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FIRST, DO NO HARM: TORT LIABILITY, REGULATION AND THE FORCED REPATRIATION OF UNDOCUMENTED IMMIGRANTS

DANIEL J. PROCACCINI*

Abstract: In *Montejo v. Martin Memorial Medical Center*, a jury found that it was not unreasonable for a hospital to return a traumatically injured, undocumented immigrant to his native country against the will of his guardian. Also known as forced repatriation, the practice of international patient dumping results from the disjointed federal regulations governing the intersection of immigration and health care law. This Comment examines the underlying causes of forced repatriation and whether tort liability is a suitable means for preventing this practice. It concludes that direct regulation, rather than tort law, is a preferable method of preventing this harm and calls upon Congress to adopt uniform regulations regarding the medical transfer of all patients to foreign hospitals, regardless of their immigration status.

INTRODUCTION

When is it acceptable to terminate medical care for a severely injured non-citizen?¹ On July 27, 2009, a Florida jury answered that question when it found that it was not unreasonable for a hospital to stop providing medical care and send a traumatically brain-injured patient back to Guatemala against the wishes of his guardian.² This verdict ex-

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¹ See *Florida Hospital Flies Patient to Guatemala; Courts to Address Care of Non-U.S. Citizens*, 12 HEALTH L. REP. (BNA) 1130, 1131 (JUL. 17, 2003) (quoting a hospital association vice president stating repatriation represents the “financial and ethical dilemma When does care stop?”).

² See Jury Verdict at 1, *Montejo v. Martin Mem’l Med. Ctr.*, No. 04000715CA, 2009 WL 3260347 (Fla. Cir. Ct. July 27, 2009); Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES, July 28, 2009, at A10. Montejo’s lawsuit took a serpentine path through Florida’s judiciary. See, e.g., *Montejo v. Martin Mem’l Med. Ctr. (Montejo II)*, 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006); *Montejo v. Martin Mem’l Med. Ctr. (Montejo I)*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004). First, in 2003, Martin Memorial sought and received a court order authorizing Luis Jimenez’s repatriation. See *Montejo I*, 874 So. 2d at 656. In 2004, a Florida District Court of Appeals reversed the lower court order on federal preemption grounds. *Id.* at 658. In 2006, on the issues of immunity and standing, the case

posed to scrutiny the “rare but widespread” practice of forced medical repatriation—or international patient dumping.³

The facts of Luis Jimenez’s experience illuminate the grave nature of this dilemma.⁴ Late in the afternoon on February 28, 2000, an ambulance hastened Luis Jimenez—a catastrophically injured accident victim—to Martin Memorial Medical Center, a community hospital in “upscale” Stuart, Florida.⁵ He was injured in a head-on collision with a drunken driver operating a stolen van.⁶ When the ambulance arrived at the hospital, Mr. Jimenez was unconscious and in shock; his injuries included extensive bleeding, three broken limbs, multiple internal injuries, and severe head trauma.⁷ His prognosis was “poor.”⁸ Despite his condition, Martin Memorial’s staff was able to provide extensive medical treatment to Mr. Jimenez, and he stabilized.⁹ Nevertheless, Mr. Jimenez deteriorated and was readmitted to the hospital in January 2001.¹⁰ The hospital subsequently determined that he should be

returned to the Florida District Court of Appeals. *See Montejo II*, 935 So. 2d at 1268. The Court found in favor of Montejo and remanded for the limited purpose of determining whether the hospital’s conduct was reasonable. *See id.* at 1272.

³ *See* Sontag, *supra* note 2. Accurately framing this issue is a challenge because “[t]he terms ‘medical deportation’ and ‘medical repatriation’ often have been used interchangeably by the press and public when discussing this issue.” Joseph Wolpin, Recent Development, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 155 n.1 (2009). “Deportation” has a specific meaning in immigration law. *See* 8 U.S.C. § 1227(a) (2006); BALLENTINE’S LAW DICTIONARY 337 (3d ed. 1969). Additionally, the term “forced” is somewhat ambiguous. *See* Wolpin, *supra* at 153. This Comment adopts the term “repatriation” denoting “to restore or return to one’s country of origin, allegiance, or citizenship.” WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE 1924 (Phillip Babcock Grove ed., 1986). The phrase “forced repatriation” shall encompass the circumstances relevant here, where the transfer was made without consent from the patient or his or her guardian. *See* Wolpin, *supra* at 153.

⁴ *See generally* *Montejo II*, 935 So. 2d at 1267–68; *Montejo I*, 874 So. 2d at 656; Deborah Sontag, *Deported, by U.S. Hospitals: Immigrants, Spurned on Rehabilitation, Are Forced out*, N.Y. TIMES, Aug. 3, 2008, at A1.

⁵ *See* Sontag, *supra* note 4.

⁶ *See id.* The blood alcohol level of the driver was four times the legal limit. *See id.* Two of the four passengers in the vehicle were killed. *See id.* The driver eventually pled guilty to D.U.I. manslaughter, D.U.I. injury, and grand theft auto. *See id.* The driver, however, was uninsured. *See id.* The victims’ families subsequently filed an unsuccessful lawsuit against an irrigation company arguing that its employees had enabled the accident by leaving their keys in an unattended van. *See id.*

⁷ *See id.*

⁸ *See id.*

⁹ *See id.*

¹⁰ *See Montejo I*, 874 So. 2d at 656; Sontag, *supra* note 4. Mr. Jimenez was “emaciated and suffering from ulcerous bedsores so deep that the tendons behind his knees were exposed.” Sontag, *supra* note 4.

treated in a traumatic brain rehabilitation facility.¹¹ Mr. Jimenez, however, was an uninsured, undocumented immigrant, meaning that long-term care would be difficult—if not impossible—to arrange.¹²

The regulations governing the intersection of immigration and health care law are a “patchwork of illogical policies” which not only victimizes critically injured patients, but also unfairly burdens health care providers.¹³ Medicare-participating hospitals like Martin Memorial are required by the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide appropriate medical screening and necessary stabilizing treatment to any individual who enters an emergency department.¹⁴ Additionally, Medicare’s Conditions of Participation require that hospitals transfer patients in need of post-hospital care to an appropriate facility capable of meeting the patient’s medical needs.¹⁵ The Professional Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, however, terminated undocumented immi-

¹¹ See *Montejo I*, 874 So. 2d at 657.

¹² See *id.* at 656; Sontag, *supra* note 4. Although uninsured and illegal, Mr. Jimenez was working in the United States. See *Montejo I*, 874 So. 2d at 655; Sontag, *supra* note 4. “[T]here is no consensus on what to call people who work in the United States in contravention of immigration laws.” Beth Lyon, *When More “Security” Equals Less Workplace Safety: Reconsidering U.S. Laws That Disadvantage Unauthorized Workers*, 6 U. PA. J. LAB. & EMP. L. 571, 573 (2004). In her article, Professor Lyons argues for the adoption of set terminology that appropriately reflects the different groups of people illegally working in the United States. See *id.* at 573–82. “[I]mmigrants who are unauthorized to work are not all undocumented and those who are undocumented did not all enter the country illegally.” *Id.* at 582. Moreover, the term “illegal alien” is “racially loaded, ambiguous, imprecise, and pejorative.” *Id.* at 576 (citations omitted). Accordingly, this Comment uses the term “undocumented immigrant” to refer to any individual “who presently possess[es] no proof of any right to be present in the United States, whether or not [he or she has] been declared deportable by the U.S. government (and the vast majority have not).” See *id.* at 581.

¹³ See Adrienne Ortega, Note, . . . *And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Care*, 35 AM. J.L. & MED. 185, 185–90, 195–96 (2009). In her Note, Ortega comprehensively describes the substance of the laws governing health care for immigrants and concludes that cash-strapped hospitals treating undocumented immigrants often resort to tactics like repatriation. See *id.* at 196; see also Ryan Knutson, Note, *Deprivation of Care: Are Federal Laws Restricting the Provision of Medical Care to Immigrants Working as Planned?*, 28 B.C. THIRD WORLD L.J. 401, 404 (2008) (“[M]edical providers are also struggling under the general prohibition on providing preventative care to immigrants.”).

¹⁴ See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a)–(i) (2006). Although hospitals could theoretically opt out of federal funding and be relieved of the burden of emergency care, most hospitals are in no position to do so. See Knutson, *supra* note 13, at 405 n.27.

¹⁵ See 42 C.F.R. § 482.43(d) (2008); Medicare and Medicaid Programs; Revisions to Conditions of Participation of Hospitals, 59 Fed. Reg. 64,414, 64,149 (Dec. 13, 1994) (providing the official comment as to what appropriate medical facility means).

grants' eligibility for non-emergency health care benefits.¹⁶ Without insurance coverage, no qualified nursing facility would accept Mr. Jimenez as a patient.¹⁷ As a result, Martin Memorial provided uncompensated treatment for more than two years at a cost of over one million dollars.¹⁸

Montejo Gaspar Montejo, Mr. Jimenez's cousin and legal guardian, argued that it was the hospital's responsibility to provide his cousin with the rehabilitation he required.¹⁹ Martin Memorial "declined to take out [its] checkbook" to pay for his care in another facility.²⁰ Having reached an impasse, Martin Memorial sought and received the approval of a Florida trial court to privately return Luis Jimenez to Guatemala.²¹ On June 27, 2003, sometime before 7:00 A.M., the hospital took Mr. Jimenez to the airport and flew him by private plane back to his native country without consent from or notice to his guardian.²² "We went to see him at the hospital," Montejo told a reporter for the *The New York Times*, "and his bed was empty."²³ Since arriving in Guatemala, Mr. Jimenez has received no further medical care and his condition has continued to deteriorate.²⁴ Left without any viable alternative, Montejo filed a lawsuit against Martin Memorial for false imprisonment, or "what he essentially saw as the hospital's kidnapping and de-

¹⁶ See Professional Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, §§ 401(a), 431(b), 110 Stat. 2105, 2261, 2274 (1996) (codified at scattered sections of 8 U.S.C.).

¹⁷ See *Montejo I*, 874 So. 2d at 657. EMTALA provides "a participating hospital that has specialized capabilities or facilities . . . shall not refuse to accept an appropriate transfer . . . if the hospital has the capacity to treat the individual." 42 U.S.C. § 1395dd(g). Interestingly, when the hospital inquired about transferring Mr. Jimenez to various Florida facilities, the typical response was simply "unable to take patient." See Sontag, *supra* note 4.

¹⁸ See *Montejo I*, 874 So. 2d at 656. The hospital was reimbursed for about \$80,000 with emergency Medicare funds. See *id.* An average stay at Martin Memorial lasts 4.1 days and costs \$8188. See Sontag, *supra* note 4.

¹⁹ See *Montejo I*, 874 So. 2d at 656; Sontag, *supra* note 4.

²⁰ See Sontag, *supra* note 4 (internal quotation marks omitted).

²¹ See *Montejo II*, 935 So. 2d at 1267; *Montejo I*, 874 So. 2d at 657. Martin Memorial argued that Montejo was not acting in Mr. Jimenez's best interest. See *Montejo II*, 935 So. 2d at 1267. This argument was predicated on a letter from a Guatemalan health official suggesting Mr. Jimenez could receive all necessary care at an orthopedic hospital in his native country. See *Montejo I*, 874 So. 2d at 657. The hospital to which the letter alluded was described as "the asylum wing of an orthopedic hospital . . . [t]hat's much like a homeless shelter in Guatemala, where people who can't take care of their relatives leave them." See Douglas, *supra* note 1, at 1130 (quoting JoNel Newman, a legal services attorney representing Montejo). The letter was subsequently found to be both inadmissible hearsay and insufficient evidence of proper discharge. See *Montejo I*, 874 So. 2d at 658.

²² See *Montejo II*, 935 So. 2d at 1268; Sontag, *supra* note 4.

²³ See Sontag, *supra* note 4.

²⁴ See *id.*

portation of his profoundly disabled cousin.”²⁵ The all-white Florida jury disagreed with Montejo and found for the hospital.²⁶

This Comment examines whether forced repatriation should be addressed through tort law, Montejo’s approach, or through some other means. Part I examines the socioeconomic and legal barriers between undocumented immigrants and health insurance in the United States. Part II analyzes a hospital’s obligation to provide medical care under EMTALA and Medicaid. This section also assesses the relationship between those obligations and the forced repatriation of undocumented immigrants. Part III discusses the merits of tort law as a solution to this problem and compares it to the alternative approach of direct regulation. Finally, this comment concludes that tort law, in light of its traditional functions and purposes, is an inadequate solution and urges Congress to adopt unambiguous regulations governing the discharge and transfer of all patients. Undocumented immigrants are not “beasts of burden that can be dumped over the border when [they] have outlived [their] usefulness.”²⁷ Rather, the law governing the provision of health care for undocumented immigrants should reflect Western medicine’s most honored maxim: “First, do no harm.”²⁸

I. UNDOCUMENTED IN AMERICA: UNINSURED AND UNPROTECTED

The United States is a nation of immigrants.²⁹ Since the 1970s, the proportion of immigrants to U.S. residents has steadily increased.³⁰ In 2007, one in eight U.S. residents was an immigrant.³¹ As of early 2009, the Department of Homeland Security estimated that roughly thirty

²⁵ See *Montejo II*, 935 So. 2d at 1268; Sontag, *supra* note 2.

²⁶ See Jury Verdict, *supra* note 2, at 1; Sontag, *supra* note 2.

²⁷ Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1 (quoting a legal immigrant who was repatriated by an Arizona hospital).

²⁸ See Michael K. Gottlieb, *Executions and Torture: The Consequences of Overriding Professional Ethics*, 6 YALE J. HEALTH POL’Y L. & ETHICS 351, 376 (2006) (examining this maxim’s mysterious history); Wolpin, *supra* note 3, at 155.

²⁹ See Peter H. Schuck, *The Morality of Immigration Policy*, 45 SAN DIEGO L. REV. 865, 871 (2008) (“All Americans, with the possible exception of Native Americans, are immigrants or the descendants of immigrants.”). Professor Schuck suggests that Americans proudly identify themselves as descended from immigrants, and explains that this sentiment is often invoked against proponents of restrictive immigration policy. See *id.* at 871–72.

³⁰ STEVEN A. CAMAROTA, IMMIGRANTS IN THE UNITED STATES, 2007: A PROFILE OF AMERICA’S FOREIGN-BORN POPULATION I (2007), available at <http://www.cis.org/articles/2007/back1007.pdf>.

³¹ See *id.*

percent of the foreign-born resident population was undocumented.³² The large and rapidly growing undocumented immigrant population suffers from a chronic lack of health insurance.³³ Uninsured, undocumented patients like Luis Jimenez are the most susceptible to the practice of forced repatriation because socioeconomic conditions, in conjunction with restrictive federal regulations, effectively preclude this class of residents from obtaining health care coverage.³⁴

A. *Poverty and Poor Education: A Recipe for the Uninsured*

The story of Luis Jimenez illustrates many of the typical qualities of an undocumented immigrant in the United States.³⁵ His journey was propelled by the dream of earning a living to support his family in Guatemala.³⁶ Indeed, most undocumented immigrants journey to America seeking employment.³⁷ Just over half are high school graduates.³⁸ Their limited educational experience is associated with a disproportionate concentration in low-wage jobs such as farming, groundskeeping, construction, and the food service industry.³⁹ At the time of his accident, Mr. Jimenez was working as a landscaper in Florida.⁴⁰ Despite being

³² See MICHAEL HOFFER ET AL., U.S. DEP'T OF HOMELAND SEC., OFFICE OF IMMIGRATION STATISTICS, POLICY DIRECTORATE, ESTIMATES OF THE UNAUTHORIZED IMMIGRANT POPULATION RESIDING IN THE UNITED STATES: JANUARY 2009, at 3 (2010). The Department of Homeland Security estimated that at the beginning of 2009 over thirty-one million people in the United States were foreign born. See *id.* The 2009 and 2008 estimates of undocumented immigrants mark the first year-to-year decreases since 2005. See *id.* at 1. At least one study concludes that the decline was due to both increased enforcement of immigration laws and economic decline. See STEVEN A. CAMAROTA & KAREN JENSENIUS, HOMEWARD BOUND: RECENT IMMIGRATION ENFORCEMENT AND THE DECLINE IN THE ILLEGAL ALIEN POPULATION 9 (2008), available at <http://www.cis.org/articles/2008/back808.pdf>.

³³ See Dana P. Goldman et al., *Legal Status and Health Insurance Among Immigrants*, 24 HEALTH AFF. 1640, 1640, 1651 (2005).

³⁴ See *id.* at 1644, 1649; Ortega, *supra* note 13, at 186–87.

³⁵ See generally JEFFERY S. PASSEL & D'VERA COHN, PEW HISPANIC CTR., A PORTRAIT OF UNAUTHORIZED IMMIGRANTS IN THE UNITED STATES, at i–v (2009), <http://pewhispanic.org/files/reports/107.pdf>; Sontag, *supra* note 4.

³⁶ See Sontag, *supra* note 4. While residing in Guatemala, Mr. Jimenez and his wife supported their family on an income of about six dollars per day. See *id.*

³⁷ See Marc L. Berk et al., *Health Care Use Among Undocumented Latino Immigrants*, 19 HEALTH AFF. 51, 56 (2000) (describing a sampling of four Latino populations, the majority of whom said work was the primary reason for immigrating to the United States).

³⁸ See PASSEL & COHN, *supra* note 35, at iv. An estimated forty-seven percent of undocumented immigrants ages twenty-five to sixty-four have less than a high school education, compared to only eight percent of U.S. residents in the same age range. See *id.* Ironically, the younger the age of arrival of an undocumented immigrant into the United States, the greater his or her chances of attending college. See *id.* at 14.

³⁹ See *id.* at 15–16.

⁴⁰ See Sontag, *supra* note 4.

employed, he was indigent and unable to afford medical care or insurance.⁴¹ Twenty-one percent of adult, undocumented immigrants live in poverty—more than double the rate for U.S.-born adults.⁴² Along with their U.S.-born children, undocumented immigrants account for eleven percent of those living below the poverty level, which is more than twice their representation in the U.S. population.⁴³

Indigent immigrants with low wage jobs fair poorly in a health care system reliant on employer-provided health insurance.⁴⁴ In 2005, approximately 68% of undocumented immigrants lacked health insurance.⁴⁵ With a median income of only \$36,000, most cannot afford to purchase their own health care plans.⁴⁶ Undocumented immigrants overwhelmingly work in the construction, food service, and hospitality industries.⁴⁷ These types of employers are unlikely to provide health care benefits to their employees.⁴⁸ The owner of the landscaping service employing Mr. Jimenez did not.⁴⁹ Practically speaking, the door to private insurance is firmly closed on the undocumented.⁵⁰

B. PRWORA: *The Barrier to Public Benefit Programs*

In 1996, Congress passed the Professional Responsibility and Work Opportunity Reconciliation Act (PRWORA).⁵¹ PRWORA was intended

⁴¹ See *Montejo II*, 935 So. 2d 1266, 1267 (Fla. Dist. Ct. App. 2006).

⁴² See PASSEL & COHN, *supra* note 35, at 17.

⁴³ See *id.*

⁴⁴ JOHN C. ALKER, KAISER FAMILY FOUND., THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, IMMIGRANTS AND HEALTH COVERAGE: A PRIMER (2004), <http://www.kff.org/uninsured/upload/7088.pdf>. In 2010, the U.S. Congress passed health care reform legislation that could have addressed this disparity. See *Health Care Reform*, N.Y. TIMES, Mar. 3, 2010, <http://www.nytimes.com> (follow “Health” hyperlink; then follow “Tracking the Overhaul” hyperlink) (providing a comprehensive summary of the health care overhaul debate). Undocumented immigrants, however, were explicitly excluded from this legislation. See Juliana Barbassa, *Health Care Reform Ignores Illegal Immigrants*, TIME, Apr. 4, 2010, <http://www.time.com/time/politics/article/0,8599,1977692,00.html>.

⁴⁵ See Goldman et al., *supra* note 33, at 1645.

⁴⁶ See PASSEL & COHN, *supra* note 35, at 16–18. In 2009, the average cost of a family health insurance policy was \$13,375. See Drew Altman, Kaiser Family Found., “*Pulling It Together . . .*”: *Simple Arithmetic*, Sept. 15, 2009, <http://www.kff.org/pullingtogether> (follow “Simple Arithmetic” hyperlink).

⁴⁷ See ALKER, *supra* note 44; PASSEL & COHN, *supra* note 35, at 4.

⁴⁸ See ALKER, *supra* note 44.

⁴⁹ See *Montejo II*, 935 So. 2d at 1267 (stating that Mr. Jimenez was indigent and did not qualify for Medicaid); ALKER, *supra* note 44; PASSEL & COHN, *supra* note 35, at 14.

⁵⁰ See Goldman et al., *supra* note 33, at 1645 (finding that virtually no undocumented immigrants purchase private health insurance and very few had employer-based coverage).

⁵¹ See Professional Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104–193, 110 Stat. 2105 (1996) (codified at 8 U.S.C. §§ 1601–1646 (2006)).

to deter immigration to the United States by encouraging self-reliance.⁵² It attempted to further this goal by reducing immigrants' access to public benefit programs.⁵³ The Act excludes virtually all undocumented immigrants from its definition of "qualified aliens" who are able to access services.⁵⁴ Accordingly, most undocumented immigrants cannot receive compensated medical care under Medicare or Medicaid.⁵⁵ Because Mr. Jimenez was excluded from Medicare coverage by PRWORA, any treatment by the hospital was uncompensated.⁵⁶

II. FORCED REPATRIATION: CAUSES AND COSTS

A single avenue of medical care survived PRWORA's wholesale elimination of benefits for undocumented immigrants: the emergency

⁵² 8 U.S.C. § 1601(5) ("It is a compelling government interest to enact new rules for eligibility . . . to assure that aliens be self-reliant."). The statute claims that the policy reflects long-standing, basic principles of U.S. immigration. *See id.* § 1601(1). *But see* Knutson, *supra* note 13, at 412 ("Restrictions on immigrant access to public health benefits are a relatively recent trend.")

⁵³ *See* § 1601(2) (stating that it is U.S. immigration policy that "the availability of public benefits not constitute an incentive for immigration to the United States"). At the heart of this legislation was an image rooted in the zero-sum paradigm of American health care discourse. *See* Brietta R. Clark, *The Immigrant Healthcare Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 249 (2008) (arguing that often the health care debate in America is based on an assumption that granting access to one person necessarily means depriving someone else). In the 1990s, this discourse was dominated by uncorroborated, anecdotal evidence suggesting access to health care benefits incentivizes immigration into the United States. *See* Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the "Contract with America" Congress*, 90 KY. L.J. 1043, 1044–45 (2001). "[G]overnment-sponsored services are so far down the list of reasons for immigration to the U.S. that they scarcely arise at all." *Id.*; *see also* Francine J. Lipman, *The Taxation of Undocumented Immigrants: Separate, Unequal, and Without Representation*, 9 HARV. LATINO L. REV. 1, 1–2 (2006) ("The widespread belief . . . that 'illegal aliens' cost more in government services than they contribute to the economy . . . is demonstrably false.") (citations omitted).

⁵⁴ *See* §§ 1611(a), 1641(b). PRWORA's narrow definition of eligibility for undocumented immigrants is a significant break with the past. *See* Costich, *supra* note 53, at 1046, 1053–54. Previously, a far more generous standard applied to undocumented immigrants, though many were still denied benefits. *See id.*

⁵⁵ *See* §§ 1611(a), (c)(1)(B), 1621(a), (c)(1)(b). If a state desires to provide unqualified immigrants with state-sponsored benefits, then it may enact laws affirmatively reinstating their eligibility. *See id.* § 1621(d). This provision implicitly requires states to take the onerous step of reenacting any pre-existing state legislation authorizing state public benefits for unqualified aliens. *See id.*; Costich, *supra* note 53, at 1052–53. New York and Maryland took the additional step of denying health care services to legal immigrants. Ortega, *supra* note 13, at 191–92. The laws were subsequently invalidated on state and federal constitutional grounds. *Id.* at 192.

⁵⁶ *See* §§ 1611(a), (c)(1)(b), 1641(b); *Montejo II*, 935 So. 2d at 1267; Sontag, *supra* note 4.

room.⁵⁷ Federal law requires hospitals to provide stabilizing medical treatment to emergency room patients regardless of their immigration status.⁵⁸ Medicare's Conditions of Participation prohibit discharging a patient in need of post-hospital care unless he or she is transferred to a facility capable of meeting his or her medical needs.⁵⁹ Hospitals, therefore, are duty-bound to provide indefinite, uncompensated care to severely injured, uninsured, undocumented immigrants.⁶⁰ Because providing that treatment is expensive, forced repatriation is an "attractive solution" to this hodgepodge of contradictory duties when a foreign facility will accept the transfer.⁶¹

A. EMTALA: One Step Forward, One Step Back

Domestic patient dumping has been recognized as a national problem since the late 1980s.⁶² Congress attempted to curb this practice by passing EMTALA.⁶³ Enacted in 1986, EMTALA requires hospitals receiving federal funds to provide emergency medical treatment to any individual, regardless of his health care coverage or eligibility for public benefit programs.⁶⁴ This effectively forbids hospitals from altering care in any way because of a patient's immigration status.⁶⁵ Its purpose was "to protect those vulnerable members of society who were suffering from life threatening medical conditions and were the object of

⁵⁷ See 8 U.S.C. § 1611(a)–(b)(1)(A) (2006).

⁵⁸ See 42 U.S.C. § 1395dd(b)(1)(A) (2006).

⁵⁹ See 42 C.F.R. § 482.43(d) (2008); Medicare and Medicaid Programs; Revisions to Conditions of Participation of Hospitals, 59 Fed. Reg. 64,414, 64,149 (Dec. 13, 1994).

⁶⁰ See 8 U.S.C. § 1611(a)–(b)(1)(A); 42 U.S.C. § 1395dd(b)(1)(A); 42 C.F.R. § 482.43(d); Ortega, *supra* note 13, at 193.

⁶¹ See Douglas, *supra* note 1, at 1131; Wolpin, *supra* note 3, at 152–53.

⁶² See 131 CONG. REC. 35,813 (1985) (statement of Rep. Stark) ("[A]ll too often, the first thing a patient now receives in the emergency room is an examination of their wallet. It's called a wallet biopsy. No money or insurance card in the wallet will often get an emergency patient dumped at the door with a map to the county hospital."); Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 696 n.9 (2006) (citing numerous newspaper articles describing incidents of patient dumping).

⁶³ See Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99–272, § 9121, 100 Stat. 164, 164–67 (1986) (codified at 42 U.S.C. § 1395dd); 131 CONG. REC. 35,813–14 (1985) (statement of Rep. Stark) (arguing in favor of EMTALA's passage to end patient dumping); Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden It Places on Hospitals*, 7 J.L. Soc'Y 146, 146 (2005); Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 590 (2003).

⁶⁴ See 42 U.S.C. § 1395dd(a)–(b).

⁶⁵ See *id.*; Knutson, *supra* note 13, at 422.

economically-based discrimination.”⁶⁶ The statute creates two distinct legal obligations: First, the hospital must provide “appropriate medical screening” when the patient arrives in the emergency department to determine whether he is suffering from what the statute defines as an “emergency condition.”⁶⁷ Second, if such a condition exists, the hospital must then either provide necessary stabilizing treatment or transfer the patient to another facility that can provide such treatment.⁶⁸

A number of scholars harshly criticize EMTALA for both its substance and its drafting.⁶⁹ Its terms have been extensively litigated.⁷⁰ Congress’s attempt at ending patient dumping—well intentioned as it may have been—was a band-aid solution to a more pervasive problem, or in the words of one commentator, “merely an attempt to flatten the tip of the uninsured iceberg with the hope that we will forget the looming bulk below the surface.”⁷¹ Although it increased a hospital’s obligation to provide emergency care, EMTALA did nothing to reduce the economic incentive motivating hospitals to dump patients.⁷² In es-

⁶⁶ Mark J. Garwin, *Immunity in the Absence of Charity: EMTALA and the Eleventh Amendment*, 23 S. ILL. U. L.J. 1, 37 (1998); see 131 CONG. REC. 35,814 (1985) (statement of Rep. Stark).

⁶⁷ See § 1395dd(a). The Act defines the term “emergency medical condition” as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or,

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

§ 1395(e)(1).

⁶⁸ See § 1395dd(b)(1).

⁶⁹ See, e.g., Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J., 389, 382–96 (1988) (suggesting it would have been better for Congress to have done nothing at all than pass EMTALA); David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 30, 50–56 (1998) (“EMTALA’s flaws far exceed its limited virtues. . . . The premise of the statute is silly at best.”). *But see* Lebedinski, *supra* note 63, at 147 (suggesting EMTALA successfully accomplished Congress’s goal of reducing patient dumping).

⁷⁰ See MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 126–27 (7th ed. 2007).

⁷¹ Hall, *supra* note 69, at 393–96.

⁷² See *id.*; Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA’s Fangs*, 61 N.Y.U. L. REV. 1186, 1223 (1986) (concluding that more precise statutory language and a stronger enforcement mechanism is required to prevent patient dumping).

sence, the combination of EMTALA and PROWRA requires hospitals to provide and fund medical care for the traumatically injured and uninsured.⁷³ It is the cost of this care that drives hospitals to repatriate patients.⁷⁴

B. *The Cost of Uncompensated Care and Repatriation*

Treating uninsured patients is expensive; Mr. Jimenez alone cost Martin Memorial over one million dollars.⁷⁵ As such, private hospitals have an economic incentive to avoid providing them with treatment beyond what is required by statute.⁷⁶ In 2008, the cost of providing uncompensated care to the uninsured by hospitals and physicians was approximately fifty-six billion dollars.⁷⁷ Funding from the federal government covered about seventy-five percent of that total cost.⁷⁸ The proportion of uncompensated care generated through the treatment of undocumented immigrants is uncertain.⁷⁹

Martin Memorial received about \$80,000 for providing Luis Jimenez with emergency treatment, but was left with an unpaid balance of over one million dollars.⁸⁰ This is a recurring problem; in 2008, the

⁷³ See 42 U.S.C. § 1395dd; Professional Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, §§ 401(a), 431(b), 110 Stat. 2105, 2261, 2274 (1996) (codified at scattered sections of 8 U.S.C.); Ortega, *supra* note 13, at 195–96.

⁷⁴ See Ortega, *supra* note 13, at 196; Sontag, *supra* note 4; see also Lebedinski, *supra* note 63, at 161 (suggesting the cost of uncompensated care “prompts hospitals to be creative”).

⁷⁵ See *Montejo I*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004); Ortega, *supra* note 13, at 196.

⁷⁶ See Treiger, *supra* note 72, at 1187. “[A] phenomenon known as patient dumping . . . occurs when a hospital that is capable of providing the needed medical care (the transferring hospital) sends a patient to another facility (the receiving hospital) or simply turns the patient away because the patient is unable to pay.” *Id.* at 1186–87 (citations omitted) (internal quotation marks omitted).

⁷⁷ JACK HADLEY ET AL., KAISER COMM’N ON MEDICAID AND THE UNINSURED, COVERING THE UNINSURED IN 2008: A DETAILED EXAMINATION OF THE CURRENT COSTS AND SOURCES OF PAYMENT, AND INCREMENTAL COSTS OF EXPANDING COVERAGE 66 (2008), <http://www.kff.org/uninsured/upload/7809.pdf>.

⁷⁸ See *id.* In 2008, uncompensated care accounted for about two percent of the total amount of health care spending in the United States. See *id.*

⁷⁹ See U.S. GEN. ACCOUNTING OFFICE, GAO-04-472, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 21 (2004); Ortega, *supra* note 13, at 194–95. Data used in studying this phenomenon is difficult to collect because hospitals usually do not record the immigration statuses of their patients. See U.S. GEN. ACCOUNTING OFFICE, *supra* at 8. Even if hospitals were to inquire about a patient’s immigration status, undocumented immigrants are unlikely to identify themselves. See *id.* Therefore, any estimate of the proportion of the costs generated by the treatment of undocumented immigrants is purely speculative. See *id.* at 8–9.

⁸⁰ See *Montejo I*, 874 So. 2d at 656.

hospital was providing uncompensated treatment for at least six other severely injured, uninsured immigrants.⁸¹ Recently, the hospital was investigated for repatriating another brain-injured patient into Mexico without approval from the Mexican government.⁸² In 2002, Florida hospitals absorbed more than forty million dollars in uncompensated care costs for the treatment of uninsured noncitizens.⁸³

The cost of uncompensated medical care and federal law's elliptical imprecision encourages the forced medical repatriation of acutely injured noncitizens.⁸⁴ Although it is difficult to paint an accurate portrait of the number of repatriations occurring each year, anecdotal evidence suggests that it is a serious and widespread problem.⁸⁵ One medical center located in Phoenix, Arizona admits repatriating as many as ninety-six immigrants a year.⁸⁶ In 2007, the Mexican consulate handled the medical cases of at least eighty-seven immigrants, most of which resulted in repatriation.⁸⁷ The practice is common enough to support several air ambulance companies purporting to have an expertise in providing such services.⁸⁸ The price of undertaking the repatriation of a patient can be considerable: Martin Memorial spent \$30,000 to charter the plane that returned Luis Jimenez to Guatemala.⁸⁹ Given the cost of repatriating a patient and the number of reported incidents, the cost of unreimbursed care provided to undocumented immigrants

⁸¹ See Sontag, *supra* note 4.

⁸² See *id.*

⁸³ See Douglas, *supra* note 1, at 1131.

⁸⁴ See HADLEY ET AL. *supra* note 77, at 66; Ortega, *supra* note 13, at 195–96; Wolpin, *supra* note 3, at 152–53.

⁸⁵ See Sontag, *supra* note 4; Sontag, *supra* note 27 (describing in detail four other cases of successful or attempted forced medical repatriations across the United States); see also Lebedinski, *supra* note 63, at 161–62 (suggesting that the cost of uncompensated care has led to the closure of emergency rooms).

⁸⁶ See Wolpin, *supra* note 3, at 152; Sontag, *supra* note 4. Arizona suffers acutely from this problem because it is a border state with low state financing for immigrant health care. See Sontag, *supra* note 27.

⁸⁷ See Sontag, *supra* note 4.

⁸⁸ *Id.*; see, e.g., Mexcare, An Alternative Choice for the Acute Care of Unfunded Latin American Nationals, <http://www.mexcare.com> (last visited Apr. 13, 2010) (offering to “arrang[e] high-quality acute medical treatment in Latin American countries. . . . that meet the needs of both hospital administrators and Latin American patients alike”); Aeromed365, Global Travel Related Medical Repatriation Service, <http://www.aeromed365.com> (last visited Apr. 13, 2010) (“Aeromed is the leading supplier of travel-related emergency medical services including . . . a complete bed-to-bed repatriation service.”). *But see* Press Release, Mexcare, The New York Times Gets it Wrong! (Aug. 15, 2008) (on file with author) (arguing that the company does not participate in nonconsensual medical transfers).

⁸⁹ See Sontag, *supra* note 4.

must be significant.⁹⁰ This financial burden was explicitly acknowledged by Congress in 2003 by its allocation of one billion dollars for the reimbursement of otherwise uncompensated care provided by hospitals to undocumented immigrants.⁹¹ Nevertheless, there are alternatives to the continual appropriation of federal dollars.⁹²

III. TORT LIABILITY VS. DIRECT REGULATION

After Luis Jimenez was repatriated, Montejo filed a tort action against Martin Memorial for false imprisonment.⁹³ The jury found in favor of the hospital because its actions were not unreasonable under the circumstances.⁹⁴ This verdict casts doubt on tort law's ability to prevent the forced repatriation of undocumented immigrants.⁹⁵ The tort system is most effective for redressing injuries that fall within traditional categories.⁹⁶ Nevertheless, forced repatriation is a novel dilemma unsuited to traditional tort law analysis.⁹⁷ Even if a theory of tort liability is pursued, the structure and operation of direct regulation is better suited to preventing the forced repatriation of undocumented immigrants.⁹⁸ In *Democracy in America*, Alexis de Tocqueville concluded, "There is almost no political question in the United States that is not resolved sooner or later into a judicial one."⁹⁹ A public forum for civil

⁹⁰ See U.S. GEN. ACCOUNTING OFFICE, *supra* note 79, at 21 (noting difficulties in estimating the cost of treating uninsured non-citizens); HADLEY ET AL., *supra* note 77, at 66 (estimating uncompensated medical costs); Douglas, *supra* note 1, at 1131 (noting that Florida hospitals spent more than forty million dollars in providing uncompensated care for non-citizens); Sontag, *supra* note 4 (reporting that Mr. Jimenez's repatriation cost \$30,000).

⁹¹ See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432 (2003) (codified in scattered sections of 26, 42 U.S.C.); Lebedinski, *supra* note 63, at 163; Ortega, *supra* note 13, at 198.

⁹² See Ortega, *supra* note 13, at 203-04; Wolpin, *supra* note 3, at 155.

⁹³ See *Montejo v. Martin Mem'l Med. Ctr. (Montejo II)*, 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006); Jury Verdict, *supra* note 2, at 1.

⁹⁴ See Jury Verdict, *supra* note 2, at 1; Susan Rose-Ackerman, *Tort Law in the Regulatory State*, in *TORT LAW AND THE PUBLIC INTEREST* 84, 100 (Peter H. Schuck ed., 1991); Thomas A. Gionis et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 299 (2002); Steven Shavell, *Liability for Harm Versus Regulation of Safety*, 13 J. LEGAL STUD. 357, 358-64, 368-71 (1984); Sontag, *supra* note 2.

⁹⁵ See Jury Verdict, *supra* note 2, at 1; Sontag, *supra* note 2.

⁹⁶ See Rose-Ackerman, *supra* note 94, at 100.

⁹⁷ See Gionis et al., *supra* note 94, at 299-300.

⁹⁸ See Rose-Ackerman, *supra* note 94, at 81-82, 100; Shavell, *supra* note 94, at 358-64, 368-71.

⁹⁹ ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 257 (Harvey C. Mansfield & Delba Winthrop eds., Univ. of Chi. Press 2002) (1835).

claims provides instrumental and intrinsic social benefits.¹⁰⁰ Under these particular circumstances, however, direct regulation is a more suitable solution for the problem at hand.¹⁰¹

A. Substantive Shortcomings

The tort system is a field that defies strict definition.¹⁰² Simply stated, it is “the body of principles that determines when one who suffers personal injuries may shift that loss to another.”¹⁰³ Though its function is contested, “[a]ll tort scholars concede that tort law seeks to compensate injured parties.”¹⁰⁴ Not every injury, however, creates a right to compensation.¹⁰⁵ Liability is limited by the presence or absence of duty, and has a “tripartite” structure encompassing intentional torts, negligence, and strict liability.¹⁰⁶ If there is no recognized duty between the alleged tortfeasor and the injured party, then the loss “must lie where it falls”—with the injured party.¹⁰⁷

I. Strict Liability

Based on a traditional strict liability analysis, forced repatriation does not create circumstances appropriate for the imposition of liability without fault.¹⁰⁸ The *Restatement (Second) of Torts* lists six factors courts should consider when determining whether to impose strict liability for abnormally dangerous activities.¹⁰⁹ Notions of fairness, economic effi-

¹⁰⁰ See WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* 237 (2009) (suggesting tort law is a valuable tool for bringing attention to ignored public health issues and for the promotion of regulatory action); Rose-Ackerman, *supra* note 94, at 85 (“The right of individuals to present their claims to a judge and lay jury is a well-entrenched social value.”).

¹⁰¹ See generally Rose-Ackerman, *supra* note 94, at 81–82, 100; Shavell, *supra* note 94, at 358–64, 368–71.

¹⁰² See W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 1, at 1–5 (5th ed. 1984).

¹⁰³ Peter H. Schuck, *Introduction: The Context of the Controversy to TORT LAW AND THE PUBLIC INTEREST*, *supra* note 94, at 1, 17.

¹⁰⁴ See PARMET, *supra* note 100, at 220.

¹⁰⁵ See Thomas C. Grey, *Accidental Torts*, 54 *VAND. L. REV.* 1225, 1272 (2001).

¹⁰⁶ See *id.* at 1269, 1272.

¹⁰⁷ OLIVER WENDELL HOLMES, JR., *THE COMMON LAW* 94 (Little, Brown & Co. 1951) (1881); see Grey, *supra* note 105, at 1272.

¹⁰⁸ See RESTATEMENT (SECOND) OF TORTS § 520 (1977). Strict liability is defined as “liability that is imposed on an actor apart from either (1) an intent to interfere with a legally protected interest without a legal justification for doing so, or (2) a breach of a duty to exercise reasonable care, i.e., actionable negligence.” See KEETON ET AL., *supra* note 102, § 75, at 534.

¹⁰⁹ See RESTATEMENT (SECOND) OF TORTS § 520(a)–(f) (1977).

ciency, risk-spreading, and deterrence inform this inquiry.¹¹⁰ If no party is at fault, and one party benefited economically from the activity that created the risk of harm, then that party should bear the burden of loss.¹¹¹ The internalization of costs increases economic efficiency because the price of a product will reflect the risk of injury.¹¹² It is most commonly employed in products liability actions or cases involving hazardous activities.¹¹³ When compared to hazardous activities and products liability—traditional dominion of strict liability—it is evident that the forced repatriation of undocumented immigrants is beyond the reach of this doctrine.¹¹⁴

2. Negligence

“[N]egligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.”¹¹⁵ Liability under a theory of negligence is predicated upon the defendant owing a duty of care to the plaintiff.¹¹⁶ At common law, neither hospitals nor physicians are obligated to provide medical care absent the existence of a physician-patient relationship.¹¹⁷ The “no duty” rule absolves hospitals of any obligation to undertake the treatment of uninsured patients at common law.¹¹⁸

Assuming that a treatment relationship exists—as it did in the case of Mr. Jimenez—a plaintiff might pursue a theory of medical malprac-

¹¹⁰ See Lynda J. Oswald, *Strict Liability of Individuals Under CERCLA: A Normative Analysis*, 20 B.C. ENVTL. AFF. L. REV. 579, 592–98 (1993).

¹¹¹ See *id.* at 593.

¹¹² See *id.* at 595–97 (“Imposing strict liability on . . . manufacturers promotes product safety because it creates a financial incentive for manufacturers to find cost-effective ways to minimize risks associated with their products.”).

¹¹³ See *id.* at 592.

¹¹⁴ See *id.* 590–603; see also *supra* note 3 (defining forced repatriation as a non-consensual transfer of a patient).

¹¹⁵ RESTATEMENT (SECOND) OF TORTS § 282 (1965).

¹¹⁶ See Grey, *supra* note 105, at 1258–59.

¹¹⁷ See HALL ET AL., *supra* note 70, at 113. The physician-patient relationship is essentially contractual. See *Castillo v. Emergency Med. Assocs.*, 372 F.3d 643, 648 (4th Cir. 2004) (“[A] physician’s duty arises only upon the creation of a physician-patient relationship; that relationship springs from a consensual transaction.”) (internal quotation marks omitted); *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (holding that medical licensure by the state does not require a physician to practice “on other terms than he may choose to accept”). This is commonly referred to as the “no duty” rule. See HALL ET AL., *supra* note 70, at 113.

¹¹⁸ See HALL ET AL., *supra* note 70, at 113.

tice if a hospital undertakes his care and then repatriates him.¹¹⁹ The physician or hospital has a duty to exercise the same degree of care as “a physician in good standing in the same medical specialty in a similar community in like circumstances.”¹²⁰ In this respect, the medical profession is privileged; as the professional consensus shifts regarding particular practices, so does the standard of care.¹²¹ Repatriation is arguably already a customary medical practice.¹²² “Although courts have been reluctant to view a defendant’s compliance with custom as conclusive evidence of non-negligence, it is still fairly unusual for a court to strike down a professional custom as falling short of the standard of reasonable care.”¹²³ Medicare’s Conditions of Participation that regulate discharge do little to enhance this duty of care.¹²⁴ Similarly, professional organizations do not provide significant guidance to physicians in this area.¹²⁵ Under these circumstances, it is unlikely that a claim of medical malpractice would prevail for a repatriated patient.¹²⁶

¹¹⁹ See KEETON ET AL., *supra* note 102, § 32, at 187 (stating that the standard of care for physicians is that a “doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing”); Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 654–59 (2001) (noting difficulties presented by a custom-based standard of care); Sontag, *supra* note 4 (noting that the hospital provided care for Mr. Jimenez). The physician-patient relationship arises where “a patient seeks care, and a physician provides the care.” See HALL ET AL., *supra* note 70, at 146.

¹²⁰ See Mello, *supra* note 119, at 655.

¹²¹ See KEETON ET AL., *supra* note 102, § 32, at 189.

¹²² See Wolpin, *supra* note 3, at 152–53 (reporting that the American Medical Association recently commissioned a study to consider this widespread practice); Sontag, *supra* note 4; Sontag, *supra* note 27 (describing in detail four other cases of successful or attempted forced medical repatriations across the country).

¹²³ See Mello, *supra* note 119, at 658.

¹²⁴ See 42 C.F.R. § 482.43(d) (2008) (requiring hospitals to transfer patients to an appropriate facility); Medicare and Medicaid Programs, Revisions to Conditions of Participation of Hospitals, 59 Fed. Reg. 64,141, 64,149 (Dec. 13, 1994) (codified at 42 C.F.R. pt. 482) (providing the official comment interpreting “appropriate facility” broadly as capable of meeting the patient’s medical needs, and not providing specific guidelines regarding repatriation).

¹²⁵ See Wolpin, *supra* note 3, at 153 (noting that the American Medical Association did not adopt a draft resolution condemning forced repatriation, but agreed to study the issue). *But see id.* (noting that the California Medical Association openly opposes the practice).

¹²⁶ See KEETON ET AL., *supra* note 102, § 32, at 187 (discussing the physician’s standard of care); Mello, *supra* note 119, at 654–59 (noting the difficulties presented by a custom-based standard of care); Sontag, *supra* note 4 (describing the facts of Luis Jimenez’s case).

3. Intentional Torts

Like domestic patient dumping, Martin Memorial's decision to return Luis Jimenez to Guatemala can be characterized as an intentional tort.¹²⁷ Broadly defined, intentional torts are acts committed "with the intent to injure the plaintiff or with substantial certainty that [the] action would injure the plaintiff."¹²⁸ The repatriation of an uninsured, undocumented immigrant can be interpreted as an act of economic or non-economic discrimination unrelated to a patient's medical care.¹²⁹ According to some scholars, this kind of discriminatory decision making "exists in a zone outside the practice of medicine" and should be analyzed like an intentional tort.¹³⁰

In *Montejo*, the plaintiff filed a claim for false imprisonment—an intentional tort—and failed only on the element of reasonableness.¹³¹ Florida's definition of false imprisonment includes abduction, but the circumstances of forced repatriation do not comport with the standard definition of the tort.¹³² The lack of a clearly recognized cause of action is not necessarily fatal; tort law's "ongoing recognition of legally cognizable rights, duties, interests, and injuries" is well-recognized.¹³³ Notwithstanding that possibility, tort liability has proven to be an inadequate deterrent where an injury falls outside of the traditional category of injury.¹³⁴

¹²⁷ See Gionis et al., *supra* note 94, at 180, 300; Sontag, *supra* note 4.

¹²⁸ See KEETON ET AL., *supra* note 102, § 8, at 33–39; Kenneth J. Vandeveld, *A History of Prima Facie Tort: The Origins of a General Theory of Intentional Tort*, 19 HOFSTRA L. REV. 447, 447 (1990).

¹²⁹ Compare Gionis et al., *supra* note 94, at 180, 300–07 (describing the proposed elements of an intentional tort of patient dumping), with Sontag, *supra* note 4 (describing the facts of Mr. Jimenez's repatriation).

¹³⁰ See Gionis et al., *supra* note 94, at 180.

¹³¹ See *Montejo II*, 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006); Sontag, *supra* note 2.

¹³² See FLA. STAT. § 787.02(1)(a) (2007); RESTATEMENT (SECOND) OF TORTS § 35 (1965) (defining traditional elements of false imprisonment without abduction); *supra* note 3 (defining forced repatriation for purposes of this Comment).

¹³³ Gionis et al., *supra* note 94, at 297; see also KEETON ET AL., *supra* note 102, § 1, at 4 ("The law of torts is anything but static, and the limits of its development are never set. . . . [T]he mere fact that the claim is novel will not itself operate as a bar to the remedy.").

¹³⁴ See Gionis et al., *supra* note 94, at 299; Rose-Ackerman, *supra* note 94, at 100.

B. *The Structural Superiority of Regulation*

1. *Ex Ante* Regulation vs. *Ex Post* Liability

The fundamental structural distinction between tort liability and direct regulation is procedural.¹³⁵ Statutory rules and regulatory standards have an immediate effect on the behavior of individuals.¹³⁶ They are public in nature and operate *ex ante*, independent of the harm they are directed at preventing.¹³⁷ Regulations are uniform and speak to all similarly situated potential injurers.¹³⁸ In contrast, the tort system is “backward-looking.”¹³⁹ It relies on private actors and “works not by social command but rather indirectly, through the deterrent effect of damage actions that may be brought once harm occurs.”¹⁴⁰ These were the circumstances in *Montejo*; the plaintiff’s personal injury suit was brought after Mr. Jimenez’s repatriation seeking damages to cover the cost of his care in Guatemala and partially to curb the victimization of undocumented immigrants.¹⁴¹

2. Factors Favoring Regulation

Whether liability or regulation should be employed to encourage particular behavior and prevent injury depends upon the nature of the regulated activity.¹⁴² Professor Steven Shavell has developed a multi-factor analysis to determine the relative desirability of these two alternatives.¹⁴³ Applying this analysis to forced repatriation, regulation proves to be the most suitable method for preventing harm to undocumented immigrants.¹⁴⁴

¹³⁵ See Rose-Ackerman, *supra* note 94, at 83.

¹³⁶ See Shavell, *supra* note 94, at 357.

¹³⁷ See *id.*

¹³⁸ See Rose-Ackerman, *supra* note 94, at 84.

¹³⁹ See *id.* at 83.

¹⁴⁰ Shavell, *supra* note 94, at 357.

¹⁴¹ See Wolpin, *supra* note 3, at 154; Sontag, *supra* note 2.

¹⁴² See Shavell, *supra* note 94, at 357. Admittedly, these means of controlling behavior are not mutually exclusive and may be more effective when acting in concert. Rose-Ackerman, *supra* note 94, at 86–94 (discussing different ways in which torts may complement statutory regulation); Shavell, *supra* note 94, at 365–66 (discussing the joint use of liability and regulation to control conduct).

¹⁴³ See Shavell, *supra* note 94, at 358–64. “Shavell’s underlying assumption is that tort law is a regulatory system that should be evaluated in terms of its consequences for the efficient control of accidents.” Rose-Ackerman, *supra* note 94, at 85.

¹⁴⁴ See Rose-Ackerman, *supra* note 94, at 83–86, 100; Shavell, *supra* note 94, at 358–64, 368–71; Wolpin, *supra* note 3, at 152–55.

The first factor in this analysis is knowledge about the activity being regulated.¹⁴⁵ This knowledge may include “the benefits of [the] activities, the costs of reducing risks, or the probability or severity of the risks.”¹⁴⁶ Civil liability is preferable when private parties have greater access to knowledge of these risks.¹⁴⁷ Evaluating the sufficiency of foreign facilities for cross-border patient transfers, however, may be a challenge for individual health care providers.¹⁴⁸ Professor Shavell argues that rule-making authorities may have better access to or ability to evaluate information regarding health or medical-related information.¹⁴⁹ The public nature of regulation and the private nature of tort law are also relevant to this informational factor.¹⁵⁰ Where the same information about benefits and risks is relevant to many instances of harm, regulation’s ability to speak uniformly and universally is an advantage.¹⁵¹

A second consideration is the ability of parties to adequately compensate the injured for the harm caused.¹⁵² Under a regulatory regime, a party’s financial status is largely irrelevant unless significant fines are levied for violations.¹⁵³ The importance of controlling costs cannot be overstated in the context of uncompensated health care given the relatively modest budgets of many hospitals.¹⁵⁴ Martin Memorial operated with a profit margin of just 3.6% in 2007.¹⁵⁵ The effect of a plaintiff’s verdict in cases like *Montejo* could be significant for a hospital and could harm the delivery of health care to the surrounding population.¹⁵⁶

The third consideration is the plaintiff’s ability to sue.¹⁵⁷ If injured parties are unlikely or unable to bring suit, then the tort system cannot

¹⁴⁵ See Shavell, *supra* note 94, at 359. In principle, negligence itself propels parties to collect information about due care. *See id.*

¹⁴⁶ *Id.*

¹⁴⁷ *See id.*

¹⁴⁸ See Wolpin, *supra* note 3, at 154.

¹⁴⁹ See Shavell, *supra* note 94, at 369. Regulations are preferable where they are based on either common sense or complex information; tort liability implicitly holds the middle ground. *See id.*

¹⁵⁰ See Rose-Ackerman, *supra* note 94, at 84.

¹⁵¹ *See id.*

¹⁵² See Shavell, *supra* note 94, at 360.

¹⁵³ *See id.* at 361 n.7.

¹⁵⁴ See Lebedinski, *supra* note 63, at 161–62 (describing the closure of emergency rooms due to the cost of uncompensated care); Sontag, *supra* note 4 (describing the burden of uncompensated care on Martin Memorial and other hospitals).

¹⁵⁵ See Sontag, *supra* note 4.

¹⁵⁶ See Lebedinski, *supra* note 63, at 161–62; Sontag, *supra* note 4.

¹⁵⁷ See Shavell, *supra* note 94, at 363.

effectively deter harmful conduct.¹⁵⁸ The importance of this factor can vary given the injured party's reasons for not pursuing a legal claim.¹⁵⁹ Indigent, undocumented immigrants have the weightiest of reasons: "In the United States, there is no general right to state-funded counsel in civil proceedings."¹⁶⁰ Luis Jimenez was fortunate enough to have his cause championed by a well-established West Palm Beach law firm.¹⁶¹ The probability or frequency of private lawsuits has no bearing on a regulatory regime's effectiveness.¹⁶²

The administrative cost associated with each of these methods is the final factor.¹⁶³ Notwithstanding the many different costs associated with litigation, including both private legal fees and public court-related expenses, the tort system is usually more efficient than regulation in terms of administration.¹⁶⁴ Even if the harm is eliminated by regulation, statutes must be continually enforced to ensure compliance and maintain the regulatory system.¹⁶⁵ Where non-compliance is easily detected, however, the administrative costs of regulation may be reduced.¹⁶⁶ The forced repatriation of undocumented immigrants has garnered no small amount of national attention.¹⁶⁷ Moreover, the problem has been acknowledged by the professional medical community.¹⁶⁸ Physicians and health care providers are already calling for the government to address the dilemma of repatriation through the existing Medicare system by the promulgation of minimum standards for transferring patients to foreign facilities.¹⁶⁹ Considered within Professor

¹⁵⁸ See Rose-Ackerman, *supra* note 94, at 83. The ability of tort law to deter unsafe conduct has been a subject of substantial debate in tort scholarship. See generally Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 422-30 (1994); Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555, 590 (1985).

¹⁵⁹ See Shavell, *supra* note 94, at 363.

¹⁶⁰ Alan W. Houseman, *The Future of Civil Legal Aid: A National Perspective*, 10 UDC/DCSL L. REV. 35, 52 (2007). Many states provide a right to counsel in civil proceedings under limited circumstances. See *id.* at 53.

¹⁶¹ See Sontag, *supra* note 4.

¹⁶² See Shavell, *supra* note 94, at 363.

¹⁶³ See *id.*

¹⁶⁴ See *id.* at 363-64. But see Walter U. Oi, *Tort Law as Regulatory Regime: A Comment on Landes and Posner*, 13 J. LEGAL STUD. 435, 439 (1984) (suggesting that the litigation costs of the tort system may be substantial).

¹⁶⁵ See Shavell, *supra* note 94, at 364.

¹⁶⁶ See *id.* at 370.

¹⁶⁷ See, e.g., Sontag, *supra* note 4; Sontag, *supra* note 27; Sontag, *supra* note 2.

¹⁶⁸ See Wolpin, *supra* note 3, at 153 (noting that the American Medical Association recognizes that forced repatriation presents "significant professional challenges for physicians").

¹⁶⁹ See *id.* at 155.

Shavell's analytical framework, direct regulation of forced repatriation proves to be the most effective and efficient method for preventing harm to undocumented immigrants.¹⁷⁰

CONCLUSION

In the words of the attorney representing the interests of Luis Jimenez, the forced repatriation of undocumented immigrants "clearly cries out for a legislative solution."¹⁷¹ This shameful practice is the result of a tangled web of federal regulations standing at the intersection of immigration and health care law. EMTALA requires hospitals to provide emergency medical treatment to all individuals regardless of immigration status, and the Medicare Conditions of Participation prohibit discharging patients in need of further medical care. Nonetheless, Congress terminated access to Medicare and Medicaid for undocumented immigrants by passing PRWORA. Due to a number of socioeconomic factors, virtually no undocumented immigrants are covered by private health insurance. Under these circumstances, forced repatriation is an attractive solution for cash-strapped hospitals like Martin Memorial. The structure and operation of direct regulation, in comparison to that of tort law, is better suited to solving this difficult dilemma. Accordingly, Congress should heed the call of health care providers to adopt unambiguous regulations governing the transfer of all patients to foreign hospitals.

¹⁷⁰ See Shavell, *supra* note 94, 358–64, 368–71.

¹⁷¹ See Wolpin, *supra* note 3, at 154.