Patients Without Borders: Extralegal Deportation by Hospitals

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PATIENTS WITHOUT BORDERS: EXTRALEGAL DEPORTATION BY HOSPITALS

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I. INTRODUCTION

Put yourself in the place of an undocumented migrant who is driving home with coworkers 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 seizes 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 and load you into a chartered plane that transports you 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 absorb your losses with no prospect of reimbursement. Allowing the patient to stay indefinitely would cost millions of dollars and take away a bed from other patients. 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 can 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 real and significant problem facing U.S. hospitals. Federal law requires hospitals to treat patients in need of emergency medical care regardless of whether 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 of undocumented migrants, unlike the Medicaid system’s reimbursements for citizens.

Several hospitals have decided to repatriate undocumented patients
needing long-term medical care at the hospitals’ expense. That is, the hospitals hire transport to return these individuals to the care and custody of their native countries. But 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 wide-spread litigation arising from their repatriation efforts in no way indicates that their conduct is above reproach. To the contrary, this Article addresses a range of potential legal challenges to private repatriation, including constitutional and nonconstitutional 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 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.” 1 Only when repatriation follows a process 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 noncitizens who have entered the United States surreptitiously 2 as well as noncitizens admitted to the country with valid documents that have since expired. 3 The exact number of undocumented migrants presently in the United States is unknown but was estimated to be approximately 10.6 million as of January 2009. 4

2. Such migrants are often referred to as “illegal aliens.”
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 of the University of California San Diego Trauma Center counted 200 people arriving at that emergency room between 2000 and 2006 seeking care after falling from the fence demarking 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 extensive orthopedic reconstruction” procedures and hospital stays from a week to two.


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.).
11. See Alan Zarembo & Anna Gorman, Dialysis dilemma: Who gets free care?, L.A. TIMES, Oct. 29, 2008, at A1 (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); id. (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 & 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.")
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 to treat patients in need of emergency medical care regardless of whether they are lawfully present in the United States. Specifically, EMTALA requires hospitals to assess whether “any individual” seeking emergency care has an emergency medical condition and further requires that patients with emergency medical conditions be stabilized before transfer or discharge. EMTALA provides Medicaid coverage for emergency treatment of undocumented migrants and, as such, EMTALA’s use of the term “any individual” clearly includes undocumented migrants.


Even before Section 1011 funding dried up, hospitals argued that the monies were wholly inadequate for treating undocumented migrants. For example, the average cost—not the charge—for treating a patient at the University of California San Diego Trauma Center for a fall from the border fence is $18,000. Yet the hospital receives an average of $4,000 in reimbursement from the federal government—less than 25% of what it spends.

13. Svetlana Lebedinski, EMTALA: Treatment of Undocumented Aliens And The Financial Burden It Places On Hospitals, 7 J.L. SOC’Y 146, 161 (2005) (“As a practical matter . . . since 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. . . .”).
14. 42 U.S.C. § 1395dd(a) (2006) (emergency medical treatment must be provided to "any individual").
15. Id.
16. Id. § 1395dd(b)(1)(A).
17. Id. § 1396b(v) (“Medical assistance to aliens not lawfully admitted for permanent residence”).
19. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 1011 (providing funding only through fiscal year 2008); see also Sontag II, supra note 10.
20. See Borderstories.org, supra note 5.
21. Id.
22. Id. Arrowhead Regional Medical Center, the county hospital in Colton, California, faces similar reimbursement woes. About 5% of all emergency room patients at Arrowhead are undocumented. The hospital has incurred some $18 million this year for the care of those patients and has been reimbursed just $5 million from the federal government. See Stephen Wall, Illegal migrants
While the federal government provides inadequate reimbursement for emergency care of undocumented migrants, it provides no reimbursement for the long-term medical care of undocumented migrants. Yet federal regulations prevent hospitals from discharging undocumented migrants after their emergency conditions, required to be treated under EMTALA, are stabilized. Federal regulations oblige 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.” The phrase “appropriate facilities” has been held to mean “facilities that can meet the patient’s medical needs on a post-discharge basis.” In addition to federal regulations, hospitals may also have their own discharge policies and procedures that require identification of appropriate post-hospital care.

Some states and local governments have stepped in to finance long-term care for undocumented migrants. California spends millions each year on Medi-Cal, which covers undocumented migrants and their long-term medical care. California’s current budget crisis, however, may result in near elimination of Medi-Cal coverage for the undocumented. The Health and Hospitals Corporation of New York City provides long-term medical coverage for medically needy undocumented migrants, and other cities and states provide coverage for certain long-term treatments, such as dialysis. But supplemental state and local coverage is the exception and not the rule. Most hospitals eat the cost of treating undocumented migrants with long-term medical needs.

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24. 42 C.F.R. § 482.43(d) (2009).
26. See Montejo v. Martin Memorial Med. Ctr., Inc., 874 So.2d 654, 657 (Fla. Dist. Ct. App. 2004) [hereinafter 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 & Gorman, supra note 11 (reporting California paid some $51 million for the dialysis treatment of 1,350 undocumented migrants in the year 2007).
29. See Sontag I, supra note 9.
30. See Zarembo & 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.”)
C. Repatriation: The Hospitals’ Response

Facing potentially unlimited expenses in the care of undocumented migrants, hospitals have begun a private campaign 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 avoids the unlimited expenses of long-term care, which can run in the millions of dollars.31

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 ninety-six immigrants a year.32
- The Broward General Medical Center in Fort Lauderdale, Florida has returned six to eight patients a year to their native countries.33
- Dr. Karla Vital of the University of Texas Medical Branch in Galveston said her hospital simply encourages Mexican nationals to return to Mexico while other hospitals pay for return plane tickets.34
- The Guatemalan foreign ministry has said that some fifty-three of its citizens have been returned by U.S. hospitals in the last five years.35
- Ten patients have been returned to Honduras from Chicago hospitals since early 2007.36
- In 2007, the Mexican consulate in San Diego handled eighty-seven medical cases—as well as 265 border-crossing injuries—many of which ended in repatriation.37

In many cases, physical return of patients has been outsourced to

31. 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).
32. Sontag I, supra note 9; Sontag II, supra note 10.
33. Sontag I, supra note 9.
34. Zarembo & Gorman, supra note 11.
35. Sontag I, supra note 9.
36. Id.
37. Id.
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.” 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.” 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.”

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.

MexCare’s quality assurances aside, there is no information about how hospitals determine that a particular patient is an undocumented migrant to be returned 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; or 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.

Patient consent is, at best, a gray area. Hospital administrators have a strong incentive to pressure patients and family to accept repatriation to keep hospital costs down. At the same time, patients may be entitled

40. Id.
41. Id.
42. 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, Frequently Asked Questions, http://mexcare.com/faq_MexCare.html (last visited Mar. 7, 2010) (follow “Will I be discharged before I am ready and well?” hyperlink).
43. See, e.g., Sontag II, supra note 10 (quoting one hospital administrator as saying, “We’re
to stay in the United States on claims grounded in, among other things, asylum, \textsuperscript{44} temporary protected status, \textsuperscript{45} or the Violence Against Women Act. \textsuperscript{46} Hospital administrators are unlikely to be immigration experts, able to gauge whether a given patient might be entitled to stay in the United States, nor do they have any motivation to inform patients of their potential rights. As a result, patient “consent” may result from hospital administrators telling patients that they have no rights and that their best and only alternative is repatriation. \textsuperscript{47}

The present questions about repatriation cannot be answered because the practice is taking place without any oversight. Though the Secretary of Homeland Security alone is charged with the investigation and removal \textsuperscript{48} of undocumented migrants within the United States, \textsuperscript{49} 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. \textsuperscript{50}

While the federal government has not addressed the problem of hospital repatriations, the issue is garnering attention from the American Medical Association (AMA). \textsuperscript{51} In November 2008, the AMA voted to

\textsuperscript{45} See id. § 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.eb1d4c2a3eb5bace89243c6a7543f6d1a/?vgnextoid=848f7f2ef0745210VgnVCMI00000082ca60aRCRD&vgnextchannel=848f7f2ef0745210VgnVCM100000082ca60aRCRD (last visited Feb. 20, 2009).
\textsuperscript{46} 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.
\textsuperscript{47} 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).
\textsuperscript{48} In 1996, the Immigration and Nationality Act was restructured so that “removal” proceedings (a new term) would encompass what was formerly termed “deportation” (removing noncitizens from the United States) and “exclusion” (rejecting the applications of noncitizens 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.
\textsuperscript{49} Id. § 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.”); id. § 1103(a)(5) (“He shall have the power and duty to control and guard the boundaries and borders of the United States against the illegal entry of aliens. . . .”).
\textsuperscript{50} Sontag II, supra note 10.
\textsuperscript{51} Doctors Study Repatriation of Uninsured, N.Y. TIMES, Nov. 11, 2008, at A18.
undertake a study regarding repatriation, but it has not taken a 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 Article is based on the story of Luis Alberto Jiménez, who sparked the only judicial opinion in the United States on the legality of repatriation. Jiménez came to the United States from Guatemala. He entered the country without inspection or documentation, and settled in Florida to work as a landscaper. In February 2000, a drunk driver hit him and three friends driving home from work. Jiménez was taken to Martin Memorial Medical Center, 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.

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 Jiménez, but he remained in a vegetative state for over a year and a half. When Jiménez unexpectedly awoke, the hospital determined that he needed traumatic brain injury rehabilitation. But the hospital was unable to find any appropriate rehabilitation center or nursing home willing to care for Jiménez, who had no funds to pay for such long-term

52. Id. In contrast, the California Medical Association voted in October 2008 to oppose the forced repatriation of patients. Id.
53. Id. 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.”
55. Id.
56. Sontag I, supra note 9.
57. Id.
58. Id.
59. Id.
60. Id.
61. Id.
62. Id.
63. Id.
64. Id.
medical care.65

Legally precluded from simply discharging Jiménez,66 and unable to secure post-hospital care, Martin Memorial faced the prospect of providing potentially unending long-term care.67 At this point, Martin Memorial contacted the Guatemalan government for assistance, and the health minister for Guatemala agreed to take over care.68

Jiménez, however, had a guardian in the United States who opposed his return to Guatemala, citing concerns about the quality of health care Jiménez would receive in his homeland. The guardian filed a guardianship plan in state court stating that Jiménez needed around-the-clock nursing care for the next twelve months.69 The hospital sought judicial review of the guardianship plan, arguing that it was not in Jiménez’s best interest and that he should instead be discharged to Guatemala.70

Circuit Judge John E. Fennelly authorized the hospital to relocate 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.”71 Jiménez’s guardian filed a notice of appeal and asked the court to stay execution of its order pending appeal.72 The court asked the hospital to file a response.73 Hours before that response was due, the hospital transported Jiménez by air ambulance to Guatemala.74 Martin Memorial paid the $30,000 flight cost,75 and closed the bill for Jiménez’s care, which totaled $1.5 million.76 For that care, the hospital was reimbursed just $80,000 from the federal government.77

Jiménez was initially placed at Guatemala’s National Hospital for Orthopedics and Rehabilitation, the country’s only public rehabilitation

65. Id.
66. See supra notes 24–26 and accompanying text.
68. Id.; see also Montejo I, 874 So.2d 654, 657 (Fla. Dist. Ct. App. 2004) (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.”).
69. Montejo I, 874 So.2d at 656.
70. Id.
72. Id. at 1267–68.
73. Id. at 1268.
74. Id.
75. Sontag I, supra note 9.
76. Id.
77. Id.
facility. After a few weeks, he was discharged to another public hospital, where his brother found him “lying in the hallway on a stretcher, covered in his own excrement.” Jiménez’s family then took him home to the mountains of Guatemala, where he has received “no medical care or medication—just Alka-Seltzer and prayer.”

Just under a year after Martin Memorial returned Jiménez to Guatemala, the District Court of Appeal of Florida reversed the order that originally cleared his removal to Guatemala.82 The court found insufficient evidence that Jiménez could receive adequate care in Guatemala.83 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.”

III. AN ANALYSIS OF THE LEGALITY OF HOSPITAL REPATRIATIONS

In evaluating the return of Jiménez to Guatemala, the Florida appellate court focused on the quality of Martin Memorial’s decisionmaking. The court side-stepped larger issues concerning the constitutionality of the hospital’s conduct. In this Part, 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.85

A. The Fourteenth Amendment

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

Several courts have held that state, local government, and public trust hospitals are state actors subject to the Fourteenth Amendment’s proscriptions. Whether private hospitals are state actors, and thus limited in their conduct by the Fourteenth Amendment, is a more difficult question. After examining this question, I turn to whether any hospital repatriation, assuming the Fourteenth Amendment applies, runs afoul of constitutional guarantees.

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. 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.” Several tests determine whether a private hospital’s action can be fairly attributable to the state so as to render it a “state actor” for purposes of Fourteenth Amendment analysis. These tests are: (1) the public function test; (2) the state compulsion test; and (3) the symbiotic relationship, or nexus test. If any of one of these three tests is met, a private hospital can be considered a state actor for Fourteenth Amendment analysis.

87. Id.

88. 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 relative little fanfare, that public trust and county hospitals are properly deemed state actors for § 1983 purposes.”).

89. 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 Hosp., 476 F.2d 671 (10th Cir.1973); see also Jackson v. Metro. Edison Co., 419 U.S. 345, 350 (1974) (“The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. Nor does the fact that the regulation is extensive and detailed . . . do so.”) (footnote omitted) (citations omitted).


91. Id.

92. 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).
Under the public function test, actions by a private hospital 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, following the public function test literally, repatriation is not attributable to the state because it is not a traditional exercise of state power. Yet a literal approach would not do justice to the test’s underlying principle. A private hospital is undertaking a public function when it repatriates undocumented migrants because it deputizes itself to enforce federal law. As such, its conduct falls squarely within the public function test and should render the private hospital a state actor 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 held that a private hospital can be considered a state actor when it acts as “reporting and enforcement machinery for . . . a government agency charged with detection and prevention of child abuse and neglect.” Kia concerned an infant born in a private hospital. The infant tested positive for methadone, and a hospital social worker, mandated by 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 acted as both a “reporting and enforcement machinery for CWA” and was thus a state actor.

Repatriation of undocumented migrants by private hospitals is analogous to the conduct 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) though such conduct is unauthorized. But

93. Wolotsky v. Huhn, 960 F.2d 1331, 1335 (6th Cir. 1992) (citations omitted); see also Ellison v. Garbarino, 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).
94. Wolotsky, 960 F.2d at 1335.
96. See Pub. L. No. 414, 63 Stat. 163 (1952) (codified as amended in scattered sections of 8
unlike the mandatory reporters in *Kia*, private hospitals are not *compelled* to be enforcers of immigration law.

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 five years.\(^{97}\) 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. Further, Arizona has not prosecuted any hospital administrators for crimes arising out of repatriation, such as kidnapping (discussed in Part III.D below), despite the involvement of police in thwarting some repatriation efforts.\(^{98}\) 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 or nexus test, has been addressed differently in different courts. The Sixth Circuit has held that the test examines 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.”\(^{99}\) As discussed above, states generally do not have a role in enforcing immigration law. But 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.”\(^{100}\) And several states and counties across the United States have taken advantage of this program.\(^{101}\) While these agreements do not extend to the removal of undocumented migrants from the 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

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\(^{97}\) Sontag II, *supra* note 10; ARIZ. REV. STAT. ANN. § 36-2903.03(B)(2) (2010).

\(^{98}\) *See* Sontag II, *supra* note 10.

\(^{99}\) *Wolotsky*, 960 F.2d at 1335.

\(^{100}\) 8 U.S.C. § 1357(g) (2006).

\(^{101}\) *See* U.S. Immigration and Customs Enforcements, Partners, http://www.ice.gov/partners/287g/Section287_g.htm (last visited Mar. 7, 2010).
and the state. In *Jatoi v. Hurst-Euless-Bedford Hospital Authority*, the Fifth Circuit found that a private hospital was a state actor because of such a symbiotic relationship. 102 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.103 While the hospital was leased to a private manager, that manager took over a job formerly performed by the state for the public benefit.104 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.105 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 next question is whether repatriation violates any of the Fourteenth Amendment’s protections.

2. Due Process

Undocumented migrants are entitled to due process under the Fourteenth Amendment. 106 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, regardless of the process, unless the infringement is narrowly tailored to serve a compelling state interest.107 But does repatriation by hospitals implicate...

102. 807 F.2d 1214 (5th Cir. 1987).
103. *Id.* at 1221.
104. *Id.*
105. *Id.*
106. Plyler v. Doe, 457 U.S. 202, 211–12 (1982) (stating that the provisions of the Fourteenth Amendment “are universal in their application, to all persons within the territorial jurisdiction” (emphasis omitted)) (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))).
fundamental interests? And, if so, is the infringement 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 inadequate or no medical care. 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.”

If repatriation is effectively a “death sentence,” then it would effect a person’s interest in his own life, which the Supreme Court has held to be a “fundamental interest.” The Constitution itself is unambiguous: States cannot “deprive any person of life... without due process of law.” 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 en banc decision from the D.C. Circuit, 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.

The focus of Abigail Alliance was an effort to enjoin the Food and Drug Administration (FDA) from continuing to enforce its policy barring sale of experimental drugs not yet approved for public use to terminally ill patients. 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.” The majority rejected this approach. Citing the Supreme Court’s decision in Washington v. Glucksberg, the D.C. Circuit cautioned against such a “broad...
generalization” of the rights at issue: “If the asserted 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 in Abigail Alliance sidestepped the issue of the constitutional protection of life. By focusing on Washington v. Glucksberg, the court transformed the analysis from examining the parameters of “depriving any person of life” to whether there was a liberty interest at issue. But whether the case implicated liberty interests does not determine whether it also implicated “life.”

The Supreme Court has never attempted to define “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 convicted criminal, blocked access to life-saving medicine, or death by deportation—there is deprivation of life that demands due process. Focusing specifically on repatriation, there is no principled distinction 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

117. Abigail Alliance, 495 F.3d at 701 n.5.
118. Id.
119. Id.
120. Id.
124. Stated differently, whenever the government “deprive[s] any person of life.” U.S. CONST. amend. XIV, § 1; see also U.S. CONST. amend. V.
126. While the Constitution specifically recognizes the death penalty, see U.S. CONST. amend. V, such “deprivation of life” cannot be accomplished without “due process of law.” Id. See also William J. Brennan, Jr., 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 . . . .”)
constitutional protection of life. For the same reasons, repatriation that would result in death also implicates the constitutional protection of life.

ii. Repatriation Implicates Fundamental Liberty Interests

The Fourteenth Amendment protects against not only state deprivation of life but also state deprivation of “liberty.” 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. The Supreme Court has also “assumed, and strongly suggested” that the right to refuse unwanted lifesaving medical treatment is a fundamental. 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 liberty interest. The next step, determining whether the asserted interest is “fundamental,” turns on whether the interest is “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed.” Of course, this inquiry depends on the interest or right 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,” “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 noncitizens 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

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128. See NOWAK & ROTUNDA, supra note 122, at § 13.3.
129. 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.
132. id. citing Cruzan v. Missouri Dep’t of Health, 497 U.S. 261, 278–79 (1990)).
133. at 721.
135. at 716 (Rogers, J., dissenting).
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. On the other side of the country, California had one of the most extensive public hospitals systems in the nation by the early 1900s. Moreover, many of our nation’s earliest immigrants came from countries with long histories of providing medical care to the poor. 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.”

This conclusion is not affected because those affected by repatriation are not U.S. citizens: While the United States has a long history of denying entry to certain medically needy noncitizens, there is no equally storied history of exporting 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.”

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 identify a fundamental liberty interest. As discussed by the dissent in Abigail Alliance, our nation has a long history of

138. See, e.g., HEALTH CARE AND POOR RELIEF IN PROTESTANT EUROPE 1500–1700 (Ole Peter Grell & Andrew Cunningham eds., 1997) (discussing medical care for the poor in Northern Europe including Holland, Belgium, Germany, Denmark, Sweden, Finland, Poland, Scotland, and London).
139. Abigail Alliance, 495 F.3d at 711 (majority opinion).
140. Id. at 711 n.19.
141. In 1882, Congress enacted legislation to bar “lunatic[s],” “idiot[s],” 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, § 2, 22 Stat. 214. In 1891, Congress added “persons suffering from a loathsome or a dangerous 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, § 2, 26 Stat. 1084. In 1903 “epileptics” were added to the excludable list. Immigration Act of 1903, ch. 1012, § 2, 32 Stat. 1213, 1214. In 1917, persons of “constitutional psychopathic inferiority” and “chronic alcoholism,” and persons afflicted with tuberculosis were also excluded. Immigration Act of 1917, ch. 29, § 9, 39 Stat. 874. 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) (2006).
supporting the “duty of self preservation.” 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. 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. They are, therefore, fundamental, and 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, states have no role in enforcing federal law. Moreover, states have made no effort to involve appropriate federal enforcement authorities—the Department of Homeland Security—in the repatriation process. 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.

Finally, 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 to how hospitals determine whether a patient has the right to stay in the country or is a candidate for repatriation. Hospitals appear to pursue 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

143. *Abigail Alliance*, 495 F.3d at 717 (Rogers, J., dissenting).


145. *Abigail Alliance*, 495 F.3d at 718.

process requirements still apply. And 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.

i. EMTALA Establishes a Property Interest in Medical Care

In 1970, the Supreme Court held that expected government entitlements could constitute property that may only be deprived with due process. The Court focused on the fact that the welfare benefits at issue were “a matter of statutory entitlement for persons qualified to receive them.”

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.’” Congress was concerned about evidence that hospital emergency rooms were denying uninsured patients the same treatment that they 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 medically needy undocumented migrants 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.

148. Id. at 262.
152. Id. § 1395dd(b)(1)(A).
153. 42 C.F.R. § 482.43(d) (2009).
155. 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.
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 debated.

(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 required for deportation proceedings. The process “due” would be that which is followed by the Department of Homeland Security pursuant to statute, including, among other things, a hearing before an immigration judge at which the government carries “the burden of establishing by clear and convincing evidence that...the alien is deportable,” notice of the right to appeal the decision; opportunity to move the immigration judge to reconsider; opportunity to seek discretionary relief of removal, and opportunity to obtain habeas review of the decision not to consider waiver of deportation. No extra-governmental process would be permitted.

Hospitals might argue that repatriation is not analogous to removal proceedings because (1) hospitals do not make judgments about immigration status but rather secure 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 inherently make a decision about that individual’s immigration status and the propriety of removing that patient from the United States. And any consent obtained from patients is necessarily infected by this improper determination of

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, 312–13 (2008).

156. See Yamataya v. Fisher, 189 U.S. 86, 100–01 (1903) (due process is required for deportation proceedings).
158. Id. § 1229a(a)(1).
159. Id. § 1229a(c)(3)(A).
160. Id. § 1229a(c)(5).
161. Id. § 1229a(c)(6).
162. Id. § 1229a(c)(4).
164. 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.”).
immigration status.165

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

(b). A Lesser Form of Process

The process required for repatriation is removal proceedings. But even if repatriation does not require the stringent process due in removal proceedings, it requires some process because it affects life, liberty, and property interests. At a minimum, there must be a means for patients to contest repatriation before a neutral decisionmaker.166

Repatriation, however, is occurring without any process. Hospitals are acting on an 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, patient’s only resort to avoid repatriation is state courts, yet state courts do not have the authority to determine an alien’s immigration status.167

Because patients do not receive the bare minimum standards of process, repatriation 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.168 Undocumented migrants have not, however, been held to constitute a “suspect class” such that discriminatory laws or state action would trigger strict scrutiny analysis.169 Nevertheless, where nonsuspect classes raise equal protection challenges that affect fundamental rights, strict scrutiny will apply.170 Thus, this analysis parallels that of

165. See supra notes 42–47 and accompanying text.
166. See In re Murchison, 349 U.S. 133, 136 (1955) (“A fair trial in a fair tribunal is a basic requirement of due process.”).
substantive due process.

As discussed, repatriation affects fundamental interests in life and liberty.\textsuperscript{171} Hospitals are infringing upon these fundamental interests in a classified manner—they are offering different courses of treatment to individuals based upon their perceived\textsuperscript{172} immigration status by seeking to deport undocumented migrants and to treat all others.

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. This standard cannot be met: States have no interest in enforcing federal immigration law and any there is no indication that repatriation is narrowly tailored to address state fiscal concerns.\textsuperscript{173}

\section*{B. Federal Preemption}

The Supremacy Clause of the U.S. Constitution dictates that federal law preempts or overrides state or local legislation where there is conflict.\textsuperscript{174} 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{175} In so doing, preemption "avoid[s] conflicting regulation of conduct by various official bodies which might have some authority over the subject matter."\textsuperscript{176}

There is no question that with the INA, Congress created a comprehensive scheme for identifying and removing undocumented migrants. There is also no dispute that this scheme leaves no room for a direct state or local role in immigration.\textsuperscript{177} The unanswered question is

\begin{itemize}
\item \textsuperscript{171} See supra Parts III.A.2.a.i & ii.
\item \textsuperscript{172} The word “perceived” is important; not all undocumented migrants are subject to deportation. See supra notes 44–46 and infra note 187 and accompanying text.
\item \textsuperscript{173} See supra Part III.A.2.a.iii.
\item \textsuperscript{174} 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 McCulloch v. Maryland, 17 U.S. 316, 436 (1819) (“[S]tates 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 powers vested in the general government. This is, we think, the unavoidable consequence of that supremacy which the constitution has declared.”).
\item \textsuperscript{175} Hines v. Davidowitz, 312 U.S. 52, 67 (1941).
\item \textsuperscript{176} Amalgamated Ass’n of St., Elec. Ry. & Motor Coach Employees v. Lockridge, 403 U.S. 274, 285–86 (1971).
\item \textsuperscript{177} See Lisa M. Seghetti et al., Cong. Research Serv., Enforcing Immigration Law: The Role of State and Local Law Enforcement 5 (2009) (“The civil provisions of the INA have been assumed to constitute a pervasive and preemptive regulatory scheme—leaving no room for a direct state or local role.”); see also 8 U.S.C. § 1357(g)(1) (2006) (specifying the only statutorily authorized
\end{itemize}
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
Supremacy 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. But when hospitals run by state or local
governments 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. Because their judgments have the force and effect of
law they are de facto laws and 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. The same analysis should be applied in the
preemption context with the ultimate conclusion that repatriation by
state and local hospitals is de facto lawmaking by the state.

The Supreme Court’s preemption analysis in \textit{Wisconsin Department
of Industry, Labor and Human Relations v. Gould, Inc.} \footnote{475 U.S. 287 (1986).} compels such
a result. \textit{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. The
Supreme Court disagreed, finding that the state was exercising its
regulatory power by attempting to enforce compliance with the
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.” It held that any state interference with the NLRA’s “interrelated federal scheme of law, remedy, and administration” would be preempted.

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. 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 spending; it interferes with the federal legislative scheme governing the removal of undocumented migrants.

Interference with the federal immigration scheme was the focus of Lozano v. City of Hazelton, 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 noncitizens. 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 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; 5) aliens who are granted deferred action “an act of administrative convenience to the government which gives some cases lower priority[.]”

Because these noncitizens 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.

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 somehow be obtained outside of a formal removal hearing.”\textsuperscript{189} To the contrary, the United States evaluates the lawfulness of a noncitizen’s presence in the United States exclusively through the complex procedures set forth in the INA.\textsuperscript{190} 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,\textsuperscript{191} state or local interference with the INA’s “interrelated federal scheme of law, remedy, and administration” must be preempted. It is irrelevant that the interference occurs through de facto as opposed to direct lawmakers.

2. The Problem of Private Hospitals

“[T]he Supremacy Clause does not require pre-emption of private conduct.”\textsuperscript{192} That is because, by its terms, the clause applies only to “Laws of any State.”\textsuperscript{193} 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.\textsuperscript{194}

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 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.\textsuperscript{195} The same considerations could be imported to preemption analysis to determine whether conduct by private hospitals could be considered de facto state actors.

\textsuperscript{189} Id. at 530.
\textsuperscript{190} Id. at 532.
\textsuperscript{193} U.S. CONST. art. VI, cl. 2.
\textsuperscript{194} Gould, 475 U.S. at 290.
\textsuperscript{195} See infra Part III.A.1.
law. Even if there is no preemption, this does not indicate that repatriation by private entities is lawful. That would lead to absurd results, and permit, for example, a change in the focus of the citizen-run Minutemen Project from monitoring the border between the United States and Mexico to repatriation.196 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. In fact, Jiménez’s legal guardian197 pursued a claim against Martin Memorial Medical Center for false imprisonment.198

The common law tort of false imprisonment generally requires (a) intent to confine, (b) confinement, (c) consciousness of the confinement or harm resulting from the confinement.199 In hospital repatriation cases, such elements would be easily met when patients are placed, or confined, in an ambulance or plane.200

The key issue in repatriation cases would revolve around the affirmative defense of consent. Where the hospital has not obtained consent, then none would be implied in law, and the hospital would be liable.201 For those patients who consented to repatriation,202 the question is whether that consent is sufficient to vitiate the underlying claim.203 Hospitals should be wary of relying on patient (or family)

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197. Jiménez’s story is recounted in supra Part II.D.


199. See RESTATEMENT (SECOND) OF TORTS § 35 (1965).


201. See Sontag I, supra note 9 (reporting about patients who did not want to be repatriated); Sontag II, supra note 10 (same).


consent because they are acting outside of the mandated deportation proceedings. Patients could, for example, claim that the consent was obtained under duress or by misrepresentation about the legal authority for hospital repatriation, which would render any consent invalid.

In Florida, where Jiménez’s suit against Martin Memorial took place, the courts use a doctrinal formulation of false imprisonment that is somewhat unclear and confused, but 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 or “color of authority” and (4) which is unreasonable and unwarranted under the circumstances.

There was no dispute that the Jiménez case met the first prong of Florida’s false imprisonment claim. Although the use of “unlawful” is arguably superfluous and the words “detention” and “deprivation of liberty” seem duplicative, hospital repatriation 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. Because repatriation effects the removal of aliens outside of these established procedures, it is unlawful. The requisite “detention” and “deprivation of liberty” are satisfied by transporting the patients internationally.

The second element—lack of consent (when used as an affirmative defense), though it shifts the burden of proof to the plaintiff.

The third element—regarding “legal authority”—was the subject of pre-trial litigation by Martin Memorial. The hospital moved to dismiss the false imprisonment suit filed by Jiménez’s guardian on the basis that the hospital was immune from suit because it had authority from the trial court to repatriate Jimenez. The District Court of Appeal of Florida rejected this argument. The court emphasized that

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204. See, e.g., RESTATEMENT (SECOND) OF TORTS, § 40A.
205. See, e.g., id. § 41.
208. Montejo II, 935 So.2d 1266.
209. 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.” Id. at 1269. 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.” Id. at 1270.
210. Id. at 1270.
the trial court lacked subject matter jurisdiction to authorize the underlying repatriation order. And because the hospital sought to vindicate a purely private right when it sought judicial approval to deport Jiménez, it was not entitled to immunity for acting pursuant to the void order. Thus, hospitals cannot obtain “legal authority” to repatriate patients; that is a power exclusively reserved to the Department of Homeland Security.

The final element—unreasonable and unwarranted under the circumstances—is a strange articulation of law and alien to traditional notions of false imprisonment. Under the common law, private persons are not privileged to deprive people of personal liberty at will, even when doing so might be objectively reasonable. Nonetheless, the Florida appellate court identified this as the sole issue for the Martin Memorial trial.

At trial, Martin Memorial argued that repatriation was reasonable and warranted under the circumstances and emphasized that it had a court order authorizing the international transfer. Jiménez’s guardian, in contrast, argued that the repatriation was unreasonable and “designed once and for all to stop the meter from running” on appellate expenses. In the end, the six-person, all-white, jury unanimously found for Martin Memorial.

While the Martin Memorial trial focused on contested factual disputes as to whether the hospital’s conduct was unreasonable and unwarranted under the circumstances, such issues are unlikely to arise in other suits against hospitals precisely because of the Montejo precedent. Hospitals are now on notice that courts cannot authorize repatriation—that is the exclusive province of the Department of Homeland Security. At the same time, if hospitals repatriate patients without any legal authority, their conduct is unlikely to be held reasonable under the circumstances.

This analysis indicates that false imprisonment may be a significant tool for challenging hospital repatriations. But there will undoubtedly

212. 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.
213. Id. at 1271; see Montejo I, 874 So.2d at 658 (“[T]he trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jimenez to Guatemala.”).
215. Montejo II, 935 So.2d at 1272.
217. Id.
be challenges to such civil suits. It will 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: A hospital with a million-dollar verdict may nevertheless have save several millions of dollars in long-term care through repatriation. Of course a conscious choice to pursue a course of improper but profitable conduct would open the door to punitive damages, which may deter repatriation.

D. Kidnapping

Kidnapping is the criminal parallel to false imprisonment. Under 18 U.S.C. § 1201, it is a federal crime to “unlawfully seize[.] . . . or carry[.] away and hold[.] for ransom or reward or otherwise any person . . . [when] the person is willfully transported in interstate or foreign commerce.”219

Repatriation by U.S. hospitals meets this definition of kidnapping. The hospitals’ conduct is unlawful. As discussed above, private deportation is not permitted by statute and patient consent is meaningless in the context of repatriation. Repatriation also involves carrying individuals across international borders. This 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 years or for life and, if the death of any person results, shall be punished by death or life imprisonment,”220 for the repatriation of patients over eighteen years old. Hospital administrators could face “imprisonment for not less than 20 years”221 for the repatriation of patients under the age of eighteen. Of course, in addition to federal charges, hospitals and involved persons could face state kidnapping charges.

E. RICO

In addition to kidnapping charges, repatriation may open hospital administrators to charges brought under the Racketeer Influenced and Corrupt Organizations Act (RICO).222 RICO makes it illegal “for any
person employed by or associated with any 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.”

Doctors, hospital administrators, hospitals, and medical transport companies may be participants in an enterprise with the common purpose of repatriating medically needy patients. The enterprise affects foreign commerce by shifting the cost of caring for the patient from the United States to the country of repatriation and the transportation costs themselves. Furthermore, the participants accomplish repatriation through “racketeering,” which, by its definition, includes “any act or threat involving . . . kidnapping.” 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. 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 repatriation, those communications may amount to mail or wire fraud, which are also predicate racketeering acts.

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).” It also authorizes fines and criminal forfeiture.

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. But civil RICO claims can only be brought upon a showing of injury to business or property by reason of a RICO violation. It may be quite difficult for an undocumented migrant to show such injury.

223. Id. § 1962(c).
224. 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).
226. Id. § 1961(5) (“[P]attern of racketeering activity’ 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. . .”).
227. Id. § 1961(1)(B) (citing 18 U.S.C. § 1341 (mail fraud); id. § 1343 (wire fraud)).
229. Id.
F. EMTALA

EMTALA 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. Individuals may “obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.”

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

In addition, some courts have found that EMTALA preempts state hurdles to lawsuits against hospitals. For example, the Eighth Circuit has held that EMTALA preempted a Missouri statute that provided immunity to state hospital districts. Courts have, however, allowed state limits on dam

IV. A NEW PROPOSAL

A. The Need for a Uniform Public Solution

The expenses of long-term care of undocumented migrants in U.S. hospitals cannot be ignored. If private repatriation is, as I argue, legally problematic, 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, ten hospitals have closed in the last five years, citing losses from treating the uninsured.

One could argue that the federal government should follow the model

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231. Id.
233. Id.
of California and New York City and fund the long-term care of undocumented migrants. Yet this solution seems unlikely and arguably runs contrary to the policy norms implicit in current immigration law.237

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 uniformly with the procedural safeguards already in place for evaluating the removal of undocumented migrants.

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—regardless of patient consent. Such a law must be passed to achieve uniformity and address the problems posed by private hospitals that may not be considered state actors for constitutional analysis, and consent by duress or misrepresentation.

B. Federal Repatriation

Establishing a federal process for repatriating medically needy undocumented migrants would not be difficult, as there is already a system in place for the removal of noncitizens. The issues unique to the medically needy would be how to involve hospitals in the process; how to quickly and efficiently determine whether an individual patient is an undocumented migrant subject to removal from the country; and 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

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237. 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 (2009), those seeking refugee status, 8 C.F.R. § 207.2, special agricultural workers, id. § 210.1(d), and applicants in the United States seeking to adjust to permanent resident status. Id. § 245.5.
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 “sanctuaries” and have accordingly passed laws that would prohibit hospitals from reporting undocumented patients to federal authorities.238 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 may not report undocumented migrants because it might discontinue 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.239

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 be 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, unreimbursable, medical care. By directing these hospitals to ICE, the law would introduce a full measure of due process and an incremental measure of humanity into the dynamic.

2. Step Two: Removal

Once notified, ICE officials should evaluate whether there is prima facie evidence that the identified patient is a noncitizen present in the United States in violation of law.240 Given the high cost of intensive medical care, legislation or regulations could be instituted to establish


239. 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, at A21 (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].”) (final alteration in original).

240. 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.
prompt deadlines for this first step. For example, ICE might be required
to look into a hospital’s request within forty-eight 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 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
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, during which the costs of
caring for the potentially removable patients would continue to rise,
making this an unsatisfying option.

Alternatively, Congress could add medically needy undocumented
migrants 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 noncitizen 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
processes, grouping medically needy undocumented patients with
inadmissible aliens poses significant problems. Because the patients are
present in the United States, and not seeking entry, they have due
process rights that demand more than adjudication by an immigration
officer without judicial review.

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 noncitizens

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241. For examples of individuals currently subject to expedited removal, see 8 U.S.C.
§ 1225(b)(1)(A)(i) (2006) (noncitizens 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); id. § 1225(b)(1)(A)(iii)(II) (noncitizens who have not been admitted or
paroled into the United States who have not affirmatively shown physical presence in the United States
(noncitizens encountered within one hundred miles of the U.S. border and who entered the United States
without inspection less than fourteen days before the time they are encountered); 8 U.S.C. § 1225(c)
(noncitizens deemed inadmissible on security grounds).

convicted of aggravated felonies. Lawful permanent residents convicted of aggravated felonies are subject to ordinary removal procedures, but there is a statutory mandate to finalize the removal proceedings before the noncitizen’s release from incarceration for the underlying aggravated felony. The scheme accomplishes speed in some instances by use of videoconference technology to hold removal hearings in detention facilities.

Noncitizens 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 review or an order of removal by the federal district court presiding over their criminal sentencing.

Congress should fashion a new form of removal for medically needy undocumented migrants modeled on the removal process for aggravated felons. New legislation should authorize expedited removal of medically needy noncitizens. 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 must consider how to handle the removal of those noncitizens who are mentally impaired as a result of their medical conditions. Traditionally, noncitizens are only entitled to legal representation in removal proceedings at no expense to the government. In medical repatriation cases, however, the lack of any representation would be unjust. Congress should appoint either counsel or a guardian ad litem for affected patients. If Congress chooses the latter option, there would be no requirement that the guardian be an attorney. This role could be assumed by the patient’s relative or friend. In the absence of any such individual, a social worker or other appropriate representative would be acceptable.

Essential to any new removal procedures will be implementing standards to evaluate whether the patient is medically stable for transport out of the United States and whether the patient will receive medical

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243. Id. § 1228. “Aggravated felony” is defined by statute. See id. § 1101(a)(43).
244. Id. § 1228(a)(1).
245. Id. §§ 1228(a)(1), (a)(3)(A).
246. Id. § 1229(b)(2)(A).
247. Id. § 1228(b).
248. Id. § 1228(b)+ (c).
249. Id. § 1229a(b)(4)(A).
care in their home country.

Critics might argue that ICE is not equipped to determine 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 intercountry travel. The U.S. military makes such determinations about soldiers wounded in Iraq and Afghanistan every day. ICE could adopt the model established by the military. ICE could hire a limited number of medical personnel on a full-time or consultant basis 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 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 noncitizens with medical concerns. For example, the Department of Homeland Security came under fire in 2006 when a noncitizen 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 avoided such a tragic result.

Evaluating the availability and adequacy of medical treatment abroad will be 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?

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

  Few countries will provide medical treatment equal to that 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.” In those cases, repatriation should be abandoned. The United States already has a policy of refusing to send migrants home to certain death—one codified in our asylum laws—and our adherence to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment—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 absence of medical care in the home country, the patient should be paroled into the United States. Regulations could be promulgated to reevaluate the patient’s medical condition and home-country conditions on a periodic basis to determine if removal can be accomplished. In the interim, Medicaid should be extended to parolees to reimburse hospitals in part for care provided to nonremovable patients.

V. CONCLUSION

  Providing long-term care to medically needy undocumented migrants is a costly proposition. But the solution cannot be institutionalized vigilism 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 establish uniform procedures for removing medically needy undocumented migrants.

251. 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.’”).

252. See 8 U.S.C. § 1101(a)(42); id. § 1158(b)(1).


254. 8 U.S.C. § 1182(d)(5)(A). Noncitizens 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.