Case 13—Are There Limits on Futile Care for Patients in the U.S. Illegally?

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JG was a 39-year-old Mexican man who was involved in a serious motor vehicle accident in Florida on New Year's Eve. He apparently lost control of his car and slammed into a highway median divider at high speed. JG was not wearing a seatbelt and was thrown from the car, and his injuries were extensive. In addition to abrasions, bruises, and broken bones, he also suffered significant head trauma. JG was taken by ambulance to the Emergency Department of the nearest hospital. He was taken to surgery immediately to repair his shattered pelvis, shoulder and right leg, and he was then admitted to the Intensive Care Unit (ICU) unconscious and breathing with the support of a ventilator.

JG had been residing in the U.S. for approximately 15 years but was undocumented. He was employed in a machine shop and lived with his significant other. The couple was not married and had two children together, ages 8 and 10. JG did not have an advance directive and had not appointed a health care surrogate. His only biological relative living nearby was a male cousin of approximately the same age. The two men were very close and saw one another frequently. The cousin was contacted and he agreed to serve as JG's proxy decision maker. He wanted all available medical treatment to be given to his cousin while his condition and chances for recovery were being determined. Both JG's cousin and partner were concerned about him, and visited frequently in the ensuing days and weeks.

Because JG was living in the U.S. illegally, he had no insurance coverage nor was he eligible for any governmental aid. *Undocumented immigrants* are not eligible to buy health insurance coverage through the Affordable Care Act (ACA), nor are they eligible for premium tax credits or other savings on ACA Marketplace plans. Medicare and Medicaid are also out of the question for *undocumented immigrants*. JG's cousin and significant other lacked the financial resources to pay for his care, and the cost was prohibitive.[1] After 2 weeks, a tracheostomy was performed (for which JG's cousin provided consent) so ventilator support could continue longer term. After 6 weeks in the ICU, JG had transitioned from a coma into what his physicians determined was a persistent vegetative state.[2] JG had brief periods of waking and sleeping, and occasionally moaned or sighed. He required

L. A. Roscoe and D. P. Schenck, *Communication and Bioethics at the End of Life*,
https://doi.org/10.1007/978-3-319-70920-8_13

extensive care; in addition to being ventilator dependent and on a feeding tube, which both required their own care routines, he was catheterized, needed to be turned to prevent pressure ulcers, and had to be treated with antibiotics for a persistent urinary tract infection as well as with anti-seizure medications. JG's cousin and partner were both informed there was no hope for JG to regain a meaningful level of consciousness, and that continuing to provide such intensive care was futile. When discussing options, the hospital's discharge planner said it was unlikely that a nursing home or sub-acute rehabilitation facility would accept JG as a resident because of his undocumented and uninsured status as well as the extent of his care requirements (JG could not be successfully weaned from the ventilator). JG's attending physician explained that it was possible for his cousin to make a decision to stop providing ventilator support, and that JG would be kept comfortable during the process and that his family could be with him as he died. The cousin and JG's partner tearfully discussed what to do, and eventually agreed that removing the ventilator and allowing JG to die peacefully was a sad but necessary decision to make. No immediate date was set for the terminal extubation, but all agreed it should happen soon.

In the meantime, the social worker assigned to JG's floor had discovered that he had a mother who lived in a small town in Mexico, from whom he was estranged. The mother and son had not spoken for over 15 years. A call was placed to JG's mother and her son's dire condition was explained to her. The nature of her son's injuries, the futility of continuing treatment, and the fact that JG would be kept comfortable during the process of discontinuing treatment were all explained in detail, carefully translated from English to Spanish and back again. The hospital administrators had also agreed to pay for JG's body to be embalmed by a local funeral home and transported back to Mexico, with additional funds for a funeral for JG. It was also explained that the mother and her family would not be required to reimburse the hospital, the funeral home, or the airline for any costs associated with JG's care and after-death expenses. After a long conversation, JG's mother tearfully agreed with the plan that had been put in place by the cousin—JG's life supportive care would be removed and he would be allowed to die. JG's mother then asked, "¿Puedo ver a mi hijo una vez mas?" (Can I see my son one more time?) The social worker was able to arrange for a Skype session, of which JG's cousin was unaware. The Skype session was to occur in three days, and the day after JG's cousin and his partner were to come to the hospital to be with JG as he was removed from life support and allowed to die. The funeral home and airline were ready to make their contributions thereafter.

The Skype session took place, and upon seeing her son for the first time in many years, JG's mother pleaded, "¡Usted debe hacer todo para mantenerlo vivo!" (You must do everything to keep him alive!). The nurses caring for JG thought that seeing her son being suctioned would convince her that he was suffering, but instead JG's mother decided that it was the suctioning that caused her son's suffering, not the life support, and she insisted that all life support and other medical care continue indefinitely.[3] She also reiterated the fact that she did not have the financial resources to pay for her son's care. The social worker explained that the hospital was not equipped to provide such care for JG indefinitely, and that an alternative placement for him would need to be determined. JG's mother stated that no appropriate care facilities existed in Mexico and that it would be impossible for her to care for JG in her home.

During his next visit, JG's cousin was told about the Skype session, and he was furious. "JG and his mother haven't spoken in years! I never would have agreed to this plan," he said angrily. JG's cousin was also angry that his decision-making authority had been usurped by the patient's mother, as he felt that he knew JG far better at this point than did his mother, and he was certain JG would prefer for him to be making decisions on his behalf. He stopped coming to the hospital for regular visits, and told the social worker she would now have to deal with the patient's mother instead of with him. He also repeated that neither he nor JG's partner had the financial resources to pay for his continued care, and neither had the space, time, or ability to care for him in their homes. JG's partner was bewildered by this sudden change of events. Both she and the cousin were confused about why JG's mother had been contacted as a proxy decision maker for him, since previously the physicians had been willing to consult with the cousin about medical decisions for JG.

The social worker and discharge planner assigned to JG's case called every possible nursing home facility in the state of Florida, and were unable to locate a facility that would accept JG as a resident. JG continued to receive care in the hospital, much to the chagrin of the nurses and physicians charged with his care, which they believed to be futile and not in his best interest. As of this writing, JG continued to receive care in the hospital, where he has been in a persistent vegetative state for over 6 months. His prognosis for recovery is nonexistent, but his life expectancy, if infections are treated and he remains on life support, is at least several years.[4]

Discussion Questions

1. Who should make medical decisions for incapacitated patients who have not named a surrogate?
2. How are hospitals to provide compassionate care to undocumented and/or uninsured patients while still being good stewards of their financial and other resources (beds, expertise, etc.)?

A Bioethicist Responds

This is another very sad, unfortunate case made all the more disturbing because of the combined social, familial, interpersonal and legal issues that would appear to block an acceptable resolution to the situation in which JG has been left. At first glance, it would appear as if the hospital is faced with having to absorb the long-term costs of his care, which could soon run into the millions of dollars. How, then might this problem be resolved, and what are the ethical issues involved in seeking resolution?

The first major issue to be addressed should be that of withdrawal of the ventilator. As mentioned in the case narrative above, once JG's cousin and partner had discussed his situation with the attending physician, the two former individuals made the only decision they felt proper, which was to allow removal of the ventilator, thus allowing JG to die peacefully. Under normal circumstances, of course, such care and treatment are not simply, or summarily, withdrawn by attending physicians from their hospitalized patients unless patients or their legally appointed representatives have signed consents to this effect, and/or valid advance directives specifying the circumstances under which withdrawal is to be carried out. It is not infrequently the case, however, that in situations of medically incompetent patients, it may little matter what standard practice, a reasonable and justifiable decision of a legally appointed representative, or a clear, unambiguous and properly notarized advance directive may be. Family members, and even close friends, can have widely different opinions about what the patient may have wanted, but physicians and hospitals are not wont to find themselves between factions or facing threatened legal action, even if they may have the "right" on their side.

In point of fact, JG's physician and the hospital do have the right on their side in this case, and they would have been entirely justified in withdrawing the ventilator and allowing him to die in a humane manner as initially proposed and agreed to by all prior to the unfortunate Skype session. Yet nobody able to authorize such a decision would likely do so, for virtually no responsible party, most especially the hospital, would lightly consider the negative publicity that such action would most surely generate. "Care Withdrawn; Illegal Mexican Dies," or some similar headline, is about all that would be necessary to give rise to a scandalous tale about a nameless, faceless, expendable, undocumented person who had entered this country illegally, had enjoyed an American way of life, had perhaps not paid his fair share of taxes, had run up enormous medical bills he was unable to pay, and who, because he was poor, undocumented and needing costly intensive care for an indefinite future, had all his care withdrawn so that he died. Add in reference to his Mexican heritage and the story takes on even greater proportions, while the media volume increases, perhaps, as well.

This case occurred during the extraordinarily volatile 2016 U.S. Presidential Campaign, a time when numerous views on immigration and certain immigrant populations were expressed by different sides; therefore, the facts of JG's national origin and undocumented status can hardly go unnoted here. This is in no way meant to suggest that politics should play a part in bioethical decision-making. In this writer's view, it should not, but since it would be impossible to ignore the facts of this case, the temporal-social context during which it occurred, and issues likely to surface in discussion as a matter of consequence, JG's undocumented status will be addressed. A review of Mexican immigration data will be useful as a first step.

The latest U.S. Census Bureau's American Community Survey (ACS) reports there were over 11.7 million immigrants from Mexico residing in the United States in 2014, thereby accounting for twenty-eight percent (28%) of all U.S. immigrants. The majority of these Mexican immigrants were concentrated in the West and Southwest, with only two percent (2%) estimated to have been living in Florida.

This may appear to be a small number, but considering that the total population of Florida in 2014 was 19,893,297, and that 3,973,515 of them were foreign born, immigrants comprised twenty percent (20%) of the state's population. The official number of foreign- born Mexicans in Florida in 2014 was 282,594.[5] It is further noted that Mexicans represent the largest unauthorized group of foreign-born persons in the U.S., not surprisingly perhaps because of the relatively porous border between the U.S. and Mexico. And of the 610,000 total undocumented persons (from all foreign countries/regions of birth) living in Florida in 2014, 171,000 of them, or twenty-eight percent (28%), were estimated to have come from Mexico.[6] Comparing this figure with that of the total number of foreign-born Mexicans for 2014 (282,594) would mean that approximately sixty-one percent (61%) were undocumented.

The presence of undocumented Mexicans in Florida has been a fact of life for many decades. It is widely believed that the harvesting of fruit and vegetable crops at current market prices simply would not likely occur but for migrant farm workers, most of whom are from Mexico. That more than half of them are estimated to be undocumented is an issue about which direct action appears to have been "deferred" or "suspended" by authorities in the absence of major problems such as crimes against persons, trafficking and blatant illegal attempts at border entry, for the simple reason that Hispanic migrant farm workers are willing to perform labor for wages, often under less than desirable working and living conditions and without recourse, than would most American citizens. Yet throughout the history of immigration into the United States, persons from Mexico have suffered prejudice and discrimination, being viewed mainly as a ready pool of low-paid laborers, as less intelligent than White Americans, as racially inferior, and even as sources of disease.

Natalia Molina's review of American attitudes toward the increasing Mexican population in the United States during the early and middle years of the 20th century offers critical insights into issues surrounding immigrants today (2011). As she points out, immigration laws did not severely restrict Mexican immigration during the very early years of the last century. In fact, restrictive laws did not begin until 1917 with the Immigration Act. However, medical screenings had begun at the U.S.-Mexico border even before that because of concerns to limit admission to a biologically fit working class. Health concerns were coming to a head in 1916 when it was generally believed that Mexicans were bringing disease into the United States. The issue reached its peak in the summer of 1916 with a serious outbreak of typhus in California. U.S. health officials saw Mexicans as the unique carriers of this deadly disease, thereby making race the organizing principle for understanding typhus, which in turn added a medicalized dimension to the nativist views of those who already saw Mexicans as racially inferior to Whites. This linkage between Mexican immigration and disease became further solidified in 1942 in what was known as the Bracero Program, a program jointly operated by the U.S. and Mexican governments by which Mexican workers would enter the U.S. to work in agriculture, on railroads or in other industries. Mexican workers were given rigorous health and psychological exams by both governments prior to beginning work in the U.S., but once settled in their labor camps, conditions there ultimately and ironically led to poor health among this migrant population, and Mexicans became even further stigmatized as bearers of disease. The Bracero Program was discontinued in 1964. In any case, the next step toward seeing Mexicans as undesirables did not have to be a big one.

Molina then convincingly demonstrates that the American view of Mexican immigrants became "medicalized" through association with disease, and they were then deemed undesirable. This then led to their becoming victims of racism, despite evidence supporting the fact that the diseases for which they were blamed were not inherent in them but due to their living conditions once settled in the U.S. No matter. Their association with disease would seem to hold within itself the inevitable foregone conclusion, for she states, "The consistent representation of Mexicans as disease carriers unworthy of social membership in US society led to the conclusion that they were unworthy recipients of publicly funded health care" (Molina 2011, 1029). And this, she affirms, has developed into the current practice found in some hospitals that have repatriated unfunded, undocumented patients requiring long-term care, a practice that serves to justify the belief that these persons are unworthy.

JG was not being cared for in one of those hospitals referred to above that have been repatriating undocumented persons needing long-term care, and the issue here is not to deal with that more global problem. Yet as was suggested earlier, JG's background combined with the socio-politics of the time during which the problems in this case occurred could not have failed to register as factors to consider, however briefly, in the minds of those attempting resolution to his situation. It would be impossible to ignore the obvious: that he was an undocumented person from Mexico; that he had lived in this country for fifteen years; that the image "Mexican" conveys a particular stereotyped image to the American mind; that many Americans hold racist views of Mexicans; and, that since Americans often believe Mexicans to be undocumented, they have no right to the same health care as American citizens. It would be a mistake, however, to fall into the trap of attempting to sort out any of these issues either individually or in groups. The dilemma of what to do regarding JG will never be resolved by approaching it from social, political or legal points of view. In this writer's view, the only fair and humane way to approach resolution to this issue is by asking once again the prudential question: "What is the right thing to do for this patient?"

Identifying the right thing to do in this case will emphasize actions that do good, do little or no harm and are fair. It would be difficult to say what could be done that would do good for JG at this point since his physician has determined there to be no hope for improvement. Surely there are those who would argue that the most good to be done would be to maintain him as he is until his death from natural causes; others would assert that to do so would provide him with none of the goods of life. Inversely, it could be argued that maintaining him in his present condition indefinitely would not only not be doing him any good, but would in fact be doing harm, forcing him to remain alive with no apparent cognitive functions or ability to enjoy being alive.

One could take the position that since JG’s cousin no longer seems willing to accept responsibility as health care surrogate, and that since JG’s mother has no legal standing in the United States to act as his legal surrogate, as she presumably could were he a citizen of this country, his physician and the hospital could decide on the basis of futility to remove the ventilator and allow him to die. This could well be seen as the most beneficent act possible, insofar as continued maintenance and treatment have been judged to be futile. It fairly goes without saying, however, that there will be detractors to this view who would insist that this does nothing but harm in that it causes his death.

The issue of justice or fairness must also be considered not only on the level of what is fair to the individual patient but what is fair to society. A decision to withdraw treatment would ensure greatest fairness, in terms of resource utilization to the hospital, although the institution would not want to proceed without first making every effort to work with the patient’s mother, on a personal level, to help her understand how this could be the right and good thing to do. This could mean sending a special envoy to the mother’s house in the person of a Spanish-speaking counselor, priest, physician or whoever might be viewed as the kind of person capable of communicating with her. It could go a long way to avoiding the negative publicity almost sure to result if the way were not paved ahead of time.

Another solution to the hospital’s dilemma should be a thorough investigation of skilled nursing facilities in Mexico. It has only been reported that JG’s mother has stated that “no appropriate care facilities existed in Mexico,” but there is no indication that the hospital social worker has done the necessary background work to determine the actual situation in Mexico and whether a successful transfer could be arranged.

In any event, despite all the efforts that have already gone into trying to resolve this very difficult issue, questions remain unanswered that should be addressed before it is assumed that nothing is to be done other than expect the hospital to care for JG in his current state for the unforeseeable future. If, in the end, all efforts fail in attempting to work with the mother and hospital to their mutual satisfaction, the hospital should feel comfortable in discontinuing life-support.

A Health Communication Scholar Responds

We include this case in our “end-of-life” casebook even though as of this writing JG was still alive and residing in the hospital that provided his original trauma care. Patients in a persistent vegetative state present a complicated array of end-of-life considerations. Under Florida law, and the laws governing end-of-life care and decision making in many other states, “persistent vegetative state” is explicitly included along with “end-stage conditions” and “terminal diagnoses” as conditions that trigger certain provisions in the law to take effect, such as using advance directives to guide decision-making. A persistent vegetative state is a difficult condition for many families of such patients to come to terms with: Their loved one looks very much alive, and moves and even vocalizes in ways that sometimes appear to be responsive to external stimuli. The brain damage that causes such a state of consciousness is too extensive to make a meaningful response possible, but when one is looking for signs of awareness, such random movements and vocalizations can be imbued with meaning and interpreted as signs of hope for recovery.

The case of Terri Schiavo, the young woman in a persistent vegetative state who lived for 15 years with the assistance of a feeding tube while her husband and parents fought about what they perceived to be her treatment preferences in court, brought these issues into high relief (Roscoe et al. 2006). The Terri Schiavo case was also the first case able to use the power of communications technology to bring her situation before the court of world opinion. Terri's parents posted videos of Terri "responding" to her mother, "laughing" at her father's jokes, and "watching" flashing lights and balloons to the Internet, where anyone and everyone weighed in with their opinions about her level of ability and consciousness. Terri's husband Michael maintained that such unauthorized sharing of his wife's image was an invasion of her privacy; in JG's case the Skype session between the hospital and JG's mother might also be seen in a similar light. Given their long period of estrangement, JG would likely not have chosen this particular moment or set of circumstances to re-engage with his mother.

JG did not leave an advance directive nor did he identify a health care surrogate. For persons in less traditional relationships and living arrangements, it is imperative that they have such documentation of their preferences for medical care, lest someone who no longer knows them well be given decision making authority (as happened in this case). Lesbians and homosexual partners who are not married or whose marriages are not recognized are cautioned to create such a paper trail so their life partners can make medical decisions (or even in some cases be allowed to visit) instead of a parent or other family member who may not approve of their union or be aware of the patient's wishes and desires. Creating such documentation requires a high level of health literacy (Araujo and Roscoe 2011), and given that he was uninsured and undocumented, it is not surprising that JG had not done so.

The laws in Florida specify a hierarchy of proxy decision makers for patients who are unable to make their own medical decisions, and the parent of such a patient is of a higher order than a cousin or an unmarried partner. JG was estranged from his mother in Mexico for many years, and even though she outranked the cousin in terms of Florida law, she was perhaps not the most suitable decision maker for her son. What was the hospital to do in this case? Pretend that JG's mother did not exist and therefore defy both state law and hospital policy? What they did do was aligned with the letter of the law, but not its spirit, which is to identify a person who either knows the patient's wishes and can use substituted judgment to make decisions, or knows the person well enough to decide what course of treatment might be in his or her best interest if they have not documented their treatment preferences.

Once a suitable proxy is identified, the appropriate process for decision making can be determined. One approach to end-of-life decision making is to weigh the relative benefit of a proposed medical treatment against whatever burdens accepting the treatment might entail. "Burden" need not be limited to the individual patient's experience, although this calculation must account for each patient's specific circumstances. Burden can include financial burden to the family—one is not required to accept treatment that would bankrupt one's family, for example. In JG's case, we have a skewed equation to solve; the benefit/burden ratio cannot apply in the same way when the family bears no financial responsibility for the patient's care. It would be heartless to withhold medical care from a person likely to recover some level of function and cognition because they lacked financial resources, but in JG's case, such an outcome is not possible. His mother's decision to continue aggressive life supportive care costs her nothing as she has no monetary assets to contribute, nor does she bear the burden of visiting her son or making any other arrangements for his care. She has made one decision that obligates the hospital to an indefinite financial burden, not to mention the burden of moral distress that the staff bears in caring for a patient whose care they believe is futile.

The decision put forward to JG's cousin and eventually to his estranged mother was whether ventilator support should be continued. For some families, discontinuing ventilator support is more straightforward than discontinuing tube feeding since ventilators are more "machine-like." Since JG was not able to be successfully weaned from the ventilator, he would have died quickly once it was removed, and no decisions about discontinuing tube feedings would have to be made. Human beings tend to associate food with comfort, and we wish to comfort and feed those we love, especially when they are ill. It is difficult to think about withholding food and water from our loved ones, even if doing so prolongs their lives in conditions they might find unacceptable. The idea that we might be "starving" our loved one is nightmarish, even though dying persons often choose to forgo eating and drinking as death approaches and the body begins shutting down. Medical science tells us that such a process is normal and comfortable, and that to force feed nutrients and liquids can increase the discomfort of a dying person by a considerable degree. A patient in a persistent vegetative state like JG is not able to perceive hunger, thirst, or any discomfort associated with either stopping or continuing tube feedings. That medical fact, however, did little to comfort Terri Schiavo's parents in the days after her husband successfully petitioned the court for permission to remove her feeding tube for the third and final time.

JG's case is one in which the spirit of our laws and ethical precepts governing and guiding end-of-life decisions come into conflict with the "letter of the law." The disconnects are many—a calculus of benefit and burden where one side benefits and the other is burdened; between a hospital's mission to provide compassionate high-quality care to all who enter and their obligations to be good stewards of their limited resources, such as money, space, and expertise. The disconnect between the Florida law's specification of biological relatives as proxy decision makers and those who might be in the best position to know the wishes of an incapacitated person, and the impracticality of relying on a document specifying medical care directives for persons who are undocumented and forced to live a shadowy life regarding their relationships with institutions such as hospitals and government agencies are also significant. There are disconnects in communication as well. Unlike many of the cases included in this book, here we seem to have helpful and clear communication between family members and hospital personnel, but still no straightforward resolution to this difficult situation. Hospital personnel, in following the letter of state law and institutional policy, were successful in identifying a family member higher up the proxy list than a cousin, alienating JG's cousin and eliminating his ability or willingness to either serve as a proxy or attempt to influence JG's mother's decisions. JG cannot speak for himself, but was nonetheless a participant in a dialogue with his mother that he may never have initiated. The use of technology was intended to bring closure, an attempt which backfired spectacularly, and started a new and difficult series of decisions with no straightforward resolution.

What is to happen to JG and others like him? This is far from an isolated case, as developed nations struggle to deal with a never-ending stream of immigrants seeking a better life away from strife, warfare, oppression, and limited economic opportunities. It is not likely that another lower cost health care facility can be found that would accept an unfunded patient with extensive needs for care and a long life expectancy such as JG, and it seems unlikely that JG's mother will change her mind about continuing his care in light of the fact that she bears no burden of inconvenience, financial obligation, or even the stress of attempting to have a continuing relationship with her son. It is likely that JG will develop pneumonia or a urinary tract infection, either of which could become life-threatening if antibiotic treatment is not initiated in a timely way. Is it possible that such a decision would become, in effect, a kind of "slow-code" in which antibiotics would not be immediately initiated? Again, it seems unlikely that JG's mother would decide that such medications should be withheld and under the present circumstances it seems she would need to be consulted. And what if JG dies, despite all aggressive treatments being brought to bear? His mother would likely lack the funds necessary to bring his body to Mexico, and the end to his story might be cremation at the city morgue and burial outside the city limits. It is a sad story, one made sadder by well-intentioned people attempting to follow well-intentioned policies, while the actual person in the bed goes unnoticed.

Notes

[1] See Dasta, Joseph F., Trent P. McLaughlin, Samir H. Mody, and Catherine T. Piech. 2005. Daily cost of an intensive care unit day: The contribution of mechanical ventilation. *Critical Care Medicine* 33: 1266–1271.

These authors' retrospective cohort analysis of the National Data Center Health's Hospital Patient Level database estimated the cost of intensive care for patients requiring mechanical ventilation at $10,794 for the first day, $4796 for day two, and $3968 for day 3 and beyond (in 2002 dollars). Those figures adjusted to 2016 dollars (using http://www.bls.gov/data/inflation_calculator.html) would put the cost of JC's first two weeks of care at close to $85,000, with an estimated cost of $37,000 per week subsequently.

[2] Jennett, Bryan, and Fred Plum. 1972. Persistent vegetative state after brain damage: A syndrome in search of a name. *The Lancet* 299: 734–737 (originally published as Volume 1, Issue 7753).

According to Jennett and Plum, patients with severe brain damage due to trauma or ischemia may survive indefinitely. Some never regain recognizable mental function, but recover from sleep-like coma in that they have periods of wakefulness when their eyes are open and move; their responsiveness is limited to primitive postural and reflex movements of the limbs, and they never speak. Such patients are best described as in a persistent vegetative state, which should be clearly distinguished from other conditions associated with prolonged unresponsiveness. What is common to these patients is the absence of function in the cerebral cortex as judged behaviorally.

[3] The upper airway warms, cleans and moistens the air we breathe. The trach tube bypasses these mechanisms, so that the air moving through the tube is cooler, dryer and not as clean. In response to these changes, the body produces more mucus. Suctioning clears mucus from the tracheostomy tube and is essential for proper breathing and to prevent a chest infection if the secretions left in the tube become contaminated. Therefore, there is a logical inconsistency in JG's mother's reasoning since continuing ventilator support would necessarily entail continued suctioning.

[4] The Multi-Society Task Force on PVS, (1994). Medical aspects of the persistent vegetative state. *The New England Journal of Medicine, 330,* 1572–1579. The Task Force reported the mortality rate for adults in a persistent vegetative state after an acute brain injury such as JG's as 82% at three years and 95% at five years; approximately 90% of patients died within 10 years.

[5] Migration Policy Institute (MPI) Data Hub, State Immigration Data Profiles Chart, **Florida—Demographics and Social**, *sources*: Migration Policy Institute tabulations of data from the U.S. Census Bureau's American Community Survey (ACS) and Decennial Census. Unless stated otherwise, 2014 data are from the one-year ACS file. Estimates from 1990 and 2000 Decennial Census data as well as ACS microdata are from Ruggles, Stephen, Matthew Sobek, Trent Alexander, Catherine Fitch, Ronald Goeken, Patricia Hall, Miriam King, and Chad Ronnander. 2011. Integrated public use microdata series: Version 4.0. (Machine-readable database, Minnesota Population Center [producer and distributor]; downloaded from www.migrationpolicy.org on 10/28/2016).

[6] Migration Policy Institute Data Hub, Unauthorized Immigrant Population Chart, **Profile of the Unauthorized Population: Florida**, *source*: Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2014 American Community Survey (ACS), 2010–2014 ACS pooled and the 2008 Survey and Income Program Participation (SIPP) by Colin Hammar and James Bachmeier of Temple University and Jennifer Van Hook of the Pennsylvania State University, Population Research Institute; downloaded from www.migrationpolicy.org on 10/28/2016.

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