Bordered Resistance: Immigrant Health Justice, Biocitizenship, and the Racialized Criminalization of Health Care

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Teresa Gowan, Lisa Sun-Hee Park, Co-Advisers

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border as well as those currently crossing or struggling to survive under the harsh realities
of punitive immigration enforcement. Hasta un mundo libre de la violencia de las
fronteras.
Abstract

Bridging critical health and migration studies, this dissertation examines the health effects of racialized processes of immigrant criminalization, focusing on the organizations that provide medical care in an informal, often underground, health system. Governed by a “biopolitics of disposability” (Giroux 2006), immigrant ineligibility for health care contributes to undocumented migrants’ experience as distinctly vulnerable, exploitable, and ultimately disposable. Whereas health institutions are usually figured as solutions to the violence embodied in unequal health outcomes, this dissertation argues that spaces of health are also perpetrators of structural violence. Clinics operate as de facto border checkpoints, leaving migrant patients susceptible to deportation for accessing emergency medical services. In the face of the violence of the mainstream health system, a network of humanitarian organizations provide health care to uninsured, undocumented migrants, while resisting the collusion between health and immigration enforcement. In contrast to medical humanitarianism’s focus on constructions of migrant “deservingness,” this dissertation argues that the concept of biocitizenship, a medicalized belonging based on common humanity, transcends dichotomies of deserving and undeserving, “good” or “bad” migrants. Biocitizenship also critiques the disentitlement and dehumanization of a biopolitics of disposability.

Drawing from twelve months of ethnographic fieldwork with free clinics and humanitarian organizations across Arizona, this dissertation examines immigrant health justice (IHJ) organizations’ use of humanitarianism as both a discursive strategy and a field of action. In the borderlands, IHJ organizations frame their politically-contentious
work as apolitical medical care and fight for the recognition of the patient status of migrants in need of emergency first aid. In the interior, the IHJ turns its critique toward “health” itself. Employing a rights-based humanitarian discourse, activists castigate the for-profit health system as complicit with immigration enforcement, indicting it for mass structural violence. Centrally, this dissertation argues that these related but distinct discourses across the borderlands and interior amount to an insurgent humanitarianism that exposes the fatal consequences of immigrant criminalization. By claiming various biocitizenships on behalf of their patients, IHJ organizations and activists use medicalized language as the basis of a politics of visibility, highlighting the health needs and fatalities of migrants across the country.
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Preface

Into the Field

“Welcome to the United States!” Michael said in Spanish, shining a light into the back of the patient’s throat. With his mouth wide open, Enrique could not respond but looked around with a similar uncertainty I’d seen in the clinic’s newer patients.

Nothing about his appearance indicated he had just survived a perilous week-long journey across the border, walking through the remote deserts and mountains of southern Arizona. Somewhere in his late thirties, a little overweight, and wearing a t-shirt and jeans, he more or less fit the description of the clinic’s other patients – he was an uninsured, undocumented Latino immigrant with a relatively-minor health complaint. Because of his lack of insurance and papers and fear of deportation however, he could not access medical care in the mainstream health system.

For Enrique, this fear was exacerbated by the fact that his health complaint stemmed from his recent border crossing – a potential case of valley fever. Valley fever is a respiratory infection caused by a fungus that thrives in dry desert conditions. Although not contagious, it is contracted by breathing in the fungus from dust kicked up by the desert breeze. As such, many landscapers in the Sonoran desert region of Arizona get valley fever, as do people who have recently walked across the desert borderlands. In most cases, the infection passes quickly, often mistaken for a bout with the flu, but in relatively rare circumstances, it has serious and even life-threatening consequences.

With the motto of “not replicating a free version of a broken system,” CommUnity Clinic of Phoenix (CCP) was more than a clinic where 500 undocumented
immigrants, like Enrique, were able to access free medical care. The volunteers worked to achieve a vision of immigrant health justice, in which their patients would have access to a similar quality care that insured U.S. citizens received and in which they did not have to live in the shadows, in constant fear of being detained and deported away from their families and lives in the U.S.

“Abra la boca,” Rosa said as she put a thermometer under his tongue. Rosa was a new nursing student volunteer from the Latino Nursing Association who had just started a six-month internship at the clinic. She pinched an oximeter onto his index finger to read the oxygen levels in his blood and waited for the numbers on the screen to stabilize. As Rosa took his vitals, Michael asked Enrique about his symptoms, “Do you have any pain in your joints? Have you had a headache? Any pain in your chest? Have you noticed a rash on your skin anywhere?” Enrique shook his head in response to each question.

“Tell me more about your journey,” Michael tilted his head. Enrique recounted briefly a few details about his crossing – waiting for nightfall at the small house along the border where the coyotes had brought him and his group, crossing over the border and into the remote desert of southern Arizona, traveling with the group at night guided only by the light of the moon and stars, and moving quickly, almost running, through the dark forests of cactus that snagged his skin and clothes. He also recounted the ones who had been left behind when they couldn’t keep up with the pace. “We all gave them a little of our food and what water we could spare,” he said. He hoped they made their way on their own somehow, or that Border Patrol found them in the desert before it was too late.

“How brave you are!” Michael exclaimed. “You are so brave to make the journey. We are glad that you made it.” Earlier in the day, Michael had been abuzz with the
impending arrival of this patient, who had contacted the clinic through an informal network of people across Arizona – many of them nurses – that provide shelter for immigrants who recently crossed the border or were released from detention. As an “emergency patient,” Enrique bypassed the usual intake procedures.

All of the exam rooms were occupied with scheduled patients for the day, so we were crammed into the clinic’s small lab. Enrique sat on the chair used for blood draws, while Armando, on whose couch he was sleeping for a few weeks, perched on the exam table used for EKGs. Rosa and I hovered at the other side of the room as Michael examined Enrique. He unwrapped a stethoscope from around his neck, put the tips into each of his ears, and rubbed the flat end to warm it up before putting it on Enrique’s back between his shoulder blades. “Breathe in,” Michael said. “And out.” He moved the stethoscope to the other side, listening to Enrique’s lungs. “Okay, in again, now out…Good,” he said after a minute, as he removed the stethoscope from his ears and slung it back around his neck. “Without further testing it would be very hard to diagnose whether this is in fact valley fever. I don’t believe that it is, but I’m going to come visit you for a house call later this week to make sure that your cough is improving and you don’t have any other symptoms. Would that be okay?”

As Enrique and Armando prepared to leave, Michael said in Spanish, “Congratulations on your journey, señor. You are brave, so very brave, and we are honored to have you here in the United States.” Michael reached out to shake Enrique’s hand and made a little bow to him. Enrique looked uncomfortable, unsure how to respond to this burst of emotion and gave an embarrassed laugh before walking out with Armando.
After they had left the lab, Michael turned to us, animated from the encounter, and said, “That’s something you wouldn’t get at just any clinic.”

The howl of a coyote—too near my tent for comfort—jolted me awake, and the adrenaline coursed through my body. Other coyotes barked and yipped in response, calling to each other across the small valley where we had set up camp. I had seen the remnants of the cans of beans we left for migrants in the desert, chewed open by their powerful jaws, and hoped to never encounter one personally.

Volunteers began stirring in their tents. To beat the heat as much as possible, we were awakening at dawn to load the trucks with hundreds of gallons of water, cans of beans, socks, and medical supplies. Committed to ending suffering and deaths in the Arizona borderlands, since 2004, No More Deaths (NMD) has distributed life-saving humanitarian aid and emergency medical care to people crossing the desert on foot. In roughly that same amount of time, NMD volunteers and other groups in the borderlands have found the remains of over 8,000 people in the deserts and mountains along the U.S.-Mexico border. These bodies represent only a fraction of the migrants who have died. The rest are never found, their bones scattered by coyotes or claimed by the desert.

As we drank sludgy “cowboy coffee” that left a thick layer of grounds at the bottom of our tin mugs, the other drivers and I circled around to divvy up the routes for the day. “How about Ori’s group takes the North Cooler Drop, Gianna’s group can do East Mountain, and we’ll do Wild Ass Pass?” suggested Cody, a core volunteer in her early thirties who had moved to Tucson just to work with NMD. She had a dark tan and
her hair had bleached blond from her many days in the desert sun. In remote areas with unknown names, the routes had been given their own titles based on local landmarks or geological features—random items, coolers or even bikes, left in the desert; old abandoned wells; or places where wild donkeys roamed the landscape. We divided into groups, making sure that each truck had at least one volunteer who spoke Spanish and another with medical or wilderness first aid training. With a full day ahead of us, navigating along the steep embankments and through the dry sandy washes meant that we could only creep along at a snail’s pace, before parking the trucks and hiking the rest of the way to the “water drops,” caches of humanitarian aid supplies located at specific GPS points along the migrant trails.

At the edge of the bombing range, we parked just inside the barbed wire fence and stopped to call in our information to the security firm. Everyone who entered the bombing range, which covers a large swath of southwest Arizona, was required to have a special permit. When we entered and exited, we had to call in the permit numbers for each volunteer and the license plate numbers of the trucks. We were only allowed in the areas of the bombing range that were no longer used for military exercises, although the informational video when we got our permits warned us to look out for “unexploded ordinances” (see Figure 1). Throughout the day, our hikes were punctuated by the explosions of bombs dropped from military planes nearby.

By the time migrants have reached the bombing range, they are over sixty miles from the border as the crow flies, having spent days, if not more than a week, walking in the desert. At that point, any water they have carried across from Mexico is long gone. Some days, the bombing range’s private security left us alone, but other times, they
would stop and question us on our way out of the bombing range, saying, “You know that is littering, right? You’re just encouraging illegals to keep walking instead of turning themselves in.”

Figure 1: The Barry M. Goldwater Bombing Range covers 1.9 million square acres of Sonoran desert across southwest Arizona.

The GPS device beeped, indicating that we had neared the place to park for the first drop. “Pull up there,” Cody pointed where I could see the faint outline of tire tracks in the dirt. The four of us jumped out of the truck, stretched, and began arranging supplies into our large backpacks. Cody reset the GPS device to the coordinates for the drop and checked the logbook. “Okay, so no one’s been to this drop in several weeks.
Last time, they left 11 gallons of water and 7 cans of beans. Let’s make sure we have at least that much with us.” Amani, a nurse practitioner from New York who was volunteering for NMD for a month, hopped up into the bed of the truck and started passing down gallons of water and cans of beans to the rest of us. I grabbed the medical kit from behind the driver’s seat.

Weighed down by supplies, we hiked until we saw a crudely-built water trough made by piling up cement around an area where water would naturally pool after Arizona’s monsoon rains that turn the dry arroyos into fast-moving rivers. A few troughs like this one are scattered across the vast Sonoran desert, usually built by ranchers to capture water for their livestock. Migrants who stumble upon these troughs are often so desperate that they drink the contaminated water, making themselves sick and causing intestinal distress that swiftly and dangerously dehydrates them in the desert heat. As we approached the trough, flies and bees swarmed around the putrid smelling water. Peering over the edge, I saw the water was covered in a shockingly bright green algae. Only someone beyond desperate would consider drinking it.

We all slung our heavy backpacks to the ground and spread out for our usual hike around the periphery of the drop, looking for signs of use – empty cans of beans or water jugs – or even someone in distress, or worse. Recently, in the span of five days, other NMD volunteers had found four bodies in this area. If a drop was completely cleared out with no rubbish left behind, then the supplies had most likely been confiscated by the bombing range security or Border Patrol officers before migrants could find them. Amani and I started unloading the full water gallons and cans of beans, lining them up on the ground. Cody passed around permanent markers to all of us. We began to draw artwork
on the outside of the jugs and cans – renditions of desert landscapes, a sky full of a moon and stars, and inspirational messages for the people who would be consuming them. On other water jugs, we wrote “agua pura” and warning messages about drinking the water from the trough – “El agua verde es igual a la muerte.” These messages were meant as more than caution or encouragement; coyotes discouraged migrants from drinking the water, telling them that the supplies were provided and tracked by Border Patrol. It would be hard to believe however that Border Patrol would have drawn a flowering ocotillo cactus surrounded by the message, “De sus amigos trabajando por un mundo sin fronteras.” From your friends working for a world without borders.

After Enrique and Michael had left the lab, Rosa stayed behind and leaned against the wall. She seemed lost in thought. I cleaned up in preparation for the next patient, using bleach wipes to disinfect the chair and changing to fresh paper on the exam table. In between patients, the lab was a place where volunteers hung out and talked about life, or debriefed when they had a particularly hard appointment.

“Before I started volunteering here, I had no idea that there were clinics like this,” she said quietly, looking down at her feet as she talked. “I haven’t really told anyone here this story, but my brother tried to make the journey across the border. He called us after he was back in Mexico. He had turned himself in to Border Patrol so that he could go back. He was sure he was going to die in the desert and terrified of the noises that he heard in the night – the howl of coyotes all around him. He was scared for his life.” She sighed and wiped her hand across her eyes, “When he got back, he called us to say that he was staying in Mexico. He said he would never make the journey again; he was sure he
wouldn’t survive it. He still has nightmares about the bodies he saw lying along the trails.”
Chapter 1

Introduction: Racialized Criminalization of Immigrants and the Ordinary Crisis of Immigrant Health

Borders are both material and symbolic. The continued fortification of the physical border has cost billions of dollars in the development of infrastructure, including the building of “the wall” and the installation of high-tech surveillance equipment, as well as the increase of Border Patrol capacity to monitor and surveil the borderlands. The symbolic demarcation of the nation – who is included and who is excluded – has required patrolling rhetorics of citizenship and migration (DeChaine 2012; Flores 2003; Ono 2012; Ono and Sloop 2002; Santa Ana 1999). Characterizing the U.S. “body politic,” this symbolic fortification uses metaphors of health, among others, to signify boundaries of belonging. In these metaphors, the U.S. nation state is figured as a (white) body whose health is impacted by the influx of immigrants (of color). Anti-immigrant tropes depict migrants as vectors of disease, pollutants, or contagions against which to be inoculated (Cisneros 2008; Kraut 1995; Mckiernan-González 2012; Markel and Stern 2002; Santa Ana 1999; Shah 2001; Stern 1999), as invading parasites attempting to leech nutrients off the citizenry (Inda 2000), or even as indigestible (or unassimilable) food to be eliminated through purging or defecation (Councilor 2017). Steeped in racist ideology and caricature, these pathological tropes form the foundations of belonging that demarcate which immigrants are welcome in the U.S. and incorporated into the “melting pot,” and which remain excluded.
Along with mythologies of immigrant economic dependency, the public health risk that immigrants supposedly pose to the U.S. citizenry as well as the (anticipated) costs of their health care have served as some of the main reasons for immigrants’ exclusion from the U.S. (Luibhéid 2002; Ngai 2004; Park 2011). Conjuring historical images of lines of would-be immigrants awaiting medical inspection at Ellis Island, this racialized pathologization has translated into exclusionary policies and punitive immigration enforcement tactics, denying immigrants entry to the U.S. at both the border or port of entry and rendering immigrants “illegal” and deportable well into the country. In this way, the inclusion and exclusion of immigrants in the U.S. are maintained by categories and metaphors of health, which in turn, perpetuate immigrant health inequalities.

The continued relationship between health and immigration enforcement has given rise to an “ordinary crisis” (Berlant 2008) of immigrant health in the U.S. Characterized by extended and prolonged processes of dehumanization that are punctuated by moments of acute emergency, the “ordinariness” of this crisis is marked by the mundane illegibility of the health needs, and even deaths, of migrants across the U.S. This includes the invisibility of the countless and unaccounted for immigrant fatalities in the militarized borderlands as well as the deaths of migrants across the interior of the country as a result of untreated health conditions. In the borderlands, border fortification and immigration control strategies force immigrants to cross in the harshest desert terrain with little access to food and water, resulting in thousands of migrant deaths (Doty 2007, 2011; Nevins 2007; Walter, Bourgois, & Loínez 2004; Williams 2015). In the interior, undocumented immigrants remain ineligible for public health care and face heightened
barriers to health care access, which translate to lower health care utilization and worse health outcomes (Akincigil et al 2011; Hacker et al 2015; Ku and Jewers 2013; Ku and Matani 2001; Siddiqi et al 2009; Martinez et al 2015). The absence of access to formal health care means that common medical conditions, like diabetes and high blood pressure, often go untreated and lead to debilitating health consequences, and even death (Barnes and Lu 2012; Coffman, Norton, & Beene 2012; McEwen et al 2007; Page-Reeves et al 2013; Ursua et al 2014; Zallman et al 2013). Taken together, the spatialized qualities of the immigrant health crisis denote the larger “biopolitics of disposability” (Giroux 2006) that marks the experience and existence of immigrants in the U.S.

Defining the exclusion and precarity of (unauthorized) immigrants, racialized constructions of “illegality” exacerbate the crisis of immigrant health care in the U.S. (Castañeda 2009; Castañeda et al 2015; Viruell-Fuentes 2007; Viruell-Fuentes, Miranda, & Abdulrahim 2012; Heyman, Núñez-Mchiri, & Talavera 2009; Ruiz-Casares et al 2010). Critical migration scholars argue that “illegality” affects immigrant health access and health disparities (Hacker et al 2012, 2015; Martinez et al 2015; Rhodes et al 2015; Quesada 2012). For instance, Hacker et al (2011) find that fear of deportation, fear of collaboration between local law enforcement and Immigration and Customs Enforcement (ICE), and concern about the documentation required to get health insurance and medical services keep immigrants from accessing health care and cause heightened levels of stress, negatively affecting their emotional well-being. Specifically, Hardy et al (2012) and Toomey et al (2014) have found that punitive immigration enforcement legislation, in particular Arizona’s SB 1070, has contributed to a marked decrease in preventative health care use and health-seeking behaviors among immigrants in the state. Even in the
midst of a life-threatening medical emergency, fear of detection and apprehension as a result of receiving medical care renders the mainstream health system further inaccessible (Berk and Schur 2001; Cartwright and Manderson 2011; Castañeda 2009; Castañeda et al 2015; Kline 2017; Maldonado et al 2013; Park 2011; Quesada 2012; Vargas et al 2017). As a result, immigrants with health needs are forced to either forego necessary medical care or access substandard care in informal medical spaces and underground free clinics.

In response to this health crisis, a loose network of immigrant health justice organizations and activists, whose work is described in the preface, assert the biocitizenship of undocumented immigrants by arguing for their status as “patients.” This network is not only involved in the provision of free medical care and humanitarian aid to uninsured immigrants but also mobilizes against the policies and enforcement tactics that criminalize their patients. Immigrant health justice organizations and activists (or the IHJ), I argue, use medical humanitarianism as both a discursive frame and a field of action to challenge the health crisis caused by patterns and processes of immigrant “illegality” and punitive immigration enforcement. The IHJ employs discourses of health and humanitarianism as both a weapon and a shield: on the one hand, these discourses provide the basis for a critique of the fatal consequences of immigrant criminalization, while on the other hand, they frame a strategic legitimation of the IHJ’s politically-contentious work as life-saving medical provision and the status of migrants as “patients.”

The discursive strategies associated with the IHJ’s medical humanitarianism largely vary depending on the geographic location within which the organizations and activists work and the socio-political implications of space in relation to the border. At its
core, “illegality” is a spatialized condition that varies by geographic and sociopolitical factors, including proximity to the border as well as the confluences of local and federal anti-immigrant rhetoric, policies, and enforcement tactics (Coutin 2005; Menjívar and Kanstroom 2013; Peutz and de Genova 2010). This dissertation takes into account the spatial variation of constructions of immigrant “illegality,” from the totalizing criminalization experienced by migrant border crossers to the partial and contingent marginalization of immigrants residing well within the nation’s borders. Within the “militarized borderlands” and the “borderized interior,” processes of immigrant criminalization lead to adverse health outcomes that ultimately prove fatal for thousands of migrants across the U.S. In the highly-politicized space of the militarized borderlands, IHJ organizations frame their work as apolitical humanitarian aid and medical provision in response to a humanitarian crisis. Their “insurgent humanitarianism” is asserted against border militarization and the totalizing criminalization of immigrant patients within this zone. In the borderized interior, discourses of humanitarianism are wielded as an indictment of the “broken systems” of immigration and health and the collusion between immigration enforcement and health care institutions. Taken together, the IHJ’s approach across these zones equates to an insurgent humanitarianism that frames their politically-contentious work as medical provision and argues for the biocitizenship of undocumented migrants across the country by asserting their status as patients. Exposing the “biopolitics of disposability” (Giroux 2006) experienced by undocumented immigrants, the IHJ engages in a politics of life and death, accounting for migrant fatalities by making them visible, not only the deaths of migrants crossing the deserts in
the borderlands but also the deaths of uninsured immigrants denied health care in the interior of the country.

**Significance of Study: Toward a Critical Analysis of Immigrant Health (Justice)**

Bridging medical sociology and anthropology, critical migration and critical health studies, this dissertation focuses on two interrelated issues: 1) the violence embodied by migrant-patients that results from immigration enforcement and 2) the organized response of immigrant health justice organizations and activists that use medical humanitarianism to address the health needs of migrants, while highlighting the health effects of punitive immigration enforcement. My dissertation centers the health effects of immigration enforcement, in particular “the collusion between state and medicine in matters of deportation” (Nijhawan 2005: 276). In addition to Nolan Kline’s (2017) assertion that immigration enforcement is both criminogenic and pathogenic in its impact on immigrant health, my dissertation argues that mainstream health care has similar effects. In denying the medical needs of uninsured, undocumented immigrants, the health system also contributes to the deterioration of migrants’ health and their untimely deaths. At the same time, the clinic (in the formal health system) increasingly operates as a de facto border patrol checkpoint, rendering undocumented immigrants susceptible to the immigration enforcement apparatus, or even worse, privately deporting immigrant patients with acute health needs.

In response to the “ordinary crisis” of immigrant health, the IHJ uses discourses of health as an indictment of the fatal consequences of immigration enforcement. My work centers the organizations and activists providing medical care for migrants in an
informal, often underground, health network, while mobilizing against the racialized criminalization of their patients. This resistance amounts to an “insurgent humanitarianism” asserted against the health effects of immigration enforcement. Within the borderlands and interior of the U.S., migrant criminalization varies from automatic and totalizing (specifically in border crossing areas) to partial, contingent, and unpredictable. Within these zones, different mobilizations for IHJ organizations within Arizona are curtailed or arise as a result of the spatialized qualities of “illegality,” as the IHJ launches a resistance to punitive immigration policies and enforcement and a health system that denies immigrants access to medical care. In the totalizing criminalization of the borderlands, their provision of medical care and humanitarian aid is more overtly positioned in direct conflict with the militarized presence of the Border Patrol, while in the interior, partial and contingent migrant criminalization enable IHJ organizations to leverage an overtly politicized critique. This critique draws attention to the structural violence perpetrated not only by the border enforcement apparatus but also by the mainstream health system and its collusion with immigration enforcement.

Through my empirical cases and theoretical approaches, this dissertation makes several contributions to scholarly inquiry in the areas of critical health, migration, and social movement studies. First, I contribute to a growing area of medical sociology and anthropology, critical health and migration studies that engages a social determinants of health analysis of immigrant health disparities (Castañeda et al 2015; Viruell-Fuentes et al 2012; Viruell-Fuentes 2007). This approach takes seriously the structural and biosocial factors that impact the health outcomes of uninsured, undocumented immigrants in the U.S., including poverty, anti-immigrant racism, and immigration status. The
acknowledgement of these structural factors is itself a direct critique of a cultural approach to immigrant health disparities. Rife within immigrant health literature, this acculturation framework problematically engages individualized and assimilationist explanations for differences in health outcomes between migrants and citizens. This framework centers an “immigrant health paradox,” in which Latinx migrants in particular initially experience better health outcomes than U.S. citizens of higher socioeconomic status. Critical migration and health scholars have questioned the reliance of this research on culture and acculturation, rather than on an evaluation of the structural factors underpinning immigrant health disparities (Castañeda et al 2015; Viruell-Fuentes et al 2012; Viruell-Fuentes 2007). They have also argued that the fear created by immigration enforcement operates as a social determinant of health, contributing to the health inequalities of uninsured, undocumented immigrants in the U.S. (Hacker et al 2011; Hardy et al 2012; Kline 2017; Maldonado et al 2013; Miller and Rasmussen 2010; Rhodes et al 2015; Silove et al 2001; Valdez et al 2013; Viruell-Fuentes 2007; White et al 2014). My dissertation argues that this fear is exacerbated by the collusion between immigration enforcement and the formal health system in the detention and deportation of immigrant patients. More than elevated blood pressure and glucose levels, the health effects of immigration enforcement and its collusion with health institutions perpetuate a “biopolitics of disposability” (Giroux 2006) that maintains uninsured, undocumented immigrants as an exploitable low-wage labor force, whose health needs are unrecognized and whose deaths are unremarkable.

Second, my dissertation contributes to an emerging area of scholarship in critical health and migration studies that asserts the relevance of biocitizenship for noncitizens
(Chavez 2018). I argue for the importance of recognizing claims of a substantive biocitizenship that is not predicated on formal membership with the state. Used in this way, biocitizenship is a particularly important as a concept for 1) interrogating the ways that the state itself, through immigration policy and the enforcement apparatus, perpetuate “biological damage” on the health and bodies of immigrants, 2) acknowledging the ways that medicine and the state collude not only in matters of deportation but also in matters of the life and death of immigrants, and for 3) recognizing the collective resistance and challenges to the biopolitics of disposability that renders uninsured, undocumented immigrants invisible, exploitable, and ultimately disposable. In this way, my dissertation argues for the importance of examining immigrant health disparities outside of constructions of deservingness and undeservingness.

Third, my dissertation contributes to analyses of health social movements and the emerging literature on medical humanitarianism in the U.S. I demonstrate the way that the immigrant health justice activists and organizations at the heart of my research deploy the apolitical and even “sacred” categories of health and humanitarianism as discursive strategies to frame the health needs of immigrants and to legitimate their own politically-contentious work in the borderlands and interior. Although it raises its own challenges, these IHJ organizations rely on the objectivity of biomedicine and the neutrality of humanitarianism to legitimate the patient status of migrants as well as to argue for the legality and legitimacy of their own work as medical provision. In this way, they portray their direct action against the militarization of the border and the exclusionary policies of immigration and health as apolitical medical provision, using these discursive tactics to cut through constructions of uninsured, undocumented immigrants as “illegal” and
“undeserving.” I use the term “insurgent humanitarianism” to describe the ways that the IHJ strategically deploys discourses and practices of humanitarianism against the fatal effects of immigration enforcement.

**Situating the Study Theoretically**

*Racialized Criminalization and the Biopolitics of Disposability*

Far from a fixed category, “illegality” is socially, culturally, and politically constructed, in particular through anti-immigrant legislation that selectively criminalizes residence within the bounds of a nation-state as well as racist tropes about “illegal aliens” (De Genova 2002; Ngai 2004). States criminalize migrants and migration not only by designating categories of individuals as “illegal” through immigration law but also by then generating the apparatuses of border control and surveillance through which migrants are policed and marginalized. This process leads to a paradox, “the ‘illegality problem’ is entirely the product of a state’s decision to make irregular entry ‘illegal’” (Amaya-Castro 2011:143). In other words, both the problem of and solution to “illegality” are inventions of the state and are used to justify state surveillance and repression. Far from benign or even neutral, immigration policy not only constructs immigrants as “illegal” but also creates a precarious status for unauthorized immigrants that facilitates their exploitation.

At their core, constructions of “illegality” amount to a racialized criminalization of migrants (that extends as well to citizens of color). The anti-immigrant legislation and enforcement that produces migrant “illegality” uses a supposedly color-blind legal framework, but this framework serves to “justify and mask racist ideologies under a guise
of ‘law’” (García 2017:474; see also Aranda and Vaquera 2015; Childers and García 2016; Dowling and Inda 2013; Romero 2008b). In analyzing the criminalization of immigrants as a racial project, Provine and Doty (2011) argue, “Contemporary policy responses to unauthorized immigration… reinforce racialized anxieties by (a) focusing attention on physically distinctive and economically marginalized minorities who are defined as the nation’s immigration ‘threat,’ (b) creating new spaces of enforcement within which racial anxieties flourish and become institutionalized; and thereby (c) racializing immigrant bodies” (261). “Illegality” then is very much a racialized category that disproportionately constructs people of color, immigrants and non-immigrants alike, as criminal (Anderson 2010; De Genova 2007; García 2017; Hernández 2008; Johnson 1998; Romero 2008a). Renato Rosaldo describes racialized notions of “illegality” as a “blemish” that Latinx citizens and noncitizens cannot escape. He says, “By a psychological and cultural mechanism of association all Latinos are thus declared to have a blemish that brands us with the stigma of being outside of the law. We always live with that mark indicating that whether or not we belong in this country is always in question” (Rosaldo 1999:255-256). Affecting all noncitizens and citizens of color to varying degrees, these patterns of racialized criminalization render (Latinx) noncitizens, whether documented or not, as deportable and hence exploitable.

In being eligible for deportation but not deported, the experience of deportability refers to the palpable and protracted threat of deportation (Anderson et al 2011; De Genova 2002, 2004; Gibney 2008; Kanstroom 2000; Peutz and De Genova 2010; Walters 2002; Walzer 1983). Alongside racialized criminalization, deportability has the pervasive and over-arching effect of being “a practical, materially consequential, and deeply
interiorized mode of being – and of being put into place” (Peutz and De Genova 2010:14). Actively disenfranchising immigrants, deportability results in multiple vulnerabilities that together entail a “form of legal, political, and economic apartheid” (Coleman and Kocher 2011:229, see also Balderrama and Rodríguez 2006). Rather than evidence of the failure of immigration policy and enforcement to apprehend and remove undocumented immigrants, the presence of (deportable) migrants serves the interests of capital accumulation by creating an exploitable low-wage labor force that is kept “in its place” by the fear of encountering immigration enforcement and being subjected to detention and deportation (Anderson 2010; Anderson et al 2011; Castles 2004; Ngai 2004; Peutz and De Genova 2010; Sharma 2006). This precarious labor force is comprised of migrant workers that have recourse to few rights (which workers are often hesitant to assert), seek to maintain invisibility from authorities (including those which oversee labor rights and working conditions), and can be made expendable depending on economic and market factors. Defining the precarity and liminality experienced by undocumented immigrants, deportability’s main consequence then is the creation of “a disposable supply of easily exploitable labor” (Anderson et al 2011:522).

This disposability and exploitation are consequences of the racialized criminalization of undocumented immigrants in the U.S. I use Henry Giroux’s concept of the “biopolitics of disposability” (2006) to analyze the central role that this precarity, and the larger state apparatus that generates this precarity, play in the “ordinary crisis” of immigrant health. Giroux defines “biopolitics of disposability” as the experience of being “excommunicated from the sphere of human concern” (48). In this way, marginalized groups, in particular poor people and people of color, “have been rendered invisible,
utterly disposable, and heir to that army of socially homeless that allegedly no longer exist in color-blind America” (Giroux 2006:175). The biopolitics of disposability links the processes of racialized criminalization that affect both citizens and noncitizens alike with the detrimental health effects that this distinct disposability creates. The exploitation of migrant workers in the interest of capital accumulation combined with the concept of “biopolitics of disposability” help to explain how and why immigrant health inequalities, including suffering, sickness, and premature deaths, remain largely invisible and do not spark a public outcry.

The Ordinary Crisis of Immigrant Health

The biopolitics of disposability is a useful analytic in explaining the unremarkable nature of the immigrant health crisis in the U.S. This crisis is marked by an ordinariness that belies the larger processes of dehumanization of undocumented immigrants that racialized tropes, policies, and enforcement effect. According to Berlant, crisis ordinariness or systemic crisis refers to “traumas of the social that are lived through collectively” (Berlant 2008:5). In other words, “crisis rhetoric belies the constitutive point – that slow death, or the structurally motivated attrition of persons notably because of their membership in certain populations, is neither a state of exception nor the opposite, mere banality, but a domain of revelation where an upsetting scene of living that has been muffled in ordinary consciousness is revealed to be interwoven with ordinary life after all” (Berlant 2007:761). In other words, the “ordinary crisis” of immigrant health is unremarkable in fact because undocumented immigrants have already been rendered disposable and exploitable through strategic and systematic
dehumanization. They are marked by what Berlant calls “slow death,” or “the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence” (2007:754). In theorizing the dehumanization of marginalized groups and the justification of the various violences that they endure, Scheper-Hughes (2004) describes the reduction of the socially vulnerable into “expendable non-persons” (14). Rendering marginalized and pathologized people ineligible for personhood leads to their allowable killing or justifiable deaths and the multiplication of “invisible genocides” (Scheper-Hughes 1996). Thus, the biopolitics of disposability that defines the ordinary crisis of immigrant health in the U.S., including the violence of the militarized borderlands and the slow death associated with immigrants’ untreated chronic health conditions, perpetuates processes of dehumanization that cause immigrants’ suffering and premature deaths to be unrecognized (or mis-recognized), unremarkable, and ungrievable (Butler 2009). In this way, Chavez argues that undocumented immigrants with serious health needs are marked by the state for a “necropolitical biocitizenship” that has “effectively left certain populations to die” (2018:118). As a politics of death that provides an important complement to Foucault’s theorization of biopower, necropolitics asserts that the “ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die” (Mbembe 2003:11). Achilles Mbembe’s theorization of necropolitics refers not only to people who are physically killed or made to die but also people who are alive but marked for death socially or politically. In this way, Mbembe uses necropolitics to explain “how the threat of violent death continues to prevail as a technique of governance in contemporary settings”
(Wright 2011:709) as well as the ways that governments justify the deaths of some (in this case that of migrants), in order to protect the lives of others (ostensibly U.S. citizens) (Braidotti 2007; Williams 2015; Wright 2011). Exposing and countering the necropolitical consequences of the biopolitics of disposability, the immigrant health justice organizations and activists at the heart of my research strategically deploy the neutrality associated with humanitarianism to legitimate both their own work and the “patient” status of uninsured, undocumented immigrants.

Medical Humanitarianism

The organizers of both CommUnity Clinic of Phoenix and No More Deaths self-identify as humanitarian activists and aid workers. These organizations are part of an emerging domestic medical humanitarianism that reflects an “inward” turn of humanitarian NGOs which have historically worked almost exclusively in Global South countries and conflicts (Fassin 2007, 2009; Gottlieb et al 2012; Ticktin 2006, 2011; Tiedje and Plevak 2014; Willen 2011, 2012a, 2012b). Shifting medical humanitarianism to Global North countries, these humanitarian organizations work within their home countries to provide medical care to marginalized populations in the absence or withdrawal of social services. As Ticktin argues, “medical humanitarian organizations have also turned their attention to socio-medical need in their own and other so-called ‘developed’ countries: they have brought their concerns back home, within their borders, and in ways which draw critical attention to borders” (2006:125-126). Their alternative health care provision, at least implicitly, involves an indictment of the neoliberal retrenchment of social welfare programs, the criminalization of undocumented
immigrants, and a resulting “humanitarian crisis” in their own countries. It is not that the work of providing medical care to immigrants within these countries is a new phenomenon, rather that the explicit use of humanitarianism as a discourse and a model of care has emerged in the transition from classic to new humanitarianism. This “new humanitarianism” seeks to address some of the critiques of classic humanitarianism, but is not without its own issues.

Historically, humanitarian organizations deliberately avoided becoming involved in political debates or taking an ideological stand in a political situation; rather, they advocated for complete neutrality in order to keep from jeopardizing their work by attracting the ire of governments. Bernard Kouchner, one of the founders of MSF, has argued that the short-sightedness of classic humanitarianism and its silence in the face of genocide effectively made humanitarian NGOs “accomplices” in these atrocities (Allen and Styan 2000; Udombana 2005). Navigating the tension between focusing only on direct immediate service provision and advocating for longer-term solutions to conflict, a new humanitarianism emerged that blurs the boundaries between neutrality and political advocacy. Whereas classic humanitarianism avoided politics at all costs in order to remain neutral in a conflict, new humanitarianism argues for the moral imperative to intervene in conflicts causing human suffering (Chandler 2001). The duty to “bear witness” or the responsibility of “denunciation” in regard to human suffering means that neo-humanitarian NGOs assert a moral imperative to publicize the abuses they are seeing. This “freedom of criticism” means that new humanitarianism has a distinctly human rights-based appeal to a higher moral or ethical standard that transcends national laws (Ignatieff 2001). Chandler argues, “The desire to politicize involvement in aid
provision without sacrificing their neutral and ‘non-political’ status, led NGOs to seek to justify their strategic choices through the language of morals and ethics rather than politics” (2001:682). Thus, in many ways, this conception of “morality” represents an attempt to maintain the apolitical provision of needs-based humanitarian aid, while asserting political critiques of a rights-based humanitarianism.

In the context of humanitarian NGOs from the Global North working in Global South countries, humanitarian principles give rise to important critiques regarding imperialism and notions of white saviorism. In claiming the right to intervene in a crisis, humanitarian NGOs from historically-colonizing countries often ignore both the legacies of imperialism of their own countries and the sovereign boundaries of formerly-colonized nations in which they intervene (Bricmont 2007; Orfore 2003). Furthermore, humanitarian NGOs can encounter criticism for turning a blind eye to human rights abuses perpetrated by their own governments, both at home and abroad. Heeding these critiques and others, some humanitarian NGOs, including MSF, have been self-reflexive about their role within globalization and global humanitarian crises. This self-reflexivity, in part, has spurred a growing presence of international and local medical humanitarian NGOs working within Global North countries.

Strategically engaging humanitarianism as both a practice and a discursive strategy, the NGOs at the heart of my research use humanitarianism as a critique of the legacies of colonialism and neo-imperialism that drive patterns of migration, in particular migration from Mexico and Central America. Contributing to the literature that examines medical humanitarian organizations in the U.S. (Tiedje and Plevak 2014), these NGOs deploy an “insurgent humanitarianism” against the fatal effects of border militarization
and immigration enforcement. They stress the “neutrality” of humanitarianism in order to legitimate their own politically-contentious work as apolitical medical provision, even as they assert the biocitizenship of the immigrants with which they work.

**Substantive and Necropolitical Biocitizenship**

In her analysis of post-Chernobyl politics and health, Adriana Petryna (2003) coined the term “biological citizenship” to refer to the process through which “the damaged biology of a population has become the grounds for social membership and the basis for staking citizenship claims” (5). Broadened by Nikolas Rose and Carlos Novas (2005) in scope and definition, biocitizenship argues that “specific biological presuppositions, explicit or implicit, have underlain many citizenship projects, shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens” (440). In thinking through its relationship with biopower and biopolitics, Johnson et al (2018) define biocitizenship as “the instrumentalization of biopower, authorized by the force of biopolitics to legitimate certain subjects of the state” (4). These biological citizen-subjects then use the facts of their biological conditions or medical needs as the basis for collective action, including organizing by those affected by the HIV/AIDS epidemic (Epstein 1996) and other chronic diseases or conditions (Fraser 2010). In revealing the relationship between medicine and boundaries of inclusion and exclusion, biocitizenship is a concept that is also salient for the experience of noncitizens, especially as “they and their biological conditions are placed under more scrutiny than those with citizenship status” (Chavez 2018:118).
In conceptualizing forms of belonging outside the bounds of “formal” citizenship recognized by the state, critical migration scholars have recognized degrees of inclusion and exclusion for noncitizens (Brubaker 1992; Chauvin and Garcés-Mascareñas 2012), giving rise to a proliferation of forms of social citizenship (Fraser and Gordon 1994; Marshall 1998 [1950]) and “noncitizen citizenship” (Bosniak 2006). According to Evelyn Nakano Glenn, citizenship is not simply “a fixed legal status, but a fluid status that is produced through everyday practices and struggles” (Glenn 2011:1). Her concept of substantive citizenship then refers to belonging that is cultivated through these practices and struggles, “through face-to-face interactions and through place-specific practices that occur within larger structural contexts” (Glenn 2011:2). Drawing from Glenn’s theorization, I use the term “substantive biocitizenship” to consider the claims made by the medical humanitarian NGOs at the heart of my research on behalf of their immigrant patients. This substantive biocitizenship is based on the “damaged biology” (Petryna 2003) that exclusionary policy and punitive immigration enforcement effect on the lives and health of uninsured, undocumented immigrants. Based on common experiences of being undocumented and the health consequences of deportability, they assert the biocitizenship of uninsured and undocumented migrant patients that make legitimate claims for health services, independent of (but related to) national citizenship claims. I also engage with Karma Chavez’s concept of “necropolitical biocitizenship” (2018) to describe the work of NMD and partner organizations to make visible the violence against migrants in the borderlands, those who die on the journey as well as those who, though alive, are always already marked for death by the racialized criminalization and necropolitical enforcement in the borderlands. Although Chavez argues that
necropolitical biocitizenship is used by the state to mark and exclude HIV positive migrants from the country, I employ the term in a way that is generative – that both highlights and challenges the necropolitics and necroviolence (De León 2015) in this region.

**Situating the Study Spatially**

Both the materiality of the border as a physical space and the socio-political implications related to this space give shape to immigrant “illegality” and the immigrant health crisis. In theorizing this spatiality, I examine two zones through which to frame the spatialization of the experience of “illegality” and to analyze the distinctly geographic, socio-political, and biopolitical implications of contentious spaces in relation to the border. The *militarized borderlands* form the first zone, just internal from the border, and beyond these borderlands is essentially the rest of the country, a spatial area that I call the *borderized interior*. Within these spatial zones, migrant criminalization varies from automatic and totalizing (specifically in border crossing areas) to partial, contingent, and unpredictable.

As the “line in the sand” demarcating the territory of the nation, the U.S.-Mexico border is becoming increasingly fortified through the development of border infrastructure, the proliferation of surveillance technology, and the increase in Border Patrol agents. Approaches to U.S. border control over the past twenty-five years have been defined by the “prevention through deterrence” strategy. Prevention through deterrence involves the fortification of the border (through the building of “the wall”) in urban areas, such as El Paso and San Diego, and the other “major travel arteries” popular
for crossing. As a result, it effectively reroutes migrants to cross in the most remote and hazardous desert and mountainous regions along the border (Doty 2011; De León 2015). As a border control strategy, it aims to discourage would-be border crossers by heightening the danger of the journey while increasing the apprehension of migrants crossing the border by giving Border Patrol “a tactical advantage” in the borderlands (Haddal 2010). Critics of this strategy point to the Border Patrol’s numbers as an indication of its failure as a policy and its punitive and fatal consequences: at the same time that Border Patrol apprehensions decreased (and thus migrant crossings are assumed to have also declined), migrant deaths in the desert increased. Complementing the physical border infrastructure is a marked increase in Border Patrol agents stationed in ports of entry as well as dispersed across the more remote areas of the borderlands. In fact, since 2001, the number of Border Patrol agents has more than doubled. Although the literal border is the threshold of the nation, it also moves figuratively and internally to police and surveil noncitizens within its bounds (Chang 1999; Bosniak 2006; Luibhéid 2002; Romero 2008).

Forming the militarized borderlands, the Border Patrol has claimed jurisdiction of a 100-mile internal perimeter around the country’s land and sea borders (see Figure 2). Not only are LA, New York, and Chicago in Border Patrol territory, but so are the states of Michigan and Florida and the majority of New England. In fact, almost two-thirds of the U.S. population lives within this territory as well as 72% of all people of color (Misra 2018). Within this 100-mile perimeter, the Border Patrol are free to operate internal border checkpoints at which they can stop and search every automobile and can question each passenger about their citizenship status. Another important aspect of the militarized
borderlands is what Todd Miller calls the “virtual wall” (2014). In addition to internal border checkpoints, the installation of electronic surveillance, particularly in rural areas has developed another layer of border infrastructure that moves many miles beyond the fortified border into U.S. territory. Within the militarized borderlands, the Border Patrol attempts to assert de facto legal control through the universalized criminalization of migrants, particularly the racialized criminalization of Latinx migrants (and citizens) in the U.S.-Mexico borderlands.

Figure 2: Map of the Militarized Borderlands

1 Retrieved from https://www.aclu.org-know-your-rights-governments-100-mile-border-zone-map
Beyond the militarized borderlands is the *borderized interior* of the country. Immigration policies and enforcement reach into the everyday spaces – the workplaces and schools and communities – that migrants inhabit. These immigration policies re-inscribe the border on the bodies of people racialized as immigrants. If prevention through deterrence defines immigration enforcement in the borderlands, the strategy of “attrition through enforcement” is the defining logic of the interior. Attrition through enforcement seeks to make the environment so harsh for migrants in terms of finding and maintaining jobs and avoiding immigration enforcement that they voluntarily leave the country altogether. This strategy includes ramping up detention and deportation while tightening restrictions and punishments for companies that employ undocumented immigrants. It also involves eliminating social service provision for migrants, including vital services such as health care and education, and rendering migrants destitute, even as employment becomes increasingly difficult to access due to heightened regulation. Punitive anti-immigrant policy proposals across the country “share a common set of policy objectives aimed at fundamentally disrupting everyday life for unauthorized immigrants by restricting access to employment, housing, health care, and social services” (Theodore 2011:91, see also Krikorian 2005; Vaughan 2006). The result of these policies and the heightened experience of “deportability” in the interior causes migrants to avoid accessing social services like health care and education (Chavez 2012; Talavera et al 2010). In cities across the U.S., migrants curtail their mobility to avoid detection and apprehension, often shirking public spaces for the safety of home and community.
Within these two zones, the spatialization of immigrant criminalization is not uniform or universal but fluctuates across rural and urban, public and private. In certain “hot spots” across these zones, where immigrants interact with the state, they face heightened forms of criminalization. For instance, in many parts of the country, accessing public sector services can be just as dangerous for undocumented immigrants as being stopped for a broken taillight. The intensity of the zones also varies with local immigration policies and enforcement tactics that are layered onto federal legislation and national border control strategies.

The Centrality of Arizona

Though these zones are national in scope, they are experienced acutely in Arizona. As “immigration ground zero” (Washington Post 2007), the state represents a strategic site for testing conservative immigration enforcement policies and tactics that are then disseminated to other states. The idea of Arizona as an epicenter for right-wing immigration legislation is no exaggeration. The American Legislative Exchange Council (ALEC) maintains a task force of conservative legislators and corporations that draft and pre-approve legislative templates on issues of immigration and other topics that they then work to get passed at the local, state, and national levels. Arizona’s legislature has the highest concentration of ALEC legislative members of any state in the nation: fifty of their ninety elected officials are members of ALEC. A report by a coalition of organizations including People for the American Way and the Center for Media and Democracy (Surgey 2013) found that at least twenty pieces of Arizona legislation in 2011
were either identical carbon copies of, or bore a very close resemblance to, ALEC pre-approved legislative templates.

Arizona’s approach to immigration is relevant beyond the state, often acting as the “canary in the mine” for gauging anti-immigrant sentiment across the nation. After SB 1070 – known as the “show me your papers” law – was passed, following Arizona’s lead similar if not identical legislation drafted by ALEC was introduced during the 2010 legislative session in five states (South Carolina, Michigan, Minnesota, Rhode Island, and Pennsylvania) but failed to pass in each instance. However, in 2011, South Carolina, Alabama, Georgia, Indiana, and Utah successfully passed the bill, and in 2012, another five states passed similar legislation (Kansas, Missouri, Rhode Island, Mississippi, and West Virginia) (NCSL 2012). SB 1070 and these copycat laws all faced legal challenges in court and were either entirely struck down, and thus not enacted, or the majority of the provisions of the legislation were deemed unconstitutional. As demonstrated by the proliferation of SB1070-like legislation after 2010, the centrality of Arizona on these issues can be summed up in the adage repeated by immigration activists across the state, “As goes Arizona, so goes the nation” (Chavez 2013:17).

Under prevention through deterrence, the fortification of the U.S.-Mexico border has effectively funneled migrants to cross in Arizona. Like the related operations in California and Texas, Operation Safeguard in Arizona involved the building and fortification of the wall between Nogales, Arizona and Nogales, Sonora in attempts to route migrants away from this popular border crossing area and into the more remote desert regions of the Arizona borderlands. In the most inhospitable and dangerous border terrain, they must traverse vast mountainous desert regions with little access to water that
take days or even weeks to cross. This has resulted in the known deaths of over 8,000 migrants across the borderlands (Fernandez 2017; Nevins 2007), the majority of which occurred in Arizona. These remains may represent only a fraction of the overall migrant deaths in the desert, as the remains of the majority of people presumed dead who go missing while crossing the expansive desert of the U.S. Southwest are never found. Furthermore, prevention through deterrence increased the number of Border Patrol agents in the Tucson sector, which covers the majority of the Arizona border (262 miles of the busiest area of the U.S.-Mexico border), not only placing a large number of uniformed agents directly “on the line” in Nogales but also dispersing officers across the more remote areas of the Arizona borderlands. This intensification in the Arizonan borderlands also includes the “virtual wall.” In terms of border surveillance technology, Arizona is the laboratory for the nation. This technology includes drones, thermo-nuclear surveillance, motion sensors, high-tech surveillance towers, and even cameras hidden in cactus.

Beyond Arizona’s borderlands, the interior of the state represents an intensification of anti-immigrant policies and enforcement tactics that heighten immigrant criminalization. Since 2004, Arizona has passed a series of immigration laws that seek to make the state less hospitable to immigrants, restricting immigrant access to employment, education, health care, and social services. For instance, Prop 300, passed in 2006, denied in-state tuition for undocumented immigrants hoping to access higher education or adult education. Perhaps the pinnacle of the attrition through enforcement doctrine, the Support Our Law Enforcement and Safe Neighborhoods Act (or SB 1070), at its passage in 2010, was the most punitive immigration legislation in the country. The
infamous legislation is explicit in its support of the attrition through enforcement strategy, stating in the text of the bill, “The legislature declares that the intent of this act is to make attrition through enforcement the public policy of all state and local government agencies in Arizona. The provisions of this act are intended to work together to discourage and deter the unlawful entry and presence of aliens and economic activity by persons unlawfully present in the United States” (2010:2). Effectively giving local law enforcement the power of federal border patrol agents, the law in its original form has four main provisions that 1) makes it a state misdemeanor for a migrant to be caught without the required documents, 2) allows law enforcement to arrest an undocumented immigrant without a warrant, 3) punishes anyone found harboring, transporting, or hiring undocumented migrants, and 4) requires law enforcement to ascertain a person’s immigration status during a “lawful stop, detention, or arrest” if they have a reasonable suspicion that they might be undocumented. The law immediately was challenged in a number of court cases, including a case brought by the Department of Justice that was ultimately decided by the Supreme Court, Arizona v. United States, which struck down SB 1070’s first three provisions as unconstitutional but upheld the portion which required law enforcement to demand the papers of anyone that they suspected of being undocumented. Another court case that was not decided until September 2016 removed some of the “teeth” from this final provision of the law. Under this settlement, officers are not required to demand a suspected undocumented immigrant’s papers but are still able to ask to see their papers “at their own discretion” and can contact U.S. Immigrations and Custom Enforcement (ICE) if they suspect that a person they have stopped is undocumented. Arizona Attorney General Mark Brnovich wrote as guidance in
response to this ruling, “Officers shall not prolong a stop, detention or arrest solely for the purpose of verifying immigration status. Officers shall not contact, stop, detain or arrest an individual based on race, color, or national origin, except when it is part of a suspect description” (FindLaw 2016).

Although these court cases have dampened the original bill, SB 1070 remains a key piece of legislation upon which local law enforcement can target people who they suspect of being undocumented and can act as immigration enforcement officials in detaining migrants. SB 1070 was the first law of its kind to mandate that law enforcement inquire into a person’s immigration status, earning it the nickname the “show me your papers” law by immigrant rights activists. Critics argue that the law encourages the racial profiling of Latinx residents as “illegal” immigrants. SB 1070 solidifies the precedent of Arizona as the site for gauging the pulse of the American public on issues of immigration and for testing punitive immigration policies. Across the state, the twin strategies of prevention through deterrence and attrition through enforcement combine to create an environment hostile to migration and suspicious of those who are perceived racially as migrants.

In its devolution of punitive immigration enforcement to the local level, SB 1070 gave former Sheriff Joe Arpaio, the self-described “toughest sheriff in America,” the additional ammunition he needed to continue enacting a reign of terror on the Maricopa County’s Latinx and immigrant populations. Under SB 1070 and other federal immigration enforcement programs, Arpaio ramped up his controversial tactics and abuses on Latinx and immigrant communities across Phoenix and the wider Maricopa County. Among his many publicity stunts that garnered outrage and attention, he ran a
controversial outdoor jail called “Tent City” for undocumented immigrants that Arpaio described as a “concentration camp.” He routinely shackled immigrant detainees together and marched them before journalists and the public and forced them to work on chain gangs. Arpaio also ran several “posses” of untrained volunteer law enforcement officials who drove Maricopa County Sheriff Office (MCSO) vehicles and carried guns. One of these posses formed in 2010 focused on illegal immigration and “identified and searched vehicles, transported people suspected of violating immigration law, helped execute worksite raids, and provided crowd control during demonstrations against MCSO immigration policies” (Flaherty 2017).2 Under Arpaio’s leadership, Maricopa County became infamous for immigration raids at workplaces, on public transportation, and even at local grocery stores. After being voted out of office in 2016, Arpaio, who was cited for racially-profiling Latinos in the state, was ultimately convicted of contempt of court for failing to comply with court injunctions but was pardoned by President Trump before he served any prison time.

Settler Colonialism and Arizona’s Demographics

Historical and enduring legacies of U.S. settler colonialism continue to impact Arizona’s demographics. Arizona was the last territory in the contiguous forty-eight states to formally become a state (in 1912). Previously part of Mexico, what is today Arizona was ceded to the U.S. in two sections: northern Arizona after the U.S.-Mexico

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2 Another posse created in 2011 was tasked with investigating President Obama’s birth certificate, as Arpaio was one of the main proponents in the “birther” movement that questioned Obama’s eligibility for the presidency based on allegations that he was not born in the U.S.
war in 1848 with the Treaty of Guadalupe Hidalgo and southern Arizona south of the Gila River in 1853 with the Gadsden Purchase or La Venta de la Mesilla. The Treaty of Guadalupe Hidalgo at the time of its signing effectively doubled the size of the United States and halved the size of Mexico. In the mid-1800s with these two treaties, at least 300,000 people, most of them Mexican nationals, found themselves all of a sudden living in U.S. territory. They had the option of relinquishing their Mexican citizenship to become U.S. citizens or leaving their land and moving south within the new boundary of Mexico. This time was marked by serious violence, including lynching, against Mexicans in newly-U.S. territory.

When analyzing issues of immigration in Arizona, it is important to recognize its colonial history that begins with the Spanish settlers and missions of the 1500s and that remains today as settled land of the Havasupai, Hopi, Yavapai, Apache, Zuni, Navajo, Uti, Paiute, Hualapai, Mohave, Maricopa/Pima, Tohono O’odham, and other indigenous groups. Many of the current inhabitants of the land now known as Arizona are members of these indigenous groups, mestizo descendants of indigenous people and Spanish settlers, and descendants of the Mexican people who became U.S. citizens or were forced off their land in the mid-1800s when it became U.S. territory. Referenced by immigration activists who assert, “We didn’t cross the border, the border crossed us,” this settler colonial history/present is evidenced by the national boundaries drawn through the middle of indigenous land along what is now the U.S.-Mexico border, in particular through the Tohono O’odham Nation in southern Arizona. This settler colonial reality of the creation of the U.S. goes hand in hand with decades of U.S. neo-imperialism in Latin America. The consequences of this imperialism are evidenced by the migrations of
Mexican and Central and South American refugees displaced by international trade policies, austerity measures, and U.S. political and military intervention in Latin America.

In discussions of immigration in the U.S., the state of Arizona occupies an important position for the examination of demographic shifts of native and foreign-born populations. Arizona’s population trends mirror those of other states that are poised to have a “majority minority” population in the next several decades. U.S. Census data shows that the state is 55% white, non-Hispanic or Latino in 2016, down from 58% in 2010, and that Hispanics or Latinos makes up almost a third of the state’s population at 31%. Almost 90% of the Latinx population is from Mexico. Like other states, the population of people of color on average is younger than the white population, a fact that is especially stark in Arizona as a destination state for retiree “snowbirds” that spend the winters in Arizona and the summers elsewhere. These demographics of age and race led one immigration activist in my research to joke that Arizonan politics was a showdown between “the browns against the grays,” referencing the gray hair of the older white Arizonans who are considered to be more conservative on issues of immigration.

From 1990 to 2013, the foreign-born population in Arizona increased from 7.6% to 13.5%, according to U.S. Census data. The rhetoric on immigration in the state makes it nearly impossible to discuss the foreign-born or Latino population without mentioning unauthorized or undocumented migration. Of the 13.5% of foreign-born residents in Arizona, an estimated 4.6% are undocumented (Passel and Cohn 2016). This number has fluctuated over the last twenty-five years with economic and legislative changes (see Figure 3).
As illustrated in Figure 3, the undocumented population peaked in 2007 at 500,000 and then declined by 40% between 2007 and 2012, averaging around 325,000 since then.

Some of these changes may be affected by SB 1070 and other anti-immigrant legislation in the state, but the economic recession seems to have driven the majority of this population decline, as undocumented immigrants left in droves when the once-booming Arizona construction industry dried up in 2007.

Immigrant Health Justice in Arizona

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Within a larger culture of fear created by punitive immigration policies and enforcement in Arizona, an organized oppositional response counters the deepening crisis of immigrant health. This response includes organizations and activists working at the intersection of immigrant rights and health justice. This movement or network of immigrant health justice organizations (or the IHJ) has mobilized in response to the criminalization of immigrants through punitive policies and enforcement and their lack of rights and access to social services, particularly health care. The movement combines direct provision of medical care with political and community organizing campaigns around immigrant rights and health justice.

Although the struggle for immigrant health justice is nationwide, the movement is particularly vibrant in Arizona. As the focus of my research, Arizona is an important case for understanding current and historical immigration policies and the resistance movements that challenge them. It has also given rise to an oppositional movement consisting of a strong and varied coalition of migrant rights organizations, legal services, faith groups, nonprofits, and community organizing and direct action campaigns to challenge and resist these policies. Within this larger movement, the organizations at the heart of my research stand at the intersection of migrant rights and health justice, comprising the immigrant health justice movement.

Comprised of a loose configuration of aboveground nonprofit and community organizations, underground clinics, and clandestine networks of temporary shelters that operate as respite care spaces for immigrant patients, it is an unlikely alliance of volunteers with various levels of formal and informal medical training, including retired medical professionals – mostly gray-haired “snowbirds” who spend the winters in
Arizona – and dyed-in-the-wool anarchists, who describe themselves as “desert rats.” The overburdened organizations and activists in the IHJ attempt the enormous task of providing medical services to migrants without access to health care. This includes limited emergency first aid for migrants as they cross the borderlands as well as an ad hoc patchwork of primary and specialist care for immigrants once they have settled in the U.S. In addition to this provision of care, the IHJ launches a critique of immigrant criminalization and the embodied health effects associated with undocumented status, working to counter the consequences of anti-immigrant legislation and punitive immigration enforcement.

As an intersectional social movement, the IHJ includes immigrant rights organizations with health projects as well as health organizations that provide care for immigrants and advocate for their access to health care. Emerging from a number of related movements, it is comprised of social movement organizations and activists as well as direct service nonprofits and community groups that include: 1) immigrant rights groups comprised of people with various immigration statuses and citizen allies that provide direct support to immigrants in their communities and engage in electoral politics and direct organizing; 2) allied groups comprised mainly of non-immigrants working on immigrant rights issues, including activists and organizations from the original Sanctuary Movement of the 1980s and the burgeoning New Sanctuary Movement as well as humanitarian and other direct aid organizations that work along the border; 3) health care access organizations that provide health care to low-income, underinsured and uninsured patients who cannot access regular medical care; and 4) health justice groups that
advocate for local and national legislation that expands health care for everyone, through single payer health care.

Although the IHJ movement has been around for decades, it has grown in significance and strength since 2010, a year that marked the increase of punitive immigration legislation and enforcement, such as Arizona’s SB 1070, and the further ineligibility of immigrants for health care access under the Affordable Care Act (ACA). In the wake of the passage and implementation of the ACA, health organizations and clinics providing health care to low-income, uninsured patients saw undocumented and uninsured immigrants make up a larger proportion of their clients (Zuckerman et al 2011). Also in the continued absence of health care access for migrants, immigrant rights organizations are increasingly developing community health initiatives, training members as *promotoras* or community health workers, or even hosting ad hoc “healing circles,” informal mental health services, and indigenous healing practices to attempt to provide some limited medical care to their communities.

**Notes on Methods, Cases, and Positionality**

This project draws on an initial twelve months of ethnographic fieldwork and participant observation with migrant rights and health justice organizations, including free clinics and humanitarian aid NGOs in Arizona from the summer of 2015 to 2016. I also have conducted (and continue to conduct) informal and semi-structured follow-up interviews and ethnographic fieldwork with informants from my fieldsites, maintaining contact with them through social media, email listservs, and personal correspondence;
social visits with people who I now consider friends and comrades at our homes across the borderlands; and attendance at public events like film screenings.

My research includes ethnographic fieldwork with nine different organizations that work across Arizona – four of them provide domestic medical humanitarian aid in some form in the borderlands and the others deliver clinic-based health provision for immigrants in an urban context. This dissertation largely focuses on two organizations where I completed the bulk of my fieldwork – a free clinic that provides limited primary care to undocumented immigrants in Phoenix that I am calling CommUnity Clinic of Phoenix (CCP) and the other, a group that provides humanitarian aid in the desert called No Más Muertes or No More Deaths (NMD).

I want to note one important point about the use of pseudonyms within this dissertation. With respect to the clinic, the name of the organization as well as the names of all volunteers and patients have been changed for purposes of anonymity. In contrast, No Más Muertes or NMD is the actual name of the organization, not a pseudonym. Part of the decision not to use a pseudonym is driven by the organization’s mission and policies. A core tenet of NMD’s mission is “transparency.” Many of NMD organizers and founders were active in the original Sanctuary Movement, which was infiltrated by informants and government operatives who used the information they gathered from undercover surveillance of the movement to indict and convict the core activists. As such, NMD considers surveillance and infiltration by government informants to be the (current) reality of the organization, and they strive to do their work “above board” to avoid the accusations of secrecy or illegal activity. This transparency includes the use of the organization’s name in the many scholarly articles written by researchers who have spent
time with the organization (Caminero-Santangelo 2009; Campbell 2012; Cook 2011; Doty 2011; Failinger 2006; Squire 2014). Additionally, my examination of the discursive strategies of NMD’s framing of their humanitarian work draws primarily from press releases and media statements, which are identifiable and publicly available. To that end, statements made by volunteers acting in a formal spokesperson capacity for NMD directly quoted in articles and media statements use their actual names, and thus where I have included these quotes they include the names of NMD volunteers as they were published in the media. In contrast, for events and observations that arise from my ethnographic fieldwork with NMD, I have employed pseudonyms to protect the anonymity of the volunteers. Although perhaps not necessary given the organization’s commitment to transparency, the use of pseudonyms in this case was an ethical decision on my part to maintain the anonymity of individual volunteers with whom I spent time. The importance of this anonymity has come to the fore in the past two years, during which government targeting and criminalization of humanitarian aid workers has ramped up, with the arrests of some of the NMD volunteers that I came to know during my fieldwork. In the face of these arrests, the convictions, and the on-going trials of NMD volunteers, I am sensitive to ethical questions and changing dynamics around what aspects of the organization and its protocols are shareable.

Below I detail my two main fieldsites, the process through which I came to these organizations, my position within them during my fieldwork, and other methodological and ethical considerations that informed my research agenda and the presentation of my ethnographic data. In many ways, these two fieldsites are quite different – one is urban, the other rural; one operates a clinic at a fixed site where patients come to them for
appointments, the other engages in a kind of guerrilla health care through the provision of material aid to travelers in the desert. Yet both of these organizations utilize medical humanitarianism and the discourses of health and humanitarianism as a form of currency that legitimates their work with undocumented immigrants in the face of larger and more powerful institutions.

*CommUnity Clinic of Phoenix*

Located firmly in the “borderized interior,” CommUnity Clinic of Phoenix (CCP) is a free clinic that operates out of a nondescript house in the middle of Phoenix. Although the main organizers and volunteers at CCP had been providing health care to uninsured people informally for years, the demand for health care for uninsured, undocumented immigrants greatly increased after the passage of SB 1070 in Arizona in 2010. This legislation instigated the ramping up of enforcement tactics and community and workplace raids around the state, in particular in Phoenix, and made immigrants even more wary of accessing health care in the mainstream health system. In 2012, CCP’s work became more formalized, with the opening of a fixed-site, dedicated clinic, although it maintained a low profile and did not have a sign on the outside of the clinic. Operating out of a small, former crack house, it was renovated into a clinic space and filled with donated medical equipment. Offering limited primary, naturopathic, and holistic health care, the clinic is open for appointments two days a week: Thursdays are for nursing, naturopathic, and midwifery and women’s health appointments as well as holistic and shamanic healing sessions, while Saturdays are devoted to physical therapy and appointments with physicians assistants. Volunteers also make house calls to patients
throughout the week, monitoring the health of the most acute patients and those with transportation issues that keep them from the clinic. In this way, CCP provides health care to about 500 uninsured immigrants, the majority of whom are undocumented. These patients suffer mainly from chronic, treatable health conditions like diabetes, high cholesterol, high blood pressures, and thyroid issues.

I first became aware of the work of CCP in 2013, when I was researching immigrant health organizations in Arizona, as part of a larger qualitative research collaboration on the impact of the Affordable Care Act (ACA) on immigrant health care in the four states along the U.S.-Mexico border. With critical immigrant health scholars Lisa Sun-Hee Park and Anthony Jimenez, we conducted interviews in the spring of 2014 with health professionals and providers, organizations tasked with ACA enrollment, advocacy and policy groups, grassroots health organizations led by undocumented immigrants, charity care hospitals, mobile health centers, free and sliding-scale clinics, and Federally-Qualified Health Centers (FQHCs). During this initial round of interviews, we spoke with two CCP organizers, who I have called Michael and Cheryl, about the work of the clinic and the impact of the ACA on immigrant health care in Phoenix. In the spring of 2015, we revisited many of the same organizations, including CCP, for follow-up interviews to better understand the impact of iterative ACA implementation on these organizations and the patients that they served. At this point, I had decided on CCP as one of my dissertation fieldsites and was able to establish more concrete links with the organization and its volunteers prior to moving to Phoenix a few months later. During our follow-up interviews and conversations about my dissertation research, Cheryl offered to let me live with her during my fieldwork.
Because CCP prides itself on its role not only as a provider of free health care for the community but also as a place where students get vital hands-on training, in many ways, I was just another student at the clinic. As a volunteer at CCP, I was trained in a variety of roles that exposed me to the clinic’s daily operations, back room discussions, and organizational strategies. Like all new volunteers, I began as an intake assistant at the front desk but quickly moved from intake to work in the lab – learning how to take vitals, do urinalysis, centrifuge vials of blood, and perform EKGs. When it was empty of patients, the lab was also an informal space where volunteer nurses, student trainees, and holistic and shamanic healers hung out and caught a break between patients. I also volunteered as a grant writer for the clinic, which meant that I was privy to the ways that CCP presented its work to potential funders, its strategies and philosophies not always discussed in the day-to-day operations of the clinic, and long-term plans and vision.

Throughout the year, I helped staff fundraising events, such as pig roasts, film screenings, and drag shows, and went to educational workshops and orientations held at the clinic, including trainings on the clinic’s philosophy of health justice and best practices for health care for LGBTQ migrants. I attended board and staff meetings and was present at the annual meeting where CCP transitioned from a collective of volunteers to a nonprofit organization, the clinic’s founders giggling at the unfamiliar formality of Robert’s Rules of Order while electing each other as board members.

No Más Muertes/No More Deaths

Whereas CCP is located in a fixed site clinic space in the urban area of Phoenix, No More Death’s work is dispersed around the vast rural areas of the militarized
borderlands. This includes the high desert valleys and craggy mountains, immediately adjacent to the border, and a military bombing range along a large swath of southwest Arizona. Started in 2004 as a response to the escalation of migrant deaths during border crossing, NMD provides direct humanitarian aid in the borderlands in the form of water, food, socks, blankets, and other supplies. With a number of partner organizations, they also provide emergency first aid to migrants. There is no medical care in the desert otherwise. Emergency 911 calls are patched through to Border Patrol, which does not provide substantial life-saving medical care. In response to the absence of emergency services in the desert, NMD operates a medical camp on private land near the border. Here weary travelers can find respite and medical attention before continuing on their journey north or south. The make-shift clinic is run out of a second-hand military-grade MASH tent with donated supplies and an informal team of medical volunteers. The group also partners with other organizations to provide search and rescue for migrants in trouble or separated from their groups or search and recovery for the remains of people who have perished in the desert.

In the summer of 2005, Border Patrol arrested two NMD volunteers who, at the advisement of NMD’s team of medical doctors, were transporting two severely dehydrated migrants from the desert to a hospital in Tucson. These volunteers were essentially charged with smuggling and faced up to fifteen years in prison, charges that were eventually dropped over a year later. These arrests led to a long (and on-going) campaign by NMD, which included targeted national media publicity in support of the legality of these volunteers’ actions as well as a broader argument for the legitimacy of NMD’s humanitarian work. During this time, the organization distributed countless t-
shirts, yard signs, and stickers that declared, “Humanitarian aid is never a crime.” This motto has maintained relevance in the face of on-going legal challenges to NMD’s work, including criminal charges against other volunteers for distributing humanitarian aid (which has earned them tickets and arrests for “littering”) and for providing food and water to migrants (for which they have been charged with “harboring” and aiding and abetting illegal immigration).

During this widespread media campaign in 2005, I first became aware of NMD and, given my interest in immigration and border militarization have followed their work since, in hopes of one day being able to volunteer and more closely observe the work of the organization. When Lisa, Anthony, and I first traveled to Arizona for our interviews in 2014, we included Tucson as one of our fieldsites, interviewing volunteers from various free clinics and immigrant health organizations across the city. Given that Tucson is and has been a “hub” for humanitarian aid NGOs working in the borderlands since the Sanctuary Movement of the 1980s, it is perhaps unsurprising that we ended up (somewhat inadvertently) interviewing a few of the retired doctors and nurses who, in addition to providing health care to immigrants on both sides of the border, also provide medical consultation and advice to NMD volunteers as part of the organization’s medical team. These interviews first piqued my curiosity about the links between the work of free clinics providing health care to undocumented immigrants across the U.S. and the emergency medical care that NMD provided for migrants as they crossed the borderlands. As I began my fieldwork in Arizona in the summer of 2015, I spent the first few months in Tucson, attending NMD events and volunteer training sessions and visiting the medical camp. In September 2015, I moved to Phoenix to begin my fieldwork.
with CCP and became active in the NMD chapter there. As internal border checkpoints have moved further into the borderlands, migrants are forced to travel for longer distances to reach “safety.” Remains of people who have perished while walking across the desert have even been found on the outskirts of the Phoenix metro area. The NMD Phoenix chapter services water stations and humanitarian aid caches in the areas closer to the Gila Mountains, the military bombing range, and areas adjacent to the U.S.-Mexico border that are further west from Tucson.

As part of my work with NMD, I drove 4x4 trucks loaded with hundreds of gallons of water and other supplies through inhospitable terrain, sometimes stopping to let the passengers out of the vehicle to drive alone across a particularly dangerous spot in the “road.” In the desert, it can take hours to drive a short distance, and even more hours to hike the heavy gallons of water through the oppressive summer heat to areas where no vehicle could traverse. Some days, it took from before dawn until dusk to reach, locate, and replenish one or two supply “drops.” After these long days, we would drive home at sunset, weary and in silence, along the dirt road adjacent to the border, listening to music waft across from the border towns on the Mexican side. Using GPS to navigate along migrant trails to humanitarian aid caches, we monitored supplies at strategic points and heavy traffic areas along the trails. These caches were named after unique landmarks or events that happened at that particular point – for instance, one drop was marked by a wooden cross where human remains had been found, while another was named after a rusted out bicycle with punctured wheels that someone had left leaning against a saguaro cactus. Miles and miles from any sort of “civilization,” NMD volunteers marveled that someone had ridden and carried a bike that far into the desert. We kept detailed logs
about the supplies that we left, the gallons we found empty and took along with us to recycle back in Phoenix as well as the ones that had been “animalized” by coyotes or “ravenized” by birds desperate for a drop of water in the desert heat. These damaged jugs would smell putrid, filled with the bodies of bees trapped inside after flying in for a drink. We also made note of the gallons that had been slashed by knives and drained by vigilantes or even Border Patrol officers. During my fieldwork, I also helped facilitate short-term groups of volunteers and alternative spring break trips, camping in the desert for up to a week at a time, taking groups out to hike the trails and drop supplies, and leading debriefing sessions about the days’ activities around the campfire at night. During our days in the desert, we would stop by Border Patrol rescue beacons to discuss the inadequacy of this intervention at saving lives. Signs of the humanness and the physical limitations of those walking across the desert, the items left by travelers along the trails told of the unspeakable violence of the journey through the desert: carpet scraps that had been tied onto shoes to avoid making footprints in the dirt; discarded cans of Red Bull at the bottom of a steep hill, drunk hastily to summon the energy to make the climb; empty blister packs of pain killers and Plan B; shoes with the top cut off to make room for

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4 In January 2018, NMD released a report as the second part of their series “Disappeared: Death and Disappearance on the U.S.-Mexico Border.” This second report titled “Interference with Humanitarian Aid” documents Border Patrol’s systematic destruction of humanitarian aid supplies left by NMD and partner organizations for migrants in the deserts and mountains of the borderlands. The report asserts, “In data collected by No More Deaths from 2012 to 2015, we find that at least 3,586 gallon jugs of water were destroyed in an approximately 800-squaremile desert corridor near Arivaca, Arizona” (1).

5 Rape and sexual assault for women crossing the border are such common experiences that many bring Plan B along with them on their journey. These assaults are perpetrated by smugglers, Border Patrol agents, and fellow travelers in their groups. A New York Times article (Fernandez 2019) documents the stories of several of these women and argues for the prevalence of experiences of sexual assault for women migrants.
swollen feet and blistered toes; and mementos from home like photos of family and rosary beads. Evidence of the long time use of these migrant trails was etched into the geology of the landscape: petroglyphs on boulders from the last millennia alongside more recent graffiti. In fact one of the mountain passes along the border where NMD drops water and supplies served as a prominent route through which Asian immigrants hiked mezcal into the U.S. during the prohibitions against Chinese migration and then alcohol in the early 1900s.

The current heightened criminalization of migrants and humanitarian aid workers continues to raise ethical considerations about the information that I am comfortable sharing publicly about my fieldwork with NMD. In the face of the arrests of core volunteers, the organization remains committed to the principle of transparency as one strategy for countering Border Patrol accusations of secrecy and illegality. Rather than foregrounding the details of my volunteer experience with NMD, I have chosen to focus on the discursive strategies that NMD uses to frame and publicly portray their work as the means through which they argue for the legitimacy of their presence and work in the borderlands. As such, I have deliberately de-centered my ethnographic fieldwork due to the shifting terrain around the heightened state repression that the organization is facing, as some of the volunteers with whom I spent time have either faced or are facing trial for their humanitarian aid work.

*Positionality*
The trajectory of my research agenda is necessarily limited by the fact that I am not an immigrant nor am I a person of color. And, in this way, the questions of positionality that I continue to consider are ones with which many of the white medical professionals and humanitarian aid workers in my research are also wrestling. I am not saying that white researchers like myself (or white immigrant health justice activists) have no place in the discussion of immigration or even Latinx or ethnic studies, just that there are epistemological and ethical limitations to our ability to “represent” immigrant politics in our academic work or to contribute to the struggle for immigrant rights.

Knowledge production about immigrants, in particular Latinx immigrants, by government, media, and academia, has long been a way in which nativism and racism has functioned and prospered. Thus immigrant and Latinx scholars and activists have often had to be occupied with dismantling racist depictions of themselves in addition to, or even more so than, doing the work of articulating immigrant rights and social justice. Non-immigrant and non-Latinx scholars can and should take up some of the labor involved in a number of related projects and I have deliberately designed and conducted my dissertation fieldwork and analysis to contribute to these projects: 1) interrogating racist, anti-immigrant rhetoric and policies as part and parcel of a white nationalist state-crafting project, 2) analyzing the effects of structural violence and racialized criminalization on migrant communities, and 3) confronting the racist and nativist legacy of academic inquiry on “immigrant assimilation” as the benchmarks of deservingness and social inclusion. My dissertation attempts to take on some of this labor. It also highlights the work of activists and organizations that are also engaging in this specific project in terms of health care.
Overview of the Study: Chapter Breakdown

My dissertation begins with an examination of the “biopolitics of disposability” (Giroux 2006) that governs approaches to immigrant health care and that maintains migrant exploitability. Created by a combination of exclusionary policies and punitive enforcement, the vulnerability and inequality experienced by uninsured, undocumented migrants in the U.S. amount to structural violence that becomes embodied in sickness, suffering, and death. Unlike other examinations of structural violence that position health care providers as part of the solution to structural violence, this chapter argues that some health care providers and institutions also act as perpetrators of the structural violence that results in the fatalities of immigrants across the country. Focused on the work of the CommUnity Clinic of Phoenix (CCP), a free clinic for uninsured, undocumented immigrants, this chapter examines the CCP’s politicized critiques of the twin “broken systems” of immigration enforcement and health care in the U.S. The lack of access to health care for immigrant patients and local devolution of immigration enforcement combine to create a culture of fear and anxiety that, on the one hand, causes migrants to avoid accessing health care, while on the other hand, renders their medical emergencies illegible to health institutions. Further devolution of immigration enforcement into spaces of health and the collusion between health providers and the enforcement apparatus are exemplified in the practice of medical deportation through which hospitals privately deport immigrant patients. In this way, the mainstream health system is implicated in the fatal consequences of an ordinary crisis of immigrant health in the U.S., a crisis defined by a strategy of pragmatic eugenics toward migrants in the country.
Focusing on immigrant health provision in the interior, the third chapter outlines CCP’s alternative vision for immigrant health justice, which asserts health care as a human right for everyone regardless of insurance or immigration status. In opposition to the brokenness of the health and immigration systems, they engage an abolitionist framework to envision an alternative health-care-for-all model; however, this vision is necessarily constrained by the realities and persistence of the for-profit medical industrial complex and the clinic’s limited resources. Within a broader field of immigrant health care, CCP volunteers work to provide “quality” health care to a limited number of immigrant patients who cannot access care in the mainstream health system. For CCP, this quality care is defined by its focus on preventing the development and deterioration associated with untreated chronic medical conditions, by its “cultural humility” that takes into account the larger structural barriers to care for CCP patients, and by its holistic collage of care that combines Western, biomedical services with naturopathic and shamanic healing remedies. However, this vision of immigrant health justice manifests in two tense factions within CCP – with one faction focused on delivering a clinical type of quality care and the other with a more activist focus. I argue that these factions give rise to two very different assertions of the informal medicalized citizenship, or biocitizenship, of their patients. On the one hand, the more clinical-focused volunteers assert a substantive biocitizenship on behalf of their patients, using their legitimacy and privilege as biomedical providers to assert the patient status of migrants and the reality of their medical needs. On the other hand, the more activist-aligned volunteers argue that the clinical faction perpetuates white saviorism and the power inequalities of patient-provider interactions. As such, they work to cultivate a collectivized biocitizenship alongside the
clinic’s patients, working to center migrants of color in a relationship of mutual aid and community solidarity.

Shifting to the militarized borderlands, the fourth chapter argues for the importance of space, including the materiality of the desert and the socio-political implications of the borderlands, to NMD’s framing and counterframing of their work as “humanitarian aid” in the contentious space of the border. NMD invokes the neutrality of health and the language of humanitarian aid and disaster relief to legitimate their work, including the provision of emergency first aid to migrants they encounter in the desert. In so doing, they establish themselves as an “apolitical” presence within a space of contentious politics that involves the total criminalization of people racialized as migrants within the borderlands. I argue that NMD engages in a discursive project to frame their work in the borderlands as apolitical humanitarian aid provision, even though it may more closely resemble direct action against the militarization of the border. Taking into account the importance of the materiality of the desert, this framing includes a re-imagining of what constitutes a “life-threatening” medical emergency in the context of the borderlands and a recognition of migrant border-crossers encountered in the desert as “patients.” Their work amounts to an “insurgent humanitarianism,” engaging humanitarianism as both a discourse and a field of action that challenges the criminalizing rhetoric of the Border Patrol and its assertions of ultimate jurisdiction in the borderlands. In this way, NMD asserts the necropolitical biocitizenship of migrant-patients in the desert (who are marked for death or left for dead) by punitive border enforcement, while also posthumously claiming necropolitical biocitizenship for the
migrant-dead whose deaths are invisible, unremarkable, and ungrievable in their
dehumanization.

This dissertation concludes with an examination of the politics of visibility within
the immigrant health justice movement and its important work of counting and
accounting for the sickness, suffering, and deaths of migrants across the U.S. In the
highly-politicized space of the borderlands, organizations like No More Deaths frame
their nonviolent direct action as apolitical medical provision in response to a health crisis.
Their work is asserted against the necroviolence of border militarization and the
totalizing criminalization of immigrant patients within this zone. In the interior, by
contrast, clinics like CCP aim a more political critique toward “health” itself. They
castigate the for-profit health system for profiteering and collusion with law enforcement,
indicting it for mass structural violence and murder. Despite the necessary differences in
their strategies, IHJ organizations and activists together engage in a “politics of life and
death.” They account for migrant deaths by making them visible. For the deaths of
migrants in the vast deserts of the borderlands, this visibility involves GPS coordinates on
a map as evidence of the fatal consequences of border militarization. In this way, they
attempt to force an “accounting” for these deaths. This politics of visibility is just as
urgent in the interior, where the deaths of uninsured immigrants remain largely invisible
and uncounted. Yet, the grave consequences of the racialized criminalization of migrants
across both the borderlands and interior is largely the same. I argue that framing the work
of immigrant health justice organizations and activists in terms of biocitizenship works to
circumvent and destabilize the false dichotomy of “good” and “bad” immigrants on
which constructions of deservingness revolve and provides a stronger critique of the health effects of immigration enforcement.
Chapter 2

The Biopolitics of Disposability: Structural Violence and the Medicalized Devolution of Immigration Enforcement

“We can’t send him home like this. He needs to go to the hospital,” Robin said in a hushed voice with an uncharacteristic urgency that got my attention. “I just don’t feel right letting him leave here with those numbers. Frankly, I’m worried about DKA.” DKA, or diabetic ketoacidosis, is a serious complication of diabetes that can result in coma or even death.

Robin and a group of volunteer nurses huddled in the cramped hallway outside the lab having a frantic whispered discussion about a new patient. I kept an ear on their conversation as I centrifuged vials of blood and double-checked patient information on lab paperwork.

During their first appointment at the clinic, patients get a “full H and P.” This medical history and physical, especially for diabetic patients, includes a head-to-toe exam looking in particular for lesions on the feet and neuropathy in the lower limbs. Patient also get a fingerprick to check glucose levels, urinalysis to measure ketone levels and assess kidney function, bloodwork to send off to the lab for analysis, and an EKG to identify any heart-related issues. Because the patients at CommUnity Clinic of Phoenix (CCP) are uninsured and mostly undocumented immigrants, this H and P process is usually unremarkable in its consistent revelation of what in other settings would be considered alarming health issues – the debilitating consequences of treatable chronic medical conditions going untreated for years. At this first appointment, volunteers
address the most urgent issues that the clinic is equipped to deal with, such as wound care for open sores they find in the physical exam, and they schedule follow-up visits with the clinic’s holistic healers, naturopaths, and physicians’ assistants.

The new patient in Room Two was different.

Unlike the usual uneventfulness of the H and P, the nurses’ reactions were almost panicked. In my time at the clinic, I had never heard anyone suggest transferring a patient to the emergency room.

As the nurses continued whispering back and forth, Michael, the head nursing volunteer, interjected above the rest of the group, “We need to take a step back and think about this. To us, this looks like an emergency. But he’s been like this, he’s had the same numbers, for the past two years. What are they going to do for him in the ER except for what we can already do here? They’re going to do his labs, vitals, urinalysis maybe, and then refer him to his primary care physician, which he has never had before and which as of today is us. And they’re going to slap him with another $8,000 ER bill that he can’t pay!”

Some of the nurses seemed appeased by this, or at least deferred to his leadership. Robin looked unconvinced by Michael’s reasoning, although she did not bring up the ER again. After some back and forth, the group decided to continue with the patient’s H and P, give him a shot of insulin, re-check his glucose levels before letting him leave the clinic, and follow-up with home visits over the next several days to monitor him closely.

When they dispersed to finish the exam, Michael joined me in the tiny lab office. “I know we have some insulin in here somewhere,” he mumbled under his breath, as he rummaged through one of the mini-fridges full of medical supplies. He found a glass vial
at the back of the fridge, held it up to the light and squinted to read the label, before putting it on the counter. Then digging through a box of syringes, he said, “We have a new patient today. I’m going to send him back for a blood draw and EKG in a minute.”

About an hour later, Diego came back to the lab. As soon as I saw him, I understood why the nurses seemed so flustered. He stood out to me as unlike any of the other diabetic patients at the clinic. For one, he was much younger, probably in his early thirties, with large dark eyes that made him seem even younger than he was. Compared to other diabetic patients who were usually overweight, he was tiny – barely five feet tall and rail thin. Left with only one leg, he used crutches to walk, a telltale sign around the clinic of someone with severe diabetes gone untreated for an extended amount of time. His empty pant leg, which had been rolled up and tied in a knot where his knee used to be, swung limply when he moved. Surrounded by five taller nurses in the cramped lab, he seemed uncomfortable, waiting for someone to give him instructions.

With surgical precision, Maggie, the lab tech, laid empty vials for his blood in a line on the table and then moved across the small room to untangle the EKG cords, swinging them over her shoulder as she threaded them free. She asked Diego to climb up on the exam table, while Michael described an EKG to him in Spanish. Saying nothing, Diego nodded and lay on the table, flaying open his shirt. While Maggie adhered the electric nodes between his ribs, I retreated to the cramped kitchen-turned-office to wait among the other volunteers.
As Diego was getting an EKG and having his blood drawn, Michael and the volunteer nurses joined us in the kitchen and continued discussing his case. Diego had heard about CCP from the Mayor of Guadalupe. Only one square mile in size, Guadalupe is a predominantly Latinx and Yaqui town wedged between the neighborhoods of Phoenix and is marked by extreme levels of poverty; many of the homes there lack running water and electricity. Before his amputation, Diego had been working and was able to rent a room on his own. Now, unable to work and without family in the area, he slept on the couch in a house, relying on his roommates, who all labored as farmworkers. His only food came from whatever extra his roommates could spare – usually a few slices of bread or tortillas each day.

The volunteer nurses had found several festering, open wounds on his other foot and indications of advanced severe neuropathy. His leg was very swollen with no feeling almost up to his knee. This was all a bad sign for Diego’s health and the progression of his diabetes.

In his usual dramatic flair, Michael declared loudly enough for everyone in the kitchen to hear, “You know, if I went to a community of color and beat every one-hundredth person with a baseball bat until they were unconscious and had to go to the ER [Michael had a way of making very vivid, if sometimes strange, analogies], people would understandably be upset with me for such an act of senseless violence. But what we are seeing here and in our communities is no different – it’s structural violence. This guy has had his leg cut off and not because he’s diabetic, because we see lots of diabetics like him that don’t have their legs cut off, but because we have built a system that is structurally violent. We need to start using this language so that people will get that.
We’ve built a system that has refused over and over again to give this patient the health care that he needs. It’s not that he hasn’t tried. He knows that he has diabetes and needs medication to control it, but he hasn’t been able to find anyone to give him any sort of care...except to cut off his leg. So it’s our responsibility to make sure he gets the care that he needs and try our best to help him not lose that other leg.”

As they were leaving the kitchen to continue Diego’s appointment, Robin said, “I’m pretty sure he’s going to lose his other leg though.”

Diego’s story is but one tragic example of the “biopolitics of disposability” (Giroux 2006) that defines the experience of marginalized groups, including people of color and poor people, in the U.S. The biopolitics of disposability refers to social, cultural, and political processes of dehumanization and disenfranchisement.

“Excommunicated from the sphere of human concern, they have been rendered invisible, utterly disposable, and heir to that army of socially homeless that allegedly no longer exist in color-blind America” (Giroux 2006:175). Although Giroux describes the relevance of this term specifically for citizens of color in the aftermath of Hurricane Katrina, this biopolitics of disposability also defines the experience and existence of uninsured, undocumented immigrants in the U.S. In theorizing the dehumanization of marginalized groups, Nancy Scheper-Hughes describes the reduction of “the socially vulnerable (even those from their own class and position) into expendable non-persons” (2004:14). This rendering of specific demographic groups “disposable” involves their strategic and systematic dehumanization, which Lauren Berlant (2007) terms “slow death” or Lisa Cacho (2012) describes as “social death.” Rendering marginalized and
pathologized people ineligible for personhood, this process of dehumanization leads to the allowable killing or justifiable deaths of marginalized people. Thus, the biopolitics of disposability that defines immigrant health in the U.S. perpetuates processes of dehumanization that render immigrants’ suffering and premature deaths invisible, unrecognized (or mis-recognized), unremarkable, and ungrievable (Butler 2009). This chapter examines the biopolitics of disposability as it relates to immigrant health inequalities in the U.S.

In considering the culture of indifference toward the sickness, suffering, and premature deaths of marginalized peoples, immigrant health in the U.S. is predicated on a biopolitics of disposability that renders immigrants’ medical emergencies unrecognized and undeserving of treatment. This biopolitics of disposability gives rise to a structural violence that has embodied consequences – the amputation of a limb or a stroke as a result of untreated health conditions. Exacerbated by exclusionary policies and punitive immigration enforcement, the resulting health inequalities are evidence of the structural violence faced by undocumented, uninsured immigrants in the U.S. Since 2010, a perpetual crisis of immigrant health has been exacerbated by the passage of exclusionary, anti-immigrant policies at the federal and local levels, combined with an escalation of punitive immigration enforcement tactics. Directly contributing to unequal health outcomes by denying immigrants access to insurance and health care, immigration and social welfare policies also render immigrants’ medical emergencies illegible to health care institutions and medical professionals. Due to punitive immigration enforcement, unauthorized immigrants are often reluctant to access what little health care to which they remain entitled, for fear of being subjected to detention and deportation. Taken together,
the effects of these policies and enforcement on immigrant health demonstrate the negative effects of structural violence on the health and well-being of uninsured, undocumented immigrants, as well as the biopolitics of disposability that values immigrants for their exploitable labor alone.

One central factor largely overlooked in the examination of structural violence involves the collusion between immigration enforcement and mainstream health institutions. In addition to the pseudo-medicalization of immigration enforcement through quarantining and medical exams at the border, immigration enforcement has devolved into spaces of health. Health institutions have become places to “catch” the criminal migrant. Described by Maria Ruiz (2002) as the “borderization” of health care, many clinics effectively operate as de facto border checkpoints. Through the devolution of immigration enforcement into spaces and institutions of health, hospitals and medical staff are increasingly operating, not just in collaboration with — but as — immigration enforcement, subjecting immigrants to detection, detention, and deportation. In this way, health institutions and medical providers are implicated as perpetrators of structural violence and complicit in the biopolitics of disposability that characterize the lives of uninsured immigrant patients.

This chapter begins with a discussion about CCP’s structural critique of the brokenness of the health and immigration systems that exacerbate the effects of structural violence on the lives and health of their patients. Next, it examines the centrality of the immigration enforcement strategy of attrition through enforcement to the biopolitics of disposability. In seeking to make life in the U.S. untenable for undocumented immigrants, attrition through enforcement translates into, on the one hand, the
disentitlement of immigrants for social services and health care and, on the other hand, the devolution of immigration enforcement to the local level. Within a biopolitics of disposability, immigrant exclusion from health care renders their medical needs (even ones that are life-threatening) illegible to the mainstream health system and forces migrant patients to manufacture emergencies that further debilitate their health conditions, in order to receive medical services. At the same time, immigration enforcement has devolved to the local level, creating a culture of fear that acts as an additional barrier to health care. This chapter’s examination of the practice of medical deportation indicates that this devolution has extended into the medical setting, rendering migrant patients susceptible to the immigration enforcement apparatus as a result of accessing health care. This chapter concludes that, although institutions of health are figured as solutions to the embodied effects of structural violence, in practice, they often operate as perpetrators of this violence, actively contributing to a biopolitics of disposability that characterizes immigrant health care in the U.S.

CommUnity Clinic of Phoenix: “Not a free version of a broken system”

Located in a small, nondescript beige house on a busy corner in central Phoenix, CommUnity Clinic of Phoenix (CCP) is a free clinic for patients without health insurance and with limited access to health care. Although it is located across the street from a city public health office, the officials there do not know of its existence. Unlicensed and underground with no sign on the outside of the house, CCP operates under the radar. But, for the communities that it serves and the nonprofit organizations and medical providers who refer patients to the clinic, its existence and services are very much a known secret.
In a volatile local context of punitive immigration enforcement, CCP remains “committed to providing quality care, with respect and dignity, to medically-marginalized people,” as stated on their publicity brochures and website. At CCP, these “medically-marginalized people” are all uninsured, mostly undocumented Latinx immigrants. The clinic provides care to almost five hundred patients who are dealing primarily with manageable and treatable chronic health issues like high blood pressure, high cholesterol, and diabetes – issues that have usually gone undiagnosed and untreated for years before they come to the clinic. Operating without government or grant funding, CCP is run completely by volunteers and funded by individual donations, fundraising events like art shows and pig roasts, and the generous donations of two wealthy core organizers.

CCP’s goal is best expressed by a pithy statement bantered about the clinic like a mantra: its unofficial mission is not to replicate “a free version of a broken system.” Cheryl, a trained nurse and long-time volunteer at CCP, succinctly described the clinic’s position to a new volunteer at the clinic, saying, “The health system is inherently broken on a structural level. It’s literally not working. I mean, it’s a health system, it’s supposed to make people healthy. Is that happening? Are we getting healthier? No, there is no way that we could argue that. So the system isn’t working for people. It’s inherently flawed.” This brokenness of the “system” is demonstrated by 1) the structural oppression of marginalized groups that leads to poor health outcomes and denies them access to care combined with 2) immigration policy in the U.S. that criminalizes Latinx immigrants as “illegal.” The resulting serious, often fatal, consequences are at the heart of the clinic’s critique of the intersecting broken systems of immigration and health care in the U.S. Specifically, this critique takes aim at the structural violence inflicted on CCP’s patients
as a result of the for-profit nature of the mainstream health care system, the exclusion of immigrants from health care coverage, and the detrimental effects of punitive immigration enforcement tactics on immigrants’ health and quality of life. This chapter focuses on the clinic’s social and political critique of the “broken system,” while the following chapter will examine CCP’s alternative vision of immigrant health justice for all and assertions of substantive biocitizenship on behalf of their patients.

CCP critiques the for-profit nature of the mainstream health system as a fundamental aspect of the “brokenness of the system.” As Donna, one of the clinic organizers, repeated again and again, “People’s health should not be a business.” At the heart of CCP’s immigrant health justice framework is a critique of the mainstream for-profit health system, which activists and volunteers at the clinic call the “medical-industrial complex.” Critical health scholars have developed a holistic critique of modern industrialized healthcare, showing how myriad entities, including pharmaceutical and insurance companies, research laboratories, hospitals, medical professionals, and even medical debt collection agencies, all have vested financial interests in health care (Lauritsen 1993; Welch 2009; Weller 1977). This medical-industrial complex relies on a “consumerist rhetoric” (Metzl 2010:6), predicated on the medicalization of social problems as health issues and thus the continual creation of patients as consumers of medical services. “In the past, people sought health care because they were sick. Now the medical-industrial complex seeks patients…if health is the absence of abnormality, the only way to know you are healthy is to become a customer” (Welch 2009:D5). Within a for-profit health system, the way to generate a profit is through a consistent proliferation of categories of sickness, combined with the ever-increasing costs of medical services
and medications. Under the medical industrial complex, this system churns out (wealthy and/or insured) patient-customers who purchase costly products and procedures in the attainment of an ever-elusive “wellness.” It also generates a class of “non-patients,” who are ineligible for health care due to their socioeconomic or immigration status. For uninsured immigrant patients, this system results in an almost complete inability to access medical care.

**Structural Violence and Immigrant Health Inequalities**

In discussing his leg amputation, Michael argued that Diego was a victim of “structural violence” that, in consequence, is the equivalent of actual physical violence. Calling out and identifying structural violence exposes the social inequalities and systems of oppressions that create unequal health outcomes for marginalized groups. In the absence of a recognition of structural violence, uninsured immigrants like Diego, facing the debilitating results of untreated chronic health conditions, bear the brunt of the “blame” for their own health conditions, supposedly the result of individual choices and risky behaviors or even a deficiency in genetics. In an elaboration on his understanding of the impact of structural violence on CCP’s patients, Michael stated, “When we see populations with poor health outcomes, it’s not because they are genetically-weak. It’s because we have built structures and systems that oppress them, that deny them access to care…It’s a method by which oppression is perpetuated.” Shifting the responsibility of ill health from individual patients to a larger structural critique, volunteers and organizers at CCP use the concept of structural violence as an indictment of the social inequalities and structural forces that result in embodied health consequences for the clinic’s patients.
Structural violence refers to physical and psychological harm systematically exerted against individuals facing social inequality and oppression (Farmer 2004; Farmer et al 2006; Galtung 1969, 1975, 1990). Embedded in social structures and normalized by social institutions and interactions, structural violence, unlike more direct physical violence, does not usually have a specific or identifiable perpetrator. As such, it often goes unrecognized as violence or mis-recognized as the result of individual behavior or choices (Farmer 2004). In this way, Nancy Scheper-Hughes argues that “structural violence erases the history and consciousness of the social origins of poverty, sickness, hunger, and premature death so that they are taken for granted and naturalized so that no one is held accountable except, perhaps, the poor themselves” (2004:14). The concept of structural violence is particularly useful in shifting from more individualized or cultural explanations of immigrant health disparities to a structural social determinants of health analysis and for exposing the broader biopolitics of disposability that characterizes immigrant health in the U.S.

As Michael insists with his comment about the baseball bat, structural violence is embodied through sickness, suffering, and death in ways that ultimately look like actual violence perpetrated on the bodies of marginalized people. In *Fresh Fruit, Broken Bodies*, Holmes highlights the importance of recognizing the embodied health effects of structural violence, arguing, “By structural violence, I mean the violence committed by configurations of social inequalities that, in the end, has injurious effects on bodies similar to the violence of a stabbing or shooting…Structural violence—with its pernicious effects on health—and symbolic violence—with its subtle naturalization of
inequalities…form the nexus of violence and suffering through which the phenomenon of migrant labor in North America is produced” (2013:43-44).

In constructing a response to the structural violence faced by their patients, CCP pushes back against the individualizing and patient-blaming narratives that vindicate or erase structural violence and the multiple oppressions of the mainstream health system. Michael and the other volunteers and organizers at CCP are not ignorant to these scholarly debates. In fact, many of them have read Paul Farmer’s work on structural violence and have modeled their own structural analyses and health practice on his and others’ writings. In this way, their work at the clinic is more than health care provision – it’s praxis. Recognizing that the health system is, at its core, structurally violent toward uninsured, undocumented migrants, CCP understands diseases and chronic health conditions like diabetes as the embodied effects of structural inequalities that are distributed along lines of race and immigration status. These inequalities are created and exacerbated by punitive immigration policy and enforcement.

In addition to Diego’s amputation, another stark example of the structural violence embodied in sickness and suffering for CCP’s patients includes the years-long struggle of one of the clinic’s patients, Dulce, to get treatment for an infected gall bladder. Dulce was a bilingual woman with two school-aged children whom she home schooled. To make money, she cooked and sold tamales informally. CCP learned of her health condition because she was Michael’s “tamale lady.” She started having gall bladder attacks – “I don’t know if you know anything about gall bladder attacks,” Daria, a main nursing volunteer at CCP told me, “but they are extremely painful, on par with the pain of childbirth. The pain causes nausea and vomiting. It’s horrible.” Dulce went to the
emergency room, but because she did not have fever or a rise in her white blood cell count indicating an infection, she was told that her condition was not emergent and, thus, not eligible for treatment under Emergency Medicaid. The hospital did tell her however that they would be happy to remove her gall bladder for a cash payment of $25,000. Dulce lived with a bad gall bladder for years, trying her best to control the attacks with diet changes. Eventually though, her gall bladder became gangrenous from gas forming bacteria inside and filling it up with infection. At this point, with the pain unbearable, she went to the emergency room again. However, instead of removing her gangrenous gall bladder, they put in a T-tube through which the bile from her gallbladder could drain into a bag attached to her body and sent her home with antibiotics for the infection. Usually a T-tube is placed after gall bladder surgery. Daria said, “Once the tube was placed, Dulce’s condition was again no longer considered an emergency, and she still had to come up with $25,000 if she wanted it removed. Basically, she lived for years with this infected sludge inside her but without fever and no systemic infection. She went from one ER to the next but they always said it was too much of a liability for them. She had to go back to the original facility for care.” Finally, Michael was able to coordinate with a friend of his who was an ER doctor and a surgeon on call, and they were able to remove her gall bladder and the T-tube from her body after years of living in constant excruciating pain. The surgeon said that the gallstone in her gall bladder was the largest he had seen in his entire career. He had to triple the size of a normal incision in order to remove her infected organ. After the surgery, she had to remain in the hospital for a week as her body was suffering essentially from starvation, having been depleted of nutrients from her constant vomiting for months before her surgery. Upon recounting her ordeal,
Dulce said, “But I’m home. I’m alive. And I’m back with my beloved family again.” In comparing the structural violence that Dulce faced, Daria referenced Paul Farmer’s writings on structural violence evidenced by his patients in Haiti, saying, “We’re not far off from Haiti, and that is saying a lot! As more stories like this circulate about the structural violence faced by migrant and citizen patients, I’m hoping that there is a sea change in favor of health care for all. The system is so broken.”

**Attrition through Enforcement: Exclusionary Policies and the Devolution of Immigrant Policing**

Part and parcel of this broken system, as the immigration enforcement strategy that governs the interior of the U.S., “attrition through enforcement” has detrimental consequences for immigrants’ quality of life and health across the interior of the country. This policy aims to make life for undocumented immigrants in the U.S. so hostile, risky, and precarious that they leave the state or country on their own accord (Theodore 2011). In this way, attrition through enforcement is a policy of disposability. The ingredients for this harsh environment include 1) the passage of legislation that limit immigrants’ access to employment and social services and 2) a devolution of federal enforcement authority to the local level that increases immigrant susceptibility to detention and deportation.

Backed by conservative politicians including former Arizona Republican Governor Jan Brewer, attrition through enforcement is at the heart of a series of “illegal immigration relief” policies across the country, including Arizona’s infamous SB 1070. These punitive and restrictionist anti-immigrant policies on the local level “share a common set of policy objectives aimed at fundamentally disrupting everyday life for
Unauthorized immigrants by restricting access to employment, housing, health care, and social services” (Theodore 2011:91). This disruption includes tightening restrictions and punishments for companies that employ undocumented immigrants, while eliminating social service provision for immigrants, including health care access.

Regardless of whether it motivates immigrants to leave the country, attrition through enforcement has material consequences for undocumented immigrants in the U.S. For the majority of immigrants who choose to remain in the U.S., the reality of daily life is becoming increasingly hostile. As attrition through enforcement has made employment, social services, and health care difficult if not impossible to access, countless immigrants have faced decreased quality of life and deteriorated health. Attrition through enforcement involves the systematic dismantling of welfare safety net services that render immigrants destitute, even as employment becomes increasingly difficult to access due to heightened regulation. As a result, it exacerbates the precarity and disposability that defines existence as undocumented in the U.S. and renders undocumented laborers that much more exploitable by their employers and vulnerable to immigration enforcement.

In particular, attrition through enforcement encourages the devolution of federal enforcement authority to the local level and the increased monitoring and surveillance of immigrants and their communities in the interior. In my fieldwork, this devolution was evident in the aftermath of the infamous SB1070 legislation in Arizona. At its passing in 2010, it was the most punitive immigration policy in the country. Known as the “show me your papers” law, it requires local police to determine the immigration status of anyone arrested or detained. Critics have argued, and indeed courts have ruled, that it
effectively legalizes racial profiling. This included the targeting of Latinx individuals during traffic stops and neighborhood and work-place raids. Increasingly, this devolution is extending to social service and other civil society organizations. For instance, in a recent court case in Washington state, Motel 6 was found to have released lists of its guests to ICE who scanned them for “Latino-sounding names” (Rosenberg 2018; see also Jacobs 2018). Central to attrition through enforcement is a disentitlement of immigrants to social services and health care.

**Immigrant Exclusion from Health Care**

Predicated on a biopolitics of disposability and notions of immigrant undeservingness, social policies and health care legislation severely restrict immigrants’ access to social services in the U.S. Over the last twenty years, federal and local policies based on the ideology of immigrants as burdensome and undeserving have defined immigrant exclusion. In particular, the 1996 welfare and immigration reform legislation drastically altered entitlements for immigrants, rendering undocumented immigrants and some legal permanent residents explicitly ineligible for means-tested social services, including welfare and health care. More recently, immigrant ineligibility for health

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6 Immigration reform, or the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), made numerous changes to the surveillance of undocumented immigrants and aimed to curtail their ability to gain employment by introducing pilot programs for what came to be known as “E-verify” to ascertain an employee’s immigration status for working in the U.S. Furthermore, the 1996 welfare reform legislation, or the Personal Responsibility and Work Opportunity for Reconciliation Act (PRWORA), limited qualified beneficiaries for federal means-tested benefits, including cash assistance and public health care, to individuals with formal citizenship. Legal immigrants also became ineligible for these benefits for the first five years of their residence in the U.S. (Okie 2007; Park 2005, 2011; Viladrich 2012).
insurance coverage was further enshrined under the 2010 Patient Protection and Affordable Care Act (ACA), which denied immigrants access to the expanded health coverage offered to previously-uninsured U.S. citizens (Agabin and Coffin 2015; Marrow and Joseph 2015; Wallace et al 2013; Zuckerman et al 2011). Immigrants who have been in the country as legal permanent residents for less than five years as well as those without formal status or papers remain ineligible for health coverage; they are even prohibited from privately purchasing insurance on the health exchanges (Buettgens and Hall 2011; Marrow and Joseph 2015).

When I asked volunteers and organizers at CCP about their opinion of the Affordable Care Act, which during my fieldwork was in a period of active enrollment for uninsured U.S. citizens, they acknowledged that the ACA did grant access to health insurance and health care for some uninsured citizens. However, they argued that rather than addressing the fundamental “brokenness of the system,” the ACA expanded to uninsured citizens access to this broken system of privatized, for-profit health care. However, if anything, the ACA actually widened the gulf in health disparities between insured U.S. citizens and uninsured immigrants. As ACA implementation has unfolded, the remaining uninsured population in the U.S. is comprised mainly of unauthorized immigrants and the poorest citizens. As a result of their continued exclusion from health care coverage, the only recourse for medical care for uninsured immigrants is either in hospital emergency rooms or in sliding-scale and free clinics, like CCP, that provide limited services.

Combined with the for-profit motive of the mainstream health system, the continued exclusion of immigrants from health care is a fundamental aspect of the
“brokenness of the system,” according to CCP organizers, who argue that health care is a right that should be available to everyone regardless of socioeconomic or immigration status. In the absence of health care provision and access for uninsured immigrants, chronic and acute health issues go untreated and often become debilitating or life-threatening. Michael called the unequal access to health care and the unnecessary deterioration of health for the clinic’s patients “a scandal,” saying,

Health care systems that don’t provide equal access are in attack, violent attack, against vulnerable people. It’s time for us to stop thinking about it as a somewhat broken system and start seeing it as a scandal. Because that’s what it is, a scandal…This isn’t some hypothetical thing to me. I see [patients] every day at the hospital because they didn’t get the care they need. And when they get to the hospital, it’s too late. The stroke already happened and maybe they’ll recover and maybe they won’t.

In this comment, Michael calls out the structural violence associated with the exclusivity of the mainstream health system that denies health care access to uninsured and undocumented immigrants. Working as a hospital nurse as well as a core clinic volunteer, Michael saw firsthand, at both the hospital and CCP, the dire consequences of manageable health conditions in the absence of health care.

One such patient, Francis, was a young refugee in his thirties from the Horn of Africa with two toddlers and a wife who was pregnant with their third child. He suffered a massive stroke as a result of untreated hypertension that left him paralyzed on his left side and unable to walk or work. At the time, he and his family were living in a Phoenix-area church, but upon his discharge from the ICU, the church determined that they did not have the capacity to house the family any longer. As they were left with nowhere to live, Michael and some other volunteers at CCP got wind of Francis’ condition and helped his family find an apartment. Because Francis did not have insurance, he did not
get the follow-up care after his stroke that he so desperately needed. As a result, his joints were immobile and his left hand and arm curled up tightly into his body. Oscar, the volunteer physical therapist at CCP, started working with Francis several times a week to stretch out his atrophied muscles and help him regain strength and mobility in his left arm and leg. Trained by Oscar on what stretches Francis should be doing, volunteers from the clinic started making regular house calls to help him with his rehab exercises and bring packages of food to the family. Gradually, he regained the limited use of his arm and was able to walk again. Donna, a core CCP volunteer, put it this way, “I’m so glad that we found him. Otherwise, I don’t know what would have happened. He probably would have laid in bed until he died.”

In this way, exclusionary policies that deny health care access for immigrants in the U.S. are a defining factor of the brokenness of the system that creates a perpetual crisis of immigrant health. As demonstrated by Francis’ stroke, this crisis involves delayed or denied treatment of what are often manageable chronic health conditions, like diabetes and hypertension, that lead to more acute (and expensive) health problems, and even hasten the premature deaths of immigrant patients. As a result, the exclusion of immigrants from health care access results in the embodiment of structural violence as debilitating and life-threatening health issues, in the form of organ failure, amputations, and the uncounted deaths of immigrants in the U.S. from treatable health conditions. The pervasive biopolitics of disposability associated with an exclusion of immigrants from health care that led to Francis’ stroke and his lack of aftercare also causes immigrants’ medical emergencies to go unrecognized or mis-recognized by hospitals and health care providers.
Immigrant Long-term Health Needs and the Illegibility of Medical Emergency

Diego’s story at the beginning of this chapter provides a stark example of the ramifications of immigrant health care ineligibility that leave millions of uninsured, undocumented immigrants unable to access medical treatment. Even though timely treatment of his condition may have made the difference between losing or keeping his leg, exclusionary immigration and health policies combined to leave him unable to access the medical care that he needed. Although his deteriorated health resulted in the loss of his leg (and potentially other debilitating medical conditions), Diego’s diabetes was not considered an “emergency” by hospitals until he needed an amputation, a costly procedure which would have been wholly unnecessary if he had received regular care to maintain his diabetes. The little care he had been able to access in the emergency room left him with exorbitant medical bills that he was unable to pay and made him hesitant to return to the hospital. In discussing the decision-making considerations around advising CCP patients when to go to the emergency room for care, Michael outlined some important things to consider,

That’s the issue we have at CCP when we have to figure out if we are going to send a patient to the ER or not. Is this issue going to be considered an emergency? Also, often when we tell patients or family members to go to the emergency room, we need to understand their hesitancy because, if it’s not an “emergency” in the sense that is covered by emergency [Medicaid], then they will get slapped with a bill, and they know that. So sometimes, we tell them to go to the ER, but they actually don’t go because they are worried about having to pay for it or being deported.

Michael’s comment raises a host of important questions about the emergency room as an option for health care for CCP’s uninsured immigrant patients. In many ways, not going
to the ER for medical care is a more rational decision, in terms of financial ramifications and personal safety, for undocumented migrants. It is perhaps unsurprising then that undocumented immigrants access health care in emergency rooms at a much lower rate than U.S. citizens (Derose et al 2009; Siddiqi et al 2009; Tarraf et al 2014). James Quesada argues, “Despite popular and official perceptions that the undocumented over-utilize medical services and purposely migrate to take advantage of health and social services, it appears that the undocumented use fewer medical services than citizens – often to their detriment, for instance when they wait until they are very sick to seek medical attention for fear of being discovered” (2012:894). Although many politicians cite as fact the drain on resources that undocumented immigrants are supposedly causing our health system, the costs of care for uninsured immigrants account for less than 1% of Medicaid costs (Galewitz 2013). One of the main barriers that keeps uninsured immigrants from accessing care in the ER is an extremely narrow definition of “medical emergency” that determines what procedures are covered by emergency Medicaid and what care the patients must pay for out of pocket, or as Michael described it, “Is this going to be considered an ‘emergency’ or not?”

In order to avoid a financial “emergency” associated with uncompensated health care costs, hospitals and Medicaid officials narrowly-define “medical emergency” to entail only immediate life-saving care to the detriment of patients’ health. As the federal legislation defining medical emergencies, the Emergency Medical Treatment and Labor Act (or EMTALA) includes the mandate related to screening and emergency health care provision for uninsured patients. For uninsured immigrants, it largely defines the conditions under which they are able to receive any medical treatment in the formal
health care system. Intended to safeguard uninsured, indigent patients from “patient dumping” by hospitals that did not want to incur the costs for their care, EMTALA requires hospitals to provide appropriate screening and triage to patients who seek medical care in an emergency room and to stabilize patients that present with an “emergency medical condition.” According to EMTALA, “emergency medical condition” is defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in – 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions – 1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or 2) that transfer may pose a threat to the health or safety of the woman or the unborn child. (CMS 2012)

Although this definition may seem comprehensive, EMTALA remains a frustratingly ambiguous piece of federal legislation in its lack of clarity and specificity of the interpretation of this definition of medical emergency as well as in “ineffective monitoring and enforcement and a lack of uniformity among courts interpreting the statute” (Schaffner 2005:1021; see also Zibulewsky 2001). In 2003, the Centers for Medicare and Medicaid Services (CMS) published regulations to explain more specifics about the law. However, these clarifications effectively weakened and narrowed the scope of the legislation, limiting hospitals’ responsibilities in the provision of emergency medical stabilization “in a way that guarantees uninsured patients even less access to emergency medical care…[and] allows the emergency department to circumvent its duties under the Act” (Schaffner 2005:1039). As a result, the legal definition of “medical
“emergency” has become increasingly narrow to the point that hospitals, for purposes of Emergency Medicaid reimbursement, largely interpret it to mean only the most immediate life-stabilizing medical treatment. Uninsured, indigent patients who present at the emergency room for care are frequently turned away because their condition does not meet this narrow definition.

In this way, medical conditions that are actually (although not immediately) life-threatening do not meet this definition. For example, when Jesus, a longtime patient at CCP, was experiencing a heart attack, he went to the emergency room at the local hospital. Donna recounted the experience that Jesus had in the ER and the care that he did (and did not) receive.

The [emergency room doctors] realized he was having a heart attack and injected him with dye to see where the blockage was. They found that he had significant blockages in two of his arteries. So they put a stent in one of the arteries, but they had already filled him with as much dye as they could. (You can only inject so much dye at one time because it can have negative effects on the kidneys.) They didn’t want to damage his kidneys, so they basically stabilized him and put a stent into only one of his blocked arteries and left the other one untreated. Then they said, ‘Come back in a week for follow-up, and we’ll put a stent in the other blocked artery.’ But the problem with emergency [Medicaid] is that it doesn’t actually pay for any follow-up. So this patient went back for his follow-up appointment, and there is nothing they can do for him because it’s not considered an emergency. They literally have to wait for him to have another heart attack before the situation is considered an emergency and they can stent the other artery. [At that point] you’ve got a patient with heart damage and congestive heart failure, who is going to be in and out of the hospital for the rest of his life. Even if you don’t have the politics and only care about the money, that makes absolutely no sense because it would have been exponentially cheaper to just treat him in the first place than wait for him to have another heart attack to treat him, and now you have a patient with a chronic health condition on your hands. It’s just the rational option, it’s much more rational monetarily. But under emergency [Medicaid], there is no outpatient follow-up once the patient is stabilized.
The hospital’s refusal to recognize Jesus’ need for a second stent as a medical emergency not only leaves him without necessary medical care but also potentially exacerbates his health condition, leaving him at risk of developing a chronic, ultimately fatal medical issue. Uninsured immigrants’ lack of preventative and primary health care creates more serious and more costly medical needs, and in doing so, turns treatable health conditions into life-threatening ones.

The example of the inadequate health provision Jesus received in the emergency room demonstrates the ways that exclusionary immigration and social policies create parameters for the narrow definition and treatment of immigrants’ long-term care needs. For patients with chronic long-term health conditions, this system for emergency treatment exacerbates their health issues with fatal consequences. These emergencies remain untreated until (or even when) they result in life-threatening medical events, like a stroke or heart attack, or the debilitation of a patient’s health until they need a leg amputated or become reliant on dialysis due to kidney failure from untreated diabetes. Adding insult to injury, the cost of putting in a second stent so that Jesus could avoid a second heart attack is exponentially less expensive than treating congestive heart failure, calling into question not only the long-term financial efficacy of this definition of “medical emergency” but also the sincerity of this financial explanation as the real reason for the denial of health care to uninsured, indigent immigrants.

This narrow definition of medical emergency and the illegibility of immigrant health emergencies demonstrates the disposability of migrant patients within a health system that refuses to recognize their health needs or grant them patient status. On the one hand, each dollar spent on the cost of care for undocumented patients is painstakingly
accounted for as a dollar *not* spent on the health care of a U.S. citizen patient. However, the cost of uncompensated care is grossly inflated by immigrant exclusion from health care coverage as well as the financially counterproductive practice of treating uninsured immigrants only when their health needs become medical emergencies that are “legible” to the mainstream health care system. This financial strain on public safety-net hospitals, created by these penny-wise, pound-foolish policies and the self-fulfilling narratives of immigrant patients as “burdens,” is then used as a justification to deny health care to these very patients. On the other hand, while each dollar is accounted for, there is a distinct lack of a “body count” for the patients who die as a result of the lack of access to care. This failure to count the bodies of immigrant patients downplays, makes invisible, and contributes to the biopolitics of disposability and the structural violence perpetrated on immigrants with health conditions across the U.S.

**Manufacturing (Medically Legible) Emergencies**

As a result of the illegibility of medical emergency created by exclusionary health and immigration policies, uninsured immigrant patients are forced to either jeopardize their own health by waiting to access emergency treatment until they are on the verge of death or to manufacture emergencies that are medically-legible to mainstream health institutions in order to receive health care. Patients must creatively work around the narrow definition of “emergency” in order to access medical care. This includes being vague or even intentionally misleading about the urgency and temporality of a health condition so that it is more likely to be defined as emergent. At another day at the clinic, a group of CCP volunteers were discussing Jesus’ case and his desperate need for the
second stent before he had another heart attack. Michael mentioned that one simple way to work around hospitals’ narrow definition of emergency is to advise Jesus to be more vague about the temporality or details of his medical condition so that it is more likely to be interpreted as an emergency both by the ER triage nurses and under Emergency Medicaid eligibility criteria:

“He could always go back to the emergency room and try to get follow-up that way,” Michael suggested somewhat cryptically.

“But you can’t do that for someone who had a health episode several weeks ago. They’ll never admit him through ER,” said Ed, a physician’s assistant who was known for being more “by the book” than Michael.

“Yeah, that’s why you don’t tell them that it happened several weeks ago,” Michael responded.

“Oh, so you just lie then!?” Ed retorted incredulously.

“Yeah, that’s just how you have to do it,” Michael said nonchalantly, unphased it seemed by the strong emotion in Ed’s response. “He just goes back in and says he is having chest pains. They will screen him for a heart attack and find the blockage in the other artery. How else is he gonna get any care without having another heart attack?”

Ed and Michael’s discussion hints at one way that uninsured immigrant patients are forced to “fudge” the details of their health conditions, fabricating an immediacy so that they are more likely to be considered medical emergencies and treatable in the ER. This discussion also points to the way that the health practitioners who volunteer at CCP act as brokers to the mainstream health system for their patients, giving them the discursive tools through which to claim patient status. This brokerage is similar to asylum lawyers coaching their clients on how to describe their experiences in a credible threat interview in order to gain asylee status. It is not that they are teaching them to “lie” as Ed asserts, but that they are giving them the discursive parameters around which to frame their
experience so that it will be recognized and deemed “actionable” or valid bureaucratically.

Another way to access care in the ER for a medical emergency involves uninsured patients actively damaging their own health in order to manufacture or hasten an immediate, life-threatening emergency. For instance, uninsured immigrants with kidney failure, who have no other option for dialysis except emergency inpatient treatments, reported deliberately trying to elevate their potassium levels by “eating entire bunches of bananas or drinking the water from canned tomatoes” before heading to the hospital, to increase their chances of being admitted to the ER and receiving emergency dialysis (Hawryluk 2016). In my own fieldwork, I heard about many harrowing examples of the lengths that patients had to go to ensure their medical conditions were considered emergencies in order to receive medical care. For example, one CCP patient Celia, who had gone to the ER with a stroke, had been given a temporary feeding tube. She returned to the hospital several weeks after her discharge to have the tube removed. However, when she returned, she was told that they would not remove the feeding tube because she was not insured and eligible only for emergency care. Feeding tube removal was not considered an “emergency” procedure. Celia called CCP from the hospital in frustration, hoping to get some advice about what to do. Cheryl recounted the advice that they gave Celia:

We said, not entirely seriously, that she could go out into the parking lot right in front of the ER, grab hold of the feeding tube where it was coming out of her abdomen and yank it right out of her body, then walk right back into the hospital, into the ER bleeding everywhere, like “well, now I have an emergency”…It’s disgusting but that would be the only way she was going to get the feeding tube out. But what is more disgusting is that hospital staff know full well that without insurance she is never going to get the care
she needs at the follow-up appointment, but they go ahead and schedule the appointment anyway. That way it’s not their problem. They’ve done technically what they are supposed to do to discharge this patient, but it has completely passed the responsibility and the issue onto someone else. The unsuspecting patient is the one that suffers. They go back for their follow-up appointment, and they can’t actually get the care they need because it’s not considered an emergency at that point.

When Cheryl was recounting this gruesome story in the clinic’s cramped kitchen that doubled as the volunteer space, the trained medical professionals volunteering at the clinic that day (who knew better than I what this “yanking out” of her feeding tube entailed) all visibly shuddered and grimaced. An abdominal feeding tube is connected directly into either a patient’s stomach or their intestines and is held in place by a coiled metal wire or a balloon inside the patient’s abdomen. It is unclear from this interaction whether Celia actually ended up pulling out her feeding tube – it would take a herculean resolve to actually go through with it – but the important point of this example is that, unable to get someone at the hospital to remove the feeding tube for her, Celia’s only option was to partially disembowel herself, pulling the entire feeding tube apparatus out of her body, in order to create a medical emergency that would be treatable and treated in the emergency room.

As a result of the narrowing legal interpretation of “emergency medical condition” under which hospitals are required to provide care to uninsured and indigent patients, immigrants without insurance or authorized status are forced to compromise their health and their very lives to create emergencies that are recognized as such by health institutions. This issue of legibility is central to the perpetual crisis of immigrant health in the U.S. In a wider context of immigrant health that is characterized by a biopolitics of disposability, patterns of structural violence dictated by exclusion from
health care and the lack of emergency care force immigrant patients to participate in their own self-harm by creating medically-legible emergencies in order to receive medical treatment.

The Local Devolution of (Pathogenic) Immigration Enforcement

In addition to immigrant disentitlement and exclusion to health care access, the second main tenet of attrition through enforcement is the devolution of immigration enforcement to local police. This local devolution is exemplified in the information-sharing and collaborative partnerships that effectively task local law enforcement with federal immigration authority. Mathew Coleman and Austin Kocher (2011) describe the trend of “an unprecedented devolution of a once exclusive federal power to regulate immigration to non-federal law enforcement agencies operating in non-border spaces in the post-9/11 environment” (228). Through programs like Secure Communities and 287(g), federal immigration enforcement authorities partner with local police and DHS officials to identify undocumented immigrants in local jails and communities for detention and deportation. These programs also extend deportation authority to local law enforcement institutions and deputize police officers and DHS officials to act as federal immigration agents. In the devolution of immigration enforcement authority to the local level, Secure Communities and 287(g) have dramatically increased the scope of monitoring and surveillance of immigrant communities around the country. They also marked an extension of immigration enforcement from the borderlands to the interior, proving to be one way the border “moves” so that “the border – and border enforcement – is increasingly everywhere” (Coleman 2007:64, see also Bosniak 2006).
Both Secure Communities and 287(g) have come under fire from immigrant rights advocates for encouraging racial profiling of immigrants and people of color. Maricopa County Sheriff’s Office (MCSO) and former Sheriff Joe Arpaio were arguably the most brazen in their use of the 287(g) authority to racially profile immigrant communities. The power given to local law enforcement in Maricopa County under 287(g) was used to justify “sweeps” and raids in Latinx communities across the county. These included traffic checkpoints set up in neighborhoods with higher concentrations of Latinx and immigrants of color, the targeting of bus stops in these same neighborhoods where kids would wait to catch the bus to school, and workplace raids at restaurants, construction sites, grocery stores, car washes, and other businesses that employed Latinx workers. As a result of the threat and fear of deportation, many immigrants limited their mobility to avoid detection and apprehension: on the one hand, not using public transportation as immigration authorities arrested people on buses and at bus stops (Chavez 2012:185-186), but on the other hand, either avoiding driving altogether or vigilantly obeying traffic laws so as not to get caught in a routine traffic stop. Under the tyranny of Sheriff Arpaio, many immigrant and Latinx residents even avoided grocery stores, as local officials were rounding people up while they were shopping. Although this chapter will not recount the litany of abuses perpetrated by the local police during Arpaio’s reign of terror, it is virtually impossible to overstate the palpable effects and the culture of fear that these tactics and abuses had and continue to have on Latinx and immigrant communities in and around Phoenix.7

7 In response to these tactics and the racial profiling used to target Latinx neighborhoods, the Department of Justice filed suit against Arpaio for unlawful discriminatory police
This culture of fear created by attrition through enforcement and the related devolution of federal immigration authority to local law enforcement impacts the health of undocumented immigrants both directly and indirectly. The fear associated with encountering immigration enforcement and being subjected to detention and deportation effectively dampens immigrants’ health-seeking behavior, adding another layer to the barriers to care that immigrant patients face. According to long-time volunteers at CCP, Sheriff Arpaio and his deputies parked sheriff’s vehicles (with the phone number for a hotline to report “illegal immigrants” emblazoned on the side) in front of hospital emergency room entrances (see Figure 4). The presence of the van was often enough to deter potential patients, but for the desperate who still attempted to access emergency medical care, sheriff’s deputies would check their immigration status on the way into the ER. At a volunteer training workshop at CCP, clinic organizers recalled these tactics and the resulting fear of accessing health care that the clinic’s patients had experienced.

“In thinking about what our own patients have gone through when trying to access health care, it’s important to remember that Arpaio and his goons used to park their trucks and sit outside the ER, checking people’s papers as they went in to the hospital,” Ed said.

Donna interjected, “They also busted health fairs.”

“Yeah,” Ed continued, “They would turn up at free health fairs put on for the [Latino immigrant] community and round people up. So that is the context for health that our patients have as their frame of reference. We need to be aware of this because for new patients walking into the clinic, this is the history of health care access in this state that they have as their frame of conduct after an investigation concluded that he “oversaw the worst pattern of racial profiling in U.S. history” (Stern 2011). Arpaio was ordered to end workplace raids and stop using the task force model of patrolling streets to round up people racially profiled as undocumented immigrants. When he blatantly refused to comply with this court order, he was found guilty of contempt of court, but before being sentenced to prison time, was pardoned by Trump.
reference. It’s a scary situation. And it’s no wonder that many of them haven’t tried to get medical care in the formal health system.”

In this discussion, Ed and Donna explained to volunteers, who are mainly medical students and health care providers, the reasons that CCP’s patients are reluctant to get medical care. Heyman et al (2009) describe this as a “learned avoidance of the health care system” (18). This avoidance is both a rational choice to protect against immigration enforcement and a contributing factor in the unequal health outcomes experienced by undocumented immigrants.

Figure 4: Sheriff Arpaio’s infamous MCSO trucks were parked in front of hospital ERs. Photo credit: Matt York/Associated Press

In addition to the negative health effects of exclusionary health policies, immigration policy and enforcement also contribute to and sustain existing health
disparities. “Pathogenic” immigration enforcement guides “immigrants’ conduct in ways that harm their well-being and have consequences that impact individual immigrants’ behaviors and support structural health inequalities” (Kline 2017:405). As a mechanism of governance that causes migrants to avoid accessing medical care, this fear exacerbates existing health conditions and contributes to negative physical and mental health outcomes, not only for undocumented immigrants but also for their family members, regardless of immigration status (Allen et al 2015; Hacker et al 2011, 2012; Hardy et al 2012; Maldonado et al 2013; Miller and Rasmussen 2010; Rhodes et al 2015; Silove et al 2001; Valdez et al 2013; Viruell-Fuentes 2007; White et al 2014). These diminished health outcomes as a result of the fear of immigration enforcement can have fatal consequences.

During one of my follow-up visits to Phoenix after my fieldwork, I met up with Cheryl, one of the main nursing volunteers at the clinic. Over dinner she asked how my project was coming along and gave me an update about Jesus’ heart condition:

I’m not sure if you knew this, but he needs a valve in his heart replaced. It’s a big deal, and if he doesn’t get it done, he’s going to die from it eventually, probably sooner than later. I’ve been trying for years already to figure out how to help him get it replaced. I’ve been asking around with CCP volunteers and other medical folks to see if there was any way he could get this surgery. I mean, it’s such a long shot, you know?

I finally connected with a resident here whose supervisor is a surgeon in the New England area, near Boston. The doctor was a Peace Corps volunteer and a real do-gooder type, and I think frankly he was excited to hear about this need and be able to do something about it, like he was looking forward to helping make a difference in this way.

The surgeon said that Jesus should come to his ER and say that he has shortness of breath, and then he would make sure he was the one who ended up treating him. He would be able to charge the surgery to the state, and Jesus wouldn’t have to pay anything. But that meant we had to get him to
Boston. He wasn’t about to fly there because he feels like it’s too risky, so
the plan was that Jesus, two of his grandchildren, and I would drive him
across the country from Phoenix to Boston.

But he’s not going to do it. I’m crushed.

I think he probably would have gone for it if Trump weren’t elected and
 cracking down so much. He’s just too scared to make the journey. He’s
worried that we’ll get pulled over en route, and he will be arrested and
deported. He said that if he is deported he will most certainly die – it would
break his heart – so he is unwilling to risk the trip, even though it means he
could get the surgery that he has needed for years.

I tried to explain to him that the rest of the country isn’t the same as it is in
Phoenix. You know people don’t care, and they don’t profile Latinos as
much. I even told him that if we were driving – because I would be the one
doing the driving – and we’re pulled over, they only want to see my driver’s
license, not anyone else’s. It’s not like when the Border Patrol pulls you
over. And if they ask, I’ll say he’s my husband. We’d be fine probably, you
know. But nothing would convince him to make the trip.

He’s such a family man. He couldn’t survive without this family. It probably
would kill him if he was arrested and deported.

But, I really believe that this was his one chance. He’s never going to get
that valve replaced now. It’ll spell a death sentence for him eventually, and
he knows it, his family knows it. I can’t blame him really. But it just makes
me sad that this is how things are. No amount of discussion could convince
him. His mind was made up. I had to call the doctor to tell him that Jesus
wasn’t willing to make the trip. I think he was disappointed too.

Jesus’ refusal to travel across the country for life-saving heart surgery is a stark example
of the way that fear acts as a mechanism of self-governance for uninsured immigrants,
keeping them from inhabiting many certain spaces, limiting mobility, and negatively
affecting their health (Chavez 2012; Kline 2017). For Jesus and many others like him,
this fear has biopolitical consequences – and even fatal ones, at that. Canceling this vital
heart valve surgery means that he will most likely eventually die from this condition. As
Cheryl put it, “this was his one chance.” But she also makes an important distinction in
her characterization of Jesus’ deliberations that were repeated consistently across my fieldwork: the distinction between a health condition leading to a patient’s death and detention or deportation figuratively and literally killing someone. Within the wider biopolitics of disposability that constrains the existence of undocumented immigrants, being subjected to immigration enforcement and separated from family and loved ones is a sentence worse than death. It is this fear that drives the reluctance of Jesus and others like him from accessing health care.

The Clinic as Border Checkpoint: The Devolution of Enforcement into Spaces of Health

When talking about the constant fear that one of his family members would be in a car accident and taken to the hospital, Alejandro, a young undocumented immigrant activist, declared, “It’s easier for us to die than to go to the hospital. Hospitals are deporting us, so we avoid them at all costs, even if it means that we don’t get the life-saving medical care that we need. In my family, we talk, we joke about how it’s easier to plan a funeral than deal with going to the hospital.” Echoing the sentiments of Jesus’ refusal to travel for surgery, Alejandro and his family consider the possibility of deportation while accessing health care in the mainstream health system to be a fate worse than death.

An important element of the “learned avoidance of the health care system” (Heyman et al 2009) is an anticipatory fear of health providers asking about or ascertaining immigration status and then acting on that knowledge. Patients fear being subjected to immigration enforcement by health professionals and administrators as a
direct result of their health care access (Berk and Schur 2001; Cartwright and Manderson 2011; Castañeda 2009; Castañeda et al 2015; Kline 2017; Maldonado et al 2013; Park 2011; Vargas et al 2017). However, this fear is often misrecognized as or conflated with the fear of encountering immigration enforcement while driving to appointments or traveling in public spaces or at certain times of day. This explanation misses a very important aspect of fear that affects health care access: the fear that immigrants will be subjected to the immigration enforcement apparatus by the very hospitals and health providers from which they seek medical care. The dismissal of this fear ignores the devolution of federal immigration enforcement, beyond local law enforcement officers, to other social service providers, in particular health professionals. One such example, the experience of Blanca Borrego received widespread publicity and national backlash.

Borrego’s encounter with law enforcement at the direction of health administrators at her doctor’s office is illustrative of this fear (and the reality) of the devolution of immigration enforcement into spaces of health:

In September 2015 (as I was starting my fieldwork in Phoenix), Blanca Borrego attended a follow-up gynecological appointment for abdominal pain caused by a cyst at a Houston-based clinic. Upon arriving for her appointment with her two daughters, she filled out the regular paperwork and provided the clinic staff with her drivers’ license and health insurance card (as Borrego had health insurance through her husband’s employee-based plan). Suspecting the ID was fake, the administrative staff alerted the Harris County Sheriff’s Office without Borrego’s knowledge. They then stalled her for the next two hours. When she was about to give up and leave the clinic, they brought her back to an exam room, where they held her on the pretext of waiting for the doctor, until the
sheriff’s deputies arrived and arrested her (Alleyne 2015; McLaughlin 2015; Thompson 2015). One of her daughters happened to see the deputies escorting their mother out a back exit of the clinic in handcuffs, and the daughters rushed out of the clinic to confront them. The deputies said that their mother was going to be deported (Cato 2015). She was charged with a felony for possessing a forged Social Security card and, after two weeks in jail, was released on $35,000 bail that was raised via a GoFundMe campaign. The Memorial Hermann Health System, of which the clinic was a part, was forced to pay a $2.4 million fine for a HIPAA violation for releasing Borrego’s name in a press release (Morse 2017).

Borrego’s arrest ignited a public outcry and a national organizing effort around her case by immigrants’ rights and health care groups alike, with the National Latina Institute for Reproductive Health (NLIRH), the Texas Organizing Project, and the ACLU all getting involved (Barajas 2015). The groups held a series of demonstrations and rallies outside of the clinic in protest of Borrego’s arrest. Ana Rodriguez DeFrates of NLIRH discussed the ripple effects of the arrest, saying, “Women tell us all the time that they are scared that this will happen. One of the many things that is heartbreaking moving forward is that [it will] validate those concerns, whether real or perceived, and make it harder for people to get the care they need.” (Perez 2015, emphasis added). Rodriguez DeFrates is correct in her assessment that this story circulated among immigrant communities, including CCP’s patients, as a further confirmation of their worst fears. It is important to note, however, that these stories were already circulating. Borrego’s experience is one of many; her story just happened to catch media attention as the result of the tireless organizing work of immigrant rights groups.
As demonstrated by this example, immigration enforcement operates within and in conjunction with institutions of health. In partnership with immigration enforcement, this clinic essentially operated as de facto border checkpoint, exposing Borrego to the border control and enforcement apparatus as a result of her health care access. This is particularly egregious as the clinic or hospital is considered a supposed “safe space” from immigration surveillance and enforcement. However, Borrego’s experience demonstrates that the devolution of federal immigration enforcement to the local level includes the surveillance of migrants in the clinical setting.

In examining the links between health care and immigration enforcement, Maria Ruiz (2002) argues for the existence of what she calls the “borderization” of health care, which entails the collusion of health care and immigration enforcement officials. This borderization of health care involves the “movement” of the border into the space of the clinic, which has consequences for health professionals and immigrant patients alike. On the one hand, it results in “the extension of U.S.-Mexico border checkpoints to the clinical setting and the recruitment of health workers as national security police” (Ruiz 2002:52). On the other hand, “when migrant workers cross national borders without authorization, they embody them – and are forced to re-cross the border in their everyday social encounters. Thus when an undocumented woman [like Blanca Borrego] walks into a formal medical setting, she carries with her historical and current political relations between the United States and Latin America” (Ruiz 2002:38-39). The very access to health care by uninsured and undocumented immigrants in the U.S. then involves another transgression of the border, albeit a figurative one, that entails the risk of discovery, detention, and deportation. Given the realities of the borderization of health care,
migrants who forego necessary medical care out of the fear of being discovered as undocumented are making a calculated and constrained, rational choice to avoid the mainstream health system.

The Medicalization of Immigration Enforcement and the Deportation of Immigrant Patients

Not only do medical professionals act in collusion with Border Patrol, alerting them to the presence of undocumented patients and holding them until they are arrested, but also medical providers themselves are acting as border patrol agents, subjecting immigrant patients to a private health-related deportation apparatus. This privatized deportation of immigrant patients by hospitals across the country is known as “medical deportation.” As a stark example of what Michael Nijhawan (2005) describes as “the collusion between state and medicine in matters of deportation” (276), medical deportation refers to hospitals’ removal of immigrant patients, who are injured or seriously ill, often comatose or paralyzed, and in need of long-term acute care. In order to avoid the incurrence of uncompensated medical costs, hospitals across the country are choosing to medivac immigrant patients to facilities in other countries which are often ill-equipped to meet their medical needs (Bresa 2010; Johnson 2009; O’Connell 2009; Park 2018; Seton Hall Law 2012; Sontag 2008a, 2008b). Although shrouded in bureaucratic mystery, evidence points to hundreds, if not thousands, of immigrant patients deported by hospitals over the past two decades (Seton Hall Law 2012).

As an extralegal practice, medical deportation represents a form of privatized deportation that is initiated by hospitals without the notification or involvement of state
or federal government or immigration officials. Lisa Sun-Hee Park (2018) argues that “by orchestrating the deportations, hospital not only extend the reach of the state but actually supplant the state by engaging in the act of removal in cases in which the state has no interest or has refused to do so” (240). In the absence of government monitoring, hospitals are able to deport patients without informing their families, without the patient or their families’ consent, and crucially without any documentation that a deportation has occurred. The secrecy that surrounds medical deportations makes it difficult to ascertain its prevalence. The Center for Social Justice at Seton Hall Law School has documented over eight hundred cases of medical deportation from hospitals across fifteen states, including Iowa, Illinois, New York, Arizona, Texas, Tennessee, and New Mexico (Seton Hall Law 2012), but actual incidents of medical deportation could be in the thousands. These documented cases include both documented and undocumented immigrants, with and without health insurance, as well as U.S. citizen children of undocumented immigrants (Gates 2013; Seton Hall Law 2012; Sontag 2008a, 2008b). Although Latinx patients make up the majority of these cases, medical deportation affects immigrants from many countries, including Poland, Lithuania, the Philippines, and South Korea (Gates 2013; Graham 2008; Pitt 2013; Seton Hall Law 2012; Sontag 2008a).

During my fieldwork, CCP organizers at a volunteer training about immigrant health justice discussed the reality of medical deportation for the clinic’s patients:

“There is collusion in Phoenix between hospitals and Immigrations and Custom Enforcement or ICE. Hospitals are deporting immigrant patients. For instance, we know that St. Joe’s for sure is deporting people,” Marisol said.

“Yeah,” Donna piped up, “We’ve had protests about that.”
“We also have evidence,” Marisol continued, “of [hospital] caseworkers calling the cops or calling ICE on people when they don’t have insurance and can’t pay for their medical costs.”

Michael said, “But medical repatriations don’t involve the government.”

“Yeah,” Ed said, “They’re considered ‘facility transfers.’ It just happens that they are facility transfers across state or country lines without patient consent, and often the patient is in a coma.”

Bonnie, who often likes to play devil’s advocate, said, “But I’ve worked at Maricopa Memorial for years and I never was told to ask people for their immigration status…although, now that I think about it, there was a patient in a coma that had been in ICU for six months, and they were trying to transfer him back to Mexico where he had family. I believe they ended up doing it.”

Although many hospitals are secretive about their use of medical deportation to transfer patients with acute long-term care needs to other facilities, St. Joseph’s Hospital in Phoenix, which Marisol references, is the most prominent hospital to publicly discuss its deportation of patients and, as such, is at the center of a number of controversies and lawsuits surrounding the practice. A New York Times article reported that St. Joseph’s “transfers” around 100 patients a year to their home countries for medical care (Sontag 2008a, 2008b). These high-profile cases include Antonio Torres, a 19-year-old legal permanent resident who was left comatose after a car accident. St. Joseph’s deported him by ambulance to a hospital in Mexicali where he laid on a gurney in a hallway for several days, with a staph infection, before his family found a hospital and rehabilitation center in California that would care for him and where he was able to recover (Sontag 2008b). Another harrowing example of an attempted medical deportation involves a St. Joseph’s patient who was brutally beaten by Border Patrol to the point that he had a hole in his skull exposing his brain (Park 2018). St. Joseph’s has a committee of doctors,
administrators, caseworkers, and other relevant hospital employees who meet regularly to
review the cases of uninsured immigrant patients at the hospital, deciding whether to
initiate private deportation proceedings to send them back to their home countries (Park
2018).

Although not well-known by the general public, for immigrant communities and
the free clinics that provide them care, medical deportation is a notorious practice that
causes immigrants to avoid the hospital, regardless of the severity of their health issues.
For example, one of CCP’s patients, a young single mother with hypertension that had
gone untreated for years refused to go to the ER when she was having a stroke for fear of
being deported. Although it may seem irrational, her refusal reinforces CCP’s critiques
about the brokenness of the system and the pathogenic consequences of immigration
enforcement that make accessing health care dangerous for immigrants. Going to the
emergency room can pose as much risk as being stopped for a broken taillight. This risk
means that CCP’s patients forego life-saving health care and endanger their own lives in
the process, subjecting themselves to hospital administrators and medical personnel who
act outside of state sovereignty or scrutiny as private immigration enforcement officers.

As demonstrated by the example of medical deportation, the borderization of
health care is another (significant) barrier to care and aspect of structural violence
experienced by uninsured, undocumented immigrants. If, as Kline argues, immigration
enforcement is both criminogenic and pathogenic, then health policy and the exclusion of
immigrants from health care has similar consequences. In other words, although spaces of
health are often seen as part of the solution for the effects of structural violence on the
health of immigrants, many health care institutions are perpetrators of structural
violence, rendering the very patients in their care susceptible to detention and deportation. This perpetration of structural violence by the mainstream health system is less about assigning individual blame to specific medical professionals – indeed the vast majority of the volunteers at CCP themselves work in formal health care – and more about recognizing the systemic barriers and challenges that structure the health system and its collusion with immigration enforcement. Just as there are particular hospitals, like St. Joseph’s in Phoenix, that are public about the frequency of their deportation of immigrant patients, there are other hospitals that are public about their unwillingness to deport their patients. Indeed, a report by RAND Health found that the primary driver of physician burnout was the inability to provide quality care to all patients, including specifically the stress and tension caused by having to deny quality care to patients who are uninsured or insured by unable to pay for their medical care. As a result, the structures of health and immigration policy in the U.S. force frontline workers, including medical professionals, to unwillingly perpetrate structural violence and cause stress, anxiety, and ultimately burnout among medical professionals who have sworn to “first do no harm.”

Conclusion

In considering the culture of indifference toward the sickness, suffering, and premature deaths of marginalized peoples, immigrant health in the U.S. is predicated on a biopolitics of disposability that renders immigrant’s health emergencies illegible and undeserving of treatment and their lives exploitable and expendable. As long as immigrants are able-bodied and willing to work in low-wage jobs, their presence in the
country has been more or less tolerated. But, if they face a medical emergency or develop a chronic health condition, they have little to no recourse to medical care. Unlike able-bodied immigrant workers who are considered “valuable” for their labor, these (disabled) immigrant patients are constructed as burdens on the state and the tax-paying, law-abiding citizenry. This biopolitics of disposability is made all the more insidious by the devolution of enforcement into the medical setting with hospitals deporting their own patients. Even (or especially) in a vegetative state, immigrant patients are constructed as actively draining resources that should belong to deserving tax-payers, and thus, hospitals are considered to not be acting “unreasonably” when they deport comatose patients, who once they are no longer able to work are “always already” criminal, burdensome, and deportable. As a result, immigrants across the country are dying from common, often easily manageable, medical conditions. Fueled by the collusion between health and immigration enforcement, the real emergency at the heart of immigrant health disparities are the deaths of immigrants across the interior of the U.S. These deaths amount to the often-unrecognized violence of “invisible genocides” (Schepfer-Hughes 1996). In this way, the structural violence that defines approaches to immigrant health in the U.S. implicates health care professionals and institutions as perpetrators of a biopolitics of disposability in relation to immigrant patients.

Diego, Revisited

After Diego’s first visit to the clinic revealed the debilitating health effects of his untreated diabetes and indications that he would lose his remaining leg, volunteers
created a comprehensive treatment and follow-up plan. Because of Diego’s serious condition and limited transportation, CCP nursing student volunteers decided to conduct home visits several times a week to monitor his glucose levels and insulin dosage and to change the dressings on his foot wounds. But, after his first appointment at the clinic which had set the volunteers into a panic, he did not turn up for his next appointment. Michael wrote a social media post that turned into a fundraising plea about what happened when they tried to track down Diego:

Last week, one of our new patients missed his appointment. That, in and of it’s self [sic], is unremarkable. The very poor face countless healthcare barriers, the majority of which are beyond their control, such as unreliable transportation and fluctuating work schedules. But here at CCP, we try to check with our patients whenever there’s a no-show. And this patient was of particular concern – we had only met him the week before, and he has very complex medical needs that aren’t yet under control.

We weren’t able to reach the patient by phone, but we did reach his emergency contact who informed us the patient had been sick for two days, dizzy and unable to keep down fluids. Someone definitely needed to lay eyes on this guy ASAP…[Two of CCP’s nursing volunteers] had a bit of an adventure finding the patient that night – the address we had on file wasn’t completely correct. But they ultimately found him, medically compromised to the point that he was in some degree of danger. They made the decision to accompany him to a local emergency room where he was treated and discharged early the next morning. They stayed with him through everything, finally returning to the clinic at two in the morning on a work night.

The next day, a nursing student bought the patient’s new meds at a pharmacy and drove out to his house for a follow-up. We explained the plan of care to him as a small herd of chickens wandered through the ramshackle house where he lives. We’ll be sending someone out to check on him and make sure he has everything he needs at least twice a week for the next month or so.

With regular wound care, Diego’s foot began to look a lot better and his wounds and infections started to heal. One of the nursing student volunteers, Elizabeth described the
turnaround he experienced with his foot, saying, “When he first came to CCP, he didn’t have any sensation up to his calf. But his edema [the swelling in his foot and leg] went away in about a week. The foot looks healthier. So, everything that we have been doing has actually really helped him.” Some sensation began to return to his foot and the neuropathy was not as complete as they first thought. With regular monitoring of his glucose levels and with the medication and nutrition education from CCP volunteers, Diego was able to start managing his diabetes. Elizabeth recounted his eagerness to get his diabetes under control, once he had access to regular care and the knowledge of his health condition, “When he came to CCP, he told us, ‘Before I knew [that something was wrong with my blood sugar] I just didn't know how to fix it.’ Now he’s understanding how to manage his diabetes – when to eat, what type of foods to eat, how much water to drink. He’s on top of it. He can tell you exactly what his glucose is, what his insulin doses are, when he takes his medications. He’s really trying to get better. At first, we were sure he was going to lose his foot, but now it looks like he’s actually going to get to keep it and stay mobile. And that is huge.”

This chapter has focused on CCP’s critique of the structural violence experienced by their patients – resulting from a combination of exclusion from health care, punitive immigration enforcement, the devolution of enforcement into spaces of health – and its revelation of the biopolitics of disposability that governs approaches to immigrant health in the U.S. But in addition to their critique of the “brokenness of the system,” CCP volunteers and organizers also work tirelessly to provide (limited) health care to uninsured, undocumented immigrants in Phoenix. The following chapter will examine the
ways that CCP works to envision and build alternative health provision, predicated on an immigrant health justice framework.
Chapter 3

“Not a Free Version of a Broken System:” Immigrant Health Justice and Biocitizenship

“Paola is in pain, and she is suffering. The surgery is scheduled for this Friday, but if the money isn’t raised by then, the hospital will cancel it,” Michael pleaded to the camera. “If you believe in us, if you believe in the mission of CCP, we need your help. We need you to step up and donate today. We need you to reach out to your friends and ask them to contribute…let’s get this done.” The screen faded to black and a link appeared for a crowdfunding campaign to “Save Paola’s Arm.”

Paola winced as Oscar, CCP’s volunteer physical therapist, wrapped her right arm back up in a thick elastic bandage. Oscar helped with rehabilitation for clinic’s patients suffering from health issues including the effects of a stroke or beatings by the cartel. Two months ago, Paola had fallen from a ladder while working on her house. She landed with her arm twisted behind her back. It was broken in several places and dislocated; her elbow was crushed. Despite her extensive injuries, she had no cast, only a flimsy elastic bandage that she wrapped around and around her arm from her fingertips to her armpit.

“She went to the ER where they stabilized it with a splint and said follow-up outpatient with this. But when she went to follow-up outpatient, they said, ‘It’s going to cost $20,000 plus, and we’ll need payment upfront.’ She was in horrible, excruciating pain. So she just ended up going from emergency room to emergency room for months because she had nowhere else to go, just praying to get different results from the same
thing. She was in deep, deep despair,” Michael recounted her struggle to get someone to help her. Because her broken arm wasn’t life-threatening, she was unable to get any care in the emergency room. Because she was undocumented, she did not have access to health insurance and relied on the informal health system for her care. However, this system was wholly inadequate to deal with her ailment.

In the crowdfunding video, Ed discusses the seriousness of her condition, “If she doesn’t get this fixed, she’ll lose her arm. She has been to numerous ERs and seen several orthopedic surgeons, and they all agree that she needs an operation. But she can’t get it because she doesn’t have the money for it.”

CCP volunteers were able to get Paola registered for Copa Care, a self-pay discount medical program for patients in Maricopa County who are uninsured and ineligible for Arizona’s Medicaid program. The program provides some (limited) accessibility for undocumented immigrants to the formal health care system. 80% of Copa Care patients are undocumented (O’Brien 2018). Donna described the program saying, “Basically, people with Copa Care are charged what the reimbursement [to the hospital for specific procedures] would be under AHCCS [Medicaid], and they can get meds at cost.” With Copa Care, Paola was able to get the surgery for a steep discount, but the $6,800 price tag was still well out of her reach. She had to come up with the money to pay upfront, or the surgery would be cancelled. A single mother of three children, Paola supported her family by cleaning people’s houses. Her injury left her unable to work and without an income. As a result, the family was getting evicted from their house, and they couldn’t even afford to buy groceries. Her son was planning to drop out of high school to work to support them.
With Paola’s permission, volunteers at the clinic created a fundraising video and launched a public crowdfunding campaign to raise the money to cover her medical costs. In the video, they plead for support for Paola saying, “Paola is a hard worker and a good neighbor who is always taking care of her own community. Paola has always paid her bills and supported her family. She came to the U.S. to make a better life for her family but because of her immigration status she is excluded from benefits under the Affordable Care Act and other areas of the law. This leaves her with nowhere to turn now that she’s had this injury.”

With CCP’s fundraising support, Paola was able to get the surgery she needed and, with a series of pins holding the bones in her arm in place, started the healing process. Once the pins were removed, she worked with Oscar to rehab and regain some mobility in her arm. After months living in excruciating pain, waiting for surgery, and recovering, Paola was able to return to work and rebuild her life with her children.

The example of Paola’s crushed arm highlights the structural violence perpetrated by the health and immigration systems discussed in the previous chapter. Although her arm was broken in more than thirty places and she was in debilitating pain, her health condition was not considered an “emergency.” Unable to access the care that she needed, she faced losing her arm. For volunteers at CommUnity Clinic of Phoenix (CCP), Paola’s experience with the medical industrial complex demonstrates the “brokenness” of the health and immigration systems in the U.S. To address this brokenness, CCP works to provide care to uninsured, undocumented immigrant patients. Because of the limited patchwork of services the clinic is able to provide, the volunteers also act as brokers,
facilitating access to pro bono or lower-cost services, in this case helping Paola get the surgery she needed and keep her arm.

This chapter examines CCP’s refusal to be “a free version of a broken system” in its provision of care to undocumented migrants. More than a free clinic, CCP provides medical care based on an alternative vision of immigrant health justice. This alternative vision asserts that health care is a human right that should be accessible to everyone regardless of immigration or socioeconomic status. As such, CCP is committed to providing “quality” medical care to all of its patients who have been denied it by the formal health system. Through their recognition of the “patient” status of migrants and the realities of their medical conditions, CCP asserts a biocitizenship of their patients. This substantive biocitizenship is an informal medicalized inclusion based on a shared recognition of the humanness and the health needs of migrants and health care as a human right and a public good, or in other words, based on a vision of immigrant health justice.

Rather than the perennial tension within many nonprofit organizations to privilege either charity or political advocacy (Tiedje and Plevak 2014), the self-described “humanitarian activists” at CCP work from an immigrant health justice model that is explicitly and unapologetically political in its indictment of the twin broken systems of immigration and health care and in its advocacy for a health care for all model. CCP’s volunteers largely share their critique of the brokenness of the system – not only in relation to the larger structures of health care and immigration but also in contrast to the “pill factory” model of immigrant health care at many free clinics. However, because of limited resources and the constraints posed by the larger broken systems of health and
immigration, tensions arise at CCP between factions of volunteers with different definitions of what “quality” health care in an immigrant health justice framework entails. On the one hand, some CCP organizers and volunteers espouse a more biomedical vision of “quality,” while on the other hand, a different faction within the clinic envisions immigrant health justice to focus on “holistic” health care. More than semantics, this difference in the interpretation of the clinic’s vision leads to different, and at times competing, approaches to care for their patients. Although Tiedje and Plevak (2014) and others focus on the emergence of a “new humanitarianism” which blurs the boundaries between apolitical service provision and political advocacy, the factions at CCP demonstrate the inherent tensions that persist within new humanitarian NGOs that must work both against and within wider structural constraints. These tensions are at the heart of how the clinic volunteers and activists stake their claims for the biocitizenship of their patients. These tensions also reveal why, I argue, the clinic ultimately asserts a substantive biocitizenship on behalf of their patients, rather than a “collectivized biocitizenship” (Chavez 2018) in solidarity with patients.

This chapter begins by discussing the history of the clinic which emerged from the work of a street medic collective that made house calls after the passage of SB 1070 but became more institutionalized with the establishment of a fixed-site clinic space. This history foreshadows the internal and external tensions that volunteers at the clinic navigate in trying to create a clinic that is not a “free version of a broken system.” The chapter then outlines the clinic’s critiques of what is broken about the immigration and health systems and their alternative framework for immigrant health justice. Although the volunteers agree that health care should be available to everyone regardless of
socioeconomic or immigration status, when this ideal translates into practice at the clinic, the volunteers face difficult decisions about how to allocate limited resources. Unlike other immigrant health organizations that prioritize maximizing their number of patients, CCP emphasizes “quality” health care provision for fewer patients. However, this chapter explores the tensions between volunteers in their interpretation of “quality.” Even though they agree in the abstract about their values, translating them into practice means that some volunteers espouse a more biomedical vision of health care for all, while other volunteers adopt a more activist perspective that is critical of centering a Western biomedical approach. These two perspectives differ substantially in more than just approaches to types of health care however. The biomedical approach grants the clinic legitimacy as a medical space, but it reinforces hierarchies of race, gender, immigration status, and types of medical care. It is only able to assert a substantive biocitizenship on behalf of its patients and contends with important critiques of white saviorism. The activist approach in contrast pushes for a “collectivized biocitizenship” that challenges power relations including patient and provider, migrant and citizen.

CommUnity Clinic of Phoenix: From “Guerrilla Clinic” to “A Clinic with Walls”

Upon first glance, CCP appears to be a relatively traditional medical clinic with patients arriving for pre-scheduled appointments, ushered into rooms with exam tables covered in sterile white paper to wait to see medical providers dressed in scrubs with stethoscopes around their necks. But a closer look belies the clinic’s roots that defy usual medical interactions – a nurse welcoming a patient with a hug as they come in the front door and asking about their new grandchild, framed photos hanging on the walls of
volunteers carrying signs and providing first aid at local immigrant rights protests, volunteers doing house calls or driving patients to the clinic for their appointments, and health providers referring patients for an appointment with a shamanic healer. These unconventional patient-provider interactions hint at the clinic’s history and its founders’ vision of immigrant health justice.

CCP was begun by members of Metro Area Street Health (MASH), a collective of street medics that monitored the health needs of protesters at immigrant rights and anti-fascist protests in Phoenix. During the protests, the medics provided water and medical attention to dehydrated and teargassed protesters. Around 2010, the group coalesced into a more organized collective after a series of protests leading up to and after the passage of Arizona’s infamous SB 1070 legislation. At one protest in particular, the police shot hundreds of rubber bullets into the crowd and indiscriminately teargassed protestors. MASH volunteers treated toddlers in strollers, pregnant women, elderly people, and others who were victims of the police’s use of force. After this protest, MASH made a commitment to maintain a presence at every demonstration in Phoenix where protesters might encounter violence from the police or counter-protesters. Donna, one of the main clinic organizers, spoke about this time saying, “Protests were literally happening all the time. Every week there were people in the streets. It was a really volatile time. There’ve been ongoing protests ever since then against Joe Arpaio, whose anti-immigration history is well-known to everyone here.”

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8 MASH and all patient and provider names in this chapter are pseudonyms.
Perhaps unsurprisingly after the passage of SB 1070, immigrants, who were already wary of accessing health care in emergency rooms and sliding-scale clinics across the city, increasingly avoided these formal health care settings for fear of encounters with law enforcement or detection as undocumented. Instead, too scared to leave their homes to seek medical attention, they called on the collective for home visits. Michael, a registered nurse who works in a local hospital and one of the main organizers for MASH and CCP, reminisced about the informal care that a ragtag group of folks with medical training were able to provide for people who would otherwise have gone entirely without medical services:

During this time, as immigrant populations were more and more afraid and as we got to become better known through the protests, we started to get calls that were not related to the protests. People saying, you know, “The baby is sick. She has a fever. Can someone come check?” Or, “my husband has had diarrhea for four days. He’s too weak to get out of bed.” People started to feel more and more afraid to interact with any sort of infrastructure, too afraid to go to the emergency room...This wasn’t something we expected when we started, but we responded as best we could...We would just cruise around town and knock out six or seven house calls in a day sometimes. Going into trailer parks or these really, really economically-challenged parts of town and knocking on doors and finding the people that we had been hearing about. We’d get a call like, “There’s this woman, and she is very sick. She’s been bleeding for three days.” And we’d say, “Call her and tell her to go to the hospital.” But they’d say, “She doesn’t actually have a phone, but I know where she lives.” “Well can someone tell her we’re coming.” [laughter] It was an adventure, and we actually got a lot done that way.

Drawing on their links within the immigrant community in Phoenix, the MASH collective created an informal network of patients and health care provision that constituted what they described as a “guerilla clinic,” going practically door-to-door to meet patients in their homes and the streets. They provided what medical services they
could muster from within the activist/immigrant communities of Phoenix as well as within their own networks from their day-jobs in formal and holistic health care.

MASH organizers described these early days as a “guerilla clinic” as more closely aligned with the local Latinx and immigrant communities of Phoenix in a model of mutual aid and community solidarity. Lorena, a Latina midwife who trained in a birthing center in Mexico and was a core founder of MASH and CCP, talked about the importance of her community “helping themselves,”

We would just figure it out. Like, what do we need? Okay, well, what health care worker do we need to find? And who’s willing to do free x-rays, and who can give us this money for medicine? And in those days, it was often just out of pocket. We would just be within our communities like “Okay, we just need to donate whatever.” You know, just trying to get people whatever they needed. So, there was always a network of people who cared and that is, that’s always been there and that comes from the community itself.

Lorena’s description of the patchwork of care that MASH was able to provide also stresses the importance of local community efforts to fundraise – in informal, pre-online crowdfunding campaigns – to ensure that community members could access vital health care services and medications.

It is this history as a “guerrilla clinic” to which Michael refers, when he describes CCP as “having always been unapologetically activist.” He waxes nostalgic about these early days, saying, “We had a lot of nurses just going around and checking on people in their homes – without a medical director, without a charting system… It was always amazing to us how much we could get done without any of the formal accoutrements of a clinic, without any infrastructure, just a handful of friends with clinical training and what we could carry in our backpacks.”
As the demand for home visits increased, some members of the collective began to talk with local immigrant organizations and community members about the need for a free clinic that was based on an understanding of and commitment to immigrant rights and health justice. Eventually, MASH volunteers began to offer regular appointments out of the small kitchen in the local worker center, describing themselves as “a clinic without walls.” As they grew in response to the demand for free health care for undocumented immigrants in Phoenix, some of the members of the collective raised money to purchase a tiny condemned crack house and renovate it into a clinic space. Coincidentally, at the same time that the renovations were being completed, a local doctor’s office was closing and donated all of their equipment to CCP. Since then, CCP has seen patients two days a week: Thursday’s clinic includes appointments for general nursing, women’s health and midwifery, naturopathic and holistic care, and limited mental health support, while Saturday’s clinic focuses on appointments with physicians’ assistants and once a month includes physical therapy. Saturday is also the day that volunteers from Thursday’s clinic often make house calls that they could not fit in during the week.

Moving from a “guerrilla clinic” to a “clinic with walls” drastically increased the capacity of the MASH collective to provide care for uninsured, undocumented migrants who were both ineligible for and too afraid to access health care in the formal system. But, as the clinic has grown to have a building, a medical director, and a charting system, tensions have emerged between volunteers at CCP, the once strong links with the immigrant community have frayed, and competing missions have opened the clinic up to critiques about the white saviorism of medical humanitarianism, rather than the cultivation of community solidarity. More than the result of interpersonal tensions
between clinic founders or the consequences of organizational decisions, these tensions within CCP point to a broader structural critique of health and immigration systems that deny immigrants access to the formal health care system and limit resources available for uninsured and indigent patients. These tensions at the clinic however manifest as friction between volunteers who align themselves generally with either a more biomedical or more holistic vision of “quality” health care within an immigrant health justice framework.

Medical Humanitarianism and Immigrant Health Justice

Within a wider field of immigrant health care that includes free and sliding-scale clinics, immigrant rights and community health nonprofit organizations, and for-profit “doc-in-a-box” health centers, a large portion of immigrant health care in this informal network falls under the umbrella of medical humanitarian organizations (Castañeda 2011; Gottlieb et al 2015; Ticktin 2006, 2007; Tiedje and Plevak 2014; Willen 2011). As I will discuss in the following chapter, some of these humanitarian NGOs provide emergency first aid and distribute life-saving supplies in the deserts of the militarized borderlands. In the interior of the country, many of these medical humanitarian organizations are free clinics that provide mostly preventative and primary care to uninsured, unauthorized immigrants. Often community- or faith-based, these clinics navigate the challenges of providing health care to immigrants whose disposability and “social illegitimacy” (Fassin 2004) has been used to justify their denial of basic human rights. These clinics often also have to manage the tensions between the “apolitical” service provision more commonly accepted as part of humanitarianism and “political” advocacy around the structural
factors that give rise to immigrant health disparities (Tiedje and Plevak 2014). A perennial issue for nonprofit organizations in many fields, Tiedje and Plevak argue that this tension circulates internally among organizers and volunteers in medical humanitarian organizations, who struggle to provide immediate health care and engage in political advocacy around immigrant disentitlement, as well as externally between the clinics and critics of their mission and work.

Unlike Tiedje and Plevak’s example, the tensions at CCP do not necessarily break down along these lines. Shirking the neutrality and apolitical nature of classic medical humanitarianism, volunteers at CCP described themselves as “humanitarian activists,” engaging in an overtly politicized critique of the structural violence inherent in the health and immigration systems. Their shared vision of immigrant health justice stemmed from their assertion that health care is a human right and that “no one is illegal,” challenging the for-profit nature of the medical industrial complex and the racialized criminalization of their patients. Especially in the context of local Arizona politics, CCP volunteers called out the racially-motivated surveillance and criminalization of Latinx and immigrant communities, through anti-immigrant legislation like SB 1070. They linked this directly to a system of white supremacy that works to limit immigrants’ ability to access “authorized” status. Aligning themselves as allies with immigrant rights organizations, CCP critiqued punitive immigration enforcement tactics, including the ramping up of detention and deportation, that create a culture of fear, force immigrants to live “in the shadows,” and exacerbate immigrant health disparities.

Beyond this brokenness of the immigration system, CCP volunteers critique what they describe as “the medical industrial complex,” in particular the exclusivity and
corporatization of health care. Arguing that health care delivery should never be associated with a profit motive, the organizers at CCP assert that medical care designed to function as a money-making corporate enterprise leads to an exponential increase in cost of medications and life-saving health procedures, while denying health care to patients who cannot afford it. In this way, the for-profit U.S. medical system is complicit in the deaths not only of uninsured, undocumented immigrants but also of uninsured and underinsured U.S. citizens who, for instance, are forced to ration their insulin with fatal consequences (Sable-Smith 2018) or told by hospitals and insurance companies to crowdfund for medical procedures, like a Michigan woman denied a heart transplant until she had crowdfunded $10,000 (Reindl 2018). For the organizers at CCP, the exclusivity associated with a privatized, for-profit health care system is at the heart of the structural violence that it perpetrates on uninsured and indigent patients. Part of the structural violence of this system includes the huge campaign contributions and lobbying efforts that maintain the exclusivity of this system, including the exclusion of undocumented immigrants from health care. For CCP’s patients in particular, the twin “broken” systems of health care and immigration force them into the shadows, with detrimental consequences that are embodied in something as simple but insidious as elevated glucose levels.

In direct response to this structural violence, CCP works to create a space for health care that is “not a free version of a broken system,” a phrase repeated around the clinic like a mantra. This unofficial mission of the clinic involves an alternative model that recognizes health care as a human right that should be accessible to everyone, regardless of immigration or socioeconomic status. Donna, one of a handful of core clinic
organizers who also is an outspoken advocate for universal health care, emphasized this value saying, “I don’t care how you got here or where you came from, every human has a right to health care. It’s a basic human right.” Adam, another board member and volunteer who runs his own international medical humanitarian organization, critiqued the hierarchy of health care quality and access in the U.S. for-profit health system, saying, “Medical care is not a commodity that only a few should have because they have the right things in their pockets – money or papers…There cannot be a hierarchy of who gets health care and who doesn’t get health care. It doesn’t speak to…the spirit of medicine to divide who gets good health care and who gets mediocre health care, who has to just get what’s left over. We should all get the same health care.” Fundamental to the motivations of CCP organizers is the right to free health care access for everyone. Their mission to create a clinic based on this alternative vision of care includes not only avoiding replicating the structural violence of the mainstream health and immigration systems, but also actively mitigating as much as possible the health effects of this violence embodied by their patients. In this way, CCP works to establish a clinic based on an alternative vision of health justice, where everyone (but especially uninsured, undocumented immigrants) can access “quality” health care.

In trying to achieve a clinic based on an immigrant health justice framework, CCP organizers channel their politicized critique of the structural violence of the health and immigration systems into the creation of an alternative model of care. During my time at CCP, the newly-formed board was in the process of rewording the work of the clinic and launching a new website. They agreed on this revised vision statement that captures their understanding of health justice: “We recognize the rights of all people to have accessible
and equitable health services through an integrative, sustainable model. By challenging the dominant culture of healthcare, we seek to promote cultural humility and inspire health justice advocacy.” However lofty this vision, CCP organizers also recognized that the clinic’s intervention and work toward achieving this ideal was limited in scope and scale. A med student and clinic volunteer, Abeni discussed the way that CCP was working to carve out, on a small level, an alternative health space that could form the basis of a larger movement, saying, “That’s what CCP is trying to do. Rather, than fight against the system all the time, which is just exhausting, they’re like ‘you know what, we’re going to go over here and just build something new.’ One clinic can’t make a difference, but we want to get the word out so that we can become a template for other clinics and work [that needs] to be done.” Recognizing the limitations of the scale of CCP’s intervention, Abeni appreciated the model of health care provision that the clinic was creating, and she herself was volunteering at CCP in order to learn about this free clinic model and replicate it in the future, once she was had her own practice.

As much as CCP organizers attempted to create an alternative model of health care based on an immigrant health justice framework, the clinic could not altogether avoid the larger “broken systems” of immigration and health within which it was forced to operate. Resisting the creation of “a free version of broken system” while continuing to work within the confines and limitations of this very broken system posed substantial challenges for the clinic and ultimately made its mission an impossible one. In many ways, CCP will only ever be able to approximate a free version within this broken system, rather than being able to vision and create something entirely separate from the medical industrial complex. CCP’s commitment to the provision of (free) health care as a
human right and a public good is always already constrained by the scarcity model of the larger for-profit system on which it is still beholden for pro bono care and donated cast-off medical supplies. As a result, tensions between CCP volunteers and organizers arose over how to allocate their limited resources to best achieve their vision of immigrant health justice, even as they worked to assert the biocitizenship of all uninsured immigrants.

A Constrained Choice: “Quality” Versus “Quantity”

In addition to the tension between apolitical service provision and political advocacy discussed by Tiedje and Plevak (2014), my research demonstrates another distinction within medical humanitarian NGOs in the informal immigrant health safety net: emphasis on either quality or quantity. In attempting to provide health care to uninsured immigrants in Phoenix, CCP faces countless challenges and limitations in achieving their mission. These challenges are a direct result of the clinic trying to create an alternative framework of immigrant health justice, all the while working within a larger context in which the realities and structural violence of the “broken system” persist. CCP cannot operate entirely outside of these systems. Their patients remain constrained by the realities of punitive immigration enforcement, their ineligibility for health care in the for-profit mainstream health system, and the collusion between institutions of health and immigration enforcement. At the same time, in order to provide care for their patients, CCP remains beholden to the formal health system for pro bono care and free screening programs for their patients, medical equipment and supplies, and the medical knowledge and expertise of a steady stream of volunteers without which the
clinic would not function. As demonstrated by Paola’s case, they must work with the formal health system to try to access care for their patients with medical conditions outside of the patchwork of mainly preventative and primary care they can provide. Surgery, for instance, is one of the many a medical services they are not able to offer “in-house.”

Although their vision of immigrant health justice is radically inclusive, CCP is forced to constrain this vision in practical terms, given the limitation of their resources within the wider deficit model of ever-increasing costs in the for-profit medical industrial complex. Rather than quality health care for all, the clinic can only ever provide some health care for some patients. Given limited resources and capacity, CCP faces the constrained choice of having to decide between “prioritizing quality or quantity,” as Michael described it. In other words, CCP has been forced to make strategic organizational decisions about whether to focus on “quantity” (taking on as many patients as possible with fewer resources for each patient), or instead to stress “quality” of care (by allocating more financial and medical resources to fewer patients). In deciding to prioritize the quality of care, CCP has to limit the number of patients the clinic can accommodate in order to provide “quality” health care to these patients. As a result, CCP organizers are forced to make difficult decisions, that directly contradict their own values of health care as a human right, their vision of immigrant health justice, and their work to cultivate a medicalized citizenship for all uninsured, undocumented immigrants.

Within the wider field of immigrant health care, the constrained choice between quality and quantity that CCP faces is not unique. In debating the merits of quality or quantity, CCP organizers compare their clinic to other local free clinics for uninsured
immigrant patients. Given the sheer demand for health care for uninsured immigrants in Phoenix, many free clinics emphasize quantity, attempting to maximize the number of patients they can assist, so that as many people as possible are able to get some basic health care, mainly free or low-cost prescription medications for chronic health conditions. The free clinics that emphasize quantity over quality include other local immigrant health organizations like Faith in Action. A Christian nonprofit that provides health care to hundreds, if not thousands, of uninsured immigrants, Faith in Action operates a mobile clinic space that has a regular weekly rotation of churches across the greater Phoenix area, focusing on neighborhoods with large immigrant populations.

The difference in the two organizations’ approaches to immigrant health is evidenced by their mission statements. Whereas CCP works to create an alternative to a broken system, Faith in Action’s mission is “healing through love by providing free healthcare.” These statements demonstrate radically different approaches, even as the organizations ultimately are working toward the similar aim of providing free health care to uninsured immigrants. CCP’s approach questions the structural violence of a for-profit system that excludes immigrants from health care eligibility, while Faith in Action’s less politicized mission instead stresses a charity model of health care provision, underscored by its faith-based focus on the healing power of “love.” These two organizations represent different approaches within the same field of immigrant health care provision.

When I attended one of the Faith in Action clinic days, I immediately noticed the stark contrast to CCP. Unlike CCP’s small fixed-site clinic space, home visits, and

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9 Faith in Action, which is a pseudonym, counts and publishes number of patient visits each year rather than number of individual patients.
personalized patient-provider interactions, Faith in Action’s focus on quantity, or on working with as many patients as possible, means that they rotate their mobile clinic around Phoenix neighborhoods. On clinic days, they transform large church halls into bustling yet organized makeshift clinics. Patients line up outside the church waiting to be called to check in for their appointments. Once inside, they wait in the area just inside the door that doubles as a makeshift waiting room with chairs set up in a circle, next to a folding table where volunteers check patients in for their appointments. Behind this folding table are stacks upon stacks of boxes full of patients’ medical files. The rest of the large, noisy room is covered in folding tables where patients meet with volunteer providers for their appointments, in an open-air clinic set up, that resembled a cafeteria. There is one room available to patients who need to disrobe for a medical exam to have some privacy. Unlike CCP, which can accommodate only twenty or so patients per clinic day, Faith in Action averages around 80 patient visits each day. Given their larger capacity and resources, Faith in Action is also able to offer free generic versions of prescription drugs onsite so patients can leave their appointments with their medications.

Although CCP has obviously decided to emphasize quality over quantity in their health care provision, the clinic organizers also recognize that the quantity model of care provided at organizations like Faith in Action is “just another model” and an important intervention in the immigrant health safety net. As Michael described it, “They are doing the work [of providing health care to uninsured immigrants] too, and it’s work that needs to be done. There’s no way that we at CCP will ever be able to address the demand for immigrant health care in Phoenix. So, we recognize the important work that they are doing. At the same time, we have chosen instead to emphasize quality over quantity.”
Although CCP organizers are diplomatic in their characterization of Faith in Action’s work, clinics that adopt a “quantity” model are often criticized as “pill factories” for their focus on dispensing drugs. Others criticize this charity model as a band-aid approach to free healthcare that does not address the deeper structural causes of immigrant health disparities and disentitlement to health care. In this way, CCP defines the work of the clinic and the quality care that uninsured, undocumented immigrant receive in contrast to both the free “quantity” model of organizations like Faith in Action and the for-profit privatized model. For CCP, the privileging of quality care is much more than a strategic decision about the allocation of resources; it is also central to the creation of a microcosm of health care provision based on an immigrant health justice framework. This prioritization of quality care is integral to their alternative model of health provision that does not replicate the brokenness of the mainstream health system. It also sets the clinic’s work apart from other organizations within the informal immigrant health safety net like Faith in Action that, in emphasizing quantity over quality, model themselves more as “free versions of a broken system.”

**Defining “Quality” Care for Uninsured, Undocumented Immigrants**

In contrast to the quantity model, the general consensus at CCP is that their “quality care” includes more comprehensive preventative and primary care services and more personalized continuity of care. In fact, CCP volunteers also argue that their level of care rivals that received even by insured patients. One of their fundraising letters described this quality care (and its relative affordability), saying,
If you’re a CCP supporter, you probably already know that we’re more than just a regular clinic. We pride ourselves on being relentless in getting our patients what they need. We’re not just prescribing pills – we’re building a movement and changing the culture of medicine in Phoenix...Because of our network of literally hundreds of amazing volunteers...we’re able to deliver high quality care to our patients for only about $200 per year per patient. That includes labs, home visits, and frequent appointments with a diverse and multidisciplinary team that includes MDs, PAs, RNs, Naturopathic doctors, acupuncturists, life coaches, case workers, physical therapists, and an amazing dedicated group of support staff ranging from phlebotomists to interpreters, and more. And the standard of care is far better than what a lot of wealthy people with good insurance get...For $200, you can help us give one of our immigrant neighbors the quality care and relentless follow-through that they need and deserve. In this time of increasingly hateful anti-immigrant rhetoric, it’s one way to push back against the tide of hate, and make sure that immigrant and asylee families here in Arizona have the services they need and deserve – no matter what our politicians say about them. Together, we really can build a better world, where all our neighbors, regardless of immigration status, know that their lives and health are valued.

In this way, CCP defines its “quality” care against both the quantity “pill factory” model and the exclusive for-profit health system that denies medical services to uninsured and indigent patients. At the same time, they define their work against the larger anti-immigrant culture in Arizona: their health care provision for immigrants and asylee families is a direct challenge to “hateful anti-immigrant rhetoric” that translates into punitive immigration policy and enforcement in the state.

In maintaining their vision of immigrant health justice, CCP works to “flip the script” of the rhetoric of immigrant disentitlement. Donna asserts, “It’s the denial of health care, not uninsured immigrants, that is a burden on society as a whole. It benefits nobody if people are denied health care.” She critiques the short-sightedness and cost-ineffectiveness (not to mention immorality) of denying immigrants health care. In a similar vein, Michael responded to critiques of the “ineffectiveness” of CCP’s more
individualized model of care, saying emphatically, “Sometimes when you’re doing house calls and you’re driving all around town trying to hunt down a patient, people say, ‘Is that cost effective because you just spent the entire day only seeing one or two patients?’ No one ever asks if it’s cost effective to let these people get sick and have them in the ICU. Right? Nobody cares that it costs $60,000 for an ICU stay. That’s just accepted. That’s normal. We don’t analyze it, we don’t criticize it…Of course [our work] is effective. Of course it’s right to find people in need.” Michael challenges CCP’s critics who try to hold the clinic to a (double) standard of effectiveness that they do not apply to the formal mainstream health system. As Michael’s critique demonstrates, the for-profit nature, exclusivity, and exorbitant costs associated with medical care in the formal system are more or less taken for granted, but the costs of not providing health care to immigrants remain largely unquestioned. The denial of health care to immigrants (and U.S. citizens) is not usually factored into assessments of the “quality” of care in the mainstream health system.

Because the clinic is bound by the persistent structural limitations of the broken systems of immigration and health care, CCP’s “high quality care” is defined in ways that not only complement their vision of immigrant health justice, but also are relatively achievable within the financial and other structural constraints and realities under which they work. This quality care, for instance, can extend to organizing a crowdfunding campaign for Paola’s surgery, but not actually providing the necessary surgery themselves. The limitations on the actual medical services that they can provide are serious and severe.
Rather than defining quality of care in terms of being able to fully meet the medical needs of their patients, CCP focuses on cultivating a model of quality care that is 1) integrative, 2) preventative, 3) culturally competent, which they also describe as characterized by “cultural humility,” and 4) equitable. Although there is general agreement among the clinic’s organizers about these principles in the abstract, in translating this ambitious vision into practice, frictions arise at the clinic. These frictions are a result, in part, of the ambiguity of defining care as not “a free version of a broken system” but also of the larger structural constraints associated with the persistence of the very broken system within which they must still work.

**Frictions and Tensions: Differing Definitions of “Quality”**

Although there is general consensus within the clinic that the quality care they offer should be integrative, preventative, culturally competent, and equitable, two factions among clinic volunteers contend over how to define “quality care” within this framework. In general, these frictions divide along the lines of volunteers who define themselves as “clinicians,” who want to achieve a quality of care that approximates a biomedical model of health care for all, and volunteers who defines themselves more as activists, who take a more “holistic” view of quality health care that is critical of broader understandings of health as defined by Western medicine. On the one hand, long-time clinic founders and organizers who espouse a more holistic perspective argue that CCP’s definition of quality should be based on their links with the local immigrant community and the resistance that they mount as an “unapologetically activist” organization that emerged from protests against anti-immigrant measures in Phoenix. Many of these
volunteers are the original members of the MASH street medic collective, and their motivations for getting more formal medical training were based in their immigrant health justice activism. On the other hand, other core organizers assert a more clinical understanding of quality that aligned with achieving the health measures and standards of care based on a universal health care model that still privileges Western medicine. These clinical markers of quality include working towards compliance with patient confidentiality measures like HIPAA, getting an official license for the clinic, applying for Federal Tort Claims Act (FTCA) coverage, which grants medical malpractice liability protection to volunteers seeing patients at free clinics, and providing Needlestick Insurance for volunteers. Also members of the MASH collective and committed to the clinic’s vision of immigrant health justice and quality care, the volunteers that comprise this “clinical” faction within the clinic were all biomedically-trained practitioners and more likely to have already been working within the formal health care system when they came to CCP.

These factions of clinical and activist do not divide neatly along the type of health modality practiced by an individual. For instance, volunteers who were biomedically-trained health professionals and had day-jobs in some aspect of the mainstream health system did not only adhere to the clinical faction; some were supportive of the activist vision that was more critical of broader notions and interpretations of “health.” This divide within the clinic organizers ended up generally falling along the two different clinic days – with the organizers of the Thursday nursing clinic day more aligned with the activist faction and the Saturday clinic staff representing the clinical faction. This distinction also meant that the organizers and volunteers in the activist faction were more
likely to be women, people of color, and themselves immigrants and/or uninsured. As a result, these factions within the clinic had broader implications for the way that race, gender, immigration and insurance status, and health modality played out within the clinic. The activist faction was also seen as being more closely linked with the larger Phoenix immigrant activist community, while the clinical faction was more closely linked with medical schools and other clinics and practitioners within the city.

Michael described how these two perspectives, clinical and activist, approached the health care provision at the clinic in different ways, saying, “Organizations that are started by clinicians start off by saying, ‘How many resources do we have and what are we able to do with those resources? What’s the best way to spend them?’ Whereas an activist starts out by saying, ‘What needs to get done?’ and then goes from there to ‘what do we have to do to make that possible?’ It’s a little bit of a different way of looking at the world. It’s more seat of your pants and gutsy, and sometimes we’re able to pull off things that didn’t look real possible.”

**Integrative**

A core tenet of CCP’s vision of quality care is its attention to “integrative” care that includes health modalities beyond Western biomedicine. Given the limited nature of the primary and specialist care available to uninsured, unauthorized immigrants, CCP provides integrative care based on a unique co-existence of various “health modalities” within the clinic. Comprised of an ad hoc patchwork of services provided by a combination of both formally-trained and lay health providers within the clinic, CCP deploys their limited resources and capabilities to create a collage of care for their
patients based on the knowledge and networks of their volunteer health care providers. Fundamental to the clinic’s integrative approach to health is a recognition of the embodied effects of border crossing and the stress and anxiety associated with living as undocumented in Arizona – embodied health effects that clinic organizers believe can and should be treated by a range of health modalities.

The volunteers at CCP describe the various categories of health services at the clinic as biomedical and holistic health services. Biomedicine corresponds to clinical, allopathic, Western health care that prescribes medication to regulate health conditions and cure diseases. At CCP, holistic health refers to a range of non-biomedical interventions including homeopathic treatments, herbs, vitamins, essential oils, acupuncture, and bodywork; informal hypnotherapy and mindfulness techniques; sound therapy; and curanderismo (a mixture of indigenous Aztec, Mayan, and Spanish spiritual shamanic and healing remedies). On a given day, the clinic is bustling with physician’s assistants (PAs) and PA students who provide routine and follow-up primary care for patients managing chronic conditions and provide prescriptions for low-cost drugs; naturopathic doctors and students from Naturopaths Without Borders, who provide acupuncture and combinations of herbs, homeopathy, and aromatherapy; a local Latina midwife named Lorena who provides the limited women’s health care at the clinic, including routine gynecological services like pap smears and pre-natal and post-partum care for mothers; a feisty, older bilingual therapist named Octavia who uses imagery and mindfulness to decrease patient’s stress levels; and a curandera named Alondra who provides shamanic and spiritual healing through a combination of tuning forks, feathers, rain sticks, chanting, and crystal singing bowls.
Hierarchies of health in the U.S. reinforce the supremacy of Western medicine and biomedical interventions, while largely ignoring or discrediting indigenous and traditional healing remedies and other health modalities. These modalities, which are often in conflict with one another but co-exist within the space of CCP, are focused on the prevention (where possible) and maintenance of chronic health conditions like diabetes. Thus, the co-existence of these modalities, which are often seen as fundamentally incompatible in their views of health and health care, is remarkable. The way these modalities work together to provide a collage of care for the clinic’s patients is best illustrated in the treatment of pre-diabetic and diabetic patients.

Because CCP’s patients are all high-risk for a number of chronic health conditions, as part of the clinic’s quality care, every patient has routine blood draws that are sent off to low-cost lab services to monitor their (risk for) diabetes. Once this labwork comes back, providers create a treatment plan, emphasizing diet and lifestyle changes combined with low-cost drugs, if necessary, to get the patient’s glucose levels under control. Abeni explained the relationship between the various health modalities using this example:

Say the patient’s A1C [one of the indications of glucose levels in the blood] comes back as say four or five percent. This would mean that they are pre-diabetic. They have some elevation of glucose levels but not to the point that they would qualify as having developed diabetes. In this case, the naturopaths would work with them to help them with vitamins, herbs, and supplements, dietary and lifestyle changes, exercise, etcetera. At this point, they don’t need to be on [prescription drugs] which can have some harsh side effects. If the person was actually diabetic and had a much higher A1C, then the naturopaths would send them to the clinical doctors to ‘get their pills.’ If their A1C is high and they are at risk of serious health issues as a result, the side effects – headaches, dizziness, GI issues – are seen as necessary side effects of a vital medication that the patient should be taking. The fact that these two types of medicine are working alongside each other
to provide a continuity of care to these patients is really unique. You definitely don’t get this at just any clinic.

Because of the limited care available for diabetic undocumented immigrants and the cost associated with the management of diabetes, the clinic places a strong emphasis on prevention so that pre-diabetic patients control their blood sugar levels and do not develop diabetes. Diabetic patients are considered more “serious” and are therefore referred to the biomedical providers who, instead of vitamins and homeopathy, put patients on Metformin and other diabetes medication that can be accessed cheaply through low-cost prescription services. The treatment of patients is focused primarily on prevention of “uncontrolled diabetes,” which involves the debilitation of the disease into insulin-dependence. Because insulin is prohibitively expensive for the clinic’s patients (who can hardly afford the test strips they need to monitor their blood sugar levels several times a day), it is considered a last resort. The price of the “effective” insulin, which used to average about $130 a month, has skyrocketed in the last few years to between $400 and $500 per month.\textsuperscript{10} CCP provides insulin-dependent patients with a cheaper but less effective insulin that costs about $30 a month. However, this less-effective insulin requires an extremely strict compliance with lifestyle and dietary guidelines in order to properly regulate a patient’s blood sugar. Beyond insulin-dependence, health complications as a result of untreated diabetes, like eyesight and kidney issues, renal failure, and neuropathy of the lower limbs, all pose extremely serious, if not fatal, challenges especially to undocumented and uninsured diabetic patients. For patients with

\textsuperscript{10} The American Diabetes Association has estimated that the medical costs associated with managing diabetes is almost $17,000 annually (ADA 2018).
advanced diabetes and renal failure, it is virtually impossible to access medical services, including regular dialysis treatments and even kidney transplants, that their conditions require.

In this way, in the absence of entitlement to medical services in the formal health system, CCP’s patients receive an attentive, individualized care that draws from the strengths of different types of medicine and health care. Together biomedical and holistic practitioners attempt to prevent and manage chronic health conditions that can be fatal for uninsured, undocumented immigrants with little access to health care.

However, this co-existence belies a tenuous relationship among the providers of various types of health care. Although the biomedical volunteers at the clinic profess a non-hierarchical relationship between these modalities, there is still a privileging of Western medicine to treat patients with more serious or “real” ailments, as evidenced by the way biomedical providers “take over” the care from the holistic providers of patients who develop diabetes. Furthermore, although biomedical practitioners declare the importance of the other modalities at the clinic, the holistic providers often chafed at the ways that biomedical providers fundamentally misunderstood or belittled their work. For instance, during my fieldwork, there was a tense discussion between providers about the derogatory (yet not necessarily malicious) language used by biomedical providers to describe holistic care as either “woo” medicine as it related to naturopathic doctors or “woo-woo” medicine as it related to more traditional and indigenous understandings of health. This tension is underscored by the gendered and racialized identities of the providers of these modalities, with mostly white, often cisgendered men as the biomedical providers wielding the most power within the clinic space.
Although the biomedical CCP organizers were quick to admit that they did not fully understand naturopathic or holistic modalities, they still evaluated the effectiveness and legitimacy of these approaches from their own Western biomedical perspective. For instance, a PA by training and a professor at one of the local PA schools, Ed said on several occasions in different iterations, often directed to other biomedical volunteers,

We just don’t know enough about [alternative health modalities]. We don’t have the evidence-based, peer-reviewed studies yet, but anecdotally, we see positive results from the holistic services that we offer patients at the clinic. You know, it’s very likely that something like homeopathy is more than the placebo effect we currently think it is. It could have physiological effects that we don’t understand. Even something like sound therapy, the frequencies it uses could have biomedical healing properties. We just don’t have the studies.

As evidenced by this back-handed argument in favor of non-Western health modalities – whose practitioners most certainly do not consider the effects to be only a placebo – their legitimation at the clinic is couched in terms of their (yet unknown) biomedical benefits. But the factions around different approaches to health did not always divide evenly along lines of health modality, some biomedical practitioners were also firmly located in the holistic camp, as strong advocates for the importance of holistic health care. Other biomedical volunteers, including Daria, a registered nurse who worked at a local hospital, were firm believers in holistic modalities. Daria cited the strength of the mind-body connection as integral in the manifestation of physical ailments for migrants under the constant threat of deportability and stresses of living as undocumented migrants in Arizona. Daria would even schedule herself for curanderismo appointments with Alondra as she found the sessions eased her social anxiety and lowered her stress levels.
How to write a medical note for an exorcism

Although co-existing at the clinic, these modalities also have fundamentally different visions and understandings of “health.” For instance, naturopathic medicine focuses on the integrated healing of mind, body, and spirit and stresses the ability of the body to heal itself through the use of herbs, body work, and attention to diet. It also questions the effectiveness of prescription medication with its often-unbearable side effects. On multiple occasions during my time at the clinic, I discussed with volunteers who practiced other alternative or traditional forms of healing about their approach to health. This approach included their focus on the health not only of the physical body but also of the “energetic body,” and an understanding of the chakras and other spiritual aspects of a person’s integrated energetic field as roots of many physical health conditions. One day, two of these volunteers, Alondra and Shira, had a particularly boisterous conversation in the kitchen about “medical intuitives,” who are holistic practitioners that use their intuition (or what some call psychic abilities) to determine where in the physical or energetic body a health problem is originating.

Although she did not self-identify as a medical intuitive, Alondra admitted that her informal training in curanderismo meant that she often worked “intuitively” rather than methodically or ritually, letting her intuition guide her sessions with patients. One clinic day, I saw her in front of a laptop at the kitchen table, an unusual sight as ordinarily only biomedical volunteers used the computers. She stared blankly at the screen, seeming out of her element. “Michael has told me that I have to start keeping track of my sessions with patients in their records [in the online electronic medical record software that CCP used, which though free and open-access, was notoriously difficult to navigate]. So I’m
trying to figure out how to put my work into words and translate my sessions into 
‘medical talk.’”

When I had first come to CCP, many of the volunteers had told me about 
Alondra, in an almost mystical way, yet could not actually describe her healing work to 
me. As a *curandera*, Alondra is a spiritual healer who does cleansing energy work. Some 
*curanderas* use prayer and holy water; some use herbs and oils. Alondra uses feathers, 
tuning forks, a crystal singing bowl, a rain stick, and a didgeridoo. When I finally met her 
and asked her what she did at the clinic, she answered me cryptically by asking if I 
wanted to “meet her feathers.” She brought me into one of the clinic’s exam rooms. 
Instead of having me sit on the table, she pulled a chair into the middle of the room and 
opened the windows to let in a dry, desert breeze. She unrolled a felt sleeve with about a 
dozen different-sized silver tuning forks and took her time choosing two of them. Seated 
in the chair, I closed my eyes as she struck the tuning forks together and the sound 
reverberated through the room. She circled the vibrating forks around my head, sounding 
 louder as they passed my ears. Then she opened a bright fabric bag and pulled out a 
bunch of feathers. With a bird wing in each hand, she brushed down from the top of my 
head as if she were dusting away cobwebs from my head and shoulders. With my eyes 
closed, I heard the soft whooshing flutter and felt the light wind the feathers made on my 
face. When the session was over and I opened my eyes, Alondra asked me how I felt. 
“Great, actually,” I said after pausing for a moment to scan from head to toe. Suffering 
from chronic neck and shoulder pain, after the session with Alondra, I was surprised that 
the stiffness was gone, and I could turn my head without pain for the first time in months.
“It’s because you have an energy blockage. You’ve been unable to speak your truth, and it’s lodged there [in your neck].”

As she leaned her didgeridoo against the corner of the room behind the exam table and stood up, swinging her wild gray curls behind her shoulder, she said, “Sometimes people will come in and have a session and we never say a word to each other, and sometimes people want to talk. Being undocumented and the trauma of crossing the border has a very particular kind of stress that becomes embodied in different parts of the body and causes physical health problems. Sometimes it’s stomach issues, headaches, insomnia, just general aches and pains. What I do helps people. People will tell me, ‘I used to have insomnia but now that I come to you I can sleep.’ Things like that. My work is completely intuitive and it helps people deal with these issues. It’s as important and powerful as what Ed and [the other biomedical practitioners] do.” She chuckled and continued, “So that’s what I do and that’s why it’s hard for me to tell you what I do here at the clinic. It’s much easier for me to show you.”

Sitting blankly in front of the electronic medical record system, in the biomedical organizers’ push to track the holistic appointments in patient’s medical records, she was tasked with just that – the telling rather than showing of her energy-cleansing work. She had just worked with a patient in her “first, what I can only describe as, an exorcism.” Laughing, she added, “I imagine it’s the clinic’s first exorcism too.”

“Wait, what?” I was not sure that I had heard her correctly, or rather, I had heard her but couldn’t comprehend how an exorcism would happen in the clinic.
“Yeah, I’m surprised too. Michael saw a woman for a stomach ache. But she said that it was hurting because her ex-husband had had a curse put on her by a witch doctor. So, he evaluated her, but what are you going to do when someone is convinced that they’ve been cursed?” Alondra explained. “What are you gonna do? This woman firmly believes that she’s been cursed and that is the reason that she is ill. So I essentially performed an exorcism to rid her of it. I used my tools, my feathers and stuff, to get some cleansing energy going around her stomach. But I’ve never done an exorcism before…Maybe it worked.” Some of the volunteer nursing and medical students sitting at the table with Alondra snuck glances her way as she talked, as if they were not quite sure what to think about this conversation. “So, now I’m sitting here trying to figure out, I mean, how do you write a medical note for an exorcism?”

Alondra was attempting to navigate the electronic medical record software to input a summary of their session into the cursed woman’s medical chart. In trying to translate her work with this patient into biomedical reporting systems, Alondra was struggling to put into words healing work that in many ways is indescribable and unintelligible to biomedical health providers. Her question – “how do I write a medical note for an exorcism?” – is a fundamental one and includes an unspoken and underlying question about the pressure holistic providers at the clinic faced to describe in biomedical terms what defies discourse.

Preventative

For the patients at CCP who have no access to health insurance with which to pay for costly medical procedures and products, and for the clinic itself which has limited
resources, preventative care is vital to maintaining good health. Donna described the centrality of preventative care, saying, “Preventative health care is enormously important, and it costs us so much less in the long run than keeping [immigrant patients] in the shadows and ignoring them and not giving them access to the health care that they need to stay healthy.” CCP’s focus on prevention as central to integrative, quality health care is a direct critique of the mainstream health system as well as the basis for an ethics of care for their patients. CCP argues against the short-sightedness of denying preventative care to uninsured patients. De-emphasizing preventative care (or refusing to cover it, as with some health insurance plans) leads to costly medical needs as diseases and health conditions progress, necessitating more medications and more costly procedures for ill patients.

As discussed in the previous section, CCP closely monitors its patients for any signs of chronic health conditions, especially diabetes and high blood pressure, and through a combination of health education, preventative care, and early intervention, attempt to stave off the development of these conditions. Providing as comprehensive preventative care as possible is time-consuming for CCP volunteers, who attempt to overcome the many barriers to health care access that their patients face, including language and cultural barriers, transportation and financial challenges, and the larger forces of structural violence and racism. This focus on prevention is also a testament to the limitations of the “quality” care that the clinic is able to provide. For instance, because insulin is prohibitively expensive, CCP invests a lot of time and effort in monitoring the glucose levels not only of patients that have diabetes but also pre-diabetic patients with slightly elevated blood sugar.
Although it may seem like preventative care is something that all providers working with uninsured patients would agree on, the specifics of the approach to prevention at CCP highlighted differing viewpoints on the efficacy of encouraging patients to take advantage of “free screening” programs put on by clinics and providers in the formal health system as well as health fairs sponsored by immigrant health organizations. Screening and diagnosis of health conditions is central to a biomedical approach to health care. Indeed, for many patients, catching their diabetes before it progressed was key to their ability to change their diets and lifestyle and thus maintain good health. But for patients with serious long-term health needs that CCP is ill-equipped to meet, encouraging them to get screened for something like cancer introduces a whole different ethics of care. During my fieldwork, one moment in particular stands out during which CCP volunteers clashed over the efficacy and ethics of a free mammogram program to which biomedical volunteers were encouraging people to refer CCP patients.

When speaking at a clinic staff meeting about a free mammogram program for uninsured women that was about to be terminated because they had run out of funding, Lorena, a trained midwife who provided all the women’s health care at the clinic, responded, “Sure, I have at least thirty women that I can refer for mammograms [before the program ends], but I know that about half of them will need biopsies. So, they get a mammogram and find out they need a biopsy. Who’s going to cover their pathology costs? And what’s going to happen when some of them come back positive?” My initial reaction to Lorena’s statement was one of shock at the thought that she had patients in her care that potentially had breast cancer and was essentially refusing to help them get a diagnosis. It seemed to go against the clinic’s critique of their patients’ exclusion from
health care and against the ethics of immigrant health justice that the clinic worked to cultivate.

However, as my time at the clinic progressed, I began to understand Lorena’s structural critique of this free mammogram program from the perspective of the holistic volunteers. What is a mammogram but a biomedical confirmation of what Lorena and her patients already knew – the presence of a lump in their breast? A mammogram is not a biopsy, that would give these women definitive information about said lump. According to the holistic volunteers at CCP, encouraging uninsured, undocumented women, who have no access to a biopsy and certainly no access to treatment if they find out they have cancer, to get a free mammogram is an unethical position that does not align with a holistic framework of immigrant health justice. In another discussion about free health screenings, Lorena shed light on the immigrant health justice ethics of not burdening uninsured, undocumented patients with a diagnosis without recourse for medical care or follow-up.

You have all these free health fairs that basically try to screen as many uninsured patients, often immigrants, as possible for a whole host of health conditions, you know, hypertension, diabetes, those sorts of things. But these health fairs are unethical. It’s completely unethical to prick someone’s finger or take someone’s blood pressure, tell them they probably have a serious health condition that should get looked at, and then not provide them with the necessary follow-up. What’s the point in giving them the diagnosis? It’s just going to make them more stressed out and anxious than they already are. What they need is actual access to care. If you’re not going to give them that, then what’s the point?

As demonstrated by Lorena’s quote, the questionable ethics of care is not her decision to refuse to refer her patients to the free mammogram program, rather it is the larger brokenness of a health system that provides free screenings for uninsured patients without
actual follow-up or medical services to treat any health conditions that the screenings discover. The larger structural constraints of an exclusive, for-profit health system then demonstrate the ethical limits of preventative care, when it relates to the push for a biomedical diagnosis as an unquestioned “good,” especially for uninsured patients who have no access to further care. Within CCP’s individualized quality care, they may be able to crowdfund and draw from their networks to pay for Paola’s surgery, but they lack the capacity to do the same for, say, thirty women with new breast cancer diagnoses.

**Culturally Competent**

In addition to personalized preventative care for their patients, CCP’s quality care is defined by an intentionally-cultivated cultural competency, that the clinic’s mission describes as “cultural humility.” This cultural humility is asserted directly against what CCP volunteers called the “sloppy racism” of the mainstream health system that is quick to label uninsured and indigent patients as noncompliant. This dismissal of patients facing the most barriers to care ignores the larger structural factors that affect their health and well-being. Ignoring these factors means that, instead of recognizing the impact of structural violence, patients’ health issues are labeled as the result of individual choices and risk behaviors. This patient-blaming also enables medical providers to “write patients off” by deeming them noncompliant for missing appointments or not complying with a health regimen, rather than investigating the wider structural issues affecting their care. Some of these structural barriers to compliance include unpredictable work schedules or lack of child care that might cause them to miss their appointments and financial challenges that keep them from being able to buy medications or other necessary health
equipment. These and so many other structural factors that keep them from being “model” patients often cause them to be labeled noncompliant by the mainstream health system and thus written off as disinvested in their own health.

Rather than focus on patient compliance, which places the burden on patients to conform to the culture and standards of Western biomedicine, CCP focuses on “cultural competency” as a central tenet of the quality care that they provide for their patients. This focus shifts the responsibility to volunteers and medical providers at the clinic to deliver health care in a way that is realistic, legible, and accessible to patients’ lives, cultures, and abilities. CCP volunteers who also worked in the formal health system saw that cultural competence, which has become a buzz word in mainstream health care, often translated into the hiring of nurses of color, which although important, placed the expectation on these nurses to treat all patients of color, as if they shared a cultural affinity, and did not affect white medical providers or actually create a cultural shift in “medicine as usual.” Put bluntly, culturally competent care became care provided by a nonwhite provider within a dominant culture of healthcare delivery that remained unchanged.

In contrast to this more popular understanding of cultural competency, CCP worked to understand their patients’ cultural backgrounds as well as the larger structural factors that affected their health and their health care utilization. During a training on health justice that the clinic held for volunteers, the facilitators, clinic organizers, and volunteer providers and interpreters had an important conversation about how cultural competency would impact a discussion about nutrition education with a diabetic patient at the clinic:
Marisol, the workshop facilitator, had herself been undocumented and a patient of CCP before she had become a citizen and gotten access to health insurance. She asked the group, “Part of cultural competency is, for instance, what would you say to a grandma with diabetes who eats ten tortillas per meal? You can’t tell her to stop eating tortillas. That’s not realistic and doesn’t acknowledge the central position of tortillas in the Latino diet. Cultural competency is about meeting people where they’re at. What would you do this in this example?”

After a brief silence, Bonnie, a middle-aged white woman who had worked as a nurse for decades, piped up, “Well, we had a diabetic nutrition training here at CCP a few weeks ago and the facilitator suggested that we get out the plate and ask them about what they are currently eating. On the CCP website, there is also an entire online training about…motivational interviewing. Part of [motivational interviewing] is about asking them what they want and helping them to set goals. People know what’s healthy already, and motivational interviewing can help you get them to tell you. I mean, you could, offer options or a list of healthier brands or something.”

“Yeah, so you could ask them what would be realistic,” Ed, the clinic’s medical director, added. “Would they think they would be able to cut down to five tortillas a day? Or switch to corn tortillas instead of flour ones that have a higher glycemic index. Or you could talk to them about which brands are healthier than others, you know, offer them options, rather than telling them to stop eating tortillas altogether. When I first started doing this work, I thought ten tortillas per meal was unreal, but the more I do it, I realize it’s normal.”

“It’s like our bread,” Marisol said chuckling.
“Another thing is for instance you have a patient who’s from Africa, and you tell them to eat more salads,” Michael chimed in. “Well, they don’t eat anything raw because it’s important in Africa to cook everything thoroughly so that it doesn’t make them sick. And it’s important to remember that the people we have as patients have been through many traumas. They’ve crossed borders and come to unfamiliar places and feel a great amount of stress. Sometimes food might be the only familiar thing they have.”

Bonnie, who as a newer volunteer to CCP was still learning about the clinic’s approach to health care, asked, “Okay, but with that example about salads, when is it okay to say, well, you’re in America now and here we eat our spinach raw, and it’s safe to do that here.”

Donna interjected quickly, “Well, sometimes it’s safe. Other times, it’s infected with E.coli.” This quippy comment evoked laughter around the room.

Nena, a young Latina who volunteered as an interpreter at the clinic, added a critique of nutrition education within the context of the U.S.’s global colonization of food systems, saying, “Yeah, but I think about how the American diet has been exported and it seems like the Americanization in terms of people’s diets that happens for immigrants – that has also been exported around the globe – is the worst of our food. It’s actually the Americanization of the diet that has caused this exorbitant increase in diseases like diabetes. I think of my mom and she has high cholesterol and high diabetes, and it’s like we [meaning Mexicans] need to get back to our original diets because our people have been familiar with juicing and other more healthy eating habits.”

Marisol built on Nena’s contribution, commenting, “That’s a great point. There’s a good cookbook called ‘Decolonizing your Diet’ about getting back to the foods that our
people have eaten for centuries that are healthy for you and not full of hydrogenated corn syrup and sugar and stuff like that. Another thing that you can do that’s cultural competent is you can ask the important question, ‘What do people eat that’s healthy in your culture? Or what do you eat when you’re trying to be healthy?’ Because people already know what’s healthy. Like we do too. We know what’s healthy and then we don’t necessarily eat that way, but we know how to do it. We may eat burgers but we know that vegetables are healthy, you know.”

As evidenced by this discussion, cultural competency at the clinic is more than a tokenistic nod to cultural specificities of diet and exercise. The clinic takes seriously these cultural differences but also acknowledges the structural factors that impact their patients’ ability to access health care or to adhere to a new regimen. Implicit in this discussion is also a difference within the clinic volunteers in interpretations of cultural competency: one approach focuses on “interpersonal” cultural competency and is embraced by both biomedical and holistic-minded volunteers, compared to “structural” cultural competency, which acknowledges larger structural inequalities and historical and political contexts within which health systems operate and is more closely aligned with the holistic approach.

Interpersonal cultural competency challenges dominant models of health care and disrupts the power dynamics of patient-provider interactions. As demonstrated by the above discussion, culturally competent nutrition education for diabetic patients at the clinic borrows from principles of harm reduction: rather than unrealistically advising patients to cut out tortillas from their diet entirely, CCP organizers encourage their
volunteers instead to offer their patients options of dietary alterations that acknowledge the centrality of tortillas to their patients’ diets, while persuading them to consider healthier nutrition choices. Through the use of motivational interviewing, volunteers ask a series of questions to solicit patients’ ideas about changes they could make to their diets, rather than directing what to do. These discursive tactics shift the power dynamics in the patient-provider relationship so that the patient tells the provider what realistic changes could be made to their diet, rather than the provider educating the patient about what to eat. This shift at once respects patients’ cultural knowledges about food while acknowledging that they already know how to “eat healthy.” In the vein of cultural humility, this approach to nutrition education also encourages parity between patient and provider through the admission that the CCP volunteers, who are doing the “educating,” do not themselves always make healthy nutritional choices. For instance, Ed’s atrocious nutritional habits were the basis of many jokes by volunteers at the clinic as he was notorious for surviving primarily on fast food combos and gas station hot dogs.

Beyond disrupting the power dynamics of the patient-provider relationship, CCP’s culturally competent approach also involved an acknowledgement of the impact of larger structural factors on patients’ diets and health. This approach was more likely to be embraced by holistic volunteers who questioned the biomedical focus of health provision. For instance, in the above conversation, Michael discusses the importance of the comfort and familiarity of food as mitigating the impact of trauma and the uncertainties that accompany migration for the clinic’s patients. This structural approach also critiques U.S. imperialism that has exported unhealthy processed foods and “colonized” indigenous and immigrant diets with “hydrogenated corn syrup and sugar and stuff like that.” As a result,
holistic volunteers at the clinic regularly described diabetes as a “disease of
colonization.” This critique recognizes the broader consequences of historical and
political events, like the passage of NAFTA that flooded Mexico and Central American
countries with lower-priced rice, corn, and other agricultural staples, destroying local
economies and farmer livelihoods and driving migration to the U.S. The structural
culturally competent approach also acknowledges the importance of cultural humility, as
evidenced by Donna’s retort to Bonnie’s question about when it is appropriate to tell a
patient “you’re in America now where we eat salad.” This recognition that raw spinach in
the U.S. is not safe either critiques the U.S. food system as not necessarily better than that
of Africa or other regions. It also recognizes the neoliberal de-regulation in the U.S. that
has led to dangerous agricultural practices and regular recalls of food-related disease
outbreaks, such as an E.coli outbreak that prompted a spinach recall (to which Donna is
referring in her response). The spinach in the U.S. then is not necessarily “safer” than
African spinach, for instance, and it is not culturally humble (nor accurate) to assume that
raw food in the U.S. will not cause diseases.

This discussion about how to approach nutritional education with diabetic patients
in a culturally competent way provides a window into the clinic’s understanding of
cultural competency as a central tenet of the “quality care” the clinic provides. It is also
the basis of CCP’s disruption of the dominant culture and power imbalance of
mainstream health care as well as its deeper analysis of systems of inequality that affect
their patients’ health. These two approaches to cultural competency in an immigrant
health justice framework demonstrates the ways that these agreed-upon ideals of the
clinic translate differently into practice.
Equitable

At the beginning of this chapter, Adam asserted that it is against “the spirit of medicine” for some people to get better health care than others and some people to get no health care at all. This value of “equitable” health care as central to the quality of care provided by CCP argues that everyone should be privy to the same quality health care regardless of socioeconomic or immigration status. In this way, CCP organizers worked to deliver the same quality health care that they themselves would want to receive. In fact, as my time at CCP was drawing to a close, one of the volunteer doctors at the clinic started a separate clinic day for people with insurance. This model was symbolically important for the clinic in challenging the quantity model of care that provided substandard medical services to uninsured patients – in effect, it was a testament to the “quality” of care at CCP that insured volunteers and community members would access the medical services at the clinic – but it also provided a material benefit to CCP. The doctor charged his patients’ insurance for their care and then donated this money to help run the clinic. In this way, insured patients directly contributed to the care for uninsured patients through mutual solidarity.

Despite the consensus around the value of equitable care, this tenet of quality care also caused the most tension between volunteers at the clinic as they were charged with trying to equitably allocate limited resources among the clinic’s patients who all had varied health needs. Although this tension manifested in various ways within the clinic, the most contentious example is the patient waiting list that the clinic maintained. Given the clinic’s decision to prioritize quality care for its patients, rather than emphasizing
quantity of patients, CCP faced a much larger demand for care from potential patients than it could accommodate. As a result, it maintained an ever-growing waiting list that was cleared when the clinic had raised enough money to take on new patients. The waiting list had been a point of contention at CCP for years, and the tensions about the waiting list are illustrative of larger factions both within the clinic and between the clinic and the “community.” Lack of transparency at the clinic raised questions from local Latinx and immigrant communities about how patients on the waiting list accessed care at CCP. To dispel what clinic organizers interpreted as misinformation circulating in the community, CCP organizers (mainly in the activist faction) created an advisory group comprised of “members of the community,” including mainly immigrant and Latinx local community leaders and friends of the volunteers. With the intent to ensure some community oversight of the clinic, this advisory group was tasked with putting together criteria for prioritizing which patients to take from the waiting list and in an order that would be deemed “fair.” In addition to specific health needs, the criteria that the advisory board created also took into account social location in terms of a potential patient’s family commitments and experience of intersectional discrimination. For instance, a single mother with multiple children that she supported and cared for would be prioritized over an elderly man with no family.

According to CCP organizers Ed and Donna, who both fell mostly within the clinical faction, the criteria that the group came back with was an “overly complicated” algorithm to decide on this prioritization. As they recounted this episode in the history of
the clinic, Donna said, “But then that meant that someone who had an A1C of nine\textsuperscript{11} would sit on the waiting list, while someone who was pre-diabetic would get care. That just didn’t make sense.” When the advisory board had constructed their formula for how to prioritize potential patients on the waiting list, they took into account social inequality and structural violence, in addition to medical need. The organizers in the clinical faction however worried that this formula would mean that someone in imminent medical danger would languish on the waiting list without care, while someone with less urgent health needs would be allowed onto the clinic’s roll. Instead of working with the advisory board to give different weight to aspects of the criteria in order to remedy these issues, they vetoed the advisory board’s recommendations, declaring them to be too complicated. Thus, after creating the advisory board to cultivate more direct relationships and transparency with the local Latinx immigrant community, upon receiving their recommendations, the clinical faction on CCP’s board ultimately disregarded the criteria. The advisory board was effectively disbanded after this incident.

In order to save face with this advisory board and the larger community, clinic organizers had to skirt around the issue of the waiting list, instead creating a “simpler” system that they could use to attest transparency and fairness. To balance these demands, the new policy dictated that they did not take anyone off the waiting list until CCP had enough money in the bank (and enough volunteer capacity and room in the clinic) to

\textsuperscript{11} An A1C of 6.5 or higher means that someone has diabetes, while an A1C higher than 8 indicates diabetes that are not well-controlled. For a CCP patient or potential patient, an A1C this high would be a reason for alarm as the patient would not have access to health care and diabetes medication and would be at risk for a host of more serious secondary health issues as a result, such as loss of eyesight, potential loss of a limb, or even renal failure.
cover the initial lab work and follow-up for everyone on the list. When this financial solvency and organizational capacity is determined by the clinic’s board, they clear the entire waiting list all at once, accepting everyone on it as new patients. In this way, they were able to bypass questions of transparency, fairness, and “overly complicated” determinations of deservingness. However, this “simpler” policy did not fix the damage done to the perception of the distance (and tension) between the clinic and the wider community. Perhaps unsurprisingly, the choice made by some of CCP’s founding board members, who were aligned with the clinical faction, to ignore the criteria decided by the community advisory board irked the more activist-leaning founders and long-term organizers, and this incident effectively solidified the two factions within the clinic.

Furthermore, the “simpler” system still did not address the primary issue with the waiting list that drove the initial creation of the advisory board and then the subsequent dismissal of their criteria: people with severe chronic health conditions and urgent health problems would still languish on the waiting list until the clinic had enough resources and capacity to accept everyone. Thus, these potential patients would still wait for months if not years before they could access care at the clinic. In order to mitigate this issue, both factions of volunteers agreed on the need for a discretionary category of “emergency patient.” Emergency patients at the clinic referred to patients whose conditions were acute enough to “skip” the considerable waiting list and be seen immediately. This designation mainly included people with severe and uncontrolled diabetes putting them at imminent risk for more serious health problems. It also included people with acute health issues from recent border crossings – severe dehydration with suspected kidney damage or potential cases of valley fever – or with workplace injuries that require more
specialized care, like Paola’s crushed arm discussed at the beginning of this chapter. In other words, it privileged patient’s deemed “emergencies” within a clinical framework of health.

In practice, the acceptance of emergency patients heightened tensions between board members and organizers in the two factions. Given the seriousness of the health issues of many patients on the list, the definition of “emergency” at CCP was ambiguous. This ambiguity reintroduced a lack of transparency and fairness around the waiting list, as patients who were referred by local organizations and friends of volunteers seemed more likely to be admitted as emergency patients than people on the waiting list who are unknown to the clinic organizers. The category of emergency patient also created challenges in terms of the allocation of CCP’s limited resources, effectively lengthening the time that other people had to wait on the list in order to access patient-status. In my experience, it also exacerbated the power struggle between the clinical and activist factions in the clinic.

Emergency patients were accepted for new patient intake appointments at the Thursday clinic because it had more scheduling leeway than Saturdays which were incredibly busy. Once the patient had their initial history and physical examination and their labwork came back, they were scheduled for a follow-up visit on a Saturday to get any prescriptions and discuss their treatment plan with the biomedical practitioners. In this way, Thursday clinic organizers, who largely represented the activist faction in the clinic, accepted more emergency patients. With his comparatively liberal interpretation of emergency, Michael often faced pushback from Saturday clinic leaders in the clinical faction for his seeming disregard of not only the established policies around taking new
patients, but also the limited resources and financial strains the clinic faced in trying to
deliver limited primary care to their existing patients. On multiple occasions when I was
at the Saturday clinic, Ed would question the qualification of these new patients as
“emergency” given the results of their labwork and would assume, sometimes rightly,
that the Thursday organizers were using the emergency patient category as a loophole for
accepting new patients. But other times, he would see only the objective health criteria of
these new patients without taking into account the broader experiences of these patients
that would qualify as “emergencies.” One particular example stands out from my
fieldwork regarding the conflict around the emergency patient status of a woman who
had recently arrived in Phoenix with her three children and had endured unspeakable
trauma before they had left Mexico:

It was already mid-morning, well into the Thursday clinic, when Michael came
into the kitchen/volunteer office and said frantically, “Okay, we have a very full waiting
room and we need to start seeing some patients. Octavia [the hypnotherapist] is in room
one with a patient and has been for the last two and a half hours. But because she’s in
room one [which is the midwifery and women’s health exam room], Lorena hasn’t been
able to get in there and see her patients. I’m going to have to ask Octavia to move to
another room so that Lorena can start seeing patients. Okay, who can see a patient?”
Michael asked to the room.

Even though Michael said the waiting room was packed, the pace in the kitchen
didn’t seem to change. Whether the clinic is full or empty on Thursdays, the kitchen
seemed to be relatively relaxed with volunteers hanging around waiting for something to
do, a marked difference from Saturday’s frantic feeling among volunteers. I headed out of the kitchen to see what the rest of the clinic felt like. Sure enough, the waiting room was as packed as I’ve ever seen it, mainly with women waiting to see Lorena. Michael was speaking to the new intake volunteer, Kristin, who I’d just met. He was mid-conversation, but I heard him say, “It’s not your fault because you’re new, but we want to make sure that room one is always available for Lorena and her patients. I’m going to have to interrupt Octavia and move her and her patient to another room now.”

After Michael moved them, I followed him back into the kitchen. He started talking about the patient that Octavia was seeing. Lupita was a new patient who Michael had decided CCP would take on as an emergency patient. Hers was the blood that I had centrifuged earlier that morning. Michael must have gotten to the clinic before it opened to start her intake paperwork and her initial history and physical exam. Michael said that she had severe diabetes and was out of her medicine but that she also had some other serious physical and mental health issues. He started to recount a horrible story about the trauma that she and her family had endured before they left Mexico. Members of the cartel had burst into her home in the night, awakened her entire family, and then made them all watch – Lupita and her three children (ranging in age from very young to mid-teens) – while they tortured her husband and their father to death. As a result, she and her children had fled Mexico for the U.S., arriving within the past week to Phoenix. They all understandably bore some very serious mental health issues from the trauma they had experienced.

About fifteen minutes later, Octavia came into the kitchen and recounted to Alondra about her appointment with Lupita. I tried to eavesdrop, but the kitchen was a
little louder at that point and I only caught snippets of their conversation in Spanish. She was saying that the woman was incredibly stressed and emotional about it all and that they had had a very long appointment. Exhausted by her morning, Octavia left the clinic almost right away. As Octavia headed off to her other job at the hospital, Michael asked Alondra if she could see someone for an appointment. Alondra headed out to exam room three with her feathers, tuning forks, and other equipment to meet with Lupita and do a session with her.

Passing through the clinic periodically for the rest of the afternoon, I could hear the rain sticks, singing bowl, and didgeridoo from room three. I tried to wait around to say bye to Alondra but had to leave before she had finished the session. Altogether Lupita must have had at least five hours of holistic health appointments that day in addition to her intake exam and bloodwork. Lupita’s marathon appointment with holistic service providers demonstrate the important role that they have at the clinic in treating the severe stress experienced by CCP’s patients: mental stress and trauma from events that happened prior to and during migration as well as the daily stress of living as an undocumented immigrant in Arizona with family, friends, and loved ones who are also undocumented. There is an implicit understanding at the clinic that biomedicine, and even naturopathic medicine to an extent, are incapable of helping patients deal with this stress and trauma – this is the domain of holistic medicine.

I returned to CCP again on Saturday for the next clinic day. As I walked in and greeted everyone, neither Ed nor Michael returned my hello, which was strange. Michael always greeted each volunteer with a hello and a hug. As I clocked in, I overheard Ed and
Michael’s discussion, and it was getting really heated. From the snippets I heard over the bustle and noisiness of the kitchen, I gathered that they were discussing the woman who had been in the clinic on Thursday and had had a bunch of labs run. Michael said something defensively to the effect of, “She has severe Type 2 diabetes and is out of her medication,” to which Ed replied vehemently, “Okay, but I’m not going to touch the adolescent psych patient!” [He was referring to Lupita’s teenage daughter, who had been with her at the clinic on Thursday.] With this statement, Ed and Michael came to a tentative agreement, Ed resigning himself to seeing Lupita as an emergency patient.

Michael usually did not come in on a Saturday. He must have sensed that Ed would be reluctant to take her on as an emergency patient so came to fill him in on Lupita’s situation, including the fact that Michael had used his “discretion” to take on this patient. I had walked into the middle of their argument.

After they had tentatively agreed to accept Lupita as a patient, Ed launched into a long lecture about the waiting list, speaking to Michael as if he were a petulant child. “Next time you have to follow the protocol,” he snapped as he stormed out of the kitchen.

This argument between clinical and activist CCP organizers demonstrates the tensions between the two factions as they play out in terms of taking on new emergency patients. Because the biomedical volunteers only examine the quantitative results from the vitals and bloodwork of new emergency patients, they miss so many aspects of what constitute these patients’ emergencies. For instance, in the case of Lupita, her A1C levels demonstrated that she had Type 2 diabetes but would not have indicated a more severe case of diabetes than other potential patients on the waiting list. This fact had spurred
Ed’s anger at Michael’s perceived “over-use” of his discretion to accept emergency patients. However, the most important information about her health – the trauma she experienced from being forced to watch the cartel torture and murder her husband and the mental health issues she faced as a result – did not appear in her bloodwork and thus caused the biomedical volunteers to question Lupita’s health needs as warranting her status as an emergency patient. The waiting list is but one example of how these two factions within the clinic – which both were in agreement that the clinic should provide equitable care within an immigrant health justice framework – approached this goal from different perspectives on the definition and designation of equity.

**Medicalized Citizenships**

These varied definitions of what “quality” health care in an immigrant health justice framework entails in practice – in what ways it is integrative, preventative, culturally competent, and equitable – demonstrate the tensions between different factions at the clinic, in either their emphasis on more clinical perspectives or more activist approaches to immigrant health care. But, even more than that, they demonstrate two types of medicalized citizenship that the volunteers at the clinic assert in relation to their patients, one that is substantive as opposed to one that is collectivized. Although both factions emphasize the medicalized citizenships of CCP’s patients, a few fundamental differences belie organizational tensions in regard to the clinic’s relationship with “the community,” which includes not only their patients but also broader Latinx and migrant communities, immigrant rights and health justice organizations, and even No More Deaths and the other humanitarian groups working along the border.
In asserting health care as a human right for all regardless of income or citizenship status, CCP organizers in both factions argue for the biocitizenship of uninsured, undocumented immigrants, asserting their informal medicalized inclusion through their status as “patients” or as humans with health needs. In theorizing biocitizenship, Rose and Novas (2005) broadened Petryna’s (2003) original concept of biological citizenship, in scope and definition away from the boundaries of national citizenship. Their understanding of biocitizenship encompasses “all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species” (440). In this way, CCP asserts the biocitizenship of its patients by drawing attention to their humanity and the reality of their actual current or potential future health needs. In the context of a mainstream health system that refuses to recognize or misrecognizes migrant health needs, this biocitizenship – the very assertion of their medical needs – is a radical act that recognizes the right of uninsured, undocumented migrants to the health care that they require.

I argue that the clinical faction at CCP asserts a “substantive biocitizenship” on behalf of the clinic’s patients, while the activist faction attempts to cultivate a “collectivized biocitizenship” with the clinic’s patients. Evelyn Nakano Glenn describes “substantive citizenship” as an informal citizenship that is cultivated on a local and even interpersonal level, “through face-to-face interactions and through place-specific practices that occur within larger structural contexts” (Glenn 2011:2). In this way, CCP volunteers cultivate their patients’ substantive biocitizenship through their own patient-provider interactions that in effect mirror the patient-provider interactions of an insured,
citizen patient. For volunteers in the clinical faction, this reflection is a powerful statement about the democratization of health care and its status as a human right for everyone.

On the other hand, volunteers in the activist faction intentionally work to cultivate a “collectivized biocitizenship,” through which volunteers and patients share expressions of medicalized citizenship through mutual aid and community solidarity. Karma Chavez (2018) has defined collectivized biocitizenship as resulting when “the noncitizen who has been left to die due to their biology and yet who is already inside the nation’s borders, fights back against the state…and reveals not only the death politics but also the ruptures that create possibilities for change to laws and political alliances that actively work against necropolitical biocitizenship” (118). In many ways, at CCP, this collectivized biocitizenship involves a deliberate de-stabilization of the power relations of traditional patient-provider interactions, which have caused lasting trauma and health issues for many of the clinic’s patients. In considering their differing approaches to patient-provider interactions (and their cultivation of differing forms of biocitizenship), volunteers within the activist faction accused the clinical faction of perpetuating the “white saviorism” of many other medical humanitarian organization both within the U.S. and abroad.

These tensions over the various definitions of “quality” care and the ways that these translated into differing cultivations of biocitizenship are exemplified in a showdown over the installation of a “check-in window” in the clinic’s waiting room. The organization of the physical clinic space may seem insignificant, especially in relation to the seriousness and magnitude of the health inequalities experienced by CCP’s patients. But, the conflict that arose within the clinic over the “check-in window” was indicative of
larger issues about CCP’s relationship to its patients and wider communities and ultimately the damage that the activist-leaning organizers perceived the clinical pursuit of “quality” to entail. Whereas the clinical faction was pursuing bureaucratic measures of “quality” including the strict interpretation of HIPAA and formal licensing for the clinic, the activist faction contended that these bureaucratic indicators involved a certain level of violence to communities that had been in many ways traumatized by the mainstream health system.

During my time at CCP, two of the wealthy clinic organizers purchased another space, gutted it, and turned it into a much larger clinic with more exam rooms, a pharmacy for herbs, supplements, and homeopathy, and a bespoke holistic services room. Sharing space with a landscaping business, the clinic had an internal courtyard with bubbling fountain and beautiful plants all around. In many ways, it was a clinic tailored to the needs of the organization and its patients, but at the same time, in comparison to the small house that had been CCP’s space for many years, it was undeniably a clinic, complete with a sign in front of the building with the organization’s name on it. This sign indicated a decisive shift from an underground “guerrilla clinic” to an above-board, licensed, official health space. This change caused the tensions between the factions at the organization to heat up. But, more than the sign on the front of the building, it was the installation of a check-in window between the patient waiting room and the volunteer space that led to an open conflict between the two factions, resulting in the resignation of all the clinic’s founders and organizers who were women of color from the board.

During the clinic renovations, I accompanied Michael on a tour of the space that he was giving to three artists from Chiapas. He was hoping to enlist their help in painting
a mural on the shed in the parking lot that held the medical supplies. During this tour, he mentioned to me the importance of decorating the clinic space in a way that destabilized traditional medical relationships for both CCP’s patients and providers:

I’m hoping that we can cover all the walls with murals and artwork and things to keep it from being such a sterile, medical feeling space. Those things make a big difference. We always said with CCP that we are not trying to create a free version of a broken system. It’s easy for those of us volunteers who work in the [formal] medical system to fall into the usual patient-provider interactions. Changing the space from sterile white walls to have murals and art is one way that we can break down that tendency and remind people why we’re here.

The original clinic was a far cry from a “sterile, medical feeling space.” The house’s original living room with a huge fireplace covered in Spanish tile became the waiting room. Chairs where patients waited lined the walls, which were covered with oil paintings and sketches donated and bought from local Latinx and immigrant artists. Volunteers would watch children play with toys in the middle of the room as parents or grandparents had their appointments. Where the living room led into a hallway to the rest of the house, intake volunteers sat behind a small folding table, taking patient information, signing them in, and scheduling follow-up appointments. As patients entered the front door, they would be greeted by intake volunteers, who many times would step from behind the table to hug the patients and their children and take a few minutes to catch up on their lives and ask about their families.

Without really consulting other clinic organizers, volunteers, patients, or members of the community, CCP organizers aligned with the clinical faction – who were also the ones with the funds to purchase and renovate the clinic space – designed and created the new space. Citing a need for HIPAA compliance, they designed the new space to include
a “check-in window” that replaced the intake folding table. This check-in window fully divided the volunteers from the clinic’s patients. The new waiting room was decorated with the same artwork from the old clinic, but instead of chairs around the perimeter of the room, they were arranged theater-style in rows. The patients would enter the clinic, walk to the check-in window where two intake volunteers would open the window and check them in for their appointment, and then close the window. Patients would wait in the chairs until they were called back for their appointment. Citing HIPAA, clinical organizers argued that this architecture helped ensure patient confidentiality, so that patients would not overhear providers discussing medical details with other patients. However, with the new physical division between the waiting room and the rest of the clinic, CCP volunteers actually did not have a reason or opportunity to enter the waiting room. In effect, this arrangement fully physically separated the patients and volunteers, solidifying a patient-provider hierarchy that angered the volunteers in the activist faction and made underlying tensions come to a head at the clinic. The physical barrier that this “check-in window” created between patients and providers was a huge point of contention at the clinic and even prompted the resignation of one of the clinic’s long-term founders and organizers, who specifically cited the check-in window in her resignation letter as a symbol of the clinic’s growing distance from the community and embrace of a more medicalized model of care.

Although all CCP volunteers and organizers espoused a vision of immigrant health justice that included health care for all regardless of income or immigration status, in defining “quality” care in terms of bureaucratic, biomedical indicators, the clinical faction at CCP fell into patterns that bordered on replicating aspects of the “broken
On the one hand, focusing on bureaucratic definitions of care made them legible to external groups that questioned their work and enabled them to assert their biomedical expertise and authority in a way that legitimated the status of the migrants at CCP as “patients,” lending credence to their legitimacy as a clinic. However, on the other hand, by replicating measures of “quality” determined by mainstream health institutions, they effectively distanced the organization from its relationship with the wider Latinx and immigrant communities in Phoenix and opened the organization up to accusations of “white saviorism.” Within this clinical model of immigrant health justice, the organizers at CCP that adhered to a more biomedical vision of quality health care asserted a substantive citizenship “on behalf of” their patients, arguing for an informal medicalized inclusion of uninsured, undocumented immigrants based on their status as humans in need of health care. But their tactics proved alienating and even (perhaps unknowingly) triggering to patients who had experienced trauma within the mainstream health system.

In contrast, CCP volunteers, who would describe themselves as first and foremost activists before medical providers, fundamentally disagreed with the distancing of the clinic from its patients and their communities, a distancing that precluded a model of care based on mutual aid and community solidarity. In arguing for a return to the original community roots of the early MASH collective days, they worked to subvert not only traditional patient-provider relationships within the clinic but also the racialized power dynamics that plague much of medical humanitarianism (and the nonprofit world in general), with white medical providers caring for marginalized patients of color. However, for these volunteers, the installation of a “check-in window” in the new clinic space indicated the organization’s complete alignment with the clinical model of
immigrant health justice. As a result, all of the women of color on the board resigned in protest over this shift in the clinic. Lorena, the midwife at the clinic, posted publicly on social media about her departure from CCP (without specifically naming the organization):

A local, Phoenix nonprofit I was a part of for a time here in the valley…breaks my heart in how far from the vision of inclusion and race equity it started out being to what it is now: regular white savorism, white power led and managed, and white staffed. People of color are a minority in positions of board, management, student and medical provider leadership…I realized many of you must, like I, disagree with the veneer the good folks at your local, helpful nonprofit are sharing…the attention is no longer on the community, but on the organizers themselves. We are the ones who must tell those leading that, no, they are still doing it wrong. Yes, you help people but you are still doing it wrong. And that makes people of color in nonprofit world unpopular. We don’t stay on white boards…but, honestly, it’s not because we are irresponsible. Usually it’s because we are not heard or listened to when we say that there are deep, problematic race issues. We are drowned out by the self-congratulatory noise of the nonprofit celebrating how they do so much for so many…how dare we complain! So, POC warn and explain until we just Can’t. No. More…I have always said that things will be smooth as long as the white folks in leadership for your nonprofit aren’t in danger of losing their perceived power…but if you threaten that - well, watch out. Suddenly people of color are no longer running much of anything, and [the stories are told] where what is celebrated is the story told by the white narrators…and the vulnerable “needy” show deep gratitude, their emotional labor worth gold. Yet…the vulnerable person giving away gratitude for help is not a story they would chose for themselves. Their dreams, like those of their ancestors, are so much brighter. Had this nonprofit abdicated whiteness…I believe a more beautiful [story] could have happened. One about radical change and radical storytelling that centered the community as the ones who saved themselves instead of a nonprofit! Alas, the nonprofit and those who run it design the narrative, while the grateful know the truth is that, for them, very little changed. #BeRadical #gettingwiser

Lorena’s indictment of the problematic racial politics of the organization that in many ways aligned with the larger clinical and activist factions speaks for itself. Her critique exposes the deeper problems with the assertions of substantive biocitizenship on behalf of
CCP patients – the ways that this version of biocitizenship reinforces the racial hierarchies within both biomedicine and the larger nonprofit sector. Lorena instead champions the radical potential in a collectivized biocitizenship based on “a vision of inclusion and race equity” that challenges the power relations between white saviors and “grateful” vulnerable people. This collectivized biocitizenship then is predicated on a vision of immigrant health justice that destabilizes these power dynamics and cultivates inclusion that emphasizes mutual aid and community solidarity.

Conclusion

Examinations of the internal and external tensions faced by medical humanitarian organizations in the U.S. argue for the emergence of a “new humanitarianism” through which the once-clear boundaries between apolitical service provision and political advocacy become blurred (Castañeda 2011; Gottlieb et al 2015; Ticktin 2006, 2007; Tiedje and Plevak 2014; Willen 2011). This chapter has taken the reality of these blurred boundaries as its starting point, examining the provision of immigrant health care within a clinic that takes a political critique of the twin broken systems of immigration and health as a given. In defining themselves against the exclusivity of the formal health system and the “quantity model” of much of the informal immigrant health safety net, the clinic volunteers largely agree on the ideological principles of “quality health care” that they envision: quality care that is integrative, preventative, culturally competent, and equitable. However, in translating their political critique into an alternative framework for immigrant health justice, the clinic volunteer’s struggle to agree on the logistics of this framework. Some volunteers privilege a biomedical understanding of quality health
care that defines immigrant health justice primarily in terms of access to health care, while other volunteers emphasize a holistic vision of quality care that questions the centrality of Western biomedical definitions of “quality.” This chapter illuminates the enduring constraints faced by medical humanitarian organizations who attempt to envision an alternative framework of immigrant health justice, while still navigating the structural barriers and constraints of both a for-profit medical industrial complex and a punitive immigration enforcement regime. More than semantics, these differing definitions of immigrant health justice have serious ramifications for the racial dynamics and power relations within the organization and between the organization, its patients, and the wider community. For volunteers who were aligned with the clinical faction at CCP, they used the legitimacy of biomedicine to assert a substantive biocitizenship for their patients, using their expertise and privilege as white medical providers to legitimate the medical needs of CCP’s patients. On the other hand, volunteers in the activist faction attempted to subvert more traditional patient-provider interactions and the racial and power dynamics inherent in this relationship. As such, they worked to cultivate a collectivized biocitizenship, predicated on mutual aid and community solidarity.
Chapter 4

Insurgent Humanitarianism in the Militarized Borderlands: Challenging the Border Patrol’s “Moral Alibi” and Asserting the Necropolitical Biocitizenship of Migrant-Patients

“Pull over, pull over,” Bill shouted. I had almost missed him standing there. The five of us were driving south from Gila Bend toward the bombing range in the “Bumblebee,” a bright yellow Xterra, loaded with gallon jugs of water, medical supplies, and food packs. We were all groggy, having met that morning well before dawn. It was seven a.m. now and already almost ninety degrees.

During the hottest time of the year especially, migrants travel at night. Under the cover of darkness, they move at a rapid pace, through forests of saguaros and teddy bear cholla cactus, along the trails of southern Arizona nicknamed the “Devil’s Highway” and the “killing field.” They sleep during the day in whatever shade they can find to conserve water and energy in the blistering heat.

Any traveler encountered in the daylight then, is in serious trouble, life-threatening trouble. Risking discovery and deportation after making it across the border, after walking for days or weeks, after spending a life’s savings on the journey.

And so we saw him, a gaunt figure in a dark hoody much too big for his slight frame, standing on the side of a two-lane highway, waving the ubiquitous black water jug most border crossers carry, like a flag to summon help. We parked in the low brush on the side of the road. He ran towards us, though he was limping. Bill and the other volunteers pulled supplies out of the back of the truck – a medical pack, a large Ziploc bag with fresh sandwiches, a gallon of water.
His name was Ignacio. He said he thought he had run out of water three days ago, hadn’t eaten in six. Not knowing whether his kidneys were damaged from dehydration, we told him over and over to drink the water more slowly. “Bebe el agua lentamente, lentamente.” He had a lump like a golf ball protruding from his shin. He shook uncontrollably. Bill asked him if he felt cold. “No, no,” he said through chattering teeth. He was going into shock. The entire bottom of each foot was a blister. Blisters that large – blisters in the desert – have to be treated like burn wounds. The skin is so compromised.

“Is that town up there Phoenix?” He asked in Spanish, pointing north toward Gila Bend. “How much further to Phoenix?” Where we had found him next to the road, he was over seventy-five miles from the border as the crow flies, yet still another fifty to Phoenix. He had been separated from his group in the middle of the bombing range, unable to keep up with their pace. He had stopped peeing days ago he said, his vision had started to blur, to go dark. He had made it to the road but was on the verge of losing consciousness.

We heard the crunch of gravel as a vehicle pulled off the road next to us, we looked up to see a white truck with a green stripe. La migra. Border Patrol. Just like that, Ignacio, in cuffs, was shoved into the back of the truck and away towards Mexico. And we were left, as if in a film, frozen, holding gauze and strips of medical tape that fluttered in the wind. The remains of a sandwich in the dirt at our feet.

Unlike the “slow death” associated with untreated chronic health conditions in the interior, the immigrant health crisis in the borderlands is defined by more acute health
emergencies and more immediate fatalities as a result of the dangerous conditions and terrain through which migrants are forced to cross. In contrast to CCP’s medical provision in the interior of the U.S., No More Deaths’ (NMD) work is dispersed around the vast rural areas of the militarized borderlands. This includes the high desert valleys and craggy mountains, immediately adjacent to the border, and a military bombing range along a large swath of southwest Arizona. In contrast to CCP’s fixed clinic site where patients come to them for appointments, NMD engages in a kind of guerrilla health care through the provision of material aid to travelers, like Ignacio, in the desert. Despite these differences, like CCP, NMD utilizes discourses of health as a form of currency to legitimate their work with undocumented immigrants in the face of larger and more powerful institutions and policies. Although CCP engages in a more overtly political critique of the “broken systems of immigration and health” framing their work in terms of immigrant health justice, NMD is adamant in the public framing of the apolitical nature of their work as humanitarian aid.

Within the “humanitarian border” (Walters 2011) between U.S. and Mexico, for the past twenty-five years, the prevention through deterrence strategy has fortified the urban areas of the U.S. borderlands, forcing migrants to cross in the most remote and treacherous terrain and dramatically increasing the dangers associated with crossing. As a result, humanitarian groups have documented the deaths of 8,000 people in the borderlands since 2001. The International Red Cross has recognized the county in which NMD primarily works as a “disaster area,” and the American Public Health Association has declared the migrant deaths in the desert a “public health crisis.” Within this humanitarian crisis, Border Patrol and NMD face off over the legitimacy of their
“humanitarian” work. The organizations’ conflict over the discursive framing of this humanitarianism often plays out as a sort of “political theater” of the borderlands – with grave consequences for the people crossing the Sonoran desert on foot.

Within this political theater, on the one hand, the Border Patrol contend that they engage in a (militarized) humanitarianism, conflating their enforcement work in the desert with a humanitarian presence. Asserting themselves as the sole arbiter of humanitarianism in the borderlands, they question the legality and ethics of NMD’s work. On the other hand, NMD attempts to challenge the Border Patrol’s claims of humanitarianism, instead framing Border Patrol’s enforcement work as directly causing migrant deaths in the desert, while reasserting their own legal right to provide life-saving care to “patients” in need of medical intervention. This political theater coalesced in the summer of 2017 around the public framing – in press releases and media statements – of Border Patrol’s surveillance and raid of a NMD clinic in the desert and the arrests of four men receiving medical care there. In the public framing of these events, NMD employs an “insurgent humanitarianism,” self-consciously and strategically using humanitarianism as a way to claim neutrality within the politically-contentious space of the borderlands. In the face of the militarization of the borderlands and a humanitarian crisis of migrant deaths, this insurgent humanitarianism involves an assertion of the apolitical nature of their work. This discursive strategy enables them to argue for the legitimacy and legality of their presence in the borderlands, expose the fatal consequences of border militarization and punitive enforcement strategies, and claim a necropolitical biocitizenship for migrant-patients marked for death in the borderlands as well as for migrants who die in the desert.
This chapter begins with a discussion of the border policy prevention through deterrence, arguing that it is responsible for the surge in migrant deaths in the borderlands and the resulting immigrant health crisis. It then outlines the emergence and work of No More Deaths and its partner organizations as a direct response to these deaths, before discussing NMD’s representation of the humanitarian crisis along the border. The chapter offers a broader analysis of humanitarian principles – highlighting on the one hand the ways that NGOs have responded to the critiques of humanitarian intervention by providing humanitarian aid within their own countries, and on the other hand how militarized groups have adopted a veneer of humanitarianism to soften their public image and further justify military intervention. This trend can be observed in the “humanitarianization” of border enforcement, as Border Patrol has increasingly engaged in small interventions that can be characterized as humanitarian, such as the installment of “rescue beacons” and the implementation of a search and rescue unit. However, NMD’s reports on Border Patrol abuses demonstrate that this humanitarianism is at odds with Border Patrol’s own “necroviolence” (De León 2015), including their enforcement of deadly border policy as well as their own tactics that lead to migrant deaths. This chapter then analyzes Border Patrol and NMD press releases and media statements in the wake of the raid of NMD clinic and the arrest of four patients, demonstrating the framing strategies that each group engages to legitimate their own work while challenging the humanitarian claims of the other. Finally, I conclude by arguing for the “insurgent humanitarianism” demonstrated by No More Deaths and the use of medicalized discourses of health and humanitarianism in the face of the Border Patrol’s criminalization, in order to assert the legitimacy of their own humanitarian aid provision.
as well as the (racialized) “necropolitical biocitizenship” (Chavez 2018) of migrant-patients.

**Prevention through Deterrence and the Immigrant Health Crisis**

Since 1994, the formal border control strategy known as “prevention through deterrence” has involved the fortification of the border in urban areas and other popular border-crossing areas. As a result, migrants have been forced to cross in the most treacherous terrain, through remote mountainous and harsh desert terrain (Andreas 2001; Cornelius 2001; De León 2015; Martínez et al 2014; Nevins 2008; Rubio-Goldsmith et al 2006; Slack et al 2016). Focusing on “the major travel arteries” along the border, prevention through deterrence as described in an official government report seeks to reroute “the illegal border traffic from traditional urban routes to the less populated and geographically harsher areas, providing [Border Patrol] agents with a tactical advantage over illegal border crossers and smugglers” (Haddal 2010:13). In funneling migration away from urban areas to the most remote and hazardous border regions, “this policy has had the unintended consequence of increasing the number of fatalities along the border, as unauthorized migrants attempt to cross over the inhospitable Arizona desert without adequate supplies of water” (Haddal 2010:19, emphasis added). Prevention through deterrence, combined with the increase in internal border checkpoints within the borderlands, forces migrants to travel for longer distances; some people are walking anywhere from thirty to eighty miles before reaching “safety” beyond the checkpoints. To stave off dehydration in the heat of the desert, a person would need to drink at least two gallons of water a day, and so would have to carry a total of at least fifteen gallons
for the trip. At eight pounds each, these gallons of water together would weigh 130 pounds. Carrying this much water is a physical impossibility, especially in the combination of the desert heat and the pace at which groups travel through the borderlands. As a result, people crossing the border are reliant on finding some kind of water in the desert to survive, often this means drinking contaminated water out of livestock troughs. As a result, Ignacio and others like him crossing the desert on foot often find themselves serious trouble.

Although Border Patrol claims that migrant deaths represent an “unintended consequence” of this strategy, prevention through deterrence relies heavily on the material conditions of the borderlands to be effective (Doty 2011; Williams 2015). The dangerous conditions of this geographic space enable the state to deflect responsibility for the deaths of migrants in the borderlands, by claiming them to be the result of “natural causes” such as exposure, heat, hypothermia, dehydration, or injury (De León 2015; Doty 2011). Doty argues that the Border Patrol’s assertion that migrant fatalities are “unintended” are crucial to the construction of the state’s “moral alibi,” through which it can abdicate responsibility for the fatal consequences of its own policies. Furthermore, prevention through deterrence specifically relies on the possibility that migrants will die during the crossing (and indeed the reality of these deaths) in order to deter any would-be border crossers; the strategy itself “would be meaningless in the absence of this possibility” (Doty 2011:608). In fact, during my fieldwork, humanitarian aid volunteers, who conduct search and rescue missions and regularly encounter human remains in the desert, referred to this policy as “deterrence by death.”
Regardless of Border Patrol’s deflection of responsibility for the consequences of prevention through deterrence, since the implementation of the strategy and the border militarization that has accompanied it, the remains of over 8,000 migrants have been found across the U.S. borderlands with the majority in southern Arizona. These deaths represent but a fraction of the migrant fatalities in the borderlands; countless other remains are never found as the desert decomposes them quickly and animals strip their flesh and scatter their bodies. In recent years, there has been an increase in the ratio of deaths in the borderlands after the implementation of prevention through deterrence (IOM 2018; Martínez et al. 2014; Reineke and Martínez 2014). At the same time that Border Patrol apprehensions decreased (and thus migrant crossings are assumed to have also declined), migrant deaths in the desert actually increased. In 2017, apprehensions dramatically dropped by 44%; however this same year, there were 412 recorded migrant deaths on the U.S.-Mexico border, which was fourteen more than the previous year (France-Presse 2018).

Alongside the strategy of attrition through enforcement in the interior, prevention through deterrence in the borderlands is a defining policy that shapes the immigrant health crisis in the U.S. Recognizing the biopolitical implications of these enforcement strategies, the American Public Health Association has declared the countless thousands of migrant deaths in the borderlands a “public health crisis” caused by border militarization. This crisis is not limited to migrant fatalities in the borderlands but also includes acute and chronic health issues that result from this journey as well as the less visible scars and traumas carried by those who survive the crossing, making it to the interior of the U.S. where they are then denied access to health care.
As in the interior, the crisis of immigrant health in the borderlands disproportionately affects migrants of color, and in this way, prevention through deterrence involves a racialized killing of (primarily Latinx) migrants. These very critiques are coming from within the Border Patrol itself. The former chief of the Tucson Sector, Ron Sanders, provided a scathing assessment of the policy after his retirement, saying,

> By every measure, the strategy is a failure. All it’s accomplished is killing people...It’s a scam that’s being pulled on the American public. You’re catching the same number you were before you started spending all these billions and you’re killing people. If you had airplanes crashing in this country with the same numbers, you’d have everybody after the FAA. But since these people are Mexicans, no one seems to care. Somebody ought to be looking at them and saying, “Why aren’t you saving these lives?” (Moser 2003)

At least as harsh as the critiques that I heard from immigrant rights advocates during my fieldwork, Sanders calls out the inherent racism in the strategy itself as well as the racist dimensions that underpin the lack of a response to migrant fatalities in the borderlands. His statement is revealing of the racialized aspect of the Border Patrol’s lazy “moral alibi” through which they attempt to place the blame for migrant deaths either on the harsh conditions of the crossing or on the migrants themselves for making the dangerous journey.

In its reliance on migrant fatalities in order to be “successful” in deterring other would-be immigrants, prevention through deterrence demonstrates the explicitly necropolitical foundations and consequences of border enforcement strategy in the U.S. As a politics of death that provides an important complement to Foucault’s theorization of biopower, necropolitics asserts that the “ultimate expression of sovereignty resides, to
a large degree, in the power and the capacity to dictate who may live and who must die” (Mbembe 2003:11). Achilles Mbembe’s theorization of necropolitics refers not only to people who are physically killed or made to die but also people who are alive but marked for death socially, politically, and literally. In this way, Mbembe uses necropolitics to explain “how the threat of violent death continues to prevail as a technique of governance in contemporary settings” (Wright 2011:709) as well as the ways that governments justify the deaths of some (in this case that of migrants crossing the U.S.-Mexico border), in order to protect the lives of others (ostensibly U.S. citizens) (Braidotti 2007; Williams 2015; Wright 2011). In considering the relevance of necropolitics to border enforcement in the U.S., Jill Williams argues that “the prevention through deterrence policies of the U.S. Border Patrol can be understood as explicitly necropolitical in that death and its potentiality is mobilized in an effort to shape the actions of potential migrants and govern transnational mobility” (Williams 2015:13, emphasis added).

In the militarized borderlands, immigrant deaths are strategically useful. Jason De León (2015) uses the concept of “necroviolence” to describe the “violence performed and produced through the specific treatment of corpses that is perceived to be offensive, sacrilegious, or inhumane by the perpetrator, the victim (and his or her cultural group), or both” (69). He examines not only how prevention through deterrence causes the deaths of migrants in the desert but also how the desert erases these bodies, rendering their deaths invisible. The necroviolence that prevention through deterrence inflicts upon the corpses of migrants has a generative capacity, in that it not only involves corporeal mistreatment but also deeply affects the loved ones of the disappeared who are left with a sense of loss, forever wondering about the ultimate fate of their missing friend or family member.
In highlighting and challenging the necroviolence of border enforcement, humanitarian aid groups and search and rescue/recovery organizations have documented the deaths of thousands of immigrants who have perished in remote areas across the vast desert borderlands. As a sea of red dots on the map of Arizona (see Figure 5), these deaths as GPS coordinates on the map (which are mirrored across the other border states) are stark reminders of the necropolitical effects of U.S. border control strategies and the humanitarian crisis at the border.

Figure 5: Migrant Deaths in the Arizona Borderlands

These groups also operate a “missing migrants hotline” through which people can report members of their group who were left behind in the desert or can inquire about missing loved ones. Depending on the context, a report through the hotline can trigger a

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12 Retrieved from https://humaneborders.org/migrant-death-mapping/
search and rescue or recovery mission to find migrants in distress or their corpses in the desert. As demonstrated by this key piece of their work, humanitarian NGOs in the desert actively counter necropolitical border enforcement strategies and challenge the necroviolence perpetrated on the corpses of migrant border crossers and the families and loved ones of these “disappeared.”

In this way, I argue that these humanitarian groups assert the “necropolitical biocitizenship” (Chavez 2018) of migrants in the desert borderlands. Karma Chavez (2018) argues that “the state’s necropolitical biocitizenship effectively [leaves] certain populations to die,” revealing “not only death politics but also ruptures that create possibilities for change to laws and political alliances that actively work against necropolitical biocitizenship” (118). Examining biocitizenship within the context of the U.S.’s ban on HIV-positive migrants, Chavez posits a “collectivized biocitizenship” that emerges from migrant organizing against the policies and politics that mark them for dead. Perhaps it is also useful here to recall Rose and Novas’ definition of biocitizenship as “specific biological presuppositions, explicitly or implicitly, have underlain many citizenship projects, shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens” (2005:440). In the context of the militarized borderlands, migrants crossing the borderlands are not only “impossible citizens,” but perhaps even more than that, as “alien,” “illegal,” even “animal,” they are also “impossible humans.” Challenging this dehumanization, I argue, humanitarian NGOs deploy a “necropolitical biocitizenship” in a generative way to cut through the state’s “moral alibi” in the face of migrant deaths. This necropolitical biocitizenship posthumously asserts the humanity of migrants who have perished in the
desert, rendering their deaths visible and grievable, while also staking claims for the humanity of migrants who, though alive, are marked for death by totalizing criminalization and necropolitical border control policies.

**No More Deaths: Humanitarian Aid in the Borderlands**

A coalition of community and faith groups and people of conscience, No More Deaths (NMD) was started in 2004 as an organizational response to the crisis of migrant deaths in the borderlands. Its mission is to “end death and suffering in the Mexico-US borderlands,” which it seeks to achieve through a variety of projects and programs along the border. These projects include the direct provision of humanitarian aid in the borderlands in the form of water, food, socks, blankets, and other supplies. On the Mexico side, volunteers from the organization cook meals, run shelters, distribute clothes and backpacks, and provide limited medical care for people who were deported from the U.S. or are waiting to make the journey across. With a number of partner organizations, they also regularly conduct search and rescue missions for migrants lost and separated from their groups or search and recovery for the remains of people who have perished in the desert. As part of their mission to “bear witness” to the fatal consequences of border militarization, NMD also releases reports and engages in media campaigns about Border Patrol abuses, including the confiscation of migrants’ belongings and dangerous apprehension tactics that scatter and separate migrant groups traveling together.

As part of a broader coalition of organizations, NMD was initially started by a core group of people, who had been active in the original Sanctuary Movement and began a number of humanitarian organizations working in partnership across the Arizona
borderlands. One of these core volunteers was Mark, a Christian minister in his 80s who had been very active in the Sanctuary Movement, working to support Central American refugees who were fleeing violence in their home countries. On a day that we were driving to monitor and replenish supplies at one of the water stations in the desert, he told me about the founding of these organizations and their links with the Sanctuary Movement, saying,

After the court rulings [in the 1986 indictment of sixteen leaders of the Sanctuary Movement that largely vindicated the movement and was a force in the instigation of Temporary Protected Status for Central American refugees], we basically closed up shop. How naïve we were to think that our work was over! Then in 1994, the Border Patrol started ramping up the fortification and militarization of the border, and the deaths started to increase again. In 2000, we looked around and realized that migrants were dying in the borderlands in great numbers. These were the same people who had been recognized as refugees from Central America during the Sanctuary Movement. The language used to describe them and the depictions of them were changing in ways that was being used to justify these deaths. Well, we couldn’t just sit around and watch this happen. So we called a meeting to talk about what we could do. I remember looking around the room and here we all were from the Sanctuary Movement, with a lot more gray hair than before, but the same people. We just shook our heads and thought, “Oh man, not this again.”

This group, many of whom had been core activists and organizers in the Sanctuary Movement, got together and started a number of partner organizations aimed at stopping migrant deaths in the borderlands. The first organization started in 2000, Humane Borders, focused on mapping where the deaths were occurring and establishing water

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13 This is a pseudonym. In this chapter, the names of migrants and NMD volunteers that I encountered during my fieldwork are all pseudonyms. The names of NMD spokespeople that are quoted in public media statements and press releases remain unchanged.

14 Eight of the sixteen Sanctuary Movement “leaders” put on trial were convicted of alien smuggling. Although they were facing many years in prison, they mostly received suspended sentences or short house arrests.
stations in places where migrants were dying. These water stations consisted of large 55-gallon barrels of water and flags on tall poles to alert travelers in the area of the presence of water (see Figure 6). The group negotiated with Border Patrol an informal agreement that they would not put surveillance near or arrest migrants at these stations, which would turn away people in need of water and jeopardize the water stations as life-saving. Two years later, some of the volunteers and activists in Humane Borders realized that the water stations alone were not enough to stymie the deaths in the borderlands and that a more hands-on approach was needed. As a result, an organization called the Samaritans was formed that had a similar mission but different tactics. Rather than maintain isolated water stations across the desert, they started to patrol the areas where the majority of the deaths were occurring, bringing with them supplies and volunteers with medical training. They would walk the desert looking for people in need of food, water, and medical attention.
Two years later in 2004, No More Deaths emerged as the next iteration in engagement in the borderlands. In contrast to Humane Borders and the Samaritans, NMD sought to maintain a presence in the borderlands. Rather than walk through the deserts looking for migrants in distress, they established a series of humanitarian aid caches at specific GPS coordinates along popular migrant routes that they regularly monitored and replenished. (The Samaritans eventually adopted these tactics as well.) These caches included water, food, blankets, socks, and other necessary, life-saving supplies. The organization also established a medical camp in the desert not far from the border, where weary travelers could find medical attention and respite before continuing their journey north or south. Initially, it only operated during the most brutal summer months when the
dangers associated with the crossing from dehydration and exposure were heightened. However, in 2008 after an extensive search and rescue effort, the group found the remains of a fourteen-year-old girl near the camp. This event served as a turning point for the group and prompted them to maintain a continual presence in the borderlands. As a result, the makeshift medical camp began to operate year-round, providing life-saving medical aid and supplies to travelers.

The volunteers and organizers at NMD amount to an organized motley crew, made up of an unlikely alliance between gray-haired “snowbirds” and self-described “desert rats.” This group is comprised the older activists in the original Sanctuary Movement and retired people, including a number of medical professionals, who spend the winters in Arizona. This seasonal migration has earned them the moniker “snowbirds.” Many of these volunteers were unaware of the work of NMD before their partial retirement to Arizona but, since moving to the borderlands, have become involved in immigrant rights activism and immigrant health provision. On the other hand, as the work of NMD became more well-known in activist circles around the country and the globe, more volunteers either traveled temporarily to Arizona to take part in the work of NMD or moved to the state to become involved on a more permanent basis. These mostly younger volunteers, many who identify as anarchists, are involved in NMD because of their personal and political alignment with its work as direct action against border militarization. These anarchists describe themselves as crusty “desert rats,” a tongue-in-cheek nickname for someone who lives in the desert borderlands of the U.S. Southwest.

As with any nonprofit or social movement organization, tensions between volunteers arise around the strategies and tactics of the organization and the political affinities and
personal motivations of the volunteers. The organization has sought to mitigate these tensions through consensus-based decision making processes during which volunteers must reach some level of agreement in order to move forward. Regardless of the differing political views of these volunteers, the work still gets done, and any tension among the volunteers is usually productive in shaping their response to the deaths of migrants in the desert. This work is encapsulated by the common response of volunteers after a day in the desert. Debriefing or just relaxing around the campfire at night, volunteers would ask each other how their day went. If the day had been uneventful, the usual reply was something to the effect of, “It was just another day of putting water in the desert.”

Within the borderlands of southern Arizona, these three groups – Humane Borders, the Samaritans, and No More Deaths – work in partnership with other organizations, community groups, and committed individuals from California to Texas. Similar groups in other states and localities employ a variety of tactics to get water, food, and medical attention to migrants in distress across the borderlands, even resorting to air-dropping supplies in the most remote mountainous areas of New Mexico. More recently, a loose network of organizations has begun working to locate missing migrants within the immigrant detention apparatus as well as conducting search and rescue/recovery missions to find migrants or human remains in the desert. In addition to these more organized groups, indigenous groups living along the borderlands, including those on the Tohono O’odham Nation which straddles the border, as well as ranchers who own land adjacent to the border have been providing this aid informally to migrants they have encountered on their land for years.
Contested Humanitarianisms in the Borderlands

As border crossing has become more dangerous, the U.S.-Mexico borderlands has become defined by the suffering and deaths of migrants walking across the desert, which has given rise to a proliferation of humanitarian NGOs attempting to prevent these fatalities. The humanitarian border – the geographic and socio-political space within which these organizations work – “emerges once it becomes established that border crossing has become, for thousands of migrants seeking…access to the territories of the global North, a matter of life and death” (Walters 2011:137-138). Within this humanitarian border, the Border Patrol and NGOs vie for legitimacy as the humanitarian presence within the borderlands. These contested humanitarianisms involve the framing and counterframing of Border Patrol’s militarized humanitarianism in contrast to the insurgent humanitarianism of No More Deaths and partner NGOs.

Once considered an oxymoron, since the 1990s, humanitarian military intervention has attempted to justify the use of military action for “humanitarian” ends, to ensure the safety and security of human life within a humanitarian crisis. Critiques of the links between humanitarian aid, (neo)imperialism, and military action raise questions about violations of state sovereignty and point to the blurring between military and humanitarian intervention (Bricmont 2007; Chandler 2001; Fassin and Pandolfi 2010). Indeed, Chandler argues that “humanitarianism has become an ambiguous concept capable of justifying the most barbaric of military actions” (Chandler 2001:14). In fact, we do not have to look far for a host of examples of the (mis)use of humanitarianism as the justification for military action in a national interest. For instance, the recent standoff around Venezuela’s refusal to accept U.S. “humanitarian aid” serves as a reminder of the
ways that this aid often acts as a Trojan horse for intervention – military or otherwise – by Global North countries in the Global South.

This blurring between military and humanitarian action has led to militarized governmental groups adopting, at least in name, the objectives of humanitarianism to justify violations of state sovereignty, to “soften” their image as a (violent) military presence, or even to enlist new recruits. In the case of the U.S.-Mexico borderlands, the Border Patrol has increasingly framed its own presence as a humanitarian one. Describing the dual roles of the Border Patrol, Williams (2014) examines the humanitarianization of border enforcement within the “safety/security nexus,” in which Border Patrol contends that migrant safety is achieved through and justifies further border militarization. She argues that this humanitarianization has three effects: “it works to counter the challenges of transnational human rights organizations and constituencies that argue that border enforcement policy violates transnational human rights; it justifies the continued militarization and securitization of national borders; and it upholds the territorialized framework of sovereignty and political subjectivity that state efforts to secure, fortify, and regulate transnational mobility are founded” (Williams 2014:28).

Given migrant fatalities in the borderlands that have been caused, at least in part, by Border Patrol’s necropolitical enforcement strategies, their assertion of the humanitarian objectives of their mission seeks to further enhance their “moral alibi” and the deflection of their responsibility for migrant deaths, while asserting a monopoly on legitimate humanitarian presence in the borderlands (Doty 2011; Williams 2014). For instance, in response to public outcry and pressure around the deaths of migrants in the border, the Border Patrol established thirty-four “rescue beacons” in the remote areas of
the desert (see Figure 7). However, critics point out that these beacons are thousands of square miles apart, and while they have lights that are visible for miles at night, they are very difficult to see during the day. In addition to these beacons, in 1998, the Border Patrol created their search and rescue unit, known as BORSTAR, tasked with conducting search and rescue efforts for migrants in trouble. However, in my fieldwork, critics argued that BORSTAR was largely ineffective and was instead used as a publicity stunt to justify the humanitarian claims as part of the Border Patrol’s enforcement mission. “The system is set up to arrest people who are findable, not to look for people who are lost,” said Genevieve Schroeder, a volunteer who leads search-and-rescue recovery missions for lost migrants with NMD (Lo 2015). In addition to the creation of more explicitly humanitarian aspects within the organization, Border Patrol also seeks to reframe its existing enforcement work as humanitarianism, including framing arrests as “rescues,” emphasizing the treatment of migrants’ medical needs during the course of apprehension. In this way, Border Patrol attempts not only to strengthen its “moral alibi” as the (only) heroes in the face of migrant deaths that incidentally result from their own enforcement tactics, but also to assert the need for even more border militarization and fortification as necessary for preventing these deaths.
Despite these public displays of humanitarianism, their assertions as the “only legitimate arbiter of humanitarianism” (Williams 2014) in the borderlands give way to conflicting missions and inconsistencies in action, in a way that obscures the Border Patrol practices and policies that contribute to migrant fatalities. For instance, the framing of Border Patrol as saving migrants’ lives does not hold up against evidence of the routine practice of “dusting,” through which officers chase and scatter groups of border crossers by flying a helicopter very low to the ground (NMD 2011, 2016). This kicks up dust, causing chaos and confusion and scattering the group so that they are often separated from their guide/coyote and each other. Once isolated and lost, migrants have an increased risk of dying while crossing the borderlands.

Figure 7: Border Patrol “rescue beacon” with water left by No More Deaths volunteers (Photo credit to Brian van der Brug)
Furthermore, the medical treatment of migrants in Border Patrol custody is patchy, at best, and migrants with urgent medical needs are often “assessed” by officers without any medical training. This assessment and treatment (or lack thereof) is predicated on a “minimalist biopolitics” (Redfield 2005) that asserts an extremely narrow definition of medical emergency, providing just enough medical care to keep immigrants alive long enough to deport them (Williams 2015). However, Border Patrol is careful to maintain plausible deniability. When migrants die in their custody, they are quick to reframe their “moral alibi” by asserting their mission as first and foremost law enforcement and not humanitarian in nature. For instance, in a New York Times article about deaths in custody, Border Patrol officials are quick to decry their lack of infrastructure to deal with the medial needs of detainees, saying “Border Patrol is a law enforcement agency. It’s not a humanitarian agency” (Fink and Dickerson 2019). This selective mobilization of the discourse and ideological framework of humanitarianism ultimately reinforces “the belief that unauthorized migrants are not rights-bearing subjects within the territorial limits of the United States – Border Patrol efforts to save and rescue undocumented migrants are humanitarian precisely because the state has no formal obligation to assist unauthorized migrants (i.e., criminals)” (Williams 2014:34). At the same time, however, Border Patrol also engages the discourse of humanitarianism in order to assert a monopoly on legitimate presence within the borderlands, while directly questioning the validity of NGOs’ presence and work as humanitarian.

In opposition to militarized humanitarianism, some NGOs like Médecins Sans Frontières (MSF) have self-reflexively engaged the critiques of the blurring between
military and humanitarian action, in order to avoid being used by the state as puppets of military intervention. This self-reflection involves recognition of the ways that humanitarianism has operated as a tool of neo-imperialism, through which states in the Global North further cast Global South countries and their inhabitants as uncivilized and their governments as inept. Some humanitarian NGOs are also increasingly recognizing the legacies of colonial exploitation by Global North countries that have disrupted social orders, imposed national boundaries, and exploited natural resources in the Global South, in many ways contributing to (if not causing) humanitarian crises (Mills 2005). This self-reflexivity has also spurred a growing presence humanitarian NGOs working within Global North countries, who recognize that patterns of migration to Global North countries are largely driven by punitive national and international policies by their own countries (Fassin 2007, 2009; Gottlieb et al 2012; Ticktin 2006, 2011; Tiedje and Plevak 2014; Willen 2011, 2012a, 2012b). As Miriam Ticktin argues, “Medical humanitarian organizations have also turned their attention to socio-medical need in their own and other so-called ‘developed’ countries: they have brought their concerns back home, within their borders, and in ways which draw critical attention to borders” (2006:125-126).

In order to “draw critical attention to borders” and the necropolitical effects of border militarization and enforcement, NMD asserts an “insurgent humanitarianism” in direct challenge to the militarized humanitarianism of the Border Patrol. Invoking the language of humanitarian crisis, their insurgent humanitarianism involves the conscious assumption of the label “humanitarian” as both a defensive and offensive framing strategy. In this way, NMD draws attention to the fatal consequences of the prevention
through deterrence strategy, effectively questioning the “humanitarianism” of the Border Patrol, while legitimating their own work and presence within the humanitarian border. Their insurgent humanitarianism involves the emphasis on the apolitical nature of their work as medical provision: 1) to legitimate their presence in the borderlands as humanitarian aid workers, 2) to assert the necropolitical biocitizenship of migrant-patients as well as migrant-corpses in the borderlands, and 3) to challenge the militarized humanitarianism and necroviolence of the Border Patrol.

In the U.S.-Mexico borderlands, the International Red Cross has declared Pima County along the border a disaster area, due to the many migrant deaths, and has recognized NMD’s camp as a medical facility. This certification is crucial to NMD who claim to abide by the Red Cross’s Code of Conduct for NGOs, even carrying a copy of the code in their vehicles to show Border Patrol officers that question their efforts. This document specifically includes two important caveats that 1) “when we give humanitarian aid it is not a partisan or political act” and 2) “humanitarian medical aid should be recognized and respected by government agents and not subjected to surveillance or interference.” In the code of conduct, humanitarian organizations should be granted unimpeded access to those in need. By invoking the Red Cross’s language of disaster, NMD positions themselves as an NGO intervening in a humanitarian crisis, similar to the work of MSF that runs clinics and provides medical care in humanitarian borders and crisis areas around the world. It is difficult to argue against NMD characterization of the borderlands as a space of humanitarian crisis. Since 2002, the remains of migrants have been found in the Arizonan desert an average of every three
days, surrounded by militarized technologies that have come home to roost from the battlefields of Afghanistan (Miller 2014; Pima County Office of Medical Examiner n.d.).

In the absence of the work of NMD and the other humanitarian NGOs that provide first aid to travelers they encounter, there are no emergency medical services in the desert. If someone happens to be in a location with cell reception and can call 911, Border Patrol answers the phone, and they do not provide substantial life-saving medical care. In fact, only 6% of Border Patrol officers have any sort of medical training (DHS 2018; Hampton 2019). Other studies have shown that Border Patrol, when they do receive emergency 911 calls, do not always do their due diligence to locate and treat migrants (Hampton 2019; Lo 2015; NMD forthcoming). In fact, a forthcoming report by NMD describes the Border Patrol’s “emergency nonresponse” when called on to provide rescue efforts and emergency medical care.

Within this humanitarian crisis, NMD provides limited medical attention to migrants who are lucky enough to encounter volunteers in the vast expanse of the Sonoran desert. Their camp includes a makeshift clinic run out of a second-hand military-grade MASH tent with donated supplies and an informal team of medical volunteers. The entire camp itself feels makeshift, although it has been a permanent fixture for over a decade. Named after the author of children’s books on whose land the camp is located, Byrd Camp is no more than a handful of mouse-infested campers and trailers scattered around a small valley. A central kitchen tent and adjacent “office” trailer serve as one hub of the camp where volunteers and patients share meals in the evenings. The camp also has a small shrine to the Virgen de Guadalupe where migrants who are hundreds of miles from “home” but also hundreds of miles still from a destination, pray and leave tokens
before continuing on their journey north or south. The other main hub of the camp, the
clinic tent has several cots for patients, a painted canvas of the Virgen carrying two
gallon jugs of water, and metal lockers full of medical supplies (see Figure 8).

![Image](image_url)

**Figure 8: No More Deaths clinic tent**

One of the founders of the organization told me as we were driving into the desert
one morning: “The MASH tent for the clinic space was a symbolic gesture. There’s a lot
of powerful symbolism in having a military tent for the medical facility. It is a sort of
political theater to have this tent in the middle of the desert, in the middle of a war zone,
caring for migrants. It signals that we’re the good guys out here.” The clinic in the
MASH tent is an apt metaphor for NMD’s strategic positioning of its work in the
borderlands. Although they may be more akin to political dissidents engaging in civil
disobedience, they are unwavering in the public framing of their work as humanitarian
aid. It is this radical disjuncture between their individual motivations and the
organization’s public image and savvy media messaging that forms the basis for NMD’s “political theater.” In the midst of this militarization of the borderlands, NMD frames their nonviolent direct action as apolitical humanitarian aid. By utilizing humanitarianism as both a field of action and a discursive frame, they claim neutrality within a humanitarian crisis and appeal to international human rights law, as a higher moral law that supersedes national policies. But, NMD’s own assertions of their humanitarian presence in the borderlands is contested by and against the “humanitarian efforts” of the Border Patrol. Within the theater of the borderlands, the Border Patrol are also calculating actors.

One central example of the grave consequences of this political theater is represented by the Border Patrol’s 2017 surveillance and raid of the NMD’s medical clinic. The press releases and media attention around this raid demonstrate the discursive strategies through which NMD legitimates its own presence in the borderlands, in opposition to the BP’s public counterframing, as well as how they assert a necropolitical biocitizenship for migrants in the borderlands against the totalizing criminalization of anti-immigrant rhetoric and border enforcement strategies.

Framing and Counterframing of Humanitarianism in the Borderlands

Since 2013, NMD and the Tucson sector of the Border Patrol have had a written agreement based on the Red Cross’s code of conduct that Border Patrol officers will respect the NMD medical facility and not subject it to surveillance. This agreement, which formalized a longer-standing verbal agreement between NMD and Border Patrol, is critical in the continued effectiveness of the camp to provide life-saving care to
migrants in the desert. If the camp is subjected to surveillance and vulnerable to raid by Border Patrol, their work is compromised as migrants in need of medical care will not enter the camp in order to avoid apprehension. However, in the past three years, the Border Patrol has violated this agreement on several occasions by surrounding the camp with agents and round-the-clock surveillance and flying Border Patrol helicopters low over the camp multiple times a day. Usually this surveillance has ended after meetings between NMD and Tucson sector officials, combined with a coordinated public outcry and media campaign through NMD support networks. Recently however, this surveillance has escalated and resulted in Border Patrol either forcing patients to leave the camp “voluntarily” and then arresting them, or forcibly entering the camp to arrest the patients there. In June 2017, there were two separated incidents – one in which eight patients “gave themselves up” and another in which Border Patrol raided the camp and arrested four patients out of the clinic. This section focuses on this second incident, examining in particular NMD’s and Border Patrol’s differing framing of the event and the actors involved, through press releases and media statements. This analysis examines the discursive aspects of the “political theater” of contestations over humanitarianism in the borderlands and the very real health effects this has on migrants traveling in this region.

On Tuesday, June 13, 2017, during a month with blistering day-time temperatures into the 120s, Border Patrol officers arrived at the NMD camp and demanded to search the property for people they suspected of crossing the border “illegally.” A press release after the raid indicated that Border Patrol surveillance equipment – “a Buckeye camera operating out of a mobile truck” (Devereaux 2017) – had detected these four migrants as
they had initially crossed the border, and then officers had tracked the men for eighteen miles, over several days, until they entered the camp for medical attention. The Border Patrol’s search warrant request revealed that the men were also photographed by a sensor just minutes before they entered the NMD camp, which further alarmed NMD volunteers about BP’s secret surveillance of the camp. When the NMD volunteers refused to let the officers enter the clinic, Border Patrol set up round-the-clock surveillance of the property. Surrounded by hills, the camp is nestled in a small valley, giving officers higher ground from which to observe the inhabitants of the camp and its operations. A NMD spokesperson described this original surveillance, saying, “Border Patrol agents were surveilling us constantly with anywhere from five to ten trucks posted at different high points around the camp” (Devereaux 2017). Before the arrests, Border Patrol also created a makeshift checkpoint at the entrance of the camp, searching every vehicle and questioning every person who came or went about their citizenship status. After over forty-eight hours of constant surveillance, on Thursday, June 15, officers arrived at the camp with a search warrant. In a show of force, they entered with over thirty officers, fifteen trucks, two ATVs, and a helicopter to arrest the four people receiving medical care in the clinic. They also brought with them a government film crew to document the operation and live-tweeted the raid. NMD volunteers also took photos and shaky cell phone footage of the raid that they uploaded to their website.

Following the raid and arrests, Border Patrol and NMD published press releases and participated in interviews and media coverage about the surveillance and arrests at the camp. From this public “political theater” over the raid, the two groups engaged in a process of framing and counterframing. Given the vast disparities in power between the
two groups, NMD has little recourse against these arrests beyond their ability to publicly frame this event as a direct violation of their non-interference agreement and international human rights law, whereas the Border Patrol, as a government institution with state-granted legitimacy and an ever-increasing range of authority (and budget) within the borderlands, has less need to engage in the public justification of their work. As such, NMD engaged in a much more extensive framing and counterframing within these media reports to question the larger narrative around border militarization as well as to argue for the legitimacy of their own work and presence in the borderlands. In what follows, I will analyze the content of each group’s public responses to the raid and arrests at the NMD camp in order to examine the discursive strategies that each organization employs to shape the discourses around the arrests. Although the raid was a moment of heightened conflict between the groups, it is not an isolated event but part of a larger, on-going struggle over humanitarian aid in the borderlands that has continued to escalate under the Trump administration.

In their own press release and other official statements to the media about the raid, Border Patrol selectively engages discourses of humanitarianization and criminalization to frame their own work against that of NMD. These discursive strategies rely on the framing of the migrant-arrestees as “criminals.” Given the current historic moment of anti-immigrant and specifically anti-Latinx politics, Border Patrol has to do little more than explicitly invoke the existing narratives of immigrants as “illegal aliens” in order to accomplish this framing. Beyond using this exact language, the press release also implicitly refers to these narratives by noting that the migrants were “wearing camouflage and walking north on a known smuggling route” (USCBP 2017), implying
that they might be drug smugglers or more “seasoned” travelers who had crossed before. Upon finding that one of the people they arrested in the clinic had served prison time for a drug-related felony and been previously deported, Border Patrol was quick to update their press release to include his makeshift mug shot, reinforcing the over-arching narrative of migrant criminality. Accompanying these discourses of immigrant criminalization, the press release also questioned the validity of the arrestees as patients, stating, “The group was assessed on scene by Border Patrol agents trained as Emergency Medical Technicians and found in good health, but were taken to a local area hospital as a precautionary measure. The professional medical staff at the hospital determined that the individuals did not require any further medical attention” (USCBP 2017). The undertones of this seemingly simple declaration forms the basis of the contested discourses around medical humanitarianism in the borderlands.

In questioning the medical needs of the arrestees, the Border Patrol also challenges the legitimacy of the humanitarian aid provided by NMD. By contrasting NMD volunteers with the officers trained as EMTs and the “professional medical staff” at the local hospital, they question the medical knowledge and training of the volunteers and, by extension, the legitimacy of the NMD clinic as a medical facility. Although many of the volunteers actually have formal medical training and also operate under the advice of a team of medical doctors, Border Patrol characterizes NMD volunteers as amateurs who are, at best, ill-equipped to assess the medical needs of migrants and, at worst, putting migrants’ lives at risk by not referring them to either Border Patrol or the “nearby” hospital that is a considerable drive from the camp.
By implying that NMD volunteers might be manufacturing medical emergencies for “criminal aliens,” the press release and media statements after the raid frame NMD as interfering with the work of Border Patrol in apprehending these “criminals” and further question the legality of NMD’s work. Daniel Hernandez, a Border Patrol spokesperson, said, “I’m not sure about the legality of practicing *clandestine medicine* in the desert. There is a hospital 40 minutes from the camp. If the patient is in distress, our priority is not to keep them in the field — in 115-degree weather, in a tent. That’s unethical and it’s inhumane” (Boodman 2017, emphasis added). By characterizing NMD humanitarian medical care as “clandestine medicine,” the Border Patrol frames the organization as ultimately enabling, even aiding and abetting, drug smugglers and criminals in the borderlands. By questioning the legality of NMD work, Border Patrol is alleging that the organization and volunteers might themselves be engaging in criminal activity.

Furthermore, Hernandez’s characterization of the organization’s work as “unethical” and “inhumane” is a direct challenge to NMD’s framing of their work as humanitarian. Through this framing, Border Patrol attempts to shift blame for migrant deaths in the desert – from the necropolitical consequences of their own border policy and enforcement to the very humanitarian efforts attempting to save their lives. In a more recent media article about the trials of NMD volunteers arrested in the desert (which is discussed in more detail in the epilogue), Border Patrol doubles down on this framing, saying that NMD aid supplies “send the wrong message: Continue your journey…We [meaning Border Patrol] don’t want them to grab a jug [of water] and walk to their deaths” (Hennessy-Fiske 2019). In this way, Border Patrol flips the script of humanitarianism in the borderlands – with the absurd assertion that somehow it is the water in the desert that
is motivating migrants’ journey – attempting to deflect responsibility for migrant deaths and the danger of the journey to NMD humanitarian efforts.

By questioning the humanitarian credentials of NMD and the legality of their work, Border Patrol attempts to assert itself as the only legitimate humanitarian presence in the borderlands. However, because they enjoy already-recognized legitimacy granted by the state as a government institution, the Border Patrol has to do only minimal damage control through their press releases and media statements. Representing themselves as simply trying to do their work in the midst of interference by NMD volunteers, they claim that they were left with “no other recourse but to request a warrant” (USCBP 2017), after unsuccessfully trying to negotiate with the NMD volunteers to gain entrance to the camp. The press release implies that they are “trained” professionals with a better ability to assess the medical needs of the migrants arrested in the clinic, ignoring the fact that the NMD volunteers are also EMTs trained specifically in wilderness medicine. Furthermore, they frame the arrests themselves as humanitarian intervention: in apprehending the men from the clinic, Border Patrol ensure that they are transferred to the hospital for the opinion of “medical professionals.” In this way, Border Patrol attempts to monopolize the legitimacy of humanitarian aid in the borderlands, while questioning the very legality and even morality of NMD humanitarian work.

**Insurgent Humanitarianism in the Borderlands and Claims of Necropolitical Biocitizenship**

In a challenge to Border Patrol’s representation of the raid and the groups involved, NMD mobilizes discourses of health and humanitarianism as a form of
currency to legitimize their own work as humanitarian aid in the borderlands. This
discursive strategy, combined with their provision of humanitarian aid and search and
rescue/recovery efforts in the desert, amount to an insurgent humanitarianism. Through
this insurgent humanitarianism, they highlight and actively challenge the fatal
consequences of the militarization of the borderlands. NMD wields humanitarian
discourses both offensively and defensively, as a weapon and a shield (Cook 2011). On
the one hand, defining the borderlands as the site of humanitarian crisis, this medicalized
frame characterizes NMD’s politically-contentious work as the apolitical provision of
humanitarian aid in response to human suffering. In this way, they work to assert the
legality and legitimacy of their work in the face of challenges by Border Patrol. On the
other hand, this characterization of humanitarian crisis draws attention to migrant deaths
across the borderlands – at once challenging the necroviolence associated with Border
Patrol’s militarized humanitarianism and enforcement strategies and staking claims for
the necropolitical biocitizenship of migrant-patients. These offensive and defensive
discursive strategies are evident in the press releases and media statements made by
NMD volunteers in the wake of the Border Patrol raid on their medical camp.

Crucial to NMD’s depiction of the urgency, legitimacy, and legality of their work
in the borderlands is the “neutrality” of humanitarian relief and health provision.
Asserting themselves as humanitarian aid workers, NMD volunteers embrace the
neutrality of humanitarianism to frame their own work as apolitical health provision in
response to the objective reality of human suffering. Central to NMD’s framing of their
work within the borderlands, these claims directly counter the Border Patrol’s
representations of its own (militarized) humanitarianism and the criminalization of other
humanitarian NGOs as “aiding and abetting illegal migration.” In media statements following the raid and arrests at the camp, NMD reiterated their relationship with the Red Cross as a counter to Border Patrol’s criminalizing rhetoric and a strategic reminder of their recognition by international humanitarian and human rights organizations. NMD volunteer Catherine Gaffney said, “We’ve always been clear that we have a humanitarian aid mission and we’ve been recognized by the Red Cross as a medical facility. We’ve never hidden that that’s what we’re doing there. We’ve always asserted our right to do it” (Devereaux 2017). In emphasizing the legality of their humanitarian mission, NMD justifies their work and presence in the borderlands by appealing to international human rights law and a higher morality that transcends national laws.

In response to previous challenges to the legality of their work, the group has for years maintained the motto, “Humanitarian aid is never a crime.” This motto was coined in 2005 as part of the media and legal defense campaign after the arrests of two volunteers transferring a patient from the desert to the hospital. As such, NMD is no stranger to legal questions about their work and attempts to criminalize their volunteers. Echoing this motto, one of NMD’s founders, John Fife, discussed the legal challenges faced by NMD volunteers, saying, “We have every legal right to provide humanitarian aid in a human disaster like the thousands of deaths that have occurred out here in the Sonoran Desert” (Hennessy-Fiske 2019). In their press release following the raid, the group warned that the raid represented an escalation of an already-violent border policy and cautioned that it may indicate a tide change in the Border Patrol’s approach to humanitarian groups within the borderlands (NMD 2017). As I discuss further in the epilogue, this prediction has proven to be accurate as the Border Patrol and other
governmental groups operating in the borderlands have since stepped up the
criminalization of humanitarian aid workers, arresting and charging them with various
felonies and misdemeanors for the distribution of humanitarian aid and the provision of
food, shelter, and medical care to migrants.

Beyond discourse, the use of a medicalized frame to underscore the legality of
their work is also evident in the everyday operations of the organization. Working within
the contentious space of the borderlands, NMD adheres to strict medical protocols.
Volunteers operate only under the advice of a team of volunteer medical doctors and
lawyers, in anticipation of legal challenges to the medical nature of their work. These
protocols include filling in a SOAP note – the same paperwork completed by clinics for
patient visits – whenever they encounter someone in need of medical attention. In
response to the harsh geography of the desert, the organization also has strict definitions
of what constitutes a medical emergency. In the harsh desert terrain, something usually
insignificant like a blister can quickly escalate into a life-threatening emergency. This
also raises questions about the assessment of the migrants arrested from the camp by the
“medical professionals” at the hospital in Tucson. The medical conditions of these
patients may not be considered serious within the context of the hospital; however, the
assessment by NMD volunteers would indicate health needs that, within the context of
the material conditions of the desert, could quickly become fatal.

Emphasizing the militarized borderlands as a war zone in which thousands of
migrants have died, NMD characterizes the Border Patrol as (only) a militarized presence
firmly implicated in the on-going conflict. Within this war zone, Border Patrol cannot be
both perpetrator of necroviolence and “savior.” By asserting their own work as life-
saving humanitarian aid, NMD directly challenges Border Patrol’s claims to a humanitarian mission. In this way, NMD frame the raid of their camp as synonymous with “obstruction of humanitarian aid” by the Border Patrol (NMD 2017). Implicating border enforcement efforts as directly contributing to migrant deaths, NMD argues that the Border Patrol is only an enforcement apparatus and that its “humanitarian” programs are motivated by the goals of softening its public image, deflecting its role in migrant deaths, and asserting its sole jurisdiction within the borderlands. Focusing on the necroviolence perpetrated by the Border Patrol, NMD effectively and directly challenges the agency’s “moral alibi” (Doty 2011) and “feigned naivete” (De León 2015) in the face of migrant deaths.

NMD’s public framing of the 2017 raid further calls into doubt Border Patrol’s “moral alibi” by characterizing the surveillance and raid on the camp as “an egregious abuse by the law enforcement agency, a clear violation of international humanitarian law, and a violation of the organization’s agreement with the Tucson Sector Border Patrol” (NMD 2017). Describing an “alarmingly militarized operation” (Devereaux 2017), NMD is unwavering in its characterization of Border Patrol’s raid in militarized language. One NMD spokesperson characterized the surveillance as a siege, saying, “It felt like a lock-down siege where anyone else who might be in distress and needing help would be completely unable to enter the camp, and obviously interfering with our ability to give good care to those people who were there” (Devereaux 2017, emphasis added). This “siege” compromised the clinic’s work as a humanitarian medical facility, keeping potential patients in need of life-saving medical care from entering the camp.
Highlighting the fact that Border Patrol officers were aware of the four men when they first crossed the border, NMD media statements raised questions about why these men were not immediately apprehended but were instead followed as they travelled for eighteen miles on foot over several days and entered the camp for medical attention. One member of the NMD legal team Margo Cowan described this delayed apprehension as a “setup” to target the clinic. This sentiment was echoed by other NMD volunteers who described it as a “trap” (Devereaux 2017) and an “attack” (Devereaux 2017; Santos 2017; NMD 2017). One volunteer, Kate Morgan, said, “What happened was not a routine apprehension. It was a trap laid for people who needed medical attention and sought it from us. And we consider this an attack not just on our ability to give aid but a direct attack on the lives and well-being of people who are crossing the desert” (Devereaux 2017, emphasis added).

Through a medicalized discourse of border crossing, NMD stakes claims to the necropolitical biocitizenship of their patients, asserting the humanity of migrants and calling attention to the realities of their medical needs and their lives and deaths in the borderlands. In this way, NMD engages an insurgent humanitarianism that draws attention to the fatal consequences of border militarization as well as asserting a necropolitical biocitizenship – for migrants crossing the desert, who are effectively “marked for death,” as well as posthumously for the migrants who have perished during this crossing.

In their own press releases and media statements about the 2017 Border Patrol raid on NMD medical facility, NMD emphasizes the dangers faced by people traveling on foot through the vast deserts in the borderlands, which they characterize as a “mass
grave” (Hennessy-Fiske 2019). In particular, they stress the record-high June

temperatures well into the 100s during what is already the deadliest month of the year for

border crossing. The heightened danger associated with the heat makes the Border

Patrol’s surveillance tactics and timing for the raid particularly egregious. NMD’s press

release asserts, “The heavy presence of law enforcement has deterred people from

accessing critical humanitarian assistance in this period of hot and deadly weather”

(NMD 2017). These surveillance tactics effectively compromised the work of the clinic

and its ability to provide care to migrants with medical needs, including exposure,

dehydration, sunstroke, sprained ankles, blisters and cactus punctures, complications of

chronic health conditions like diabetes, and even rattlesnake bites.

By focusing on the bodily health needs of migrants in the desert, NMD reinforces

the necessity of their own humanitarian work within the borderlands. By extension, NMD

volunteers characterize the migrants they encounter in the desert as “patients” in need of

life-saving medical attention, rather than “criminals.” In NMD’s press release about the

raid, they frame the four people arrested from their clinic as “patients receiving medical

care.” In fact, during my time with NMD, they specifically changed the language in their

volunteer handbook so that, where it once mentioned “migrants,” it was replaced with

“patient.” In this way, NMD argues for the recognition of their medical work and the

status of the people they care for as patients, in direct contrast to narratives of “illegals”
or “criminal aliens.” At the same time, this language medicalizes migration in order to

challenge the totalizing immigrant criminalization in the borderlands, using the neutrality

and supremacy of “health” and the facts of life and death to cut through the political

rhetoric of the border. Amounting to an insurgent humanitarianism, NMD strategically
employs discourses of humanitarianism against the necropolitical consequences of border militarization as a way to assert the (necropolitical) biocitizenship of migrant-patients.

**Conclusion**

The border fortification strategy of prevention through deterrence has created and exacerbated a humanitarian crisis of migrant suffering and death in the borderlands and contributed to the deaths of thousands of migrants in the U.S.-Mexico borderlands. By asserting these deaths as the “unintended consequences” of the policy, the Border Patrol seeks to establish a “moral alibi” that deflects responsibility for migrant fatalities and explains them as the result of natural causes or the material conditions of the borderlands. To further strengthen this moral alibi, the Border Patrol positions itself as the sole arbiter of humanitarianism in the borderlands, directly challenging the legality of humanitarian NGOs like NMD, while reframing their apprehensions as “rescues.”

By contrast, within this humanitarian border, NMD contests the militarized humanitarianism of the Border Patrol by drawing attention to the necropolitical consequences of border militarization and enforcement strategies. In the midst of the totalizing criminalization of migrants in the borderlands, NMD is unwavering in the public framing of its work as apolitical humanitarian aid for patients in need of medical attention. In strategically claiming neutrality, it engages in an insurgent humanitarianism, not only to legitimate its own work but also to challenge the crisis of migrant deaths and the necroviolence of the militarized borderlands. In response to this crisis, NMD distributes humanitarian aid supplies at high traffic areas and localities where human remains have been found in the desert and provides medical care to migrants with health
needs in their camp near the border. In this highly-politicized space of the borderlands, NMD frame what could be described as nonviolent direct action as apolitical medical provision in response to a public health and humanitarian crisis. By asserting the humanity and the status of migrants with health needs as “patients,” NMD stakes claims for the necropolitical biocitizenship of their migrant-patients, drawing attention to the ways that migrants in the borderlands have been marked for death, their (inevitable) deaths then used to justify even further border securitization. Furthermore, through their search and rescue or recovery efforts, NMD also (posthumously) asserts the necropolitical biocitizenship of migrants who have died in the desert, rendering their deaths visible and grievable. NMD uses the medicalization of border crossing as a strategy to cut through the racialized criminalization of migrants, the moral alibi of the Border Patrol, and the necroviolence perpetrated on the bodies and corpses of migrants in the borderlands.
Chapter 5

Conclusion
Politics of Visibility: Counting and Accounting for Migrant Deaths

Undocumented immigrants in the U.S. are marked by a “biopolitics of disposability,” created through a combination of anti-immigrant rhetoric that racializes immigrants as pathogens and parasites, exclusionary policies that enshrine migrant ineligibility for health care and other social services, and punitive immigration enforcement that criminalizes migrants’ presence in the U.S. Historically, in times of economic prosperity, their presence in the country has been tolerated as long as they are able-bodied exploitable workers who are kept “in their place” by vulnerability to immigration enforcement. For undocumented immigrants, this biopolitics of disposability is characterized by the liminality of deportability, which creates a culture of fear and anxiety and causes migrants to live in the shadows.

In the interior, this disposability becomes all the more apparent when migrants have or develop a health condition that requires medical care, in particular a debilitating injury or a chronic illness that requires regular treatment and monitoring in order to avoid it deteriorating into a more serious medical problem. Immigrants’ lack of access to health care provision within the formal health system means that they are unable to get the necessary medical care. In my fieldwork, this was evident in the patients at CCP with amputations, renal failure, and the lasting complications from a stroke or violence at the hands of the cartel. Exclusionary health policies contribute to the aims of attrition through enforcement, to make life for immigrants so precarious and harsh that they choose to
leave the country or live in the shadows as exploitable workers. Mainstream health institutions’ refusal to recognize the medical emergencies of uninsured, undocumented immigrants that are not immediately life-threatening implicate them as collaborating actors in the attrition through enforcement strategy. Furthermore, the devolution of immigration enforcement into spaces of health and the collusion between health care institutions and immigration enforcement mean that many hospitals effectively operate as de facto border checkpoints, rendering immigrant patients susceptible to detection and to the enforcement apparatus, even to deportation by the very hospitals required to treat their medical emergencies. These policies and enforcement strategies in the interior generate immigrant precarity with fatal consequences. As a result, immigrants are dying invisible deaths across the U.S. from lack of access to health care.

In the borderlands, the immigrant health crisis is marked by the countless thousands of migrant deaths in the desert as a result of border enforcement strategies. Prevention through deterrence has effectively weaponized the desert, heightening the danger of border crossing and pushing migrants into ever more remote and dangerous areas of the desert valleys and mountains. Additionally, the internal movement of Border Patrol checkpoints further and further into the borderlands forces migrants to travel much longer distances, making it impossible to carry enough water, food, and supplies to make the journey. In the borderlands, the biopolitics of disposability appears starkly as a necroviolence that marks migrants for death.

Across both interior and borderlands, migrants are dying invisible, ungrievable (Butler 2009), and “justified” deaths. The “moral alibi” (Doty 2011) asserted by the Border Patrol in the borderlands extends to medical professionals in hospitals across the
interior. Just as migrants’ deaths in the desert are explained away as the result of “natural causes,” so too are immigrant patients’ deaths in the interior. In the interior, the necropolitical consequences of immigration enforcement are more mediated than the stark necroviolence and totalizing criminalization of migrants in the borderlands. The deaths of migrants across the country from treatable medical conditions going untreated demonstrates the insidious necropolitics of the interior as well as the challenges of immigrant health justice activists and organizations in making these deaths visible.

In the face of this biopolitics of disposability, medical humanitarian organizations cultivate a politics of visibility that emphasizes the bare life and deaths of migrants across the U.S. In response to an “ordinary crisis” of immigrant health, immigrant health justice (IHJ) activists and organizations provide medical care and humanitarian aid to undocumented immigrants across the U.S., while mobilizing against the racialized criminalization of their patients. The IHJ employs health and humanitarianism as both a field of action and a discursive frame. They spotlight the fatal consequences of migrant criminalization and position their own politically-contentious work as life-saving medical provision.

Because of the spatialized qualities of immigrant criminalization across the borderlands and interior, the strategic framing and discursive work of IHJ organizations demonstrate radically different mobilizations. In the highly-politicized space of the borderlands, IHJ organizations like NMD frame their nonviolent direct action as apolitical medical provision in response to a health crisis. Their work is asserted against border militarization and the totalizing criminalization of immigrant patients within this zone. In the interior, by contrast, clinics like CCP aim a more political critique toward
“health” itself. They castigate the for-profit health system for profiteering and collusion with immigration enforcement, indicting both “broken systems” for mass structural violence and murder.

Despite the necessary differences in their strategies, IHJ organizations and activists together engage in a “politics of life and death.” They account for migrant deaths by making them visible. For the deaths of migrants in the vast deserts of the borderlands, this visibility involves GPS coordinates on a map as evidence of the fatal consequences of border militarization. In this way, they attempt to force an “accounting” for these deaths. This politics of visibility is just as urgent in the interior, where the deaths of uninsured immigrants remain largely invisible and uncounted. The grave necropolitical consequences of the racialized criminalization of immigrants across these two zones is largely the same.

In the interior, this politics of visibility involves highlighting and challenging the collusion between health care institutions and immigration enforcement that creates a culture of fear and anxiety among migrants with health conditions – making death a preferable option to being deported as a result of accessing medical care in the formal health system. CCP’s work involves the public framing of the life and death challenges faced by their patients as a result of their lack of entitlement to formal health care. CCP engages in a more overtly politicized discourse that critiques the broken systems of immigration and health that refuse to recognize the health needs of migrants as “emergencies.” In this way, medical conditions that are actually life-threatening are reclassified as untreatable. Furthermore, their patients’ access to emergency medical care in charity hospitals – the only form of care to which they remain legally entitled – where
they are able to access it, renders them vulnerable to the immigration enforcement apparatus, even to deportation by the very hospitals that are legally required to provide emergency services. This vulnerability and the fear associated with detection as a result of accessing emergency medical care in the mainstream health system means that immigrants in the interior are foregoing life-saving health care. CCP’s critique then is an indictment of the for-profit medical and immigration enforcement industrial complexes that relegate undocumented immigrants in the interior to substandard and inadequate health care, and ultimately contributes to immigrant fatalities. Challenging the collusion between the broken systems of health and immigration enforcement, immigrant health justice organizations assert a substantive biocitizenship of immigrant patients that is based on their “hereness” and the ethics of health care as a human right. Though the strategies for how to cultivate this biocitizenship are contested even within the space of the clinic, the volunteers at CCP work to reframe narratives of deservingness to instead focus on a politicized critique of the “broken system.”

In the totalizing criminalization of the borderlands, NMD provision of medical care and humanitarian aid is more overtly positioned in direct conflict with the militarized presence of the Border Patrol. As a result, NMD strategically engages the neutrality of humanitarianism in order to frame their work (which may appear as direct action against the necropolitical effects of border militarization) as apolitical humanitarian aid provision. Although they rely on an overtly apolitical legitimation of their presence in this space and their humanitarian intervention, the very assertion of their work as “humanitarian” is itself a critique of border control policy and its fatal consequences for immigrants in the desert. By invoking the humanitarian crisis in the
borderlands that necessitates their medical intervention, NMD makes the deaths of migrants due to border militarization visible and dramatic. Invoking humanitarianism frames the borderlands as a conflict zone, and the deaths of migrants due to border militarization as a humanitarian crisis. In the borderlands, the negative effects on immigrant health is stark; the deaths of migrants from enforcement strategies that weaponize the material conditions of the desert are practically immediate. As such, NMD’s challenge to punitive immigration enforcement includes humanizing the migrants in the borderlands – both those that are very much alive but marked for death or left for dead and those that have perished during the journey. Engaging in an ethics of care for both the living and the dead, NMD asserts the necropolitical biocitizenship of migrants who face totalizing criminalization and a racialized dehumanization within this militarized space. They also counter the Border Patrol’s conflation of enforcement with humanitarianism and the agency’s attempts to monopolize the legitimacy of humanitarian aid within the borderlands.

In the politics of life and death in terms of immigrant health in the U.S., IHJ activists and organizations work to render visible what Nancy Scheper-Hughes calls “invisible genocides” (1996). In fact, humanitarian activists across the borderlands and interior characterize the current malicious disregard for immigrant lives as tantamount to genocide. In critiquing the systematic oppression of undocumented immigrants in the U.S., volunteers and organizers across my fieldsites repeatedly used the word “genocide” to characterize the deaths of immigrants. During a training for medical humanitarian volunteers, a Phoenix-based lawyer wrapped up his presentation about the legal challenges of supporting undocumented immigrants in Arizona, saying, “I am here
because I fundamentally believe in the right of people to cross the border. I’m also here
because I believe that this work is incredibly important. We will look back at these deaths
[he pointed behind him at the map of Arizona covered in red dots symbolizing the deaths
of immigrants in the borderlands] and will recognize that the crisis of immigrant deaths
across the country is the grossest human rights violation in our lifetimes. We are
witnessing a genocide in the U.S., and it is occurring in our very backyard.” By asserting
genocide, IHJ organizations and activists are making a powerful critique about the
systemic oppression and fatal consequences of racialized criminalization for immigrants.
And, they are positioning themselves as “bearing witness” to a crisis of humanitarian
proportions.

Perhaps paradoxically, migrants who perish in the deserts or the interior are much
more “visible.” Those that remain alive are relegated to the shadows in order to survive.
And thus, the volunteers in both the interior and the borderlands stake claims for
biocitizenship on behalf of their patients, in a way that they act as proxies, using their
own legitimacy as medical professionals to attest to the suffering and deaths of migrants
across the U.S. In this way, my dissertation has argued for the usefulness of taxonomies
of medicalized forms of citizenship, or biocitizenship, as central to the claims of IHJ
activists and organizations. Much of the literature on medical humanitarianism
emphasizes the importance of constructions of patient deservingness by these
organizations and activists in order to counter their “social illegitimacy” (Fassin 2004,
see also Gottlieb et al 2012; Ticktin 2006, 2011; Tiedje and Plevak 2014; Willen 2011,
2012a, 2012b). Certainly, this work is important in framing the need for health care for
uninsured, undocumented immigrants. However, immigrant rights struggles have been
coopted to argue for the deservingness of some immigrants – those deemed “good” who are not criminals and who are exemplary of the narrative of immigrant vulnerability and gratitude – in opposition to “undeserving” immigrants, who have criminal convictions, who do not fit the overall narrative of immigrant victimhood, and even who are LGBTQ or otherwise outside of heteronormative frameworks (Castro-Salazar and Bagley 2012; Nicholls 2013; Nicholls and Fiorito 2015). This false dichotomy between “good” and “bad” immigrants is deployed as a means to divide and conquer and even coopt immigrant rights movements, for instance, pitting DACA-mented young people against the supposed criminality of their parents. Aihwa Ong argues about this distinction, “Neoliberal exception gives value to calculative practices and to self-governing subjects as preferred citizens. Meanwhile, other segments of the population are…rendered excludable as citizens and subjects” (2006:16). Thus, in the face of dehumanization and criminalization of immigrants across the U.S., it is not enough to focus on constructions of “immigrant deservingness” of health care within this context, as much of the immigrant health literature does either implicitly or explicitly. Rather, as my research demonstrates, there is a need for a stronger critique of the (fatal) health effects of immigration enforcement and the humanizing possibilities of biocitizenship.

Epilogue: Immigrant Health in the Age of Trump

Given that my fieldwork with CCP and NMD officially finished in the summer of 2016, this dissertation would be incomplete without some accounting of the changes to immigration enforcement in the intervening years and the impact of these changes on the organizations at the heart of my research. The Trump administration has inherited an
immigration enforcement infrastructure that has been developed by Republican and Democratic administrations alike for decades. In fact, during my research, the activists and organizers in the communities in which I was working regularly referred to then-President Obama as the “deporter-in-chief.” Under his watch, 2.5 million immigrants were deported from the U.S. This number represents more deportations than all of the presidential administrations of the twentieth century combined. According to data from the Department of Homeland Security, from 1892 until 2008, the United States averaged 40,000 deportations per year, while during Obama’s first term especially, the U.S. deported an average of almost 400,000 people annually – a tenfold increase from the previous century (Simanski and Sapp 2012). The increase in the investment in immigration enforcement infrastructure since the 1990s and particularly since 9/11 provides evidence of the rise of the U.S. as a “deportation state,” in which “deportation has changed from a state response to specific events and crises through much of the twentieth century to a normalized and quotidian part of immigration and social control” (Anderson et al 2011:552, see also Schuster 2005 and Cornelisse 2010). In this way, the Trump administration’s approach to immigration enforcement does not represent a radical departure from previous administrations’ tactics.

That said, Trump made immigration policy a cornerstone of his campaign with repeated promises to build a wall along the southern border and “make Mexico pay for it.” His characterization of migrants as “bad hombres” during his campaign foreshadowed a deeper racialized criminalization of (undocumented) immigrants under his administration. Unlike previous administrations that have acknowledged the benefit of some immigration in the U.S., Trump has taken a hardline about the supposed wholly
negative economic consequences of migration on U.S. workers. To be frank, keeping up with the numerous changes under his “zero tolerance” approach to immigration and the dramatic increase in punitive immigration enforcement in the first half of his presidency has been challenging. This zero tolerance approach has included a ramping up of enforcement tactics in the interior of the U.S. (including ICE agents arresting immigrants in courthouses, in their communities, and at routine check-in appointments), an effective end to prosecutorial discretion, a government shutdown and declaration of national emergency over the funding of the “wall” along the southern border, a dramatic slowdown and backlog of processing visa applications and asylum claims, the attempted elimination of DACA as well as Temporary Protected Status (TPS) for immigrants from numerous countries, the reintroduction of dramatic workplace raids and a ramping up of the Obama administration’s “silent raids” through auditing employers, the increase in indefinite detention of immigrants, the criminalization of asylum seekers and the “remain in Mexico” policy, and the introduction of family separation, through which thousands of migrant children have been separated from their parents, caged in “tender age” shelters, adopted out to citizen families against the will of their parents, subjected to physical and sexual abuse, and effectively lost by the administration who has not put into place any sort of infrastructure to track them or their parents, many of whom were deported without them. This laundry list of substantial changes represents just the “highlights” of the staggering increase in punitive immigration enforcement in the U.S. in the past few years. Perhaps it goes without saying that these changes represent the expansion of the totalizing criminalization of migrants experienced in the militarized borderlands to the interior of the country.
Unsurprisingly, this shift in tactics has exacerbated the culture of fear and anxiety that shapes the lives of migrants in the U.S. This increase in fear of ramped up immigration enforcement has affected the patients and work of CCP. Since Trump’s inauguration, CCP has seen an increase in even long-time patients skipping their appointments. As a result, volunteers have increased home visits, as they did after the passage of SB 1070, for patients too frightened to leave their homes. This trend is not isolated to CCP or Arizona. In October 2018, the Trump administration has proposed changes to the definition of “public charge” in the U.S., signaling that it may take into account immigrants’ use of public health care in determining whether they are placing a burden on collective resources or are dependent on the government for subsistence, and thus less likely to get access to a visa. The announcement of these proposed changes “has jolted many immigrants who are awaiting decisions on their legal status, inspiring shock waves that continue to destabilize immigrant medical care” (Pape 2019). In the wake of this announcement as part of a broader decisively and more dramatic punitive turn in immigration policy and enforcement, many migrants who had some limited access to health care through Medicaid or even free community clinics, are foregoing medical care altogether. In addition to their provision of health care, CCP’s cultivation of substantive biocitizenship for their patients also includes (as much as possible) keeping them from being targeted by ICE for their access to health care. Since my departure from the clinic, the organizers at CCP have begun to run regular drills to educate providers and volunteers about what to do if ICE arrive at the clinic.

These changes with the Trump administration have also coincided with a major shift within the clinic itself – with the volunteers and organizers aligned with the activist
faction more or less ousting the main organizers that espoused a clinical approach. In this way, although they still maintain the clinic space, CCP has returned to the more guerrilla tactics of its early days. This shift has also entailed a re-cultivation of CCP’s once-strong links with the Latinx and immigrant communities in Phoenix, as well as a demographic change within the organizational leadership. The board of directors and core volunteers are now almost entirely people of color and immigrants. Although this is a fairly recent change at CCP, it seems that the organization has reckoned with accusations (both internal and external) of a drift towards white saviorism. Without drawing conclusions at this point, these changes suggest a shift as well in the role of biocitizenship – indicating a subtle but important move from claims of substantive biocitizenship on behalf of their patients to a more “collectivized biocitizenship” (Chavez 2018), a biocitizenship asserted with rather than for the clinic’s patients.

In addition to an expansion of totalizing racialized criminalization from the borderlands to the interior, medical humanitarian organizations working with undocumented immigrants across the U.S. have themselves faced heightened criminalization and accusations of aiding and abetting “illegal migration.” At NMD, the totalizing criminalization of migrants in the borderlands has extended to the humanitarian aid workers with the arrest of eight volunteers in the summer of 2017 and another volunteer in January 2018. Just two months after the Border Patrol’s raid on the NMD medical camp, the eight volunteers were arrested on the Cabeza Prieta National Wildlife Refuge, home of the infamous “Devil’s Highway.” This area represents one of the increasingly popular corridors for people walking across the desert on foot, but also one of the most dangerous and most remote. As a result, it has been the focus of NMD
humanitarian work and search and rescue/recovery efforts. In 2017, the remains of 32 people were found on the Refuge. In fact, four of the volunteers arrested were at the time were actually conducting a search and rescue mission, looking for three migrants who had gone missing in the area. Marking the first conviction of humanitarian aid volunteers in over a decade, these four volunteers were found guilty of misdemeanors related to entering the refuge without a permit and leaving behind “personal property” in the form of water, food, and other humanitarian aid supplies. After the conviction of the first four volunteers, the misdemeanor charges were dropped against the second four volunteers, who were cited for a civil infraction.

The other volunteer Scott Warren faces federal felony and misdemeanor charges related to harboring undocumented immigrants and conspiracy to transport and harbor them and could face up to twenty years in prison if convicted. Warren was arrested at a private property called “The Barn” that is used by NMD and other humanitarian organizations in Ajo, Arizona. The Barn holds humanitarian aid supplies and is used as a locale for volunteers to camp while distributing supplies in the area. Two undocumented immigrants from Central America were also arrested with Scott at the Barn, and he is accused of providing them with food, water, and shelter – which the state argues amounts to “harboring.” In a coordinated media campaign, NMD has been unwavering in their assertions that Scott’s arrest amounts to retaliation against the organization for the release of a report documenting Border Patrol destruction of humanitarian aid supplies. The release of the report corresponded with the recirculation of a viral video of Border Patrol agents destroying gallons of water and kicking them across the desert. Scott’s arrest took place a mere few hours after the public release of the report. On June 11, 2019, after three
days of deliberation, the jury was unable to reach a verdict on Scott’s case. However, he has not been acquitted of the charges and there is a possibility that the prosecution could attempt to retry his case. His misdemeanor and felony trials represent a critical point in the criminalization of humanitarian aid under the Trump administration, and the outcome (in terms of whether the government will continue to pursue his prosecution will push for a retrial in his case) has huge consequences on humanitarian aid for immigrants across the U.S. as well as for the willingness of citizens to provide necessary help to fellow humans in distress. A few months before the arrests of these volunteers, the Trump administration circulated new directives to ramp up prosecution for “harboring” and changed the guidelines for prosecution from people who have supposedly “harbored” five undocumented immigrants to as few as three. As a result, prosecutions of harboring have increased by a third since 2015 and have extended to “good Samaritans,” residents along the southern border who encounter severely-dehydrated and injured migrants with serious health needs and attempt to help them (Nathan 2019). The criminalization of humanitarian aid represents the state’s attempts to stifle any challenges to the total criminalization of migrants and the dehumanization that marks them for death through necropolitical border enforcement strategies.

Since 2016, ICE has gained an additional $1 billion for detention and deportation operations, and the population of immigrants in detention has increased by 40% from 34,276 immigrants detained daily to 48,000. Trump’s 2019 budget request included funding for 52,000 beds for immigrants in detention. In March 2019, the U.S. Supreme Court ruled that immigrants with criminal convictions (regardless of the severity of the crime or when the crime occurred) can be held in detention indefinitely without a bond
hearing. This move toward the increased (indefinite) detention of immigrants for crimes as petty as possessing a stolen bus transfer (Levine 2019) indicates a third immigration enforcement strategy. In addition to prevention through deterrence and attrition through enforcement, I argue for the existence of another immigration enforcement policy that I call “incapacitation through detention,” a strategy which has grown dramatically since 9/11. This strategy also implicates the health of immigrants in the U.S. Incapacitation through detention refers to the increasing prevalence of the (indefinite) incarceration of immigrants. This strategy corresponds with the growth of a public-private “detention industrial complex” that profits enormously from the detention and unpaid labor of immigrants. In the face of indefinite detention without recourse to the legal protections and representation afforded to citizens, detention centers operate as one current example of Agamben’s camps, defining their inhabitants through “bare life.” Within detention centers, the criminalization of immigrants is totalizing. The profit motive of private prison companies subcontracted to run the detention centers directly contributes to the stark conditions within these centers. These harsh living conditions include the medical care that detained immigrants receive (or do not receive, as it were) within detention. Ironically, detention centers are one of the only places where undocumented immigrants are entitled to receive health care in the U.S. However, the care that they receive is woefully inadequate. Reports have uncovered dangerous practices within these centers such as the employment of medical professionals with suspended licenses, the pressure on medical staff not to call 911 or transfer patients to the hospital, and the widespread lack of treatment that borders on malicious neglect, including treating serious medical conditions like bone cancer with ibuprofen (Bernstein 2008). In the past two years alone,
these conditions have led to the deaths of more than 30 immigrants within detention and the deteriorated health of countless immigrants, including the deaths of multiple children in detention (Lopéz 2019; Seville et al 2019). In this way, the deaths of detained migrants under Border Patrol and ICE’s watch not only amount to a necropolitical biocitizenship but also demonstrate a “carceral biocitizenship” (Burgess and Murray 2018) through which “a subject [is] caught between biopolitical practices and scenes of legal sovereignty…this form of biocitizenship…radically diverges from accounts that find in biocitizenship a form of agency through which one might lay claim to life in an affirmative biopolitics” (Burgess and Murray 2018:53). However, I would argue that there are important links to be made between the carceral biocitizenship of migrants and of incarcerated citizens that could lead to productive challenges to the carceral state.

As such, given the heightened punitive immigration enforcement tactics, the continued fortification of the border, and the increased (indefinite) detention of migrants in the U.S., the potential of biocitizenship to expose and critique the “biopolitics of disposability” in relation to undocumented migrants remains as relevant as ever. Under the Trump administration, the state recognizes migrants in the U.S. regardless of immigration status as always already criminal. As such, it would be tempting, and even expedient perhaps, for immigrant rights groups to engage in arguments about the deservingness of (some exemplary) migrants. Framing migrants as humans with medical needs, using the language of “health,” to cut through the punitive dehumanization of migrants in the U.S. is a productive way to counter the continued racialized criminalization of migrants across the borderlands and interior.


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