EDITORIAL

Upholding Our Duty to Care for Undocumented Immigrants

Cary P. Gross, MD; Ilana B. Richman, MD, MHS; Ishani Ganguli, MD, MPH; Timothy S. Anderson, MD, MAS; Eve Rittenberg, MD; Nathan M. Stall, MD, PhD; Jerard Z. Kneifati-Hayek, MD, MS; Raegan W. Durant, MD, MPH; Deborah Grady, MD, MPH; Heather G. Allore, PhD; Giselle Corbie, MD, MSc; Sharon K. Inouye, MD, MPH

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Recent federal actions targeting undocumented immigrants have highlighted the urgent need to address the unique health needs faced by this population. There are an estimated 11 million undocumented immigrants in the US (ie, immigrants without legal status), comprising approximately 3% of the population. Compared to the general population, undocumented immigrants tend to be younger and have lower rates of some chronic conditions.[1,2]

Yet undocumented immigrants face many health challenges due to their vulnerable position in US society.[3,4] They are more likely to work in dangerous or physically taxing jobs—increasing their risk of occupational injury—although they do not have the same workplace protections as US citizens or those with legal immigration status.[5] Undocumented immigrants also experience mental health consequences of discrimination, exacerbated by trauma experienced prior to immigrating, hazards faced during their journey, and ongoing fear of deportation and family separation.[6,7] Because of their legal status, they are often less able to advocate for themselves or seek redress through traditional legal channels.

Health challenges experienced by undocumented immigrants often are compounded by substantial barriers to accessing health care, including unsympathetic health care systems and staff, unfamiliarity with the health care system, limited English language proficiency, and prohibitive out-of-pocket costs.[8] Most notably, undocumented patients may avoid health care because of law enforcement involvement in the clinical care setting or from the paper trail left by using public services.

These myriad barriers to care have had a profound effect on access for undocumented immigrants. In one study of a large health system in Maryland, start of the 2016 presidential election campaign, and the accompanying anti-immigrant rhetoric, was associated with a large decline in primary care use and an accompanying increase in emergency department use among undocumented adults and children.[9] In a national study, living in a state with higher immigration enforcement activity was associated with a decreased likelihood of having a primary care clinician.[10] Undocumented status may also be associated with lower use of emergency services, often the last resort for care, as was seen during the COVID-19 epidemic.[11]

In *JAMA Internal Medicine*, Santos et al[12] examine the role that state policy plays in health care access for undocumented immigrants. As Louis Brandeis posited nearly a century ago, states are the laboratories of democracy—and health policy is no exception. The authors describe how health care coverage for undocumented immigrants varies across states. For instance, many states use emergency Medicaid to provide limited coverage of emergency care by waiving the traditional Medicaid eligibility requirements. Yet state waivers vary widely in policy designs such as qualifying income thresholds, duration of coverage, and which conditions constitute an emergency: 43 states provide emergency Medicaid for labor and delivery, 21 for dialysis, and only 5 for cancer. Twenty-two states have expanded coverage to include health care from conception to the end of pregnancy, 10 of which further extended coverage for 12 months post partum. Two states (Washington and Colorado) have received waivers to allow undocumented immigrant patients to access Affordable Care Act Marketplace plans.

Although these examples demonstrate ways in which individual states have acted to provide health care access for undocumented immigrants, these policy levers will be constrained by the new administration, with major consequences. It is unlikely that new waivers will be approved to facilitate coverage for undocumented immigrant patients. Proposed reductions in federal Medicaid cost sharing would further restrict states' financial resources. Backsliding on Medicaid coverage for undocumented immigrants could have a profound impact on patients, communities, clinicians, and health systems. When immigrants are afraid to seek care, such as for a cough due to tuberculosis or a new viral illness, the downstream clinical consequences can result not only in catastrophic consequences for the individuals involved, but also in public health threats for communities and populations. For clinicians and health systems, reductions in coverage may mean that the care they are ethically and legally bound to provide to patients with acute needs—required by the Emergency Medical Treatment and Active Labor Act—will go uncompensated. Beyond insurance coverage, recently amplified threats of deportation and the end of long-standing protections that previously barred US Immigration and Customs Enforcement (ICE) agents from entering hospitals and medical clinics will have a chilling effect on undocumented immigrants seeking needed health care and on health care professionals who care for them.

Medical societies have affirmed their commitment to key ethical principles salient to the care of undocumented patients, including duty to treat, nondiscrimination, and confidentiality. The American Medical Association, for instance, has advocated for expansion of federal funding for emergency medical services for undocumented immigrants and against

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requiring proof of citizenship as a precondition for receiving health care or requiring clinicians to collect or report citizenship data.[13,14] Similar statements have been released by the American College of Emergency Physicians, the American College of Physicians, the Society of General Internal Medicine, the American College of Obstetrics and Gynecology, and others.[15-17]

What can individual clinicians do? Access to health care is a human right for all, and the most important action is to uphold our professional duty to put the health care needs of patients first.[18] The presence of ICE agents, or other federal officials, should not impede the provision of appropriate medical care. Clinicians should familiarize themselves with relevant federal, state, and local policies, and their rights and responsibilities to avoid the trap of anticipatory obedience. For instance, protected health information cannot be disclosed to immigration authorities without patient authorization or an applicable warrant.[19,20] Additionally, ICE administrative warrants (unlike signed judicial warrants) under Health Insurance Portability and Accountability Act guidance are generally not sufficient to give these authorities access to patients undergoing medical care. Ultimately, physicians should work with their health system or practice's legal team to finalize, implement, and disseminate information about their policies throughout their health system.[21]

Health systems also play a vital role in ensuring access to care. One area of concern is the physical security of patients, given evolving policies regarding ICE access to sensitive locations such as clinical care sites in hospitals and outpatient clinics. In 2021, the Biden administration issued guidance against ICE enforcement actions "...in or near a location that would restrain people's access to essential services..."[22] This guidance was recently rescinded by the Trump administration, suggesting that immigration enforcement activities can occur within public areas of health care settings such as waiting rooms, while access to interior, "private" areas would require a judicial warrant.[23,24] Importantly, these policies are in flux, and much of the administration's pronouncements have lacked legal backing, so institutions' legal counsels should clearly convey their policies regarding interactions with immigration enforcement officers. Institutions can also facilitate care for people who are afraid to leave their homes by offering virtual or home visits and facilitating medication orders through mailed prescription pharmacy services.

In sum, in this time of unique federal threats to the health and well-being of undocumented immigrants, state policies play an important but incomplete role in protecting health care access for this population. Even immigrants who have legal status may be fearful, given uncertainties about how immigrants may be perceived or investigated. Individual clinicians and health systems have a great responsibility to ensure that all patients—regardless of documentation status—receive effective, confidential, and equitable care. We can play our part by staying attuned to legal and policy developments that affect our settings of care, by advocating to our institutions, professional organizations, and elected leaders to preserve health care settings as safe places for all, and to be guided by our north star: doing right by our patients.

ARTICLE INFORMATION

Author Affiliations: National Clinician Scholars Program, Yale School of Medicine, New Haven, Connecticut (Gross); Associate Editor, *JAMA Internal Medicine* (Gross, Ganguli, Anderson, Durant, Corbie); Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut (Richman, Allore); Editorial Fellow, *JAMA Internal Medicine* (Richman, Stall, Kneifati-Hayek); Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital, Boston, Massachusetts (Ganguli); Division of General Internal Medicine, Department of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania (Anderson); Division of Women's Health, Brigham and Women's Hospital, Boston, Massachusetts (Rittenberg); Viewpoints and Online Editor, *JAMA Internal Medicine* (Rittenberg); Division of General Internal Medicine and Geriatrics, Sinai Health and the University Health Network, Toronto, Ontario, Canada (Stall); Division of General Medicine, Columbia University Irving Medical Center, New York, New York (Kneifati-Hayek); Division of General Internal Medicine and Population Science, Department of Medicine, University of Alabama at Birmingham, Birmingham (Durant); Diversity, Equity, and Inclusion Associate Editor, *JAMA Internal Medicine* (Durant); University of California, San Francisco School of Medicine, San Francisco (Grady); Deputy Editor, *JAMA Internal Medicine* (Grady); Perspectives Editor, *JAMA Internal Medicine* (Grady); Statistical Editor, *JAMA Internal Medicine* (Allore); Departments of Social Medicine and Medicine, School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill (Corbie); Harvard Medical School and Marcus Institute for Aging Research, Hebrew SeniorLife, Boston, Massachusetts (Inouye); Editor in Chief, *JAMA Internal Medicine* (Inouye).

Corresponding Author: Cary P. Gross, MD, Primary Care Center, Yale School of Medicine, 333 Cedar St, New Haven, CT 06510 (cary.gross@yale.edu).

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