate dialysis options that are not the

have developed. It is unknown whether this practice has led to higher mortality rates among these patients because in many ways, these patients are invisible. They are not included in the United States Renal Data System and they are not closely monitored by hospitals, states, or counties. However, it is known that the risk of sudden death increases in well-dialyzed patients after a three-day weekend.<sup>10</sup> Therefore, common sense would predict that the brutal approach of offering only emergency dialysis would lead to an increase in morbidity and mortality.

Patients are sometimes encouraged to relocate to other states such as California, which provides coverage for dialysis. Barriers such as prohibitive relocation costs, isolation from friends and family, and lack of income may make this unfeasible. Repatriation is also encouraged and offers to pay for relocation costs have been reported.<sup>11</sup> Many of these undocumented immigrants have lived in the U.S. for many years and therefore have no government health benefits waiting in their home countries. In his 2005 paper describing renal replacement therapy among disadvantaged populations in Mexico, Guillermo Garcia-Garcia provided an insight into possible options for repatriated patients with ESRD.<sup>12</sup> Salaried workers in Mexico are usually covered by Mexican Social Security, which pays for dialysis costs. However, more than half the population does not have Social Security and few dialysis options exist for these patients. A limited number of dialysis units exist for the uninsured, but despite representing 54% of the states' population, the uninsured represent only 18% of the prevalent dialysis and transplant population. It is clear that some rationing of dialysis is occurring in Mexico and a U.S.-repatriated patient would need to wait in line along with the other uninsured ESRD patients in Mexico. The situation is similar, if not worse, in many of the other Latin American countries of origin. From a patient's perspective, few options exist except for a life of desperation and suffering.

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setting only after presenting with acute life-threatening indications for dialysis.

It is difficult to comprehend these disparate treatment options when considering that lives are at stake and each stakeholder is left making heart-wrenching decisions. The concept of only offering emergency dialysis to these vulnerable patients is a product of administrators interpreting Medicaid policy, and not a concept based on optimal medical care.

## Decision Left to Individual Centers

In states that do not cover chronic dialysis costs, individual medical centers are left to decide how to care for these patients. Most offer only acute dialysis and policies about catheter and permanent vascular access differ among different medical centers. A number of U.S. safety-net hospitals, such as Grady Memorial Hospital in Atlanta, have operated independent dialysis units and in keeping with their mission, provided dialysis care to vulnerable patients such as undocumented immigrants.<sup>6</sup> This policy of offering uncompensated outpatient dialysis care is cost effective when compared with the high cost of hospitalization associated with acute dialysis.<sup>7</sup>

standard of care in the U.S. Hoping these patients move to other states, repatriate, or receive emergency dialysis seems to overlook the fact that patients will die from these policies.

## The Patient Perspective

It is difficult to think of a more vulnerable population than undocumented immigrants with ESRD. Anti-immigrant sentiment has been growing in the U.S., and immigration reform is not a political priority. The complexities of the immigration debate are lost on those who see immigrants as a drain on U.S. taxpayers. Evidence that immigrants utilize fewer services than the revenue they generate, or that a quarter of undocumented immigrants are part of a mixed family with at least one member being a U.S. citizen should be part of the debate when considering the fate of these men and women.<sup>4,8,9</sup>

The "Life and Death Committee" of 50 years ago was controversial because patients who were not offered dialysis had no other treatment options. Undocumented immigrants today have a few imperfect options when struggling to survive with ESRD. One option is to present to an emergency room and hope that life-threatening indications for dialysis

## The Medical Provider Perspective

I fortunately have not practiced in a state that restricts outpatient dialysis. There must be an emotional toll on physicians and

other medical professionals when faced with ESRD patients who cannot be offered chronic dialysis. In 2002, the American College of Physicians published "Medical Professionalism in the New Millennium: A Physician Charter." Along with reaffirming the ethical underpinnings of our profession, this document challenged our profession by stating that "medicine's commitment to the patient is being challenged by external forces of change within our societies."<sup>13</sup> The charter presented three principles to which physicians should adhere, including the primacy of patient welfare, respect for patient autonomy, and the promotion of social justice in the healthcare system, including the fair distribution of healthcare resources and elimination of discrimination.

Physicians caring for undocumented immigrants must feel that these principles are being severely challenged. From an ethical standpoint, physicians should ensure that all sick people receive appropriate treatment.<sup>14</sup> Edmund D. Pellegrino, MD, professor of medicine and medical ethics at Georgetown University in Washington, DC, said it well: "No matter what happens in the social, political, or cultural milieu, a universal reality in the predicament of illness imposes obligations on anyone who professes to be a healer. Across history, culture, and nation, ill persons are vulnerable, dependent, nervous, fearful and exploitable."<sup>15</sup> In the U.S., it would be considered unethical to deny chronic dialysis to prison inmates or even prisoners of war, but there is no outcry about the current situation concerning undocumented immigrants.<sup>16</sup>

Given the current healthcare debate in Congress, and when considering the number of uninsured U.S. citizens, some may argue that the current situation represents a fair distribution of healthcare resources. ESRD therapy is of course different. Fifty years ago, the debate focused on the life-and-death nature of dialysis and the inspirational leadership of physicians like Dr. Belding Scribner moved Congress to pass Medicare legislation providing near-universal coverage for dialysis.

## Moving Forward

With a consensus that the renal community has an ethical obligation to treat undocumented immigrants with ESRD, the various stakeholders, including the renal

professional organizations, large dialysis organizations, renal networks, safety-net hospitals, and others, should explore all possible options for dialysis funding.<sup>17</sup> The current inaction may reflect pragmatism when considering the prospect of changing federal or state policy, but creativity and ingenuity should be used to identify funding sources. Along with addressing the vagaries of current policy, other avenues, such as cost-sharing among the stakeholders or philanthropy should be explored. The life-and-death nature of this debate should not be forgotten among the stakeholders, and hopefully a compassionate approach to this difficult problem can be developed and implemented rapidly. **D&T**

## References

- Dukeminier J Jr, Sanders D. Legal problems in allocation of scarce medical resources. The artificial kidney. *Arch Intern Med.* 1971;127:1133-1137.
- Campbell GA, Sanoff S, Rosner MH. Care of the undocumented immigrant in the United States with ESRD. *Am J Kidney Dis.* 2010;55:181-191.
- Straube BM. Reform of the US healthcare system: care of undocumented individuals with ESRD. *Am J Kidney Dis.* 2009;53:921-924.
- Passel JS, Cohn D. A Portrait of unauthorized immigrants in the United States. Pew Hispanic Center website: [pewhispanic.org/reports/report.php?ReportID=107](http://pewhispanic.org/reports/report.php?ReportID=107). Updated April 14, 2009. Accessed February 14, 2010.
- Collins AJ, Foley RN, Herzog C, et al. United States Renal Data System 2008 Annual Data Report. *Am J Kidney Dis.* 2009;53:S1-374.
- Brumback K. Cuts leave indigent dialysis patients in limbo. *The Seattle Times* website. [seattletimes.nwsour.com/html/nationworld/2010970241\\_apusimmigrantsdialysis.html](http://seattletimes.nwsour.com/html/nationworld/2010970241_apusimmigrantsdialysis.html). Updated February 3, 2010. Accessed February 14, 2010.
- Sheikh-Hamad D, Paiuk E, Wright AJ, Kleinmann C, Khosla U, Shandera WX. Care for immigrants with end-stage renal disease in Houston: a comparison of two practices. *Tex Med.* 2007;103:54-8, 53.
- Mohanty SA, Woolhandler S, Himmelstein DU, Pati S, Carrasquillo O, Bor DH. Health care expenditures of immigrants in the United States: a nationally representative analysis. *Am J Public Health.* 2005;95:1431-1438.
- Porter E. Illegal immigrants are bolstering social security with billions. *New York Times*. [www.nytimes.com/2005/04/05/business/05immigration.html](http://www.nytimes.com/2005/04/05/business/05immigration.html). Updated April 5, 2005. Accessed February 14, 2010.
- Bleyer AJ, Hartman J, Brannon PC, Reeves-Daniel A, Satko SG, Russell G. Characteristics of sudden death in hemodialysis patients. *Kidney Int.* 2006;69:2268-2273.
- Sack K. For sick illegal immigrants, no relief back home. *New York Times*. [www.nytimes.com/2010/01/01/health/policy/01grady.html](http://www.nytimes.com/2010/01/01/health/policy/01grady.html). Updated January 1, 2010. Accessed February 14, 2010.
- Garcia-Garcia G, Monteon-Ramos JF, Garcia-Bejarano H, et al. Renal replacement therapy among disadvantaged populations in Mexico: a report from the Jalisco Dialysis and Transplant Registry (REDTJAL). *Kidney Int Suppl.* 2005;S58-S61.
- ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136:243-246.
- Snyder L, Leffler C. Ethics manual: fifth edition. *Ann Intern Med.* 2005;142:560-582.
- Pellegrino ED, Caplan A, Goold SD. Doctors and ethics, morals and manuals. *Ann Intern Med.* 1998;128:569-571.
- Zupan D, Solis G, Schoonhoven R, Annas G. Dialysis for a prisoner of war. *Hastings Cent Rep.* 2004;34:11-12.
- RPA position on dialysis for non-citizens. Renal Physicians Association. *Clin Nephrol.* 2000;54:253-254.