

CONCEPTS

Ethics

Ethical issues in the access to emergency care for undocumented immigrants

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Abstract

Patients who are undocumented immigrants (UIs) frequently present to emergency departments in the United States, especially in communities with large immigrant populations. Emergency physicians confront important ethical issues when providing care for these patients. This article examines those ethical issues and recommends best practices in emergency care for UIs. After a brief introduction and description of the UI population, the article proposes central principles of emergency medical ethics as a framework for emergency physician decisions and actions. It then considers the role of law and public policy in health care for UIs, including the Emergency Medical Treatment and Labor Act, the Patient Protection and Affordable Care Act, and current practices of the US Immigration and Customs Enforcement agency. The article concludes with discussion of the scope of emergency physician practice and with recommendations regarding best practices in ED care for UIs.

KEYWORDS

duty to care, EMTALA, emergency medicine, ethics, rights, undocumented immigrants

1 | INTRODUCTION

The United States is rightly described as a nation of immigrants, but for most of its history, US immigration policies have been contentious political issues, and immigrants have often faced daunting challenges to survival and well-being in their new surroundings.¹ Recent years have witnessed a dramatic increase in anti-immigration rhetoric and public policy, including presidential denigration of the character of immigration seekers, construction of a border wall to deter immigration, sepa-

ration of immigrant children from their families, and large reductions in the number of legal immigrants.²

This article examines a specific moral issue within the current, politically charged immigration debates, namely, the role of emergency physicians in providing health care for undocumented immigrants (UIs) in US hospital emergency departments. It briefly describes the UI population and proposes central principles of emergency medical ethics as a framework for emergency physician decisions and actions. The article then considers how current US federal law and policy, including the Emergency Medical Treatment and Labor Act (EMTALA), the Patient

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Protection and Affordable Care Act (ACA), and current practices of the US Immigration and Customs Enforcement (ICE) agency, affect access to health care for UI patients. Finally, the article examines the proper scope and limits of ED care for UIs and recommends best practices when providing care for these patients.

2 | UNDOCUMENTED IMMIGRANTS

UIs are residents who have entered the United States in multiple different ways for a variety of reasons.³ They are commonly referred to as “undocumented” because they lack legal documentation or authorization for their entry or their continued residence in the United States and so are subject to immigration enforcement measures, including deportation. This article focuses on UIs and does not include documented or “legal” immigrants, such as those who have temporary work visas, humanitarian status, are in the asylum application process, are green card holders, and are naturalized immigrants. In 2019, there were an estimated 10.5 to 12 million UIs in the United States, or 3.2% to 3.6% of the entire US population.⁴ Because they lack legal documentation, UIs are not eligible to vote or to enroll in most public assistance programs. UIs struggle to access emergency care because of fear of reporting of their UI status, feelings of unworthiness, and inability to pay for care, among other reasons.⁵ A series of political and public health obstacles are associated with UIs’ limited health care access.⁶

Collectively, immigrants tend to be mentally and physically healthier and have fewer chronic medical problems than native-born homeless individuals.⁷ They also tend to be mentally healthier than the US-born population.⁸ Because they lack ready access to health care, UIs with serious illness or injury may experience undue levels of suffering and fear. The COVID-19 pandemic has magnified known health disparities among minorities, including undocumented immigrants. The pandemic also affected the legal status of UIs by eliciting a court injunction that prohibited the Department of Homeland Security from enforcing the Public Charge Final Rule for several months during the pandemic. (The Public Charge Rule states that any UI who is likely to become a “public charge,” that is, to receive public benefits for a prolonged period, is ineligible to become a permanent resident.)⁹

UIs are sometimes stigmatized by those who mistakenly believe that they bring rampant disease into the United States and use large amounts of health resources. As is noted later, however, UIs actually contribute more in payroll taxes to Medicare and Medicaid than those programs expend for UI care.¹⁰

3 | MORAL FOUNDATIONS

We propose that ED care for UI patients be guided by 3 basic principles of emergency medical ethics endorsed by the American College of Emergency Physicians (ACEP) as part of its *Code of Ethics for Emergency Physicians*.¹¹ The ACEP *Code of Ethics* begins with a statement of 10 “Principles of Ethics for Emergency Physicians,” described as “funda-

mental moral responsibilities of emergency physicians.” Among those 10 principles are the following 3:

Principle 2: Emergency physicians shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.

Principle 5: Emergency physicians shall respect patient privacy and disclose confidential information only with the consent of the patient or when required by an overriding duty, such as the duty to protect others or to obey the law.

Principle 10: Emergency physicians shall support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

We contend that these 3 principles have clear implications for emergency physicians’ care of UI patients. Principle 2 identifies the *need for emergency medical care* as the basis for emergency physicians’ responsibility to respond with prompt and expert treatment. This principle does not identify other necessary conditions for that response, and it explicitly excludes prejudice or partiality as appropriate considerations in the responsibility to respond. This principle thus affirms an emergency physician’s responsibility to respond to all patients in need, including UIs.

Principle 5 recognizes an emergency physician’s responsibility to protect the confidentiality of patients’ personal information. Immigration status is clearly sensitive personal information for UI patients. Its disclosure is not required to protect others, nor is it a legal duty of emergency physicians, and so protection of that information is required under this principle.

Principle 10 calls on emergency physicians to be advocates for public health and safety measures and for access to both emergency and other basic health care for all. Because UIs often lack access to basic health care and because provision of that care for UIs can make important contributions to public health, this principle also supports emergency physician efforts to care for UI patients.

These 3 principles are directed toward and widely embraced by emergency physicians, but they also reflect more general formulations of basic principles of bioethics, including principles of beneficence, non-maleficence, and justice proposed and defended by bioethics scholars Tom Beauchamp and James Childress.¹² ACEP Principle 2 is, in effect, an emergency physician-specific formulation of the principle of beneficence, which asserts a duty of health care professionals to provide beneficial care for their patients. The duty to protect patient confidentiality in ACEP Principle 5 reflects a recognition that respect for confidentiality is essential to achieving the benefits of health care. Because failure to protect confidentiality can cause significant harm to patients, respect for confidentiality is also required by the principle of non-maleficence, or the duty to avoid infliction of harm. Finally, ACEP Principle 10 endorses emergency physician advocacy for societal efforts to enhance public health and provide access to health care for all. This principle commits emergency physicians to work for an

equitable or just distribution of health and health care, as required by the principle of justice.

To emphasize the importance of prioritizing medical care and solving health system complexities for UIs, we apply the ACEP principles to the areas of EMTALA/ACA, ICE, scope of practice, medical repatriation, and health costs.

4 | LEGAL AND POLICY CONSIDERATIONS

4.1 | EMTALA and the ACA

US federal law supports emergency physicians' provision of prompt, impartial, expert response in caring for UIs (Principle 2). EMTALA is the federal statute underpinning the role of EDs in our nation's health care safety net.¹³ Congress enacted the EMTALA in 1986 to prevent the transfer of unstable patients, including women in labor, from one hospital to another, by requiring that all patients who present to an ED receive a screening evaluation and stabilizing treatment for emergency conditions. EMTALA thus established a de facto limited right of all persons in the United States to emergency services.¹⁴ EMTALA is a federal mandate that applies to all Medicare-participating hospitals that offer emergency services. If a hospital is unable to stabilize a patient within its capacity, then an appropriate transfer to a facility that can care for the patient is required. Although EMTALA mandates emergency care regardless of a person's ability to pay at that time, it does not prevent the hospital from issuing a bill.¹⁴ EMTALA also makes EDs more vulnerable to the market forces of health care by being an underfunded mandate that imposes financial obligations on hospitals and health systems.¹⁵

The emergency treatment mandate created by EMTALA provides crucial legal support for emergency physicians' commitment to provide emergency care for all in need. The mandate also reinforces the importance of providing impartial medical care to UIs (Principle 2), because most publicly funded health insurance plans, including those established under ACA, explicitly exclude coverage for UIs.¹⁶ Furthermore, the ACA excludes UIs from purchasing health coverage through its health exchanges.¹⁴ Although $\approx 80\%$ of UIs are in the labor force, they are often in lower-income occupations that do not provide employer-subsidized health insurance or wages that would enable the purchase of private health insurance.¹⁶ As a result, the majority of UIs do not have a primary care doctor, receive preventive care at far lower rates than US citizens, and cannot comply with guidance to call primary care clinician.¹⁶ In addition to these financial and insurance barriers, UIs face other barriers in access to care, including language barriers, lack of transportation, jobs with limited or no sick leave benefits, and reduced power to negotiate time off due to their undocumented status.¹⁶ The exclusions from and barriers to most sources of health care in the United States elevate the importance of EMTALA and EDs for enabling UIs to access medical care.

EMTALA was initially an unfunded mandate, but the federal government enacted legislation in subsequent years providing hospitals with some, albeit insufficient, reimbursement for the care of UIs. Title

XIX of the Social Security Act, 42 U.S.C. § 1396b (v), permits Medicaid coverage for undocumented persons requiring emergency care.¹⁷ The Medicare Modernization Act of 2003 also allocated a total of \$1 billion for fiscal years 2005–2008 to reimburse hospitals for the care of UIs; that funding did not, however, cover all costs incurred by hospitals.¹⁷

The EMTALA mandate applies to the care of patients admitted to the hospital until their emergent medical condition is stabilized.¹³ In 2004, the US Department of Health and Human Services extended the obligations of hospitals in § 1396b (v) by requiring that hospitals prepare a discharge plan for every patient requiring continuing care, including UIs.¹⁷

4.2 | Immigration and Customs Enforcement

Emergency physicians have duties to protect their patients and to obey the law, particularly when it comes to preserving patient privacy (Principle 5). One prominent example of a threat to the UI's personal information is the activity of ICE, a federal agency within the US Department of Homeland Security that is responsible for enforcement of US immigration law. The Enforcement and Removal Operations directorate of ICE is composed of 20,000 law enforcement officials and support staff who conducted 226,199 deportations of UIs from the United States in 2017.¹⁸

ICE currently has a policy of not taking enforcement actions at "sensitive locations," including hospitals.¹⁹ This ICE policy of refraining from enforcement actions in hospitals represents a significant, albeit tacit, recognition that hospital care for patients in need should take precedence over enforcement of immigration law. It enables emergency physicians to focus on providing medical care for their UI patients without fear of interference. The priority of health care over law enforcement also reinforces emergency physicians' commitment to protect the confidentiality of information about UIs' immigration status.

Despite the aforementioned protections for UI hospital patients, UIs sometimes avoid presenting to the ED because of fear of deportation or future status adjustments, further reinforcing the need to preserve confidentiality. In 2017–2018, 24% of undocumented Latino immigrants (UDLI) and 26% of Latino legal residents/citizens reported that they had friends or family members who had not come to the ED because of fear of discovery.²⁰ For the 12% of UDLI who reported fear of coming to the hospital because of discovery in 2009–2010, 71% said that their primary concerns were being reported and deported.²¹

The fears of UDLI are not completely unfounded. In 2019, Rosamaria Hernandez, a 10-year-old child with cerebral palsy, was detained during ambulance transport between hospitals for emergency surgery.²² Legislative initiatives have also incited fear and placed individuals at risk, such as Congressman James Sensenbrenner's 2005 proposed legislation that would have required hospitals to identify UIs to law enforcement officials.²³

Best practices with regard to emergency physician interactions with ICE include the following:

1. Uphold the professional duty to respect patient confidentiality and do not contact ICE: 1 physician defended this view by pointing out that “My Hippocratic oath doesn’t say anything about what country a person is from.”²⁴
2. Think about your relationship with the patient as a physician and do not contact ICE. Calling ICE can break the therapeutic alignment and the special bond between patient and clinician. Emergency physicians have embraced the duty of preserving a local and national culture for providing access to health care and of strengthening the provision of health care services. Studies show that in some countries, law enforcement agencies may unintentionally create other downstream effects that impede access to health services.²⁵ Making sure that UIs present to the ED or other health care venues to receive treatment is critical from a humanitarian perspective and for protecting the well-being of UI patients, the general population, and health care personnel who must all work together to preserve the ultimate “safety net” of our health care system. Mandatory reporting of diseases, such as HIV and tuberculosis, to a public health agency has nothing to do with ICE notification.^{26,27}
3. Cooperate with ICE when it coincides with best care practices for the patient: When a UI is brought to the hospital by ICE or Border Patrol agents, for example, the patient is likely brought for a good medical reason, such as dehydration or rhabdomyolysis, and should receive appropriate treatment for his or her condition.²⁸ Ultimately, cooperation with ICE agents should depend on whether doing so improves patient care and aligns with important moral (and ethical) principles.

These practices reinforce the fundamental importance of protecting patient confidentiality expressed in ACEP Principle 5.

4.3 | Scope of practice and limitations of care delivery

As previously noted, UIs are explicitly excluded from most publicly funded health insurance programs and from many social safety-net services.²⁹ This, coupled with often-exorbitant charges in the US health care system, creates a significant barrier to health care for UIs and highlights the duty of emergency physicians to support societal efforts for improving access to care (Principle 10). These barriers to care are not unique to UIs, as uninsured status is also common in non-citizen immigrants who reside in the United States legally.³⁰ There are inherent limitations to follow-up, specialty care, social services, and other medical resources not mandated by EMTALA. Emergency physicians should therefore anticipate being faced with the decision whether to provide care for UIs beyond their usual scope of practice in order to further reduce the harmful effects of injury and illness on UI patients due to lack of access to follow-up outpatient care after discharge from the ED.

Chronic hypertension, cholesterol and weight management, home durable medical equipment prescriptions for chronic conditions, sub-

stance abuse treatment, and smoking cessation counseling are not typical parts of emergency medicine training and practice. Yet, despite the previously mentioned barriers to accessing even ED care for UIs, the ED is the only point of access in the US health care system obliged to provide medical care to these patients. Without the ability to pay, UIs face significant difficulties accessing primary care or specialty care services.³¹ As a result, although emergency physicians’ approach to non-emergent conditions may typically involve referral to primary care or specialty follow-up, it may be reasonable and beneficial to change their practice for UIs. Modifications also may include initiating chronic hypertension, hyperlipidemia, diabetes management and prescriptions. In general, beneficial services for UIs may include attempting to address more of these patients’ health care needs beyond their chief complaint for any given ED visit.

Provision of primary or specialty care in the ED may be suboptimal, but it nevertheless may be morally permissible, because it is the best or only care available to an undocumented patient, as it is for other uninsured and indigent patients who present to the ED for non-urgent care.³² EPs must balance these services beyond the scope of emergency medicine training against the risk of harm by embarking on non-emergent treatment without the appropriate follow-up and management mechanisms available, as well as the potential consequences for care of other ED patients with more urgent needs. Standards do not exist for training and certification of emergency physicians for non-emergency care, and the decision to embark on such an expanded scope of practice for this patient population will be highly individualized and situation-dependent. Some emergency physicians may not have adequate experience or knowledge of chronic hypertension management and hence should not initiate or adjust chronic hypertensive medication, but other emergency physicians, in the same practice setting and with the same patient, may ethically provide such active medical care if their experience and knowledge is sufficient.

In addition to this practice of beneficent care, emergency physicians should engage in broader advocacy for societal efforts to meet health care needs. They would also do well to learn about, engage with, and refer patients to the indigent care clinics and community-based organizations in their local communities in order to support the ongoing care of UI patients most effectively.

Along these lines of advocacy, emergency physicians may find themselves in a unique position to recognize and intervene in situations of human trafficking when caring for UIs. Similar to rooting out dependent abuse, when there is inconsistency in a patient’s history and exam, and especially when a trustworthy parent or guardian does not accompany a child, emergency physicians should consider consulting social work. It is better to err on the side of asking more questions and risking offense than not investigating and leaving a patient in a dangerous situation. Some UIs may even be eligible for a U visa as victims of a crime.^{33,34}

Patients with end-stage renal disease on dialysis present a unique circumstance. Some states, individually managing their federal Medicaid funds, have elected to provide Medicaid coverage to UIs specifically for regularly scheduled maintenance dialysis, whereas other states cover dialysis for UI patients only when their uremia has become an emergent medical condition. The practice of providing maintenance

dialysis for UI patients has been shown to reduce the cost and improve the quality of their care, rather than relying on individual hospitals and EDs to shoulder the burden of dialyzing these patients on an emergency-only basis. This example demonstrates that even complex, expensive, non-emergent care, such as routine hemodialysis can be provided to UIs, with significant benefit to these patients and at a reduced public cost.³⁵ Dialysis coverage offers a model for how to approach the management of UI health care on a state and national level; it carries real promise for a more equitable and affordable system of providing health care to UI patients.

4.4 | Medical repatriation

The federal EMTALA mandate is a limited legal requirement; it does not include continuing medical care for patients in stable condition, an area ripe with opportunity to advocate for patient safety and access by the emergency physician (Principle 10). Many US hospitals provide continuing medical care for undocumented patients who are indigent and uninsured, but such care can impose a heavy financial burden on facilities that care for large numbers of UI patients. The high cost of indigent care raises the difficult moral problem of determining the scope and limits of societal, institutional, and individual duties to provide unreimbursed and under-reimbursed medical care. Some states, such as California, have attempted to bridge this financial gap with funds from the Global Payment Pool, Prop 99 Tobacco Tax, and Disproportional Share Hospital designation.^{36,37,38} As noted previously, UIs are explicitly excluded from virtually all publicly funded health insurance programs. In her review of the legal implications of medical repatriation, Fruth reports that ICE also will not respond to requests from hospitals to assume responsibility for UI patients, in order to avoid responsibility for the significant costs of their medical care.³⁹ For UI patients who are indigent and uninsured and whose conditions require continuing medical care, individual hospitals or health systems currently bear the entire financial burden of providing that care.

To address this problem over the past several decades, some hospitals have engaged in a practice called "medical repatriation."⁴⁰ In this practice, hospitals provide or arrange transportation back to their home countries for immigrant patients who require ongoing medical care. Most commentators condemn medical repatriation as tantamount to deportation and a violation of human rights to health care and of the important medical maxim "first, do no harm." These commentators also acknowledge, however, that responsibility for the cost of ongoing medical care for UI patients should be assumed by governmental agencies rather than individual health systems or health care professionals.^{41,42} Other commentators argue that medical repatriation can be morally justifiable in at least some circumstances.^{43,44} Despite growing attention and criticism, this practice remains unregulated in the United States.^{44,42}

The practice of medical repatriation can vary along a spectrum of options, and moral evaluation of the practice at the opposite ends of that spectrum is reasonably obvious. At one end, a hospital might forcibly transport an unwilling immigrant patient out of the country

despite the absence of adequate medical care at the destination. This hospital is engaging in a morally indefensible kind of extralegal deportation that has also been characterized as "international patient dumping." Medical repatriation of this kind requires false imprisonment and exposes the patient to grave risk of harm.³¹ At the other end of the spectrum of options, a hospital may provide transport for an immigrant patient who desires to return to his or her country of origin, with that patient's informed consent, and when it has verified that a receiving facility is willing and able to provide continuing treatment in accord with that patient's goals. Medical repatriation of this kind shows clear respect for patient self-determination and patient welfare.³⁹

In 2012, the Center for Social Justice of the Seton Hall Law School reported that it has evidence, from media reports and its own investigations, of > 800 cases of unlawful forced medical repatriations between 2007 and 2012.⁴¹ No public agency requires reporting of medical repatriation, however, and thus the actual prevalence of the practice remains unknown.

If the moral evaluation of the extreme cases described above is clear, assessment of intermediate cases is more difficult. Consider, for example, the following hypothetical situation: A hospital has provided emergency care for serious illness for an undocumented immigrant patient who is indigent and uninsured. The patient is admitted to the hospital, and his condition is stabilized, but the patient needs high-cost continuing treatment (a novel chemotherapeutic drug regimen or a solid organ transplant, eg.,) for his advanced disease. Hospital leaders decide that they cannot provide that high-cost treatment without reimbursement, and they cannot identify any other source of financial support for the patient's medical care. They therefore offer the patient the following choice: discharge from the hospital, with continuing palliative care on an outpatient basis, or transportation at the hospital's expense to the patient's country of origin, where a hospital has agreed to provide palliative care but is unable to provide high-cost life-prolonging treatment. Of these 2 limited options, the patient chooses repatriation based on a desire to reunite with family and friends. Is this hospital's denial of high-cost medical treatment and offer of medical repatriation morally permissible, or is it a morally indefensible departure from the hospital's mission and moral responsibility to provide whatever continuing medical care may benefit the patient, regardless of its cost? Should hospitals consider the cost-effectiveness of medical treatment when medical repatriation is an option?

Bioethicist Mark Kuczewski proposes the following answer to these vexing questions. He argues that medical repatriation is morally permissible if the following criteria are met:

1. Transfer is in the patient's best interests aside from the obvious issue of reimbursement.
2. The hospital must ensure adequate medical support available at the patient's destination.
3. The patient or surrogate must give informed consent to being returned to another country.

Kuczewski asserts, without supporting evidence, that individual hospitals can afford to assume the costs of continuing care for UI

patients and have a duty to do so, but he also claims that “there is a tremendous unfairness to asking hospitals to cope with the intersection of two inadequate systems, that is, US immigration policy and health care financing.”⁴⁴

Medical repatriation poses difficult questions for individual and institutional clinicians beyond mandated care in US EDs; it represents just 1 example of the ongoing and highly contentious US public policy debate over the proper scope and limits of access to health care. As a potential alternative to medical repatriation, consular services in a patient’s home country may provide family communication methods, travel and visa services, legal representation, and repatriation assistance.

4.5 | Cost and UIs

Health care reform has been and continues to be debated. Health care for UIs has often been unfairly politicized because of their higher rates of uninsurance, the stigma of their illegal residency status, and their perceived high-cost burden on the system. Many observers perceive immigrants as a major burden on the health care system.⁴²

Whereas 8% of US citizens lack insurance coverage,⁴⁵ 45% of UIs are uninsured. UIs’ high rate of uninsurance status reinforces the importance of emergency physicians’ duties to protect them and provide access to basic health care (principles 5, 10). Children of undocumented immigrant families are uninsured at a rate of 31% compared to their citizen counterparts at 4%. Although many UIs are uninsured, their children who were born in the United States and are therefore US citizens may be eligible for Medicaid and other medical and social programs such as food stamps and the Special Supplemental Nutrition Program for Women, Infants and Children. Previously discussed barriers to enrollment of these US-born children and fear of “public charge” policies hinder acute and ongoing medical care for the US-citizen children of UIs. These barriers and fears also hinder proper immunizations for children of UIs. Limitations of employer-provided benefits and restrictions of federally funded programs contribute to these discrepancies in health insurance coverage.⁴⁶

Despite, or perhaps because of, their lack of insurance, undocumented populations spend 40%–50% less on health care in medical expenditures than their citizen counterparts.⁴⁶ In 2009, UIs accounted for 5% of the population, but they incurred only 1.4% of US personal health expenditures.⁴⁸ Immigrants were found to have contributed a greater amount in payroll taxes to the Medicare Trust Fund than they withdrew. From 2002 to 2009, immigrants generated surpluses in Medicare revenue between \$11.1 and \$17.2 billion annually, in contrast to US-born individuals who generated a \$30.9 billion deficit.¹⁰ These surpluses contributed by UIs could be used to subsidize their health care.

UIs and their families are falsely perceived to impose a heavy financial burden on the health care system because of their high rate of uninsurance. Because UIs often lack access to preventive and primary care services, they may have a greater need for tertiary care. UIs’ overall spending on health care is nevertheless significantly lower than

that of US citizens. Emergency physicians should continue to stabilize critical conditions and consider provision of other types of care to undocumented individuals. It may also be beneficial to refer uninsured patients, including UIs, to available community resources for follow-up, reassessment, and preventative services.

In conclusion, we contend that the primary responsibility of health care institutions and professionals is to provide beneficial treatment for patients in need. We have proposed that 3 basic principles of ethics for emergency physicians should guide care for UI patients in the ED and beyond. To protect the primacy of their duty to provide emergency care, emergency physicians and institutional clinicians should not accept roles that undermine it, including denying emergency care to patients who are UIs and reporting undocumented patients to law enforcement agents for the purpose of detention and possible deportation.

This article has described the UI population and proposed a new framework to address ethical issues relating to access to emergency care, including discussion of the role of EMTALA, ICE, the scope of emergency medicine practice, ongoing limitations of care delivery, medical repatriation, and economic costs. We offer several observations (Table 1) and recommendations (Table 2) based on our examination of these issues. We hope that this discussion will empower emergency physicians to continue to provide emergency care to UIs, to consider other ways to provide health care for them, and to offer new solutions based on the proposed moral framework.

TABLE 1 Summary of observations

1. Undocumented immigrants (UIs) are a vulnerable population.
2. Immigration and Customs Enforcement policy recognizes hospitals as sensitive locations and so refrains from conducting immigration enforcement within them.
3. Health care, including emergency care, for UIs actually costs less than many Americans believe.

TABLE 2 Summary of recommendations

1. Emergency physicians should provide emergency care to undocumented immigrants (UIs), guided by Principle 2 of the American College of Emergency Physicians Code of Ethics and by the legal mandate of the Emergency Medical Treatment and Labor Act.
2. Emergency physicians should protect the confidentiality of the personal information of UI patients, including information about immigration status.
3. Health care in the emergency department should support and enhance comprehensive care, including chronic disease management, mental health services, and protection of overall patient well-being, especially for vulnerable populations such as UIs. This support can include provision of non-urgent care for UI patients in the ED.
4. Medical repatriation may be an option for post-emergency care when patients give informed consent for a viable treatment plan.
5. Emergency physicians should advocate for measures to increase access to health care for UI patients.

Limitations to our analysis include the scarcity of studies pertaining to the ED-based care of UIs. Further study is needed to determine the health outcomes of these patients, including the effect of implementation of recommendations contained within this article.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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