Relevant "Material": Importing the Principles of Informed Consent and Unconscionability to Analyze Consensual Medical Repatriations

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Introduction

Antonio Torres, a teenage farmworker from Gila Bend, Arizona, "suffered catastrophic injuries in a car accident" in June 2008.[1] Mr. Torres was a legal immigrant, but he carried no health insurance. His status barred him from federal healthcare funding.[2] Soon after stabilizing him, the hospital began planning to repatriate the comatose Mr. Torres to his native Mexico, over the objections of his parents.[3] The hospital transported Mr. Torres to Mexicali, in the Mexican state immediately south of California, where he sat unattended in a busy emergency room for days. His parents refused to give up and found a California hospital willing to treat him at no cost. They drove him back to the United States, where he recovered from his injuries.[4] This Article proposes that courts considering the legality of medical repatriations apply a two-step test—which utilizes the principles of informed consent and unconscionability—that enables immigrants like Mr. Torres to challenge the legality of their repatriations using *existing* federal discharge guidelines. This test ensures hospitals meet their federally mandated discharge obligations, which limits their potential liability, and ensures these immigrant patients remain free from coercion and deception when deciding whether or not to consent to repatriation.

"Medical repatriation" refers to the process of extrajudicially deporting and returning an immigrant to his or her home country to continue receiving treatment.[5] Financial considerations drive the process. Hospitals that re-

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[1] Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, N.Y. Times, Nov. 9, 2008, at A1.

[2] *See id.* A 1996 law bars undocumented immigrants from nonemergency federal funding for health care services, and bars even legal, "qualified aliens," including Lawful Permanent Residents ("LPRs"), asylees, and refugees, from federal healthcare funding unless they meet a stringent list of requirements. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-196, §§ 401, 431, 110 Stat. 2105, 2261–62, 2274 (1996) (codified at 8 U.S.C. §§ 1611, 1641 (2006)).

[3] Sontag, *supra* note 1.

[4] *Id.*

[5] *Cf.* Lori A. Nessel, *The Practice of Medical Repatriation: The Privatization of Immigration Enforcement and Denial of Human Rights*, 55 Wayne L. Rev. 1725, 1727 (2009) (defin-

ceive federal Medicare funding must treat and stabilize all patients that arrive with emergency medical conditions, including uninsured immigrants who are ineligible for Medicaid.[6] Federal funds reimburse this emergency treatment.[7] Once stabilized, however, uninsured immigrants become ineligible for federal funding, and their care becomes the responsibility of the treating hospital.[8] Federal regulations require patients that need continuing care be discharged to "appropriate" facilities,[9] but appropriate long-term care facilities, to which stabilized Medicare or Medicaid eligible patients would routinely be transferred, are generally not required to accept uninsured immigrants.[10] Hospitals are stuck; appropriate facilities will not accept uninsured immigrants, but hospitals must transfer patients to appropriate facilities. The immigrants stay at the hospitals, and so do their bills.

These patients' uncompensated bills force hospitals to consider medical repatriation as a solution. Hospitals arrange, on their own or through a third-party company, for the uninsured immigrant to be repatriated outside the formal structures of immigration law.[11] While it is unknown how long medical repatriations have existed, they have only recently drawn the attention of legal scholars. *Montejo v. Martin Memorial Medical Center*,[12] the first and only case to consider the legality of medical repatriations, was first cited by a scholarly article in 2005. Of the eighteen articles to cite *Montejo*, thirteen

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ing nonconsensual medical repatriation as the "forced or coerced extrajudicial deportation" of an undocumented individual).

[6] *See* 42 U.S.C. § 1395dd(b)(1)(A) (2006) ("If any individual (whether or not eligible for benefits . . .) comes to a hospital and . . . has an emergency medical condition, the hospital must provide either . . . treatment as may be required to stabilize the medical condition, or . . . for transfer of the individual to another medical facility . . . .").

[7] *See id.* § 1396b(v)(2)(A).

[8] *Id.* § 1396b(v).

[9] *See* 42 C.F.R. § 482.43(d) (2010).

[10] *See* Sontag, *supra* note 1 (noting that hospitals "generally cannot find nursing homes to accept illegal immigrants, or legal ones with less than five years' residency, because long-term care is not covered by emergency Medicaid").

[11] Medical repatriations occur either consensually or forcibly (without patient or guardian consent). For those individuals who are forcibly repatriated, because consent is not given, existing causes of action under tort law provide adequate methods of redress for immigrants to vindicate their rights. *See* Caitlin O'Connell, Note, *Return to Sender: Evaluating the Medical Repatriations of Uninsured Immigrants*, 87 WASH. U. L. REV. 1429, 1452–58 (2010) (outlining potential suits for breaches of federal discharge requirements, tort liability for false imprisonment, and Fourteenth Amendment due process violations as potential causes of action arising from forcible repatriations). Even if hospitals provided immigrants they planned to forcibly repatriate with every possible piece of information to prepare the immigrants for post-discharge care in an attempt to satisfy the hospital's burden under 42 C.F.R. § 482.43(c)(5) to "counsel [the patient and family members] to prepare them for post-hospital care," tort law mechanisms would be available. It is in the context of consensual repatriations that § 482.43(c)(5)'s requirement assumes additional significance. The potential common law liability stemming from forcible repatriations has led hospitals to contract with third-party companies to repatriate the immigrants on the hospitals' behalf. These companies shield themselves from liability by first requiring the patient's consent to the transfer. Existing scholarship has not sufficiently addressed this group of repatriated immigrants—those who appear to have consented to repatriation but may not have been given sufficient information to effectively consent. This Article will therefore focus on medical repatriations that appear, prima facie, consensual.

[12] 874 So. 2d 654 (Fl. Dist. Ct. App. 2004).

were published in 2010 alone. The recent scholarship primarily proposes changes to federal law that will provide new federal programs aimed at streamlining the medical repatriation process.[13] The toxic nature of the recent health care debate and complete exclusion of undocumented immigrants from any of healthcare reform's intended benefits, however, reflect the impractical nature of recommendations that rely on Washington to address the issue. The law's current and often-overlooked standards, however, can help regulate medical repatriations.

One subsection of the federal discharge regulations, 42 C.F.R. § 482.43(c)(5), requires that "[a]s needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care."[14] This provision holds a possible key to regulating medical repatriations. This Article promotes a two-part test for courts that employs tort law's doctrine of informed consent and contract law's doctrine of unconscionability to analyze the consent obtained in consensual medical repatriations, and that ensures hospitals meet their § 482.43(c)(5) obligation. The benefit of this approach over other proposed policy changes is in the test's ease of administration and immediate applicability. Implementing this two-part test requires no alteration to any legislative or administrative promulgations, nor the recognition of new analytical methods judges should employ. Informed consent and unconscionability are clear-cut, familiar tools for judges. The analysis would help immigrant patients determine whether a cause of action exists that would allow them to challenge their repatriation, and help hospi-

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[13] *See, e.g.*, Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CIN. L. REV. 657, 692 (2009) (advocating for a new federal program in which hospitals would contact the Department of Homeland Security to report suspected undocumented immigrants in need of long-term care, and Immigration and Customs Enforcement would then place the immigrants in expedited removal proceedings); Lindita Bresa, Comment, *Uninsured, Illegal, and in Need of Long-Term Care: The Repatriation of Undocumented Immigrants by U.S. Hospitals*, 40 SETON HALL L. REV. 1663, 1680–95 (2010) (proposing Congressional reform requiring nursing homes and long-term care centers to accept undocumented immigrants, extending Medicaid eligibility to uninsured workers, or establishing an accepted national policy for medical repatriation); Sarah E. Greenlee, Comment, *Cast Back into "Tempest-Tost" Waters: The "Uncharted Seas" of Private Medical Repatriations*, 60 CASE W. RES. L. REV. 281, 300 (2009) (proposing that undocumented immigrant patients be given the same access to the judicial processes as those immigrants undergoing formal deportation proceedings); Emily R. Zoellner, Note, *Medical Repatriation: Examining the Legal and Ethical Implications of an Emerging Practice*, 32 WASH. U. J.L. & POL'Y 515, 536–37 (2010) (proposing, *inter alia*, to redefine "emergency medical condition" in the Emergency Treatment and Active Labor Act (EMTALA) and to amend the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) in order to allow states to provide healthcare for undocumented immigrants). Another author has suggested clarifying the standard for "appropriate" facilities in § 482.43. *See* Vishal Agraharkar, Note, *Deporting the Sick: Regulating International Patient Dumping by U.S. Hospitals*, 41 COLUM. HUM. RTS. L. REV. 569, 596 (2010) (proposing an amended federal regulation that redefines "appropriate facilities" as those that "(1) can meet the patient's assessed medical needs after discharge, (2) compl[y] with federal, state, or equivalent health and safety standards, and (3) [are] within a reasonable distance of the patient's home, so that friends and family may visit"). However, such a standard would be of little use as a tool for undocumented immigrants because bringing them within a "reasonable distance" of their "home" could easily be read to suggest repatriation.

[14] 42 C.F.R. § 482.43(c)(5) (2010).

tals ensure the proper information is given to these immigrants to limit future liability.

Part I outlines the statutory and regulatory framework that has spawned medical repatriations. Part II outlines hospitals' attempts to avoid liability for medical repatriations and explains the emergence of third-party companies as a vehicle for repatriations. Part III briefly explains the doctrines of unconscionability and informed consent. Part IV analyzes § 482.43(c)(5) in light of these principles, and concludes with a brief discussion detailing why this two-step policy provides a better immediate solution than other policy suggestions.

I. The Statutory Framework: The Source of the Problem

Medical repatriations exist at the confluence of several conflicting federal authorities. First, the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA)[15] requires that all Medicare-participating hospitals with emergency rooms treat any individual, "whether or not eligible for benefits," who has a medical emergency.[16] Because Medicare is accepted by almost all public hospitals in the United States, EMTALA effectively requires that hospitals provide emergency medical treatment to practically all individuals, regardless of immigration status or insurance coverage, until they are stabilized.[17] However, the funding only reimburses treatment that resolves an immigrant's "emergency" situation[18] and ceases once the uninsured immigrant is stabilized.[19] For those individuals who have been stabilized but need continued care, like coma patients, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)[20] makes their medical costs the responsibility of the treating hospital.

Pre-PRWORA, hospitals that continued treating uninsured immigrants after stabilization could receive funding for this care. When Congress passed PRWORA, it severely curtailed the funding of post-emergency treatment for

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[15] 42 U.S.C. § 1395dd (2006).

[16] *Id.* § 1395dd(a).

[17] *See* Russell Korobkin, *Determining Health Care Rights From Behind a Veil of Ignorance*, 1998 U. Ill. L. Rev. 801, 829 (1998).

[18] 42 U.S.C. § 1396b(v)(2)(A) ("Payment shall be made under this section for care and services that are furnished to an alien . . . only if—(A) such care and services are necessary for the treatment of an emergency medical condition.").

[19] *See id.* "[T]he term 'emergency medical condition' means 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" placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." *Id.* § 1396b(v)(3). Treatment after the patient has been stabilized does not alleviate any of these risks, and is therefore ineligible for federal funding because it is not "emergency" treatment.

[20] Pub. L. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 8 U.S.C.).

uninsured aliens.[21] Although the combination of EMTALA and PRWORA seems to provide an easy formula for hospitals to follow—treat the emergency symptoms of uninsured immigrants and nothing else—the federal discharge requirements in 42 C.F.R. § 482.43 complicate this simple calculus.

Section 482.43 provides several significant safeguards that prevent hospitals from simply discharging uninsured patients that require continuing treatment post-stabilization. Hospitals may transfer or refer patients only to "appropriate facilities,"[22] and it is the hospital that "must arrange for the initial implementation of the patient's discharge plan."[23] Additionally, "[a]s needed, the patient and family members or interested persons *must* be counseled to prepare them for post-hospital care."[24] Failing to properly counsel a patient in preparation for post-hospital care thus violates federal discharge requirements. Suits to enforce these discharge requirements can begin to regulate the medical repatriation process.

When an uninsured United States citizen needs post-discharge continued care, a hospital can generally transfer or refer him or her to long-term "appropriate facilities" because federal funding may cover the patient's continued care. These long-term care facilities, however, are not similarly mandated by EMTALA to provide care to all. Hospitals have nowhere to transfer uninsured immigrants, because PRWORA limits post-stabilization healthcare funding for immigrants' continued care. Nearly all the "appropriate facilities" that would otherwise admit patients needing continuing care will refuse uninsured immigrants because the facilities cannot afford to provide unreimbursed treatment.[25] This dilemma illustrates why medical repatriations have become increasingly appealing to hospitals.[26] Hospitals arrange, via private companies, repatriation to the immigrant's native country where he or she may receive proper care in appropriate facilities. These companies will repatriate the uninsured immigrant only after obtaining his or her consent. However, depending on what information is disclosed to the patient to prepare him or her for post-hospital care, hospitals may violate the

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[21] Excluding funding for emergency services, aliens who are not "qualified aliens" are ineligible for federal medical funding, *see* 8 U.S.C. § 1611(a) (2006), and even "qualified aliens" are subject to numerous restrictions before becoming eligible for federal funding, *see* 8 U.S.C. § 1612 (2006). Chapter 14 of Title 8 of the United States Code is titled "Restricting Welfare and Public Benefits for Aliens," reflecting the clear intent of Congress in passing PRWORA. 8 U.S.C. § 1601 (2006).

[22] 42 C.F.R. § 482.43(d) (2010).

[23] *Id.* § 482.43(c)(3). The hospital, therefore, is responsible for ensuring that the patient be transferred to an "appropriate facility," even if it uses a third-party company to execute the transfer.

[24] *Id.* § 482.43(c)(5) (emphasis added).

[25] *See* Sontag, *supra* note 1 (noting that hospitals "generally cannot find nursing homes to accept illegal immigrants, or legal ones with less than five years' residency, because long-term care is not covered by emergency Medicaid").

[26] *See id.* ("Hospitals have limited options in discharging immigrant patients who need continuing care: keeping them indefinitely, with or without providing rehabilitation; finding them charity beds or subsidizing them at nursing homes; sending them home to relatives; or repatriating them.").

"adequate counseling" duty imposed by § 482.43(c)(5), and the immigrant would then have a cause of action to contest repatriation.

II. The Practice of Medical Repatriations: How Hospitals Repatriate Patients

In the facts that gave rise to *Montejo v. Martin Memorial Medical Center*, a Florida hospital facing $1,500,000 in unpaid medical bills from Luis Alberto Jiménez, an uninsured immigrant who needed continued care, sought authorization from a state court to medically repatriate him to Guatemala, his native country.[27] After successfully intervening in Jiménez's guardianship proceedings, the state court authorized the medical repatriation.[28] Faced with the risk of having to cover the astronomical costs of Jiménez's continued medical care, the hospital repatriated him under the authority of the state court order. On appeal, the Florida Court of Appeals overturned the initial state court order and found that "there was no competent substantial evidence to support Jimenez's discharge from the hospital."[29]

Hospitals are caught between EMTALA's mandate for emergency care, PRWORA's limitations on federal funding for immigrants' healthcare, and the federal regulations governing patient discharge. Some hospitals have taken drastic steps to discourage immigrants from seeking medical treatment.[30] Other hospitals choose to forego medical repatriations.[31] Many, however, must medically repatriate uninsured immigrants—especially in areas where large immigrant populations make mass uncompensated care financially impossible.[32] The burden of providing adequate information to prepare a client for post-discharge care, however, remains with the hospital that initiates repatriation.[33]

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[27] *See* Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. Times, July 28, 2009, at A10.

[28] Montejo v. Martin Mem'l Med. Ctr., Inc., 874 So. 2d 654, 656 (Fl. Dist. Ct. App. 2004).

[29] *Id.* at 658.

[30] *See, e.g.*, Brietta R. Clark, *Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DePaul J. Health Care L. 1023, 1033 (2005) (dressing hospital security guards in uniforms resembling border patrol agents) (citing Thomas Perez, Director, Office for Civil Rights, Department of Health and Human Services, Address at the New England Regional Minority Health Conference (Apr. 13, 1999)); Julia Preston, *Texas Hospitals Reflect Debate on Immigration*, N.Y. Times, July 18, 2006, at A1 (questioning immigrants about their immigration status upon arrival at hospitals).

[31] *See* Sontag, *supra* note 1 ("El Centro Regional Medical Center in California . . . never sends an immigrant over the border. 'We don't export patients,' said . . . its chief executive. 'I can understand the frustrations of other hospitals, but the flip side is the human being element.'").

[32] The comments of Sister Margaret McBride, vice-president of the hospital in Arizona that repatriated Mr. Torres, illustrate the burden: "'We're trying to be good stewards of the resources we have.' . . . . 'We're trying to make sure that the acute-care hospital is available for individuals who need acute care. We can't keep someone forever.'" *Id.*

[33] The Department of Health and Human Services has made clear that "[t]he *hospital* is required to arrange for the initial implementation of the discharge plan. This includes arranging for necessary post-hospital services and care, and *educating* patient/family . . . about post-

Despite the fact that Martin Memorial obtained a court order authorizing Jiménez's repatriation, Jiménez's guardian, Montejo, sued the hospital for false imprisonment on the grounds that neither he nor Jiménez personally consented to the transfer, and the state court's order was overturned.[34] The suit made it all the way to the jury, which declined to award damages.[35] Despite Martin Memorial's victory, this case demonstrates the potential common law liability hospitals face when they forcibly repatriate immigrants. To avoid this potential liability, hospitals in Martin Memorial's situation are now turning to private, third-party companies to execute the repatriations. These companies serve as a safeguard against the potentially costly lawsuits faced by the repatriating hospitals, because they will not repatriate the immigrant without obtaining his or her consent.[36] The transfer of the patient to a native hospital that will accept him or her provides two safeguards. First, it allows the U.S. hospital to meet its federal obligation to "arrange for the initial implementation of the patient's discharge plan."[37] Second, obtaining the patient's consent to the transfer, pre-repatriation, may shield the company and hospital from tort liability. Despite the apparent benefits of third-party repatriation companies, serious questions surround the nature of the consent they obtain from immigrants. If an immigrant, before consenting to the repatriation, receives insufficient or erroneous information about the post-repatriation care to be provided, the hospital may not be meeting its duty under § 482.43 to provide pre-discharge counseling to prepare the patient for post-hospital care. Analyzing the information provided to immigrants pre-repatriation highlights this danger.

MexCare, a leading medical repatriation company, purports to have significant safeguards in place for patients who might be repatriated. They repatriate patients only after receiving "a signed consent of the patient or their Legal Guardian . . . with extensive communication with their family."[38] Additionally, "[i]f a patient chooses not to accept the transfer, MexCare immediately stops contact with the patient and family and notifies the referring physician of the patient's decision."[39] MexCare's website portrays repatriation as a desirable option, stating that the repatriated immigrant will never

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hospital care plans." U.S. DEP'T OF HEALTH & HUMAN SERVS. CTR. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL, APPENDIX A–INTERPRETIVE GUIDELINES § 482.43(c)(3) (2009) (emphases added). When educating these patients, "[e]vidence should exist that the patient and/or family and/or caregiver is/are provided information and instructions in preparation for post-hospital care and kept informed of the progress." *Id.* § 482.43(c)(5).

[34] *See* Sontag, *supra* note 1. The manner in which the hospital repatriates the individual may expose the hospital to multiple forms of liability. *See, e.g.*, O'Connell, *supra* note 11, at 1452–58 (outlining hospitals' potential liability for breaches of federal discharge requirements, false imprisonment, and due process violations).

[35] *See* Sontag, *supra* note 1.

[36] *See* Press Release, Mexcare, The New York Times gets it wrong! (Aug. 15, 2008) (on file with the Harvard Law School Library).

[37] 42 C.F.R. § 482.43(c)(3) (2010).

[38] Mexcare, *supra* note 36.

[39] *Id.*

have to repay MexCare for any of its services, will be sent to a facility capable of meeting the individual's needs, and that if the family of the repatriated immigrant stays with them at the hospital, they will receive room and board at no cost.[40]

Still, at least three serious questions surround the substantive nature of the information given to the individuals who sign consent forms. First, MexCare's website's "Frequently Asked Questions" page fails to mention immigration consequences from repatriation.[41] The MexCare consent form, which the patients sign to authorize the repatriation, is a brief, standard-form agreement with blank spaces to be filled in for each patient's transfer; it also fails to mention any immigration consequences.[42] Second, some of the responses on Mexcare's "Frequently Asked Questions" webpage evade significant issues. For example, the response to "Will I be discharged [from the native hospital] before I am ready and well?" evades the question. It states, "Your discharge will be determined by your condition, the doctor and the services you require."[43] Third, MexCare does not list a single partner hospital to which its patients have been transferred, despite claiming that the "facilities [to which the immigrant is transferred] are all private and are as close to your place of origin as possible."[44]

Failing to properly inform an immigrant of the type of post-repatriation care he or she will receive in order to obtain consent to repatriation directly conflicts with § 482.43's mandate to properly counsel patients for post-discharge care. Improperly obtained consent, on the basis of improper counseling, cannot trump a hospital's federal obligation to properly counsel patients for post-discharge care. Hospitals and repatriation companies possess divergent goals. The hospital merely needs to offer information to prepare the patient for post-discharge care, while the transfer company needs to convince the immigrant to consent to repatriate. The possibility of transfer companies withholding important information from the patient, material to the decision to consent, is substantial. This possibility suggests hospitals—which are responsible for the information disclosed by the transfer companies they selected—might not be meeting their responsibility under § 482.43(c)(5). Tort law's doctrine of informed consent and contract law's doctrine of unconscionability provide practical, expedient methods to analyze the sufficiency of the information provided to immigrants pre-repatria-

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[40] *Frequently Asked Questions*, MEXCARE, http://mexcare.com/faq_mexcare.html (last visited Mar. 6, 2010) (on file with the Harvard Law School Library).

[41] *Id.* 8 U.S.C. § 1182(a)(9)(B)(i) (2006) contains one particularly important immigration consequence: immigrants who reside in the United States illegally and leave will not be able to obtain lawful admission to the United States.

[42] *MexCare Transfer Agreement*, MEXCARE, http://mexcare.com/forms/html (last visited Apr. 19, 2011) (on file with the Harvard Law School Library).

[43] MEXCARE, *supra* note 40.

[44] *Id.*

tion and pre-discharge. Both doctrines can immediately be employed by courts to address medical repatriations.

III. Informed Consent and Unconscionability Explained

The doctrine of informed consent has traditionally referred to a physician's duty to apprise his or her patient of all information the physician possesses that would be material to the patient when deciding whether to undergo a proposed procedure.[45] If the physician does not obtain the patient's "informed consent," he or she may be liable for malpractice.[46] More generally, informed consent is defined as "[a] person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives."[47] At its essence, the doctrine of informed consent requires all material information be disclosed to a patient so he or she can best select what is proper for his or her body.

Unconscionability is a tool originally used in courts of equity to prevent the enforcement of contracts that are so unreasonable as to "shock the conscience."[48] Two forms of unconscionability exist: procedural and substantive. Procedural unconscionability results from improprieties surrounding the contract's formation, such as disparities in bargaining position or failures to disclose critical information, rather than from the contract's actual terms.[49] It is routinely described as an absence of meaningful choice, and it operates to rescind agreements because it presumes that without relevant facts, one cannot make a meaningful decision. Substantive unconscionability occurs when the "actual contract terms are unduly harsh, commercially unreasonable, and grossly unfair given the existing circumstances."[50] Substantive unconscionability also refers to terms that, given the circumstances surrounding the contract's formation, unreasonably benefit the party free from the procedural pressures.[51]

In most circumstances, for a court to rescind an agreement for unconscionability, both procedural and substantive unconscionability must exist.[52]

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[45] *See, e.g.*, Harrison v. United States, 284 F.3d 293, 298 (1st Cir. 2002) (noting that a physician must "disclose 'sufficient information to enable the patient to make an informed judgment whether to give or withhold consent to a medical or surgical procedure' " in order to avoid liability for malpractice) (quoting Harnish v. Children's Hosp. Med. Ctr., 439 N.E.2d 240, 242 (Mass. 1982)).

[46] *Id.*

[47] Black's Law Dictionary 346 (9th ed. 2009).

[48] Osgood v. Franklin, 1 N.Y. Ch. Ann. 275, 2 Johns. Ch. 1 (1816).

[49] *See* Black's Law Dictionary, *supra* note 47, at 1664.

[50] *Id.*

[51] *See* Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965) ("Unconscionability has generally been recognized to include an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party.").

[52] *See* Gillman v. Chase Manhattan Bank, N.A., 534 N.E.2d 824, 828 (N.Y. 1988) ("A determination of unconscionability generally requires a showing that the contract was both procedurally and substantively unconscionable when made.") (internal citations omitted).

Generally, courts use a sliding scale, where the existence of a substantial amount of the former will offset a lesser amount of the latter—or vice versa.[53] However, an agreement "is not substantively unconscionable merely because it was foolish for one party and very advantageous to the other party."[54] Unconscionability, at its core, examines both the contract itself and the situation surrounding its formation for severe inequities.

IV. Applying Unconscionability and Informed Consent to the Discharge and Medical Repatriation Process

Documented and undocumented immigrants face different pressures before providing consent. This Article's proposed two-step test, which considers first, whether an immigrant provided informed consent to repatriation, and second, whether the repatriation agreement was unconscionable, addresses both classes of immigrants. The choice to consent to repatriation is ultimately the immigrant's. Documented immigrants, faced with the liability for millions of dollars of medical bills if they remain in the United States, may face heightened pressure to consent to alleviate their financial struggles. Documented immigrants, therefore, have a heightened interest in ensuring all the material information regarding their health care and financial responsibilities is properly disclosed to them. Step one, the informed consent analysis, is thus particularly relevant to documented immigrants. Undocumented immigrants, on the other hand, may face heightened pressure to consent out of fear of being reported to Immigration and Customs Enforcement (ICE). Even if the discharging hospital provides all material information to the undocumented immigrant, he or she may feel compelled to consent by the very circumstances. Accordingly, step two, the unconscionability analysis, is particularly relevant to undocumented immigrants.

When the Florida appellate court determined that Jiménez's discharge should have been barred because "no competent substantial evidence [was presented] to support Jiménez's discharge,"[55] it signaled that patients facing repatriation can contest discharges that are not in accordance with federal regulations.[56] Specifically, immigrants can challenge their pending discharges under § 482.43(c)(5), which requires that "[a]s needed, the patient and family members or interested persons *must be counseled* to prepare them for post-hospital care."[57] Informed consent and unconscionability provide

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[53] *See, e.g.*, Nagrampa v. MailCoups, Inc., 469 F.3d 1257, 1281 (9th Cir. 2006) (noting that "courts employ a sliding scale in analyzing whether the entire arbitration provision is unconscionable" and so "even if the evidence of procedural unconscionability is slight, strong evidence of substantive unconscionability will tip the scale and render the arbitration provision unconscionable").

[54] Mich. Non-Standard Jury Instr.–Civ. § 39.36 (2010).

[55] Montejo v. Martin Mem'l Med. Ctr., Inc., 874 So. 2d 654, 656 (Fl. Dist. Ct. App. 2004).

[56] The court ruled that the hospital should not have discharged Jiménez because the evidence indicated that no appropriate facility existed in Guatemala. *Id.* at 657–58.

[57] 42 C.F.R. § 482.43(c)(5) (2010) (emphasis added).

proper standards to weigh this counseling requirement because of the theories' ease of administration and immediate applicability to documented and undocumented immigrants. The emphasis of this two-part test will vary depending on the pressures faced by each individual immigrant, but courts can capably apply each factor in different situations.

First, courts should separately assess the information given by the hospital to the patient concerning post-hospital care, and the information given by the transfer company to the patient to obtain consent to transfer. Separately analyzing the information provided by the hospital and the transfer company closely parallels the manner in which the patient receives his or her information. An immigrant may severely discredit what the hospital tells the immigrant about post-hospital care if the information provided by the transfer company differs markedly from that provided by the hospital. Focusing only on the hospital's own disclosure when determining whether it has met its burden to inform the patient is misguided, because the hospital is employing the very transfer company potentially undercutting its statements. Analyzing the hospital's discharge obligation and informed nature of the patient's consent, therefore, should incorporate the transfer company's statements. A court considering a challenge to a medical repatriation should compare the information provided to the patient by both the hospital and transfer company in order to obtain a complete picture of the counseling provided to the patient. It, accordingly, can determine whether proper counseling was provided under § 482.43, identify what the patient consented to, and determine whether the agreement was unconscionable or not.

Step 1: Informed Consent Considerations

Informed consent requires that all material information be disclosed to the patient before he or she elects to undergo a procedure.[58] Material issues to repatriation should, at a minimum, include: immigration ramifications, post-transfer health consequences and treatment options, and payment responsibilities. The patient should also be informed of the possible outcomes if he or she declines to consent—i.e., possible reporting to ICE or health care opportunities in the United States. Both the hospital and the transfer company should separately disclose this information to the immigrant because each entity has a different goal, and some factors may be more important to the immigrant than others. Material disclosures permit the immigrant, regardless of status, to make an informed decision about whether to consent to repatriation.

The immigrant's signature on the transfer company's form triggers repatriation, so courts must carefully analyze the sufficiency of the information provided to the patient on the form. MexCare's current disclosures fail to mention immigration implications, and its discharge form only states, "I

[58] *See* BLACK'S LAW DICTIONARY, *supra* note 47, at 346.

agree to voluntarily be transferred," "I understand the prescribed care will be provided free of charge," and "I am voluntarily agreeing to my transfer."[59] While such a document may serve as useful evidence to defend a false imprisonment claim, it fails to inform the patient about two of the immigrant patient's major concerns—post-transfer care and immigration consequences. Obtaining patient consent after omitting material information undercuts the validity of the company's transfer agreement, and can undermine the information provided by the hospital to the immigrant.

After analyzing the information that both the hospital and the transfer company provided to the immigrant in their separate capacities, the court should compare each party's disclosures to ensure that all material information was provided. When the hospital, individually, provides the information necessary to adequately prepare the patient but the transfer-company has made a material omission, then the company's omissions should be weighed against the hospital's material disclosures to determine whether the consent was informed. Each case should be fact-specific. For a hospital to avoid violating § 482.43(c)(5), it should ensure that its staff and the transfer company disclose all material information relative to each actor's respective interests—the hospital in counseling and the transfer company in obtaining consent. If material omissions are found, the hospital's ability to meet its § 482.43(c)(5) burden is endangered, and the court should determine whether the hospital has met this burden. If it has not, courts should void the consent form and ensure that the immigrant receives complete, accurate information material to his or her decision. Such information is essential to documented immigrants because they have the option to legally remain in the United States. If all material information was disclosed, the court should proceed to analyze the consent using the doctrine of unconscionability.

Step 2: Unconscionability Analysis

Disclosing all material information to an immigrant does not automatically ensure that the immigrant voluntarily consented to repatriation. The immigrant enters into a contract when he or she signs the transfer agreement; and, the court should ensure that procedural and substantive unconscionability did not taint the immigrant's consent.

Hospitals communicate with ICE and local law enforcement regarding immigrants in their hospitals. The fear of being discovered is at the forefront of undocumented immigrants' minds—especially in public settings like hospitals. If immigrants refuse to consent to a transfer company's repatriation plans, the hospital is not barred from contacting ICE. This is a powerful weapon for hospitals and transfer companies. The risk of procedural unconscionability is high, since immigrants possess minimal bargaining power. In an immigrant's mind, there are two realistic choices—sign a "voluntary" repatriation form and be removed by a private company without a record of

[59] MEXCARE, *supra* note 42.

the immigrant's illegal presence made by ICE, or refuse.[60] Refusing to sign the transfer agreement forces the hospital to continue providing treatment, contact ICE, or forcibly repatriate an individual against his or her will. This situation is the essence of an "absence of meaningful choice," and such an unfavorable dilemma could reasonably be thought to "shock the conscience." Documented immigrants face similar, albeit less forceful, unconscionability pressures. Because the risk of being reported to ICE is nonexistent, documented immigrants will have a harder time demonstrating that the pressures surrounding their consent equate to an absence of meaningful choice.

Substantive unconscionability must also be demonstrated. Courts should find the terms of medical repatriation transfer agreements, which allow hospitals to jettison the costs of the immigrant's healthcare upon transfer, to be "unreasonably favorable" to the hospital, and thus unconscionable when coupled with the situational pressures inherent in the contract's signing.[61] This benefit accrues to hospitals regardless of the immigrant's status. In addition to the unreasonably favorable terms, the omission of information concerning the health and immigration consequences of consenting to repatriation could contribute to substantive unconscionability by courts in situations where the omissions did not rise to material omissions under the informed consent analysis. After assessing the consent and agreement using informed consent and unconscionability, the reviewing court can determine whether hospitals have met their burden to counsel clients for post-hospital care.

While the potential exists for Congress or the Executive Branch to regulate medical repatriations or extend federal funding for all immigrants, such actions are increasingly unlikely in this toxic political environment. Challenging medical repatriations under § 482.43 and employing this Article's two-part analysis affords an efficient, convenient method for preventing cognizable abuses in the medical repatriation process. Most importantly, the proposed two-part analysis of such challenges is readily employable, since it is based on familiar standards and legal principles. No group needs to lobby Congress for legislation and no additional federal regulations or programs need to be implemented. The benefit to the documented immigrants is the ability to hit "pause" and ensure that the court tells them what is really happening, instead of having to rely on the potentially incomplete information provided by third-party companies. Rather than capitulating under the burden of mounting medical bills, this process provides documented immigrants with a mechanism to get all the information that is often likely to escape them in this situation. Furthermore, the process serves as a check to prevent third-party companies hired by the hospitals from providing incomplete information to an immigrant that causes him or her to waive an other-

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[60] The question of whether ICE can deport an immigrant without potentially violating federal discharge requirements is beyond the scope of this Article.

[61] *See* Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965).

wise enforceable right to remain in the United States. Finally, ensuring that hospitals and third-party repatriation companies provide material information to immigrants allows hospitals to obtain consent free from collateral, post-transfer attack like that consent at issue in *Montejo*.

The primary benefit of this test for the undocumented immigrant exists in the very gaps in the law that spawned medical repatriations. Federal regulations prevent patient dumping, but no federal funding covers uninsured immigrants' continued care. Hospitals must provide for these patients' bills. While an immigrant's refusal to consent to repatriation may force some hospitals to engage in nonconsensual repatriations, the substantial risk of common law liability may dissuade hospitals from this course. Leaving hospitals to pay for this care is unfair, but it is the current legal landscape that is to blame, as Washington has refused to address the situation. Ultimately, the application of this analysis to undocumented immigrants would provide hospitals with an impetus to pressure Washington to confront the current paradoxical statutory framework and address medical repatriations at a systemic level.

Conclusion

Companies and hospitals should not be allowed to shirk their responsibilities to patients solely on account of the patients' immigration status. Federal guidelines govern the discharge of all patients, and hospitals should be held responsible for meeting these guidelines. Applying the theories of informed consent and unconscionability to federal discharge requirements allows courts to assure that hospitals are meeting their mandated responsibilities to counsel patients pre-discharge. Medical repatriations occur to multiple segments of the immigrant community—documented and undocumented. Until Congress takes appropriate action to regulate medical repatriations, these proposed safeguards should be applied to both avoid erroneously repatriating legal immigrants and ensure hospitals are fulfilling a federally mandated responsibility.