Title
Balancing Risks: Health, Immigration, and Biopolitical Exclusion in the U.S.

Author
Van Natta, Meredith

Publication Date
2019

Peer reviewed|Thesis/dissertation

Balancing Risks: Health, Immigration, and Biopolitical Exclusion in the U.S.

by
Meredith Van Natta

DISSERTATION
Submitted in partial satisfaction of the requirements for degree of
DOCTOR OF PHILOSOPHY

in

Sociology

in the

GRADUATE DIVISION
of the
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Approved:

DocuSigned by:
Catherine Bliss
3621A67CF635431...

Catherine Bliss

Chair

DocuSigned by:
Cecilia Menjívar

Cecilia Menjívar

DocuSigned by:
Howard Pinderhughes

Howard Pinderhughes

DocuSigned by:
Janet K. Shim
A58526EDCCB041A...

Janet K. Shim

Committee Members

Acknowledgements

Whatever success I have achieved in earning a doctoral degree I owe in large part to the steadfast support of my family, friends, and colleagues. This dissertation is the collective product of everyone who has helped, challenged, and loved me over the past several years as I have learned and faltered in equal measure. I thought this process would be easier, but much has happened in this time that I never anticipated. I have not emerged unscathed, but that I have emerged at all is a testament to everyone who encouraged me and lent me their strength when mine failed. Rather than recount these struggles here, I celebrate those who enabled me to weather them. To all of you, I am grateful.

Thank you to my family. To my parents, Joan and Tim, I will never find the words to express my appreciation for all that you have done for me. Always. All I can say at this moment is thank you both for being here now. We are all indescribably fortunate for the miracles that made this small fact possible: You are here now, and I am so grateful.

To my siblings: thank you for how you have inspired me over the years. Pete, your strength, intelligence, and willfulness are an example to us all, and I thank you for bringing Katie and Raylee into our family to brighten our lives incalculably. Canaway, I have never met anyone who is at once so kind and yet so fierce. Your quiet power never ceases to amaze me. Amy, I have always admired your boldness and generous spirit. You inspire me to live in the moment and hold fast to joy, and I thank you for that. Timog and Ian, you have taught me to be strong and brave. The lessons we have learned as a family have sometimes been hard ones, but we have borne them together and will, I hope, become better because of them.

To my extended family and friends: I could not have made it this far without you. Pais and Phil, I appreciate your generous support more than I could ever express. I can never repay

your kindness to me, but I will strive to live in your example. *A la familia Fuentes, gracias por todo lo que han hecho por mi y por mi familia. Siempre llevaré en mi corazón el ejemplo de su cariño, apoyo, y generosidad.* Meilyn Santana, *o projeto que entrego aqui não existiria sem você, e agradeço a você e Jean por me apoiar desde o começo até o final.* Crystal Loucel, not only did you enable the expansion of this project beyond where I ever envisioned it could go, but you lifted me up whenever I faltered and helped me always to see the light at the end. Celina González, the depth of your wisdom, patience, and kindness are unmatched, and I am humbled by your example and grateful for your support. RaeAnn Anderson, for more than a decade you have shown me what it means to be a true friend and a committed scholar, and I am grateful every day for both. Nessa Nemir, you taught me to find my confidence and to boldly become the person you knew I could be. Zainab Altai, you have been both my biggest cheerleader and greatest source of inspiration. *Te agradezco por tu entusiasmo, alentamiento, y amistad. ¡Que sigan nuestras aventuras!*

This research was inspired by my work at OA and funded in part by UC MEXUS, the UCSF Department of Social and Behavioral Sciences' Harrington and Strauss Scholarships, the UCSF Graduate Division, and the UCSF School of Nursing Century Club. To my UCSF colleagues and dissertation committee, I deeply appreciate your patient guidance and unwavering support. Rina Bliss, Howard Pinderhughes, and Janet Shim: I have learned much from each of you and appreciate how you have, in your own ways, helped me grow as a scholar and human being. Thank you for teaching me how to see the world as a sociologist, letting my mind run wild, and helping me rein it back in when needed (which was often the case). Cecilia Menjívar, I am grateful for your focused guidance as I have navigated research obstacles and the academic job market. Nancy Burke, thank you for the many opportunities you have made possible for me

throughout my doctoral education and as I embark on my postdoctoral journey. Zachary Zimmer, I appreciate you introducing me to the world beyond qualitative research and giving me the chance to become a part of it through our mutual collaboration. Brandee Woleslagle, thanks for keeping me on track since day one.

I also owe much to my classmates and peer mentors at UCSF and beyond, including Chadwick Campbell, Taylor Cruz, Naina Khanna, Tessa Nápoles, Sara Rubin, Ariana Thompson-Lastad, and Lily Walkover. Special thanks go to Mel Jeske, Florencia Rojo, and Rosalie Winslow for their dedicated emotional and writing support - particularly as I neared the end of this project. Your remarkable patience and kindness have carried me forward more times than I can count. I am also grateful for my Unstuck writing group, Margaret Bostrom and Ami Schiess, for somehow always being "there" for one another despite never actually converging in the same place. To both of you I can attest: *progress is being made*.

To my participants and the extended community who made this research possible – *les doy mil gracias desde el fondo de mi corazón.* I am especially grateful for Christina Araiza-Quiter and the Araiza family for their generosity and C.C. at my red state field site for his encouragement and support in getting my project off the ground. This project unfolded during an especially painful time for immigrant communities in the U.S., and the patience and generosity of my participants and community partners allowed me to be a witness to both the structural and symbolic violence of this moment of history and the strength of human resistance against it. I hope that I have done your stories justice and that my work can contribute in some small way to that remarkable resistance.

This dissertation is dedicated to my family.

Balancing Risks: Health, Immigration, and Biopolitical Exclusion in the U.S.

Meredith Van Natta

Abstract

The politics of citizenship and health care are two of the most contentious issues in the U.S. today, and their unstable intersection results in health inequalities for millions of people. My dissertation explores how anti-immigrant policies in the U.S. affect how immigrants and their healthcare providers have negotiated biological and social risks during turbulent political times. Through qualitative methods and social theory, my dissertation interrogates citizenship as a structural determinant of health in the U.S.

Specifically, I ask: How does political polarization around U.S. health and immigration policy affect the health care of noncitizen patients in safety-net clinics? To answer this question, I conducted ethnographic observations and in-depth interviews with 59 participants in two states with juxtaposed immigrant policies. Between 2015 and 2018, I spoke with immigrant patients, clinic staff and providers, and community partners to understand how they responded to changing federal health and immigration policies. I also shadowed clinic workers and attended public meetings where these policies were discussed. Using grounded theory methodologies and theories of legal violence and biopolitics, I reveal how anti-immigrant administrations at federal and state levels have used policy uncertainty to discipline both immigrant patients and the institutions that serve them. In the progressive state, the 2016 election set local clinics on a crash course with increasingly aggressive federal immigration enforcement and turned their trusted medical-legal bureaucracies into a potential tool for immigrant surveillance through a process I refer to as "medical legal violence". In the conservative state, clinics seemed more prepared to weather federal policy realignment but worried about expanding federal health exclusions. In

both states, participants expressed increasing panic as the Trump administration enacted zero-tolerance immigration enforcement and broadened surveillance strategies.

My comparative fieldwork suggests that anti-immigrant policymakers have ingeniously leveraged medical bureaucracies to expand legal violence against noncitizens in the U.S. In my dissertation, I contextualize how contemporary U.S. health and immigration policies came to be, with a particular focus on how the increasing criminalization of Latinx immigrants results in biological harms while reproducing existing inequalities. I also examine case law and bureaucratic documents and trace a before-and-after arc from 1996 immigration and welfare reforms, to the announcement of President Obama's executive orders on immigration, and through the first years of the Trump administration. I review the political evolution that led to heightened exclusion and enforcement through clinical mechanisms in the U.S., and I trace how participants from two juxtaposed sites have weathered these challenges in relation to the biopolitics of immigrant health today. These timely findings suggest that the biomedicalization of citizenship boundaries in the U.S. has material consequences for immigrant health, with implications for sociological understandings of citizenship, immigrant health policy, and health justice in the United States more broadly.

TABLE OF CONTENTS

Chapter 1: Introduction 1

Background & Statement of the Problem 3

Research Questions & Specific Aims 4

Review of the Literature 5

Immigration and Illegality 5

Crimmigration and Health 9

Structural and Symbolic Violence 14

The Biopolitics of Contemporary U.S. Citizenship 16

Description of the Research 19

Note on Methodological Challenges 22

Overview of the Dissertation 26

Chapter Two: First Do No Harm: Medical Legal Violence and Immigrant Health in Coral County, USA 26

Chapter Three: Plate Tectonics and Torque: Immigrant Health Topographies in Chapulin County 27

Chapter Four: States of Exception: Bare Life and (Non)citizenship in the Contemporary United States 27

Chapter 2: First Do No Harm: Medical legal violence and immigrant health in Coral County, U.S.A 29

INTRODUCTION 29

Balancing Risks 29

FINDINGS 32

Before the 2016 election: "We know nothing bad is going to happen." 33

Post-election Uncertainty: "Don't worry until after January 21st. Then worry." 42

CONCLUSION 50

Chapter 3: Plate Tectonics and Torque: Immigrant Health Topographies in Chapulin County 52

INTRODUCTION 52

Heart-wrenching choices, body-wrenching policies 52

Injurious Assemblages 53

Chapulin as Assemblage 56

FINDINGS 58

Medical Legal Violence as Cause and Consequence 58

"These are not normal times for us." 63

"De vida o muerte": Medical Legal Violence, Difficult Decisions, and Torqueing Bodies 70

"It's all in limbo… It's something that's a little unstable." 73

"When it's an emergency, then we take that risk." 76

CONCLUSION 82

Chapter 4: States of Exception: Bare Life and (Non)citizenship in the contemporary United States 85

INTRODUCTION 85

States of Exception and Emergency 85

Defining the Enemy 91

States of Injury 96

Slow Death 101

Becoming the Enemy 110

CONCLUSION 112

Chapter 5: Dissertation Conclusion 114

Summary of Key Findings 115

Sociological Implications of the Research 116

Limitations of the Research *118*

Recommendations for Future Research *120*

Conclusion *122*

CODA **123**

REFERENCES **126**

Chapter 1: Introduction

This dissertation aims to understand contemporary healthcare and immigration reform in the United States during a time of sweeping political change and great uncertainty. This project was initially designed during the Obama administration to explore opportunities for expanding healthcare coverage to immigrants following the implementation of the 2010 Patient Protection and Affordable Care Act (also known as the ACA or Obamacare), the expansion of the 2012 Deferred Action for Childhood Arrivals (DACA) program, and the announcement of Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) in 2014. Soon after I defended my dissertation proposal, however, the Trump administration came to power and sparked uncertainty in the realms of health and immigration policy alike. While it is unnecessary for the sake of this introduction to recount verbatim the negative characterizations of the ACA and immigrants that several Republican candidates espoused during the 2016 election cycle, such campaign promises transformed into immediate policy priorities on January 21, 2017.

Many Americans were surprised by this turn of events. Those living in progressive jurisdictions assumed that the country might be heading in a different, more inclusive direction where healthcare and immigration policies were concerned. Under DAPA and expanded DACA programs, almost half of the nearly 11.5 million undocumented immigrants living in the country at that time might have qualified for deportation protections and access to public benefits (Pew 2014, USCIS 2014). In a move that Republican lawmakers took to calling "executive amnesty", President Obama had bypassed the partisan gridlock obstructing congressional immigration reform and taken what he called our "badly broken" immigration system into his own hands (Obama 2014). The previous year, President Obama had urged the following of Congress: "We've got to lay out a path [to citizenship] — a process that includes passing a background

check, paying taxes, paying a penalty, learning English, and then going to the back of the line, behind all the folks who are trying to come here legally" (Obama 2013). By focusing on the fulfillment of individual civic obligations and economic productivity to signal legitimacy, President Obama hoped to galvanize support for the sorely needed reforms.

Such proposed reforms suffered, however, from the fact that President Obama had already expended significant political capital on getting the contentious ACA through Congress in 2010. The ACA represented an historic attempt to reform the nation's embarrassingly expensive, inefficient, and unequal healthcare system, and its passage required deft political maneuvering and concessions to powerful stakeholders (such as pharmaceutical and insurance lobbies and Conservative party leadership) (Oberlander 2010, Emanuel 2014). Among the achievements of the ACA were an end to discrimination based on pre-existing conditions; the expansion of Medicaid to a greater portion of the population; the creation of federally-subsidized, state-run health insurance exchanges; and monitoring of healthcare standards, costs, and quality (Oberlander 2010). Among the many compromises, however, was the explicit exclusion of undocumented immigrants (as well as legally-present immigrants living in the U.S. less than five years) from the Medicaid expansion program and state insurance exchanges (Jerome-D'Emilia and Suplee 2012).

This dissertation originally intended to explore these two highly contested policies – healthcare reform and immigration reform – in a nation tempered by the ACA, DAPA, and expanded DACA. It did not consider that these programs may not be in place by the time the proposed research began. Since President Trump's inauguration, health and immigration policies in the United States have faced a situation of great uncertainty. His party had campaigned on a platform that decried Obamacare as a "catastrophe" and boldly embraced anti-immigrant, anti-

refugee, and frequently racist rhetoric. Grappling with the details of how these campaigns achieved victory is not the direct province of this dissertation, however. Suffice it to say that new priorities have aimed to transform health and immigration policies in this country. These constant policy contestations between the federal administration and opposing sects at local and state levels make the landscape that noncitizens must navigate to access health care increasingly hazardous.

Background & Statement of the Problem

Of the approximately 24 million noncitizens currently living in the United States, nearly half (11.1 million) are "unauthorized" or "undocumented" – that is, they lack definitive legal permission to do so (Passel & Cohn 2015; DHS 2013). The vast majority of these undocumented immigrants, as well as many authorized immigrants, are excluded from public benefits, including health care coverage (Kaiser Family Foundation 2015). Programs that under the ACA reduced the numbers of uninsured Americans by 13 million individuals (especially through Medicaid expansion and the subsidized healthcare marketplaces), explicitly excluded undocumented immigrants and recent immigrants (KFF 2014, 2016). While millions of noncitizens would have become eligible for such coverage through DAPA and expanded DACA, legal challenges at the state and federal level have overturned DAPA and suspended DACA enrollment. At the time of this writing, the future of DACA remains tenuous (NILC 2017).

Both health and immigration reform efforts face an uncertain future under the Trump administration. Noncitizen patients, their healthcare providers, and policymakers must interpret these complex overlapping policy arenas, often at the very moment urgent medical decisions must be made. A growing body of research has drawn attention to immigration status as a social determinant of health (e.g. Davies *et al.* 2006, Castañeda 2009, Quesada *et al.* 2011, Zimmerman

et al. 2011, Castañeda *et al.* 2015), but there is little evidence of the effect of recent political turmoil on noncitizens' health decisions. Further, examinations of health and citizenship tend to be atheoretical and do not adequately consider how these politics and potential biological consequences are intimately interconnected. This dissertation examines the shifting terrain of noncitizens' health potential in the U.S. and advances existing scholarship through the lens of contemporary policy upheaval. The proposal especially makes use of Foucault's (1978) notion of "biopower" and Bourdieu's concept of "symbolic violence" to formulate a qualitative exploration of how noncitizens navigate health crises in the U.S. today. It finds that existing theories in this vein are helpful but insufficient in theorizing this topic. A new theory grounded in empirical data is needed, and that is precisely what this dissertation provides.

Research Questions & Specific Aims

This dissertation involves three interrelated aims that were pursued in two phases of the project: Phase 1 - Blue State, and Phase 2 – Red State. The first aim was identify the ways in which noncitizens negotiated access to state-provisioned health services in the midst of the ACA, its possible repeal/replacement under the Trump administration, and obstacles to immigration reform. How were noncitizens balancing biological and social risks in a rapidly changing and frequently hostile policy environment? What were the specific challenges and opportunities they encountered as they weighed these risks?

My second aim was to evaluate the role of safety-net providers and clinic staff who diagnosed and served noncitizen patients in navigating them through an unstable political landscape. How were clinical staff and those who advised them working at and around the boundaries of citizenship and biomedical bureaucracies on behalf of their patients, and how did they calculate risk in an atmosphere of great uncertainty? From which sources – biomedicine,

policy, administrative hierarchy, etc. – did biomedical personnel get the information they use to weigh such risks and counsel patients? Did such risk assessments differ from those of patients, and – if so – with what consequences?

My third and final aim was to develop an empirically grounded theoretical framework to explain these processes of biopolitical risk negotiations by noncitizen patients and their healthcare providers. What is the value of citizenship in these negotiations, and what do my data suggest about the potential consequences of narrowing windows for citizenship and public benefits opportunities in an age of enhanced immigration enforcement and the retrenchment of public pathways to health care?

Review of the Literature

Immigration and Illegality

Scholarship on citizenship and illegality must accelerate to keep pace with the right-wing populist movements that have swept through the U.S. and Europe in recent years. Anti-immigrant sentiment has already helped secure nationalist victories in the U.S. and the United Kingdom, and other nations – including France, Germany, Austria, and the Netherlands – have followed these trends (Calamur 2016). These victories aim to put citizens first, thereby reasserting the primacy of geopolitical belonging as a prerequisite for political, economic, and social inclusion. Such movements invoke an imagined, cohesive past in which the nation-state protected the wellbeing of its patriotic citizens from threats at home and abroad. This is the ethos behind President Trump's campaign slogan, "Make America Great Again". This slogan signals the interconnection of deservingness and citizenship, and it promises to restore the rights and benefits of that citizenship which illegitimate forces have eroded.

Importantly, these nationalist movements both implicitly and explicitly frame citizenship in racial terms, wherein white European ancestry is the default determinant of legitimate national belonging. It is no secret that "nationalist" parties in the U.S. and Europe very much construct the "nation" in terms of a homogenous white imaginary in juxtaposition to "invading" outsiders of color. Politicians from these parties generally rely upon criminalizing tropes of Latin American migrants (in the U.S. case) and migrants from African and Middle Eastern countries (in the case of Europe, but also the U.S.) to vilify and other such migrants and exclude them from the formal benefits citizenship enables.[1]

Thus while neoliberalization and globalization during the late 20th and early 21st Century suggested a retrenchment of geopolitical citizenship in favor of a more post-modern kind of belonging, we are now witnessing a shift toward its racialized reaffirmation. And as citizenship proper comes back into play, so too will the notion of proper citizens. Who gets to be a citizen, how do they achieve citizenship, and what is that citizenship worth? More important for the purposes of this proposal are the corollaries to these questions: Who does not get to be a citizen, how are they excluded from citizenship, and what are the consequences of that exclusion? What "states of exception" (Agamben 2005) are enabled by present configurations of citizenship in the U.S., and how do they shape noncitizens' health prospects? Given the link between legal status and social welfare benefits in many countries, such questions frame the delicate nexus between citizenship status and health.

In the United States, scholars of citizenship are increasingly drawing attention to the growing sphere of "illegality" and criminalization that bars noncitizens from legitimate socio-

[1] Examples of such rhetoric are too numerous to specify here but can be found among prominent right-wing and right-center political platforms, including within the U.S. Republican Party and the U.K.'s Conservative Party.

political inclusion. Legal scholars (including Miller 2003, Stumpf 2006, and Kurzban 2008) have traced the process by which criminal law and immigration law have become ever more intertwined, and many refer to this phenomenon as "crimmigration" (Chacón 2009, Stumpf 2013, García Hernández 2014). Just as Alexander (2010) has elaborated the process by which racism and the expansion of the criminal justice system have systematically disenfranchised African Americans in the United States, Vázquez (2015: 599) explains that crimmigration:

> not only redesigned the criminal and immigration systems, but also brought about a cultural transformation in the United States—restructuring social categories, diminishing economic and political power, and perpetuating the marginalization of the largest minority population in the United States—Latinos.

Crimmigration delegitimizes particular noncitizens, including legal permanent residents, and especially targets immigrants from Mexico and Central America (De Genova 2014). It also enables the power of enforcement among state and municipal agencies through programs such as the Secure Communities program and the 1996 addition of §287(g) to the 1965 Immigration and Nationality Act (Menjívar & Kanstroom 2014). At the state level, crimmigration policies have included such notorious legislation as Arizona's SB 1070, which allowed local police to racially profile individuals and stop and hold them solely to investigate their immigration status (AZ SB 1070). Ensuing legal challenges ultimately deemed these practices unlawful, but the enhanced surveillance has resulted in negative consequences for Latinx communities (NILC 2016, Santos *et al.* 2013).

This conflation of criminal law and immigration law is especially significant given bipartisan promises to focus on "criminal" immigrants when, since 1996, the very act of entering the United States without proper documentation is automatically a criminal, not a civil, offense (IIRIRA, Fragomen 1997). De Genova (2002) traces a history of what he calls "the legal production of migrant 'illegality'" to illuminate the taken-for-granted process by which

historically-situated immigration law has constantly evolved to become more exclusionary in recent years. This process began in the mid-20th century and has accelerated through present-day legislation and enforcement. As the 20th Century progressed, immigration legislation became ever more discriminatory and criminalizing, particularly as it related to immigrants from Mexico and Central America. De Genova argues that failure to examine the contingency of the laws that have led to illegalization makes them seem "fundamentally unchanging – thereby naturalizing a notion of what it means to transgress that law" (De Genova 2014). As Bourdieu (2000) has suggested, perceiving law as natural or inevitable results in symbolic violence that disproportionately falls upon those who fail to "play by the rules" that are deemed intrinsic to society.

Such legislative developments ultimately created the vast space of illegality and "liminal legality" (Menjívar 2006) that exists in the contemporary United States. Such spaces include shifting gray zones between legality and illegality, among which are non-statuses (Heeren 2015), "precarious statuses" (Goldring *et al.* 2009), and "permanent temporariness" (Bailey *et al.* 2002) that lead to what Menjívar and Abrego (2012) call "legal violence" (which I discuss in more detail below). Under the auspices of identifying "criminal" immigrants for removal, the Obama administration oversaw a record number of deportations by capitalizing on this recent history of criminalized immigration offenses (González-Barrera & Krogstad 2016). The idea seemed to be a carrot-and-stick approach that demonstrated a commitment to deporting criminals while identifying deserving individuals for deferred action.

Yet steps that promised to legitimize certain undocumented immigrants' inclusion in U.S. society – such as DACA and DAPA – at the same time signaled a perpetual state of exclusion from full political participation. According to Menjívar and Kanstroom (2014: 12):

> While those covered under DACA, or others not categorized as criminals, may no longer be deportable, they will not be legalized either (and their status will remain uncertain), a situation that accentuates their liminally legal position, and a legal action that creates a separate class of individuals in society. Thus … they will continue to live inside the country but in spaces of illegality, in a gray zone of nondeportability but also of exclusion.

Thus while deportation of ostensibly "criminal" immigrants accelerated, so did the apparatuses of exclusion for liminally legal immigrants. Subjects of deferred action may not face immediate physical removal, but their legitimate inclusion in society remains out of reach.

As undemocratic as this "gray zone of nondeportability" appears, it may be preferable to the mass deportation proposed by President Trump and many Republican legislators. It is uncertain whether or in what form such liminal statuses will persist under the present administration, but rolling back protections on "liminally legal" individuals – such as Temporary Protected Status (TPS) and DACA – has been a practical starting point for a more aggressive enforcement environment (Cohn *et al.* 2019). Immigrants who sought greater protections by turning themselves in, so to speak, to the federal government in exchange for temporary deportation relief, may now fear that they are easy targets for removal precisely because they are "in the system" (Asad 2019). In this way TPS and DACA are similar in many ways to the Emergency Medicaid and state-funded comprehensive Medicaid enrollment I discuss in the following chapters, in that people must wager their personal security in exchange for potential benefits. Rather than deportation deferral, work permits, or educational benefits, however, medical benefits often carry an added urgency that results in fraught life-and-death decision-making.

Crimmigration and Health

The changing state of immigration policy represents only half of the picture that the proposed research seeks to examine, however. The goal of this dissertation is to explore how

these changes specifically interact with noncitizens' health. Therefore it is also necessary to consider the literature that links health policies with contemporary citizenship regimes. Illuminating scholarship emerged early on in France when scholars began to examine the claims of belonging that the *sans-papiers* made on the State on the basis of what are deemed (in European states, at least) basic human rights (McNevin 2006, Ticktin 2011, Larchanché 2012). Regarding health, Ticktin (2011) in particular highlights how humanitarianism on behalf of the *sans-papiers* has come to operate in opposition to increasing anti-immigrant politics. The state itself has framed humanitarian practices through a supra-political, moral imperative to protect "basic human dignity in the face of acute suffering" (Ticktin 2011, 2). Exceptions to anti-immigrant policies there have included an "illness clause" that grants legal residence to undocumented immigrants with a life-threatening illness in the event that they are "declared unable to receive proper treatment in their home countries" (Ticktin 2011, 2).

Similar literature is somewhat underdeveloped in the U.S., however. Scholarship on health and citizenship in France only partially transfers to the U.S. context due to the relatively high degree to which neoliberalization shapes social welfare contexts here. As a subset of social welfare, health in the U.S. is conceptualized as a commodity rather than a right (Light 2000), and social welfare more generally is increasingly neoliberalized (Turner 1997, Sainsbury 2012) and racialized (Gilens 1999). While some scholarship, primarily in the fields of law and public health, has focused on the nexus between citizenship status and health in the United States, it tends to be framed in terms of social determinants of health (Davies *et al.* 2006, Castañeda 2009, Quesada *et al.* 2011, Zimmerman *et al.* 2011, Castañeda *et al.* 2015). Many scholars (Castañeda *et al.* 2014, Capps *et al.* 2009, Pourat *et al.* 2015, Marrow 2012, Joseph 2015) focus on the persisting exclusion of noncitizens from healthcare reform, while scant legal scholarship (e.g.

Hernandez 2014) explores the overlap between the two legislative realms. Hernandez, for example, argues that, at the national level, "the alien exclusion [of the ACA] functioned as a political stopgap against backlash about the nation's crumbling federal immigration system" (Hernandez 2014, 300).

Furthermore, as recent anti-immigrant movements have reaffirmed, social welfare discourses are highly racialized at the same time that they invoke citizenship as a measure of deservingness (McAdam & Kloos 2014). Literature exploring the intersection between immigration and social welfare demonstrates that it is in line with the negative depictions of U.S. minority groups in social policy discourse. Asad and Clair (2017) suggest that *de jure* citizenship classifications that are ostensibly race-neutral have the *de facto* consequence of discrediting racial/ethnic minority groups' social position what they refer to as "racialized legal status". This can particularly affect Latinx citizens in the U.S., who experience the spillover effects of being associated ethnically with a discredited racial status in ways that may have chilling consequences on their benefits uptake.

Such racialized depictions also fault particular groups for failing to embody neoliberal values of personal responsibility and economic productivity. A key example of this is the 1996 Personal Responsibility and Work Opportunity Reconciliation Act – also known as welfare reform. Much of the Conservative-led charge against "entitlements" (at that time and currently) depicted low-income, minority "welfare queens" who leeched from the system without contributing anything in turn (Viladrich 2011). The contemporaneous passage the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), which restricted noncitizens – including many permanent legal residents – from accessing public benefits further solidified the racialized exclusions of noncitizens from social and political belonging (De Genova 2014).

Social policy scholar Diane Sainsbury has referred to this intersecting legislation as "one of the largest disentitlements in welfare history" (Sainsbury 2012, 152). This evolving understanding of social welfare in the U.S. is culturally and historically contingent. In a recent comparative international analysis of immigrant rights in various types of welfare regimes, Sainsbury highlights the features that are distinct to the contemporary U.S. context. "In granting immigrants' access to welfare benefits," she argues, "equal rights and equal treatment were an important frame – but not social rights. In fact, social rights are not part of the U.S. political vocabulary. Instead Americans emphasize civil and political rights" (Sainsbury 2012, 157).

The problem for noncitizens in this country is that civil and political rights correspond to U.S. citizenship, a designation that is becoming ever more difficult for immigrants to attain. Sainsbury goes on to outline three aspects of U.S. welfare discourses that obstruct immigrant rights: 1) welfare reform as restorative of "personal responsibility and self-sufficiency" rather than an enabler of dependency, 2) the contractual nature of rights in which one must fulfill obligations before one is worthy of rights, and 3) "deservingness" as uniquely linked with citizenship (Sainsbury 2012, 157-158). Given the increasing pace of crimmigration and reality of racialized legal status (Asad & Clair 2017), Latinx immigrants' exclusion from citizenship both disqualifies them from benefits that only citizens "deserve" and perpetuates their exclusion from political participation. Such exclusions reproduce health inequalities on the basis of legal status while enlisting American citizenship values to uphold white supremacy under contemporary neoliberal capitalism.

Citizenship discourses in the U.S. expose a philosophical contradiction, however: neoliberalization theoretically erodes geographic borders in matters of labor and trade flows, but Conservative values of personal responsibility and self-sufficiency reassert the primacy of

geographic affiliation for individual rights claims through U.S. citizenship. This view is supported by the "line" metaphor that dominates immigration reform rhetoric in the U.S. If entitlements are to be properly restricted to deserving, responsible citizens, then citizenship must be the goal – not public assistance. For this reason, even President Obama's executive action announcement repeatedly called for undocumented immigrants to "get in the back of the line" behind immigrants who have "followed the rules" (President Obama 2014).[2]

This position reflects the transformations that have taken place in the role of the state and the idea of citizen rights and responsibilities in the neoliberal turn of the past few decades. As Turner (1997: xix) asserts, this shift represents:

> …the new environment of risk cultures, political contingencies and deregulated welfare systems. The burden of dependency … is being answered increasingly with the privatization of medicine and a doctrine of obligation. The traditional notions of citizen rights (to health and social welfare) are being questioned by a liberal ideology of individual obligation (to save and to create personal bases of security).

For U.S. citizens, this has meant a focus on encouraging individuals to take care of themselves without relying upon the state. In this context, it is not surprising that national healthcare reform rejected a nationalized system in favor of expanding the market for private coverage (Emanuel 2014). Government benefits continue to be determined on a state-by-state basis, meaning that U.S. citizenship itself does not necessarily guarantee any standard for healthcare access.

Nevertheless, political citizenship remains a non-negotiable prerequisite for many of the provisions of healthcare reform. Medicaid, in some form or another, does exist in every state for

[2] The trouble with this metaphor is that it rests on the assumption that there is one clear path to citizenship in the U.S. – which in fact is not the case. According to a recent policy brief by the Migration Policy Institute, the "myth" of the single line to citizenship has resulted in unrealistic expectations for immigration policy reform (Bergeron 2013). There are multiple channels for seeking legal permanent residence (primarily family- or employment-based), and various priority levels within those channels. Additionally, numerical quotas on immigrants from certain countries (such as Mexico and the Philippines) have not kept pace with actual migration patterns.

its low-income residents. Yet the ability for states to allot services on their own terms results in radically different material consequences for residents. While federal law under the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requires that any emergency department at a hospital receiving federal funds must treat any patient experiencing a medical emergency, regardless of immigration status or ability to pay, the law's definition of "medical emergency" is open to interpretation (Sommers 2013). In most cases, only acute conditions or complications apply. In New York, however, radiation and chemotherapy treatment for undocumented immigrants is covered under emergency Medicaid services. In California, New York, and North Carolina, outpatient dialysis is also covered under Medicaid for undocumented immigrants (Gusmano 2012).

This situation makes the intersection of serious illness and illicit or liminally legal status a dangerous one. In places where health systems do not have a mechanism to specifically include undocumented people in primary or specialty care, "managing" a complex illness is impossible. Acute symptoms may warrant emergency treatment under EMTALA, but the accouterments of responsible disease management – medication, durable medical equipment, diet and exercise changes, and regular primary and specialty care visits – remain out of reach. It is often only when medical conditions get "out of control" that a claim to treatment becomes available for noncitizens.

Structural and Symbolic Violence

This dissertation extends Menjívar and Abrego's (2012) concept of "legal violence" (mentioned above) to clinical sites to examine the biological stakes of anti-immigrant policies and practices. Here I describe the theoretical frameworks that underpin the concept of legal violence: *structural violence* and *symbolic violence*. Several scholars (e.g., Galtung 1969, Farmer

2003, Pinderhughes *et al.* 2015) have defined and described "structural violence", which I summarize here as the ways in which structural inequalities – such as institutionalized racism, poverty, sexism, nationalism, etc. – harm individuals and groups through socially embedded arrangements that mask the sources of that violence. Unlike direct interpersonal violence, the institutionalized violence of these structural harms more efficiently evades culpability because it is not a matter of one person injuring another. The effects of structural violence are often slow and methodical, and existing scholarship has explored the intersection of structural violence and immigration in the U.S. (Quesada *et al.* 2011, Mendenhall 2012, Holmes 2013, Horton 2016). This dissertation acknowledges the theoretical and empirical foundations of this scholarship and goes beyond it by examining the spaces where immigration and health policies overlap with structural violence in the form of racism, poverty, and nationalism, to magnify the embodied harms on Latinx immigrants in the United States.

Legal violence also relies upon symbolic violence to normalize and reproduce the social harms that undermine Latinx immigrants' wellbeing. Bourdieu (2000: 170) defines "symbolic violence" as:

> […] the coercion which is set up only through the consent that the dominated cannot fail to give to the dominator (and therefore to the domination) when their understanding of the situation and relation can only use instruments of knowledge that they have in common with the dominator, which, being merely the incorporated form of the structure of the relation of domination, make this relation appear natural […]

Importantly, Bourdieu asserts that even less powerful citizens – as well as noncitizens – are complicit in their own domination even while they are losing at the game. This is the genius of symbolic violence and what makes it so much more insidious, and therefore more powerful, than physical violence. The dominated play along, so to speak, because they cannot do otherwise.

Like the powerful, they misrecognize the game as inevitable reality; but unlike the powerful, they do not benefit from this misrecognition.

The Biopolitics of Contemporary U.S. Citizenship

This dissertation also makes use of Foucault's (1978) notion of biopower and later iterations of biopolitics (2004/2007) and governmentality (1978) to analyze noncitizens' health negotiations in two U.S. states in recent years. Foucault (1978) refers to "biopower" as a post-Enlightenment form of power that has waxed as the absolute power of sovereign monarchs has waned (but not disappeared). Biopower is a bipolar form of power characterized both by 1) the disciplinary "anatamo-politics" that subjugates human bodies and 2) the regulatory "biopolitics" that controls populations (Foucault 1978, 139-140). These are of course inseparable from one another, and both are at play in the context of contemporary health and immigration policy in the United States. Here I focus on how other scholars engage with and develop this Foucauldian notion in ways that are relevant to the present research. Such intersections include explorations of governmentality, risk, and biopolitical citizenship.

In his lecture entitled "Governmentality", Foucault (1978) provides a complicated definition of the term that is steeped in his genealogy of biopower and knowledge-power. Rather than drawing a historical vector from pre-modern sovereignty to modern governmentality, he suggests an ongoing "triangle" that includes sovereignty, discipline, and governmentality (Foucault 1978, 102). At its core, governmentality relates to how the modern state enacts its obsession with population management through particular institutions (especially the school, family, military, etc.), specific types of knowledge (especially political economic knowledge), and the technical application of "apparatuses of security" within and upon said population (Foucault 1978, 102).

Many contemporary scholars have taken up the notion of governmentality to understand aspects of society that cannot be explained by simple rule of law. Clarke *et al*. (2003) emphasize how governmentality operates alongside and through the increasing incursion of biomedicine into everyday life in a process they call "biomedicalization". They stress the role of expert knowledges and discourses of self-surveillance and self-regulation in shaping biomedical subjects and buttressing more coercive mechanisms of social control, such as laws and policing (Clarke et al 2003, Kindle Locations 1057-1061). Turner (1997) further articulates governmentality as a relationship between the health of the individual body and the health of society as a whole, with a particular emphasis on medicine and labor (xiii). "The body is the target of the medical gaze and governmentality," he asserts, "… health is a form of policing which is specifically concerned with the quality of the labor force" (Turner 1997, xv).

In his genealogy of freedom, Rose (2004) emphasizes that these three aspects of Foucault's triangle – law as decree (sovereignty), the anatamo-political surveillance of individual bodies and their optimization (discipline), and "maximizing the forces of the population collectively and individually (governmentality) – are all caught up with one another in contemporary states (Rose 2004, 23). For noncitizens who live and work in the U.S., these anatamo-politics of the body and biopolitics of the population are always already at play. They must manage biological risks to their health at the same time that their presence in the U.S. is considered "risky" (yet economically productive) by the state, thereby creating a positive feedback loop among self-surveillance, biomedical surveillance, and political surveillance.

With respect to the United States of the 21st Century, the governance of health and citizenship regimes also displays the presence of these three elements of governmentality in various bureaucratic sites. Rodriguez and Paredes (2014) specifically examine governmenality in

relation to the "coercive bureaucracies" of U.S. immigration agencies, particularly Customs and Border Patrol (CBP) and Immigration and Customs Enforcement (ICE). They focus on the ideological component of coercion that constructs "illegality" as something related to but not delimited by legislation. As they assert (Rodriguez & Paredes 2014: 67):

> Bureaucratic ideological work transcends laws and rules; it is a tactical representation of what is considered illegal, with negative associations often portrayed as well founded and real … At a minimum, bureaucratic ideological work is intended to promote the view that the large-scale process of coercive enforcement is valid and necessary, and, at a maximum, that it is essential for survival.

This bureaucratic governmentality becomes especially complicated when immigration enforcement seeps into and is at times reinforced by biomedical bureaucracies. Some forms of state-funded Medicaid (such as I discuss in Chapter 2), for example, demand a declaration of *legitimate illegality* to public benefits authorities, which is of course a risky move as it makes noncitizens legible to federal immigration bureaucracies. And biomedical providers and institutions sometimes find themselves caught between the imperative to manage biological risk and the technologies of the crimmigration apparatus. As Sontag's *New York Times* exposé on hospital-initiated deportations reveals, noncitizen patients often come to embody "the collision of two deeply flawed American systems, immigration and health care" (Sontag 2008).

This dissertation explores how noncitizens with serious health conditions navigate this complex, contingent, and continuously changing sea of *de facto* and *de jure* rights and responsibilities. How do noncitizens with Type 2 diabetes, for example, balance their physiological, socio-political, and economic wellbeing in the face of often-negative public representations of their identity? How do they reconcile their individual health responsibilities with a paucity of rights at their disposal? How do they "manage" their conditions without adequate socio-economic and biomedical resources? What happens – physiologically, socially,

economically – when a noncitizen with a medical need does not qualify for medical coverage? In what spaces and at what point does engaging with federal medical bureaucracies become an option, and what happens to the individual once that option is summoned?

Description of the Research

To answer these questions, I undertook in-depth interviews and ethnographic observations in two states with diverging immigrant and health policies from 2015 to 2018. As the background section makes clear, the politics of citizenship and health care have become two of the most contentious issues in the U.S. today, and their unstable intersection results in health inequalities for millions of people. My dissertation explores how anti-immigrant policies in the U.S. affect how noncitizens and their healthcare providers have negotiated biological and social risks during turbulent political times. In the three data chapters that follow here, I leverage qualitative methods and social theory to interrogate citizenship as a structural determinant of health and what these biopolitical exclusions mean for citizenship more broadly in the contemporary U.S.

My original goal when embarking on this dissertation research was to understand how healthcare coverage in the U.S. might expand among noncitizen patients as immigration reform progressed. And while it quickly became clear over the course of my research that this would not be the story I imagined, neither is it a mere testimony of the effects of Trump administration policies on immigrant patients or clinical care. In the following chapters, I aim to go beyond facile documentation of a particular moment in history, turbulent though it may seem, to grasp the context and consequences of immigration and health policies that have evolved in the U.S. over decades.

This dissertation emerged from my previous work as a surgical case manager coordinating donated charity care for low-income, uninsured patients – the majority of whom were undocumented Latinx immigrants. My job was to process surgical referrals from community clinics in several counties and match cases with volunteer surgeons at local private hospitals. I received few referrals from my own county, however, because I lived and worked in a county that offered public health coverage for low-income patients on the basis of county residence rather than national citizenship. This meant that most of the referrals I coordinated came from community clinics in counties where undocumented immigrants were not eligible for comprehensive health care – or where there was no public hospital in the first place. During the three-and-a-half years I worked in this role, I frequently witnessed patients having to make difficult choices when their cases proved too costly or complex to manage through outpatient charity care. It was in these moments of biopolitical drama that the first inkling of this dissertation took root.

My case management experience drew me to wonder how clinics and their immigrant patients were navigating political polarization around U.S. health and immigration policy as they negotiated health care in safety-net clinics. I began by launching a pilot project in a progressive "blue" state in October 2015 to find out more about how clinics were responding to Obama-era reforms in both spheres. I wondered how providers, as well as patients like those I served as a case manager, were responding to the winnowing of federal health opportunities alongside the apparent softening of certain federal immigration enforcement priorities. There was some hope that avenues were opening to expand healthcare coverage among some sectors of the undocumented population, and I wanted to identify and analyze the viability of these inroads.

Things began to change during the 2016 presidential primaries and candidate debates, however. It became clear that the blue state perspective was not capturing the full picture of national immigration and health politics, and such a myopic approach would do little to illuminate the nuanced interplay of federal, state, and local policy. I therefore reached out to clinics in multiple "red" states – which herein refers to a tendency to favor Republican candidates, including Trump – in the hopes of seeing for myself how biopolitical risk negotiations unfolded in more conservative, less immigrant-inclusive jurisdictions. Through professional networks, I connected with an enthusiastic community of clinic workers in a large metropolitan area with a recent history of anti-immigrant policies and support for Republican candidates at multiple levels of governance.

Across the two states, I conducted ethnographic observations and in-depth interviews with 59 participants. Between 2015 and 2018, I spoke with immigrant patients, clinic staff and providers, and community partners to understand how they responded to changing federal health and immigration policies. I also shadowed clinic workers and attended public meetings where these policies were discussed. Using grounded theory methodologies and theories of biopower (Foucault 1978 and legal violence (Menjívar & Abrego 2012), I reveal how anti-immigrant administrations at federal and state levels have used policy uncertainty to discipline both immigrant patients and the institutions that serve them. In the progressive state, the 2016 election set local clinics on a crash course with increasingly aggressive federal immigration enforcement and turned their trusted medical-legal bureaucracies into a potential tool for immigrant surveillance through a process I refer to as "medical legal violence".[3] In the conservative state,

[3] "Medical legal violence" is the expansion of legal exclusions and disproportionate surveillance of noncitizens through health institutions and clinical care. I introduce and elaborate on this theory in Chapter 2.

clinics seemed more prepared to weather federal policy realignment but worried about expanding federal health exclusions. In both states, participants expressed increasing panic as the Trump administration enacted zero-tolerance immigration enforcement and broadened surveillance strategies.

My comparative fieldwork suggests that anti-immigrant policymakers have ingeniously leveraged medical bureaucracies to expand legal violence against noncitizens in the U.S. In my dissertation, I contextualize how contemporary U.S. health and immigration policies came to be, with a particular focus on these policies intersection with the increasing criminalization of immigrants. I also trace a before-and-after arc from 1996 immigration and welfare reforms, to the announcement of President Obama's executive orders on immigration, and through the first years of the Trump administration. I review the legal evolution that led to heightened exclusion and enforcement through clinical mechanisms, and I trace how participants from two juxtaposed sites have weathered these challenges in relation to the biopolitics of immigrant health today. These timely findings suggest that the increasing role of biomedical practices and institutions in shaping citizenship boundaries in the U.S. has material consequences for immigrant health, with implications for sociological understandings of citizenship, immigrant health policy, and health justice in the United States more broadly.

Note on Methodological Challenges

Conducting this dissertation research during an upsurge in anti-immigrant rhetoric and policies at the national level presented a number of unanticipated challenges. I knew from my previous work as a surgical case manager, healthcare interpreter, and researcher on academic teams that I might face a bit of an uphill battle recruiting patients and gaining their trust. I already understood that building rapport with patients in healthcare settings required respect,

patience, and transparency on my part. The fact that many of the patients I spoke with were undocumented immigrants enhanced this challenge, but – again – I had a strong base of experience to draw from when recruiting prospective participants. I also recognized that my positionality as a relatively young white woman with U.S. citizenship placed me in a privileged position in relation to many of my participants, but conversing fluently in Spanish and mentioning my family roots in Mexico almost always established some common ground from which to build rapport.

At the outset of this project, I faced few challenges recruiting patients while remaining transparent about the aims of my research. While I never explicitly asked anyone about their immigration status, I was able to describe my project candidly and explain that I wanted to understand how changes such as the ACA and immigration reform might impact immigrants' health because these were largely viewed – by providers and patients alike – as positive phenomena. My goal at the time was to undertake a project that contributed to expanding health care to more categories of noncitizens, and patients and clinics in the "blue state" (where I began this research) welcomed this endeavor. Conversations were easy and relatively positive, and a shared sense of optimism propelled my research in its early stages.

As my data chapters describe, this optimism waned as the 2016 presidential campaigns unfolded and the Trump administration came to power. My research project became highly politicized and relevant in ways that I had not anticipated, and I started having to rethink 1) how what I was doing fit into the national debate, and 2) how I should characterize it to prospective participants moving forward. I began describing my project in increasingly vague terms, saying things like "it's about immigration and health" or "I want to learn more about how people who

aren't from the U.S. navigate the healthcare system here." These things were true, but they did not convey the whole picture because, frankly, I no longer grasped the whole picture myself.

At the same time that the Trump administration began turning campaign promises into actual policies, I was expanding my research into a red state and entering a political context that was deeply unfamiliar to me. I began to realize that in that place, at that time, it made sense for patients to assume that I was a Trump supporter. After all, many of the people who looked like me in that area were indeed Trump supporters – and vocally so. For example, one day as I waited for a clinic provider to meet me in a shopping center café where she asked to hold our interview, I noticed Fox News playing on a wall-mounted television. I seemed to be the only white person in the café, and no one else was paying attention to the news story about President Trump moving the U.S. embassy in Israel to Jerusalem. Suddenly a white man passed through the café, glanced at the television, and shouted to everyone there, "All *right!* That's *my* president!" Everyone looked up at him, then at me, and then went back to their business as if nothing had happened. I swore audibly and continued making notes in my field journal.

While the other café patrons seemed unfazed by the outburst, I found it disturbing – on its own and for the way I seemed to be implicitly associated with it. This occurrence sensitized me to the way I might be perceived in the clinics and prepared me for questions I otherwise might not have anticipated. In several instances, patients in clinic waiting rooms where I was recruiting participants asked me to explain Trump's policies to them. Some asked with what seemed like suspended judgment, saying things like, "People tell me that there's supposed to be something good in all he's doing, but I can't see what it is." Others came to me with rumors they had heard on Spanish-language media and asked me to corroborate or deny them. These ranged from requests to explain news about Russian collusion allegations to the rumored firing and

deportation of an undocumented member of Trump's staff. Some asked me bluntly if I was a Republican or a Democrat. In all cases, I tried to answer candidly and to the best of my ability without misrepresenting my project's aims, and I found that this approach often enhanced rapport rather than derailed it.

Despite my attempts to adapt to the changing political reality, however, some things were beyond my control. Although I continued to connect with clinic staff and patients during this time, some clinic administrators became concerned about the effect my presence might have on patients who were becoming more leery of seeking care as national immigration enforcement priorities took shape following Trump's inauguration. Eventually, as I mention in Chapter 2, these policies created such rampant fear and anxiety that the Chief Medical Officer of one of my key clinic sites asked me to cease fieldwork and patient recruitment there. I was welcome to interview staff, he explained, but he feared that the presence of an outsider like me in the clinic would raise suspicion among an already wary population and further justify their choice to avoid seeking care at that location. I understood this concern and complied, recognizing that it was merely a symptom of the larger drama that was unfolding at the time.

At the same time, interviews with patients I had already recruited were becoming more emotional. As I discuss in each of the following data chapters, the news of family separations at the border intensified patients' fears, and this was at the forefront of many participants' thoughts when I spoke with them.[4] It was a tense time, and I found that even people who seemed reticent

[4] On April 6, 2018, then-Attorney General Jeff Sessions announced a "zero-tolerance" policy at the U.S.-Mexico border, which directed federal prosecutors to criminally prosecute all adult migrants entering the country without authorization. Because the 1997 *Flores v. Reno* settlement prohibits children from being held in a detention facility, the policy effectively led to the separation of families at the border. This resulted in widespread public outcry, as it emerged that not only were families being separated, but the administration was unable to keep track of those they had separated – and thus unable to reunite many families (CLINIC 2018).

at the outset of our conversations ultimately had a lot to get off their chest once the opportunity presented itself in the form of an interview. While I can never know what the people who avoided the clinics out of fear may have been thinking, nor can I speculate about the interviews I may have done were I able to continue patient recruitment during that time, these unanticipated research obstacles are data in and of themselves. They were challenges that emerged only in the wake of the Trump administration's ascendance, and for that reason it is worth documenting them here – both as a potential limitation and a snapshot of a particular moment in our collective history that felt, in many ways, especially exceptional.

Overview of the Dissertation

Chapter Two: First Do No Harm: Medical Legal Violence and Immigrant Health in Coral County, USA

This chapter highlights legal status as a technology of social exclusion and determinant of health by capturing the effects of recent policy uncertainty on immigrant health in a relatively progressive "blue state" jurisdiction. By examining the case of Coral County (a pseudonym), I highlight the challenges facing safety-net clinics and their immigrant patients making life and death decisions amidst uncertainty before and after the 2016 presidential election. Observational and interview data with patients, clinic workers, and community partners (n=27) reveal that growing anxiety over federal immigration policies altered clinical risk calculations through a process I theorize as medical legal violence. Whereas previous risk negotiation strategies leveraged bureaucratic routines to elevate imminent threats of illness and/or injury in health decisions, heightened immigration enforcement under the Trump administration shifted the balance in clinical risk calculations toward social risks of detention, deportation, and family separation. This transformed clinical care in Coral County by turning trusted medical-legal

bureaucracies into potential tools for federal biopolitical surveillance of immigrant patients, blocking healthcare pathways and increasing patients' fear and anxiety.

Chapter Three: Plate Tectonics and Torque: Immigrant Health Topographies in Chapulin County

Chapter 3 examines the case of Chapulin County (a pseudonymous "red state" county), where an injurious assemblage of bureaucratic obstacles, punitive immigration laws, and restrictive health policies subject Latinx immigrants to medical legal violence. I illustrate this assemblage through observational and interview data with patients, clinic workers, and community partners (n=32) in Chapulin County to analyze how, in an alternative instance of medical legal violence, local and federal immigration policies have interacted synergistically with exclusionary health policies to trigger serious health consequences for immigrant individuals and families. Participants describe the challenges of balancing risks of illness and injury against the risks of detention, deportation, and family separation. I conclude that newly converging U.S. medical-legal bureaucracies have forced immigrant patients in Chapulin County to make agonizing decisions that often destabilize their own health and the wellbeing of their families.

Chapter Four: States of Exception: Bare Life and (Non)citizenship in the Contemporary United States

In the fourth and final data chapter, I use data from both sites to demonstrate how the accelerating symbolic violence of crimmigration enables the continued political exclusion of non-white noncitizens, especially those from Latin America, from full social belonging in the U.S. I focus specifically on the discursive and material "state of emergency" as a form of medical legal violence that typifies the Trump administration's approach to immigration law. I argue that the symbolic violence of anti-immigrant rhetoric and legal violence that the Trump

administration has implemented interacts synergistically with existing structural violence to keep Latinx immigrants in a "state of exception" (Agamben 2005). The codification of these violences into medical legal violence produces participants' experiences of being indispensable yet disposable labor, and facing both immediate and compounded injury. This chapter addresses this condition as both the result of historically continual processes in the global political economy of capitalism, and as historically specific to the contemporary U.S.

Chapter 2: First Do No Harm: Medical legal violence and immigrant health in Coral County, U.S.A

INTRODUCTION

Balancing Risks

Across the United States, noncitizen patients and their healthcare providers must make critical medical decisions while contending with overlapping health and immigration policy uncertainties. Accelerating political polarization around immigration and healthcare reform has expanded noncitizens' exclusion from healthcare networks, leaving them "frozen out" of coverage (Marrow & Joseph 2015). As the Trump administration has prioritized more aggressive immigration enforcement and promised a reckoning with the Affordable Care Act (ACA), uncertainty is transforming noncitizens' risk calculations in the face of grave health decisions. News stories abound documenting how this uncertainty makes noncitizens, and members of mixed-status families, leery about seeking health care (e.g. Ibarra 2017, Lowrey 2017, Boyd-Barrett 2018, Kennedy 2018). Despite this uncertainty, noncitizen patients must make urgent medical decisions in confronting illness and injury. This urgency requires immigration and health scholarship to track this phenomenon as it unfolds. In this chapter, I address this demand with empirical evidence of how safety-net clinic staff and patients have navigated this turbulence in a place where politically progressive policies are increasingly at odds with federal ones.

Observations and interviews with 27 participants (11 patients and 16 clinic affiliates) associated with pseudonymous "Coral County" community clinics reveal that growing fear and anxiety over federal immigration policies altered clinical risk calculations through medical legal violence. Medical legal violence refers to the expansion of legal exclusions of noncitizens through health institutions and clinical care, and in Coral County clinic workers and noncitizen patients came to perceive once-trusted medical-legal bureaucracies as potential tools for federal

biopolitical surveillance. Before the 2016 election, clinics leveraged bureaucratic routines to elevate the imminent threat of illness and/or injury in health decision-making. After the election, however, threats of heightened immigration enforcement shifted the balance in clinical risk calculations away from biological risks of illness/injury toward the social risks of detention, deportation, and family separation. In their effort to care for the subjects of this expanding medical legal violence (noncitizen patients) after the 2016 election, clinics found themselves caught between providing care and possibly contributing to the surveillance, detention, and deportation apparatus their patients feared.

As I described earlier, lack of legal status of millions of Latinx immigrants in the U.S. puts them at perpetual risk for deportation and compromises legitimate social integration, including numerous barriers to obtaining health insurance. The ACA contributed to existing medical legal violence by continuing benefits exclusions established in the 1996 welfare and immigration reforms, excluding undocumented immigrants and legally present immigrants living in the U.S. less than five years from receiving Medicaid (Fragomen 1997). It also barred these groups from new state insurance exchanges (Kaiser Family Foundation 2016). Further, the Trump administration subsequently announced plans to expand benefits categories that would count as a "public charge" penalty against immigrants' chances of naturalizing (DHS 2018). This would include public food and shelter assistance as well as health care received through publicly-funded mechanisms such as Medicaid and Medicare, likely making undocumented immigrants, legal permanent residents, and mixed status families more reluctant to seek health care. This avoidance of federal immigration bureaucracies to limit one's perceived visibility and concomitant vulnerability to immigration consequences – what Asad (2019) refers to as "system embeddedness" – may negatively impact noncitizen individuals and mixed-status families.

Interdisciplinary scholarship has drawn attention to the importance of legal status as a social determinant of health (Quesada *et al.* 2011, Viruell-Fuentes *et al.* 2012, Castañeda *et al.* 2015, Philbin *et al.* 2017), as well as the disproportionate criminalization and racialization of Latinx immigrants into groups with a discredited status – thus portending diminished health potential (Menjívar 2006, Joseph 2016, Asad & Clair 2017). Further, given the federalist nature of U.S. immigration policy (Varsanyi *et al.* 2012), this health stratification unfolds differentially among federal, state, and local jurisdictions. Federalism allows immigrants to be "frozen out" of health care across the country despite locally inclusive immigrant policies, such as sanctuary ordinances, in some regions (Marrow & Joseph 2015, Van Natta *et al.* 2019).

I argue that health and immigration laws synergistically interact to undermine noncitizens' wellbeing through medical legal violence, a concept that highlights the biological aspects of suffering and social control that existing theories insufficiently capture. Whereas legal violence focuses on how a "vast technological infrastructure and state bureaucracy" effect legal violence in the family, workplace, and schools (Menjívar & Abrego 2012, 1391), my empirical site is the clinic. The crucial difference between other forms of legal violence and medical legal violence is that while both involve institutionalized harms that materially affect individuals' lives, medical legal violence also inflicts embodied harms that immediately threaten noncitizens' physical wellbeing and enroll clinics as potential agents of that harm. Through increasingly exclusionary policies, noncitizen patients became the subjects of medical legal violence, and their providers became both its subjects and agents – caught between potentially facilitating yet consciously resisting that violence.

In this chapter, I narrow in on a safety-net clinic with multiple locations throughout Coral County to highlight findings that are especially relevant to "progressive" political contexts.

Located near multiple longstanding, urban "sanctuary" jurisdictions with healthcare coverage programs accessible to all residents regardless of status, relatively remote Coral County shares the region's politics while lacking the safety-net health infrastructure of its urban neighbors or adequate public transportation to reach that infrastructure. Without a public county hospital since privatization schemes in the 1980s, and excluded from federal Medicaid programs, low-income noncitizen residents of Coral County are especially vulnerable during health crises. Further, one in six residents in majority-white Coral County identify as Hispanic/Latino, nearly half of whom were born in Latin America and almost none of whom have naturalized as U.S. citizens (U.S. Census 2018, UCLA CHPR 2018). Coral County's noncitizen population is thus primarily Latinx and particularly susceptible to medical legal violence. Additionally, while there was no formal sanctuary policy in Coral County until 2018 (meaning that the sheriff's office might cooperate with federal immigration enforcement agencies when requested), participants explicitly distinguished Coral County from other jurisdictions where local law enforcement actively participated in immigration enforcement.

FINDINGS

Prior to the 2016 election, clinics' routines and relationships around healthcare documentation and provision made them view enrolling noncitizens in healthcare coverage as a net positive. While medical legal violence existed (through exclusions such as the ACA), it was seen as largely happening outside the clinic, and clinic workers worked creatively to relieve the embodied suffering that medical legal violence imposed. As the Trump administration pursued more aggressive immigration enforcement priorities, however, clinics weighed the risk of untreated medical issues against the risk of contributing to medical legal violence through enrolling patients in federal bureaucracies via their health utilization. In attempting to uphold the

Hippocratic adage to "do no harm", they began to worry how their treatment of medical legal violence might inadvertently contribute to its expansion.

Before the 2016 election: "We know nothing bad is going to happen."

Prior to the 2016 election, clinics and their patients balanced various biological and social risks according to bureaucratized procedures that routinized those risks. Given many noncitizens' exclusion from "normal" social spaces through immigration and health laws, clinics worked around such laws to create innovative care conduits. Clinic leadership reached out to counties that were successfully providing care to noncitizens to transfer similar strategies locally. They also developed close relationships with county Medicaid agencies and immigration lawyers to build workflows that maximized patients' eligibility for state-funded Medicaid (which only a handful of states make eligible to their undocumented residents). Paradoxically, clinics created care pathways for *undocumented* patients by leveraging substantial *documentation* – in the form of favorable state health policies, patients' immigration and medical files, and Medicaid application forms – to get patients the medical services they needed.

When I began research in 2015, clinic staff expressed confidence in such processes to provide health care for patients without compromising their security. Clinic workers conveyed trust in both healthcare and immigration reform and assuredly collaborated with local arms of federal agencies to maximize coverage for undocumented immigrants within the existing legal infrastructure. They amassed substantial written documentation from local and federal health and immigration agencies to bolster patients' trust. I also observed that many patients overcame their initial hesitation to share personal information with the clinic, based on a combination of trust with clinic staff and providers and a sense that they had few other options. According to patients and clinic workers alike, prior to the election there was a shared sense that whatever might

happen with immigration enforcement in the rest of the country, Coral County's noncitizen population was relatively safe from federal immigration agencies. They suspected regional politics would protect them, and they documented all available evidence to anchor such expectations.

Under the Obama administration, clinics were able to facilitate high-level care (such as surgery and chemotherapy) primarily through charity care and federal and state-funded Medicaid programs. Federal funding provided Emergency Medicaid access to undocumented immigrants, and the state-funded component provided full-scope (comprehensive) Medicaid for gravely ill undocumented immigrants who could aver that immigration agencies knew they were in the U.S. but did not intend to deport them. Eligibility for the latter option was established through a public benefits category used by administrative agencies in some states since the 1970s to "deliberately sanction the inclusion of cases that are, in strict terms, outside the law but are near the border" (OpenJurist 2016). This provision enabled clinics to direct noncitizen patients to life-saving treatment through Medicaid. Importantly, they did so within the bounds of the law, and U.S. citizens continued to receive health services and insurance enrollment support from Coral County clinics irrespective of noncitizens' changing eligibility.

Unlike counties with strong safety-net healthcare systems where specialty care is accessible to most residents regardless of citizenship status (Marrow 2012, Joseph 2016), community clinics in Coral County often had to persuade patients to apply for Emergency and comprehensive Medicaid to access such care. I observed such an exchange in September 2016, when a Central American asylum-seeker told a clinic worker named Elizabeth[5] that she worried that if immigration agents discovered that she was using any benefits, they would "come to my

[5] All names are pseudonyms.

house and capture me…" She expressed concern that the clinic forms might go directly to immigration agents, who would then arrest her. Elizabeth replied that the clinic paperwork was merely "administrative" and added confidently, "If you haven't committed any crime, [immigration agents] won't come looking for you because they are giving you an opportunity to fight your case [via asylum]."

Even though the patient was in asylum proceedings, her hesitance shows how medical legal violence permeates the documentation status continuum (Joseph 2016), wherein variously "documented" or undocumented immigrants might fear the respective consequences – permanent disenfranchisement or deportation – of seeking health benefits and thereby becoming legible to federal bureaucracies (Asad 2019). To counter these fears, staff formed coalitions across clinics, with legal teams, and with county Medicaid offices and amassed information to alleviate the anxieties of prospective enrollees who feared that receipt of benefits might bar naturalization or provoke deportation. In particular, clinics countered patients' fears by presenting written documents to emphasize their confidence in the security of U.S. medical-legal bureaucracies. As an outreach and referrals director explained, "When [federal agencies] make a decision, it always comes in writing, that is very important because we can show the patient." Such documentation included the 1996 Health Insurance Portability and Accountability Act (HIPAA), which protects private health information, and a 2013 memo from the U.S. Immigration and Customs Enforcement (ICE) Agency stating that seeking health care would not make patients targets of ICE. The 2013 memo affirmed that when individuals provided information for health coverage, this could *only* be used for health coverage eligibility determinations. The memo stressed that ICE did not use information obtained for eligibility purposes "as the basis for pursuing a civil

immigration enforcement action against such individuals or members of their household" (DHS 2013).

Taking these documents at their word, clinic personnel looking to meet patients' healthcare needs expressed confidence that enrolling qualified noncitizen patients in Medicaid would not put them at risk of immigration penalties. In the face of a heavy bureaucratic burden (of Medicaid, state health insurance exchanges, immigration documentation, etc.), clinics responded with an institutional culture that actively sought information to find and/or forge pathways to services. One clinic staff member remarked that the gravity of a patient's health conditions tended to supersede questions of legal status. "It gets to a stage of the patient's health that it's a do or die kind of thing," he asserted. When a situation could be clearly understood by patients and providers as a medical crisis, and when the clinic had a mechanism for enabling treatment (such as Emergency or comprehensive Medicaid), clinic staff could often persuade patients to put their security concerns aside and prioritize their health.

One clinic worker demonstrated how she usually counseled noncitizen patients with cancer who seemed afraid on multiple levels. Her description illustrated how patients came to embody medical legal violence through intersecting fears of 1) diagnosis and 2) what might happen if they tried to access health services from which they believed they were excluded. She began by outlining all the social risks involved, especially acknowledging patients' fear of immigration enforcement penalties. To allay their anxieties, she informed patients that she had never known anyone to suffer a negative immigration consequence after applying for comprehensive Medicaid. She summarized the negotiation as "balancing one fear over another":

> The fear of potentially being found out by immigration services and having implications like possible deportation or other circumstances with them and their family versus the fear of being in debt, not following up with their medical appointments that they need and the fear of having a recurrence of their disease.

Despite these fears, clinics seldom found status-related barriers insurmountable prior to the 2016 elections. Most challenges involved the need to refer undocumented immigrant patients to local hospitals for surgical and specialty care. Without U.S. citizenship, and without comprehensive insurance coverage (from which they are excluded due to employment and ACA restrictions), treatments such as surgery and chemotherapy could be accessed only out of pocket, through a hospital's charity care program, or through comprehensive Medicaid. Unless a patient could afford advanced care out of pocket, getting health care required trust – between patients and clinic providers, as well as between clinics and health and immigration agencies – in opaque bureaucratic processes. This created a tense contradiction: patients feared this bureaucracy's association with the federal government, while clinic workers embraced local- and state-level opportunities to engage with that bureaucracy to make it work for their patients. Clinic administrators organized frequent meetings with county health agencies to train all parties on Medicaid eligibility and built mutual capacity to streamline referrals among health institutions, and over time there were fewer barriers to Medicaid approval. More patients were getting covered, emergency department visits were ostensibly prevented, and clinic workers observed no negative immigration consequences for patients.

This arrangement suited the clinics, which through their increasing confidence and success were able to persuade patients to prioritize biological risks over risks to their own and/or their family's security. Through county-level collaboration and comprehensive documentation, clinic workers felt they had mastered at least the medical-bureaucratic uncertainty that kept patients from accessing adequate care. Health care was their priority, and actively pursuing Medicaid enrollment allowed them to maximize care provision while suppressing other perceived risks. Prior to the 2016 election, if a patient's life was at stake, clinic workers'

perception of the apparently low risk of immigration consequences did not figure prominently into a clinical care plan.

For some patients, this was a fairly straightforward decision. The case of undocumented immigrant patient Alicia illustrates how the Medicaid process unfolded for noncitizens in Coral County prior to 2017. Alicia, a friendly but visibly exhausted middle-aged woman, came to the clinic because of excessive vaginal bleeding that required multiple blood transfusions in local emergency departments. In 2014, the clinic referred her to a charity care program in a nearby county with high capacity for diagnostic and surgical services. She made special arrangements to miss work and travel out of county, and the charity care program provided a healthcare interpreter for Alicia's diagnostic procedure and surgical consult. The gynecological surgeon informed Alicia that she may have cancer and needed a hysterectomy, and possibly adjuvant cancer treatment, but that these were beyond the charity program's scope. Yet because Alicia was not a resident of the county where she received this diagnosis, which offered low-income healthcare coverage irrespective of citizenship status, she was ineligible for treatment there.

Alicia returned to the Coral County clinic and expressed her deep distress to her case manager. They discussed her remaining choices: returning to her country of origin, paying fully in cash, or applying for comprehensive Medicaid. During an interview in 2017, Alicia explained that she did not understand the process but felt like comprehensive Medicaid was her only choice. She could not return to her home country for treatment, and with her limited housekeeper's income she could not afford care in the U.S. Though she struggled as an undocumented Latina in the U.S., she never felt particularly in danger of deportation. "Look, if you don't do anything wrong, if you're just working, like me, I've never had any problems," she explained. "There are things you can do, and things you can't," she shrugged. Alicia therefore

elected to apply for comprehensive Medicaid and trusted the clinic to advance her case. The process lasted over a year. During that time, Alicia's health declined, and one of her case workers told me Alicia looked close to death. Eventually, however, Alicia had her operation. After a difficult recovery, she returned to work and told me that she was doing well. "It turned out all right," she sighed, "but it could be easier."

Clinic workers told me they had developed a standardized process for applications like Alicia's. First, they worked actively with regional clinics and legal counsel to train frontline workers at the local Medicaid agency to understand noncitizens' statewide eligibility. Then, once relationships and workflows were established, the clinic's eligibility counselors compiled all relevant health and immigration documentation that a Medicaid eligibility worker would need to process the patient's file. As one pediatrician explained, the clinic's enrollment counselors did the "lion's share of the work" by gathering patients' documents, handing them to the county Medicaid office, and saying, "We think this will qualify, tell us why it won't." By working closely with legal experts and regional clinic administrators, clinics were able to identify pathways to services that were otherwise hidden in Medicaid's labyrinthine bureaucracy. Clinic workers used favorable interpretations of existing law to circumvent the medical legal violence that excluded their patients from care, and they educated Medicaid staff on noncitizen eligibility to get their patients that care.

Other patients described a more circumspect experience of being undocumented in Coral County prior to 2017. On one occasion, I spoke with patient Marcos, who had enrolled in Medicaid before the election. Despite his frail appearance, Marcos narrated his recent medical tribulations with surprising energy as we sat across from one another in the clinic's empty conference room. As an undocumented immigrant with a deportation order in place after his

work permission lapsed and he was unable to renew it, he took special care not to be in a position that could get him into trouble with authorities, such as driving a vehicle or drinking alcohol in public. Marcos was used to being careful, but a sudden illness complicated his cautious routine. In a tone more of casual curiosity than self-concern, Marcos told me of how he had begun noticing blood in his urine but thought little of it at first. He continued working as a landscaper until one day at work he went to relieve himself and unleashed copious blood and clots. Despite his distress, Marcos decided against borrowing a colleague's vehicle to drive to the hospital and instead rode his bicycle directly to a trusted Coral County clinic. He was afraid to go to the Emergency Department, but the clinic insisted, and he was soon diagnosed with advanced bladder cancer.

Given the gravity and urgency of his condition, Marcos' primary care provider and clinic support staff helped him apply for comprehensive Medicaid to cover his surgery and chemotherapy. Furthermore, the Medicaid designation made him confident that if immigration officials apprehended him, he could explain to them that he was undergoing serious medical treatment and must not be detained. "[The doctors] told me that they were going to try to find a way to get rid of [my existing] deportation order because I was going to be undergoing medical treatment," he explained.

Despite how cautiously Marcos lived his life before cancer, he vividly recalled compounding social and biological risks. He monitored his behavior and tried to be a good worker, but without papers he was forced to work under toxic and exploitative conditions that left him injured and were, he suspected, the source of his cancer. His illicit status thus made him a prime target for legal violence, for perpetual exclusion from everyday social spaces. After his cancer diagnosis, however, he hoped that his medical treatment might counteract his precarious

status. Because he had cancer, he explained, "…if for some reason immigration picks me up … I can declare that I am undergoing medical treatment. … and if they deport me it's not fair." Yet while Marcos' biological condition had begun to outweigh the security risks that had led to conscious strategies to avoid immigration confrontations, it was through cancer that Marcos came to embody medical legal violence. He accepted the care and the concomitant federal visibility that he once feared because he would have certainly died without that care, and he hoped immigration enforcement agents would respect the humanity of that choice.

Marcos' case exemplifies the clinic's positive expectations of Medicaid enrollment and the perceived gravity of their task: the provision of health care in what were often life and death situations. This led them to prioritize health care in the health-security balance as they worked to remedy the harms of medical legal violence to which patients like Marcos were subjected. Yet even as they resisted legal violence through paving pathways to health care for noncitizen patients, they also had to work within the very federal structures that injured those patients. In this way, prior to the 2016 election, both patients' and clinics' healthcare options were constrained by medical legal violence.

Before the election, clinic workers' confidence in resisting medical legal violence through intensive documentation was typified by comments like those of eligibility supervisor Olivia. Olivia, who had once been undocumented herself but was now a U.S. citizen, explained that the clinic knew "exactly" what the government was doing with Medicaid application information: checking a patient's immigration status against some shared database. She did not know if it was "immigration's database" or another agency's, but she believed that "they're just checking that against it and if it doesn't match they will let you know it doesn't match." County Medicaid agents told her those files stayed on a shelf in their office, and once eligibility

determinations were made, they went no further. Olivia therefore trusted that seeking health care through Medicaid would not put noncitizens in harm's way. Progressive regional policies supported this assumption, yet clinics understood that they were beholden to federal policy when it came to both health and immigration. Olivia emphasized the provisional nature of this guarantee when she offered the following caveat:

> As we know, policy changes all the time. Right now we know that if we help you fill out [comprehensive Medicaid applications] … we know that nothing bad is going is going to happen. But … we don't know what could happen five years from now.

As the political environment in which clinics tried to remedy medical legal violence began to shift during the 2016 presidential campaigns, however, clinic workers increasingly shared patients' fears that their health-promotion strategies might put noncitizens in harm's way – thus making the clinics potential agents of the very violence they sought to ameliorate.

Post-election Uncertainty: "Don't worry until after January 21st. Then worry."

After the election, Olivia's hypothetical statement became reality as clinics wondered what would become of Obama-era health and immigration policies. Clinics adjusted to the realization that medical legal violence not only happened beyond the clinic but potentially *through* the clinic depending on federal biopolitical priorities. Whereas before the election clinic workers expressed confidence in their routines and relationships to alleviate their noncitizen patients' subjection to medical legal violence, afterwards they became more cautious about how those very routines and relationships might make them complicit in medical legal violence's expansion. Elsewhere I elaborate on patients' post-election perspectives (see chapters 3 and 4); here I focus particularly on clinics' evolving perceptions of patients' vulnerability to biopolitical surveillance and their potential role in that surveillance.

A few weeks after the 2016 election, I spoke with Margaret, an oncology social worker at a hospital that received referrals from Coral County. She explained that the day after the election, undocumented immigrant patients receiving cancer treatment through Medicaid began calling her to ask, "Am I on a radar now?" Margaret did not know how to answer them, saying, "I haven't heard anything. Don't worry until after January 21st. Then worry." She tearfully explained to me that this situation had never occurred to her hospital administration. They had assumed business as usual would continue or even improve through ongoing implementation of the ACA and deferred immigration action proposals, and care plans proceeded accordingly. Yet the sudden election-related uncertainty eroded the confidence and mutual trust between local healthcare institutions and federal agencies.

In situations of life and death, fearful patients often asked enrollment counselors for advice on whether to sign the comprehensive Medicaid forms. Elena, an enrollment counselor and Latina immigrant I spoke with in June 2017, relayed increasing reluctance toward persuading patients to enroll in comprehensive Medicaid. She felt compelled to inform them of potential risks – namely that ICE might find a patient in the Medicaid system and penalize them through "public charge", detention, and/or deportation. She frequently sent patients to local legal aid centers to help them decide. Elena's attitude toward the risk-benefit calculations involved in comprehensive Medicaid enrollment became one of extreme caution and transparency. She voiced concern that federal agencies might start reviewing Medicaid applications and begin deporting people on that basis. "Social services says that they don't send those documents to [ICE]," she said, "but honestly, I don't know because I don't work [there]." Her concern exemplified the rising threat of medical legal violence: that in seeking health care, noncitizens

might unwittingly provide the U.S. government with a mechanism for using apparently neutral laws to locate and differentially discipline them.

Elena's caution revealed a growing fear among clinic workers that by promoting comprehensive Medicaid enrollment, the clinic might 1) compound patients' fears of becoming visible to punitive arms of the federal immigration bureaucracy (see Asad 2019) and/or 2) reproduce medical legal violence rather than ease it. Before the election, clinic staff and providers believed that patients who were at immediate risk of illness or injury, yet who lacked access to health insurance, had two options: the Emergency Department or preemptive Medicaid enrollment to facilitate comprehensive treatment. After the election, as Elena's hesitation made clear, clinics began reconsidering how they counseled patients to balance their actual or impending biological crisis against the safety of themselves and their families.

Following the election, it also became increasingly difficult for clinics to get the information they once relied upon to assuage patients' anxieties. Previous immigration and health legislation had laid out clear paths for implementation, with explicit goals of insuring more American citizens and making it possible for more immigrants to become authorized residents. These proposals set into motion sweeping changes for safety-net clinics in Coral County and across the country, and clinic workers fully subscribed to them. Yet this momentum halted as political changes undermined the Obama administration's signature legislation and executive orders. As several states brought legal action against portions of the ACA and the 2014 executive orders on immigration, and as the Trump administration announced new priorities in health care and immigration enforcement, clinic workers began to consider more seriously the potential material consequences for patients and their families.

This concern burgeoned across neighboring counties throughout the year. Several months after the election, regional clinic representatives gathered to establish a standardized ICE response protocol. I observed leadership from various counties and healthcare organizations describe their own strategies, all of which aimed to create a personnel bottleneck that protected patients and bought staff time to deflect the incursions of immigration enforcement officials into clinical spaces. Legal experts led workshops in which copies of warrants were distributed to providers, and they participated in exercises to learn the difference between administrative warrants (which were insufficient to enter clinics) and judicial warrants (which must meet a specific, nearly impossible, standard to grant admission into a clinic). They also advised clinic leaders to designate a small team at each site to deal with ICE encounters. Only members of this team would be allowed to engage with ICE representatives, and there were suggestions that all warrants would have to be reviewed by a clinic executive before agents could enter clinic spaces.

Before the 2016 election, it was uncommon for these medical providers to become versed in immigration law. While some physicians, like the civil surgeons who completed immigrant entry paperwork, were familiar with immigration policies, most did not contend with them regularly. In Coral County, for example, providers and support staff in the clinics developed instrumental Medicaid expertise to get services that were otherwise beyond their patients' reach, and they expressed confidence without knowing precisely how various forms of Medicaid utilization operated in relation to immigration enforcement. It was sufficient to know that noncitizens did not seem to be targeted while undergoing medical treatment, including through Medicaid. With differential diagnoses and treatment plans foremost in mind, and a vague sense that progressive politics would keep patients safe from legal ramifications, clinics proceeded in finding ways to improve the health of their noncitizen patients.

As national politics took a surprising turn, however, clinics began to worry about the incursion of federal health and immigration enforcement policies into the supposedly safe space of the clinic. They deepened their trust in existing legislation, such as HIPAA, to protect the privacy of patients' health information, and they learned about constitutional protections and warrant standards. And as regional and state administrations began to emerge as powerful opponents of federal policies, clinic workers strengthened their resolve to continue care provision practices as long as possible. At the same time, however, this put the clinics in a difficult position because they received federal funding and could contravene a federal agency such as ICE. One of the clinic's front-desk supervisors described a diplomatic and pragmatic response developed by clinic administrators shortly after the 2017 Muslim Travel ban was announced. Their new protocol instructed staff to swiftly and subtly move all patients to the back of the clinic, where exam rooms were protected by HIPAA, if immigration enforcement officers entered the site. Through this protocol, clinics attempted to adapt to the uncertainty over whether such apparently drastic policies would become reality, especially when their legality remained in question. "You respond to what media says," the front-desk supervisor remarked. "You don't know if it's true or not. It's everything. You get influenced by both."

Just as the clinic began making protocols without the solid footing in hard fact as they once they once believed they could, patients' risk negotiation strategies became even more inflected by perception and rumor. For the immigrant community of Coral County, constant media coverage of policy uncertainty increased panic among patients and their families. A year and a half into the Trump administration, the clinic's Chief Medical Officer, Dr. Carrera, described matter-of-factly some of the ways in which the risk calculations of patients and providers had changed. He explained that immigrant patients still would probably (though not

always) go to the ER in cases of acute trauma, but they had begun avoiding more routine preventive care, such as mammograms, child immunizations, and diabetes checks:

> You're not sick. You're fine, and you're not gonna seek that type of care, and you're probably not gonna bring your kids in for immunizations if you've heard that ICE is around. Your kid's healthy and fine so you're not gonna do that. If you're a diabetic, you're probably not gonna come in to get your eyes examined for your annual exam just because, you know, you're worried that if you show up someplace, you might not be able to get home to see your kids.

Dr. Carrera stressed that whatever ultimately happened at the level of policy, "perception is real, and stress kills." He noted an uptick in referrals for behavioral health for treating conditions relating to depression and anxiety as patients struggled with constant news of raids, detentions, and deportations alongside personal experiences of traumatic border crossings and family separations. Although Dr. Carrera articulated his own perspective of patients' perceptions, the cause of these material impacts seemed clear to him. The clinic's funding structures and institutional culture had not changed in relation to noncitizen patients, but the political climate around them had, and so he inferred that the latter was to blame for the changes he was witnessing.

Dr. Carrera also conveyed that providers were struggling to serve their patients as their health care options narrowed and their confidence in the security of Medicaid enrollment was shaken upon the public charge memo's leak shortly after the inauguration. This exacerbated provider burnout – already high in the safety net – as the disciplinary regimes governing undocumented immigrants began extending to clinic spaces to constrain their already challenging work and potentially enroll them in the very medical legal violence they had been trying to treat. They perceived that the tools they once used to provide care might, in the hands of the Trump administration, become a potentially efficient technology for expanding medical legal violence.

When I spoke with pediatrician Dr. Green in July of 2018, she reported that several families had recently come to her in distress after their administratively closed immigration cases were

suddenly reopened (an increasing occurrence after then-Attorney General Jeff Sessions curbed administrative closure a few months earlier):

> I think they really thought their immigration stuff was behind them. I had two kids that I scheduled for acute behavioral health support because they were in my office tearful and having panic attacks because their mom was potentially going to be deported in two weeks. And the case had been closed.

Dr. Green described how anxiety over policy uncertainty was "percolating" through the whole community and getting picked up by patients and their families in embodied ways. Clinics stepped up their mental health services in response to the Latinx community's rising sense that things were changing and that Coral County would not be immune.

While I cannot speak to the experiences of fearful patients who avoided the clinic – and therefore remained beyond my sample – my conversations with several patients confirmed clinic workers' perceptions of mounting fear and anxiety. A legal permanent resident who had recently undergone colon cancer treatment told me how he now warned undocumented friends and family to take precautions, and he showed me the copies of the many immigration documents he carried with him everywhere he went. It was a practice he began only after the Trump administration announced their immigration enforcement priorities. An undocumented patient awaiting a liver transplant also told me he heard rumors that the Trump administration had increased immigration enforcement activities nearby because of reprisals against "sanctuary" jurisdictions and that state Medicaid might be cut as a penalty. He asked Elizabeth – the clinic worker who I observed in 2016 telling the Central American asylum-seeker that she had nothing to fear from immigration authorities if she had committed no crimes – what would happen with his liver treatments if he could not get state-funded Medicaid. By 2017, Elizabeth's response had apparently become more guarded. "She says, 'I don't know'," the patient recounted, "'there's nothing I can tell you.'"

By June 2018, there was widespread outcry over the Trump administration's family separation policy as a deterrent to unlawful entry, and Dr. Carrera asked me to refrain temporarily from patient interviews. It had been nearly three years since eligibility supervisor Olivia raised the hypothetical possibility of political changes affecting the clinic and its patients, and I spoke with her again that summer to understand the impacts of these proposed policies. Olivia told me that noncitizen patients were now much more reluctant to apply for state-funded Medicaid, "even if they're really sick, because they're afraid not only of what can happen to them, but what can happen to their families." She said it was nearly impossible to assuage patients' fears now because even the clinic workers had lost confidence in the process. Olivia no longer felt certain that noncitizens' enrollment forms merely sat on a shelf at the county Medicaid agency and now worried that "anything could happen" if anyone got ahold of those forms for immigration enforcement purposes. "Now when we talk [to noncitizen patients]," she explained, "we say we don't know, that we can't guarantee anything."

Olivia illustrated the potential consequences of this change by describing the case of a gravely ill Central American patient, Marta. Marta had told clinic workers that immigration agents warned her when she entered the U.S. recently (with a then-valid tourist visa that had since expired) that they would be watching her and would find out if she used any benefits while in the country. Olivia said this startled Marta, who was now being seen at the clinic for a life-threatening condition involving her stomach and liver. Marta told her physician that she was afraid of being deported or having her family members exposed to immigration enforcement if she applied for Medicaid. Marta's physician replied that she would advocate for Marta and write a letter to immigration officials to impress upon them how urgently she needed surgery, but clinic administrators agreed with Marta that bringing attention to her illicit presence was too risky under the present immigration

enforcement climate. I asked Olivia what would happen to the patient without the surgery. "Probably she will die," Olivia replied. She said the clinic would continue to look into other options for Marta, such as hospital charity care, but the waitlists were dangerously long given Marta's situation. "Now we're getting a little disheartened," Olivia remarked, "because we can't do the work like we used to before."

CONCLUSION

Given the Trump administration's position regarding health and immigration policy, it is unsurprising that the 2016 election changed the nature of noncitizen health negotiations in a particularly progressive region of the U.S. Political uncertainty has become widespread across the country, but the case of Coral County illuminates particular facets of this disquiet that have immediate vital consequences, as well as *how* such uncertainty affects clinical care. Prior to the election, clinics in Coral County had leveraged the local medical-legal bureaucracy of Coral County for noncitizen patients despite federal exclusions. Through sophisticated documentation at the county level, noncitizens obtained health care not only through federal Emergency Medicaid, but also the more comprehensive state-funded component. Coral County clinics used the progressive politics of the region to work around legal violence at the federal level on the basis that health was a priority that must not be limited by political citizenship.

After the election, however, clinic confidence in these processes rapidly disintegrated. The realization that health care could well become a site of federal immigration enforcement undermined their trust in the safety of clinics and medical records. This fear was less a matter of ICE physically entering clinics and more a recognition that the medical and legal documentation that once served their patients now appeared to clinic workers (as it already had to clinic patients) as a ready tool for biopolitical surveillance by an increasingly panoptic administration.

Clinics braced for the looming public charge rule change and stopped guaranteeing patients' safe Medicaid enrollment. Patients continued to face life and death decisions, and clinics still provided valuable care, but they had to do so without the benefits of public pathways.

The concept of medical legal violence uniquely illuminates how clinical care can be leveraged to maximize the legal violence of immigration laws that have operated to exclude immigrants from U.S. society for decades. The Trump administration did not create these laws, but it aims to optimize their exclusionary potential. The public charge proposal exemplifies this medical legal violence potential by using safety-net services aimed at basic biological wellbeing to discipline immigrant families. By including health care in the federal disciplinary regime of anti-immigrant governance, safety-net clinics and their noncitizen patients are subjects of a coordinated biopolitical strategy of medical legal violence. These laws frame the receipt of subsidized health care as a criminal use of services to which noncitizens are not entitled, and they aim to permanently disenfranchise immigrants on that basis. By providing legally sanctioned health care within the bounds of state health and immigration policy, Coral County clinics – and immigrant-serving clinics in similarly progressive regions – must now consider how coordinating care for gravely ill patients through Medicaid may contribute to that very disenfranchisement. The impulse to do no harm puts clinics in a contradictory position as they balance treating the biological consequences of medical legal violence against the possibility of reproducing its exclusionary potential.

Chapter 3: Plate Tectonics and Torque: Immigrant Health Topographies in Chapulin County

INTRODUCTION

Heart-wrenching choices, body-wrenching policies

On December 6, 2018, U.S. Customs and Border Patrol agents encountered approximately 163 migrants crossing the border in a remote area of New Mexico (DHS 2018). Among them was a seven-year-old Guatemalan girl named Jakelin Caal Maquin who Department of Homeland Security (DHS) officials claimed had gone without food or water for several days. She began having seizures shortly after she and her family were taken into DHS custody and was airlifted to El Paso, TX, for emergency treatment (DHS 2018, Simon 2018). Jakelin died within hours, reportedly from septic shock. DHS Secretary Kirstjen Nielsen admitted that this tragedy was "heart-wrenching" yet stressed that the responsibility lay not with her agency but with the migrants themselves. "This family chose to cross illegally," she said. "They were about 90 miles away from where we could process them. …We cannot stress how dangerous the journey is when migrants come illegally" (Oprysko & Hesson 2018).

DHS echoed Nielsen's sentiment in a statement regarding Jakelin's distress and death, which was posted to Facebook in response to public outcry (DHS 2018):

> As we have repeatedly said, traveling north illegally into the United States is extremely dangerous. Drug cartels, human smugglers and the elements pose deadly risks to anyone who attempts to cross the border illegally… Please, we are begging you, present yourselves and your children at a port of entry and seek to enter legally and safely.

Such messages literally implore migrants to avoid the dangers of crossing outside of legal ports of entry while simultaneously placing the blame for "heart-wrenching" consequences on incautious migrants and the cruel human and non-human foes they will encounter in the northward journey. What such statements omit, however, is the intensive militarization that such points of entry had experienced over the previous few months prior to and immediately after the

2018 midterm elections amidst the administration's claims of an impending migrant "invasion" (Grinberg & Castillo 2018). They also obscure the legal violence (Menjívar & Abrego 2012) and administrative violence (Spade 2015) that extend beyond the physical border to delimit firm categorical boundaries between U.S. citizens and noncitizens once migrants become immigrants in America.

The recent tragedy of Jakelin's death – one which would be repeated only days later when a young Guatemalan boy also died of illness in DHS custody – reveals that the situation facing contemporary migrants from Central America and Mexico is a Catch-22, in which avenues to legal entry or presence in the U.S. are systematically narrowed or blocked while at the same time laws increasingly criminalize those who enter or stay in the country in conditions of illegality and/or liminality. For decades, the U.S. government has stressed the need for immigrants to "get in line" and wait their turn, while simultaneously foreclosing opportunities for legal migration and civic inclusion – particularly for migrants from Latin America (Obama 2014, De Genova 2014). The ensuing criminalization of immigrants whose presence has become illicit by virtue of shifting legislative priorities has been the predictable result of U.S. foreign policy in the Americas alongside domestic policies that expand the illegality of many migrants coming to and residing in the U.S. Below, I discuss the health consequences of this crimmigration for noncitizens' health at a time of heightened policy uncertainty.

Injurious Assemblages

In the previous chapter I discussed how the legal violence (Menjívar & Abrego 2012) of exclusionary immigration laws collides with medical bureaucracies to create synergistic medical legal violence that disciplines immigrant patients and the clinics that serve them. In this chapter, I apply the notion of medical legal violence to the case of a so-called "red state" with a modern

history of anti-immigrant policies and aggressive immigration enforcement. The story of "Chapulin County" illustrates the consequences of constant, widespread surveillance and intimidation of Latinx immigrants (and anyone who looked to law enforcement like a Latinx immigrant)[6] and traces how such policies drive people, like young Jakelin and her family, to life-and-death decisions beyond the border dramas that capture our attention. Below, I contextualize the unique configuration of local and state policies in Chapulin County in relation to federal policies and theorize the imbrication of these policies, noncitizen patients, and health and law enforcement agents (i.e, doctors, benefits eligibility workers, sheriffs, ICE workers) as an assemblage through which medical legal violence operates to delimit these decisions. Through interview and ethnographic data, I identify the mechanisms that constrain the scope of noncitizens' health potential in the U.S. on ever narrowing terms. Importantly, although the Trump administration did not create these mechanisms, these examples demonstrate how it has capitalized on their exclusionary potential and found ways to expand the incorporation of vital services in federal immigration governance.

In addition to identifying the various actors, policies, and places involved in the assemblage of medical legal violence, the concept of assemblage is also helpful in illuminating the embedded infrastructures that subtly scaffold the conditions of possibility for immigrant health in Chapulin County. In their analysis of classification systems, Bowker and Star (1999) suggest a topographical approach that accounts for the dynamic nature of systems that we usually consider to be fixed grids, urging "a plate tectonics rather than a static geology" (Bowker & Star 1999, 33). Such a topographical approach aligns well with Deleuze and Guattari's (1987) rhizomatic articulation of assemblage as something that is neither linear nor hierarchical but

[6] See Asad & Clair (2017) regarding Racialized Legal Status. Also note that one of the main provisions struck down in Law X was its tendency toward racial profiling of people of color throughout the state.

"always in the middle" and constantly in motion (Deleuze & Guattari 1987, 25). Such an approach suits one of the most problematic aspects of this dissertation: how to map the topography of immigration biopolitics in the U.S. when they seem to shift daily?

While Bowker and Star (1999) do not speak directly of assemblages, their topographical method illuminates the often-invisible work of embedded bureaucracies and infrastructures in constraining human lives. They examine particular cases "where the lives of individuals are broken, twisted, and torqued by their encounters with classification systems" that can be every bit as effective in constraining human potential as Weber's "iron cage of bureaucracy" (Bowker & Star 1999, citing Weber 1905/1930, 28). They caution that "iron cage" may not adequately capture systems' ability to stretch and bend to constrain individuals and families, emphasizing that systems' *flexibility* is all the more violent because of how it forces people to contort to fit in spaces meant to exclude them. Bowker and Star (1999: 30) refer to this contortion as "torque":

> [Torque is] a twisting of time lines that pull at each other, and bend or twist both patient biography and the process of metrication. When all are aligned, there is no sense of torque or stress; when they pull against each other over a long period, a nightmare texture emerges …biographies and categories fall along often conflicting trajectories. Lives are twisted, even torn, in the attempt to force the one into the other.

While it is true that Weber's metaphor of the cage does not adequately capture the flexibility and movement of the assemblage by which medical legal violence torques patients' bodies and lives, it uncannily evokes the material consequences of the bureaucratic misalignment of noncitizens' medical eligibility and their health needs. The end aim of the exclusions I refer to here, and in other chapters, is both a literal and a metaphorical cage. Sometimes, it is a physical cage of indefinite detention on the way to deportation. Other times it is a symbolic cage – for example, being trapped in exploitative labor conditions without hope of social or political inclusion to remedy such conditions (see Chapter 4). Regardless, the classification system itself remains

oriented toward ever-greater exclusion and ever fewer opportunities to make it through the shifting strata of belonging in one piece.

Scholars have highlighted the ways in which immigration and health legislation have historically excluded millions of undocumented, liminally legal, and legally present immigrants in the U.S. (Menjívar 2006, Menjívar & Abrego 2012, Golash-Boza 2016) and negatively shaped immigrants' health chances in the U.S. (Quesada *et al.* 2011, Castañeda *et al.* 2015, Marrow & Joseph 2015, Joseph 2016, Philbin *et al.* 2017, Van Natta *et al.* 2018). Less is known about the contemporary consequences of these converging exclusions under the uncertainty and polarization of the Trump administration. In this chapter, I present evidence from ethnographic observations and in-depth interviews with 32 patients, clinic providers, and community partners to argue that the convergence of immigration and health policies in the late 20th and early 21st centuries has assembled a topography of unevenly overlapping, constantly shifting, and mutually reinforcing ineligibilities that constrain immigrants' wellbeing in the U.S. and delimit the boundaries of citizenship on ever more exclusionary terms.

Chapulin as Assemblage

When it comes to noncitizens' wellbeing, one of the major differences between Coral County (a progressive, immigrant-inclusive blue state site) and Chapulin County (an immigrant-exclusive red state site) is the particular assemblage of state and local institutions, policies, and actors that have shaped patients' and providers' healthcare negotiations. While both sites have been subject to exclusionary federal health and immigration policies, statewide immigrant policies in Coral County have tempered these federal exclusions in many ways. The primary obstacle in negotiating care for noncitizen patients there is getting the local arms of federal health agencies – such as county Medicaid offices – on board with clinics' inclusionary

strategies. While it is true that Coral County patients in this study sometimes expressed concern over local law enforcement practices (e.g., the fear of being pulled over by police while driving), they more often worried about federal immigration enforcement in the form of ICE apprehension (such as through a workplace raid). Coral County clinic personnel therefore focused on collaborating with local health agencies to fit as many people into service eligibility as possible rather than contending with the effects of local law enforcement activities. Even the possibility of ICE incursions into clinic spaces – which raised alarm among clinics in the region – had to do with a *federal* agency at odds with local sanctuary policies. In other words, clinics and their patients focused primarily on negotiating health services by engaging with local health agencies.

In Chapulin County, on the other hand, the synergy between local law enforcement and federal immigration enforcement agencies has more forcefully shaped noncitizens' wellbeing and health potential. This local-federal partnership constrained options for noncitizens to attend to their health under threat of enhanced surveillance and racial profiling. Additionally, unlike in Coral County, state-funded, full-scope Medicaid was not available to noncitizens in Chapulin County.[7] As participants made clear, Emergency Medicaid in Chapulin was reserved for cases *"de vida o muerte"* ("of life or death"). The assemblage in which life and death choices played out for Chapulin's noncitizen patients thus included many of the same components as that of Coral County – including federal immigration policies, clinical spaces, Medicaid documentation, etc. – but were arranged differently and in tandem with disciplinary elements that were unique to that red state during recent years. To illustrate the vital consequences of this assemblage, I illuminate in this chapter the novel associations among government, noncitizens, physical terrain,

[7] In certain cases of clear medical need, such as childbirth or trauma surgery, noncitizens could qualify for federally funded Emergency Medicaid (just as in Coral County).

and medical and legal bureaucracies that have coalesced in 21st Century Chapulin County to transform immigrants' wellbeing there.

This chapter focuses on 1) the assemblage of actors/actants, policies, practices, and moments of controversy and uncertainty in contemporary immigration and health policy that have enabled a recent expansion of medical legal violence in Chapulin County, and 2) how this assemblage torques noncitizen patients in search of health. By concentrating on the assemblage through which noncitizen patients and their providers negotiate vital issues in Chapulin County, I demonstrate how medical legal violence forces some noncitizens into dangerous spaces of liminality that result in delayed care, medical crises, and life-and-death decisions. Among the human actors implicated in this assemblage are immigrant patients, federal and county agency personnel, lawmakers, and clinic workers. Among the non-human actants are the border, "papers" (legal documents, medical records, *et cetera*), and disembodied laws that appear static and inevitable. The effects of the border politics that harm people like Jakelin Caal Maquin do not end once someone crosses the physical boundaries between nations. They continue in the ongoing medical legal violence produced by the assemblage of policies, practices, and infrastructures that often push noncitizen patients into protracted conditions of endangerment.

FINDINGS

Medical Legal Violence as Cause and Consequence

The story of this particular assemblage of overlapping exclusions that "torque" present-day noncitizen patients into precarious health situations begins in 1994, when U.S. Customs and Border Patrol (CBP) adopted a comprehensive strategy to embrace "prevention through

deterrence".[8] This involved increased Border Patrol funding and personnel and diverting immigrant entry routes through terrain that was so inhospitable that people would not dare cross it (Dunn 2009, De León 2015, Macías-Rojas 2016).[9] Yet the effects of this "prevention through deterrence" strategy do not end once someone crosses the border. They remain very much at play in federal public benefits strategies – such as the 1996 welfare and immigration reforms I mentioned in the dissertation's introduction – once individuals and families try to build their life in the U.S. In this way, immigration and health laws increasingly push undocumented immigrants into dangerous situations by excluding them from health care.

The contemporary assemblage of medical legal violence in the U.S. functions similarly to the desert borderlands in that it demands that noncitizen patients and mixed-status families traverse an uneven, treacherous bureaucratic terrain with few hospitable points of entry. Sometimes and in some places these points of entry – such as Medicaid eligibility – broaden to include more individuals (as in Coral County before the 2016 election), but more frequently they narrow. Whether a noncitizen patient facing a health crisis finds medical help in this metaphorical desert depends largely on the federal immigration climate and local will to aid or hinder these negotiations.

[8] Prior to this time, immigration policy in relation to Latin American migration alternated between periods of greater and lesser exclusion, including a temporary "amnesty" in 1986 that enabled approximately 2.7 million migrants to adjust their status (get a green card) within an 18-month period (Plumer 2013).

[9] Anthropologist Jason De León has documented the geographic contours of this assemblage in brutal detail (De León 2015). De León analyzes the human and nonhuman actants whose "complex relationships at different moments across time and space … sometimes create things or make things happen" (De León 2015, 39). He stresses the way in which the desert has become a key actant in U.S. immigration policy as avenues to legal residence and naturalization diminish, particularly for Latin American immigrants. De León uncovers the human cost of driving people through dangerous landscapes as a strategy that both effectively limits the number of successful "illegal" border crossers (in that thousands die each year en route) and – as in the case of Jakelin Caal Maquin – absolves federal immigration agencies from blame over those deaths.

As I mentioned in Chapter 2, the Trump administration's recent proposal to enhance the 1996 welfare and immigration restrictions by expanding the types of public benefits use that would render immigrants inadmissible on the basis of "public charge" explicitly signaled a more hostile federal immigration climate.[10] Thus at the same time that the federal government is garrisoning the southern border and enlisting the desert as an ally to deter migrant entry, federal health and welfare agencies are likewise creating new boundaries to discredit noncitizens and mixed-status families who are already within its borders. For undocumented immigrants in Chapulin County and their healthcare providers, living in a border state where anti-immigrant policies converge with an expanding federal health bureaucracy has created a situation of intense medical legal violence. Undocumented immigrants' citizenship and health potential are thus being squeezed through constantly shifting, ever narrowing pathways to eligibility into constricting spaces where life-and-death decisions must be made.

This analysis follows the dynamic, time-bound associations of human and non-human actors in the spaces where they collide and traces the work these associations do in shaping health possibilities. In this case, certain human actors (notably U.S. politicians) have sought refuge behind the supposed intransigence of U.S. immigration law, suggesting that it operates as somehow separate from humans, doing work of its own accord and determining the flow of action and conditions of possibility for immigration reform (or lack thereof). While it is true that Democratic administrations have developed and expanded some of the most harmful immigration laws on the books, accelerated rates of deportation, and expanded biometric

[10] Historically, this has referred to the likelihood that an immigrant will become a burden to American taxpayers through their excessive use of public benefits. Currently, the use of government cash assistance programs and/or long-term institutional care can count against immigrants attempting to acquire permanent legal residence (Federal Register 2018). The proposed rule would add certain health care, housing, or nutrition assistance benefits to the list of grounds for immigrant inadmissibility.

surveillance of migrants (De Genova 2014, USCIS 2008), the Trump administration has leveraged existing laws and cunningly adapted them to a "zero-tolerance" regime. The legal framework has long been in place, and few political leaders seem willing or able to dismantle it. In that void – where legislative action appears impossible, judicial action mercurial, and executive action bewildering – immigrant patients have to make life-altering decisions amidst panic, uncertainty, and fear.

In many ways, Chapulin County is an ideal case study of expanding medical legal violence because it illustrates the conditions under which vital exclusion may be maximized through the concatenation of medical bureaucratic expansion (through the implementation of the ACA), the criminalization of Latinx immigrants through local law enforcement practices, and the magnification of federal anti-immigrant policies through local interpretation and collaboration. First, Chapulin includes a major urban core while also encompassing several rural and remote areas, and is relatively close to a treacherous stretch of desert on the U.S-Mexico border. Second, Chapulin County is also located within a state that not only favored Trump in the 2016 election, but also has a history of anti-immigrant policies at state and local levels. Indeed, these policies make Chapulin County a standout example of open hostility toward immigrants and thinly veiled racism toward Latinx individuals.

Finally, Chapulin is a significant case study because, unlike several other "red" states, the state's governor decided to expand Medicaid through federal funds provided via the ACA. Following massive budget cuts that squeezed many residents out of insurance coverage and furloughed many healthcare workers following the 2008 recession, the ACA revived the state's safety net and expanded Medicaid coverage for its nearly half a million residents (Healthinsurance.org 2018). This included thousands of residents of Chapulin County, the most

populous county in the state (U.S. Census Bureau 2017). While undocumented immigrants and legal permanent residents living in the country for less than five years remained excluded from this expansion, it nevertheless extended Medicaid's bureaucratic reach in Chapulin County. Yet while this expansion benefitted Chapulin's low-income citizens and bolstered its community clinics, this transformation also penalized undocumented residents and mixed-status families through Medicaid's new federal documentation requirements and growing public benefits exclusions.

Exacerbating such exclusions was Chapulin County's location within one of several states that enacted omnibus immigration bills during the first Obama administration (NCSL 2012).[11] (For the purposes of this chapter, I will hereafter refer to the statewide omnibus immigration law affecting Chapulin County by the pseudonym "Law X"). The majority of these bills were modeled after Arizona's SB 1070, which included provisions such as requiring law enforcement agents to inquire about someone's immigration status during a lawful stop, enabling state residents to sue local and state agencies if those agencies did not comply with federal immigration enforcement laws, mandating the use of E-Verify technology for employment, penalties for failing to carry alien identification and registration, and requiring schools to verify students' legal status (Arizona State Senate 2010, NCSL 2012). Despite these laws' popularity with anti-immigrant hardliners, the U.S. Department of Justice eventually overruled many of these provisions due to their broad unconstitutionality and propensity for racial profiling (DOJ 2012).

[11] An **omnibus** bill encompasses a wide range of (often unrelated) issues, all packaged into one document that the legislature considers as a single vote. For example, Alabama's HB56 (signed in June 2011) "addressed a range of topics including law enforcement, employment, education, public benefits, harbor/transport/rental housing, voting and REAL ID" (NCSL 2012).

In addition to omnibus immigration action at the state level, sheriff's offices at the county level had significant autonomy over the degree to which they interacted with federal immigration enforcement agencies. County and municipal law enforcement agencies were empowered to collaborate with federal immigration enforcement agencies through §287(g) of the Immigration and Nationality Act and the Secure Communities Program (mentioned in this dissertation's introduction), which enabled the sharing of biometric data on apprehended immigrants across law enforcement agencies, including DHS and the Federal Bureau of Investigation (FBI). This Secure Communities program was launched in March 2008 under the Bush administration but suspended during the second Obama administration. On January 25, 2017, four days after Trump's inauguration, the program was revived – thus foreshadowing the direction immigration enforcement priorities would take in the years ahead (ICE 2018).

All of this meant that local law enforcement, particularly county sheriff's offices, long had the tools and mandate to participate in federal immigration enforcement. When combined with the state-level Law X, this expanded the conditions for harming noncitizens living in Chapulin County through geographic and bureaucratic "torqueing." At the same time, the ACA was expanding health care coverage to U.S. citizens and creating an extensive bureaucratic infrastructure – including new documentation requirements for Medicaid eligibility. Through the strange collision of anti-immigrant and pro-health policies, a tectonic shift in the biopolitical topography of Chapulin County occurred. As the ground shifted beneath the feet of noncitizen patients and the clinics that served them, many individuals and families fled the county or risked being torqued by expanding medical legal violence.

"These are not normal times for us."

In June 2018, I met Dr. Young, the medical director of a free clinic that served a large undocumented immigrant population, located in an urban area of Chapulin County. Dr. Young had clinical and research experience in border health transformations over the past two decades of U.S. immigration policy. In fact, Dr. Young had done a hospital chart review on the period from the early 1990s through the early 2000s and tracked how trends of cancer and chronic illness treatment gave way to more traumatic injury cases as immigration enforcement ramped up during that time, including forcing people through more dangerous routes and having to face extrajudicial anti-immigrant practices, such as trenches dug by the Minutemen[12] opposite high border fences. He brought up all of these points during an interview over lunch in the clinic's cafeteria, saying:

> So [the Minutemen] made the fences higher … They dug trenches on our side of the border where the fence was to make it a further drop. …I'd be reading a chart and it would be a 65-year-old lady who jumped off this 13-foot fence into a 5-foot trench and broke both [her legs] that were open [fractures], and now she can't walk or do anything.

Dr. Young also recounted how a van had turned over in the desert while being chased by border patrol "in an area where cars really shouldn't be, and the van was not an off-road van, so it tumbled and eight people ended up with all these orthopedic things." The hardening of the southern border created a new category of noncitizen trauma patients arriving in ambulances. Dr. Young stressed that the policy change had "overwhelmed" the emergency rooms now that acute trauma cases were outpacing what had previously been a contained situation of transborder elective procedures and chronic care management.

Dr. Young was one of the few providers I spoke with (in either state) to locate patients' health negotiations within the broader historical arc of immigration enforcement policy in the

[12] The Minutemen are vigilantes who organized in 2004 to oppose illegal immigration through direct action at the border and political lobbying for intensive immigration enforcement measures (Doty 2007).

U.S. But while Dr. Young's experience highlighted the biological consequences of immigration policies that increasingly forced Latinx immigrants into acutely dangerous situations, not all of these effects involved direct injury through border militarization. Even as the physical boundaries between the U.S. and Mexico became more treacherous through prevention through deterrence strategies, the boundaries between citizens' and noncitizens' medical eligibility similarly hardened through the 1996 immigration and welfare reforms and subsequent exclusionary health and security laws. Unfortunately for the undocumented residents of Chapulin County, local lawmakers doubled down on these exclusions by enabling aggressive immigration enforcement and intimidation that undermined the health and wellbeing of Chapulin's immigrant communities. Providers and community leaders I spoke with also stressed more insidious incursions of local immigration enforcement into spaces of immigrant health and wellbeing well beyond the border. Many argued that the coalescence of local (e.g., Law X) and federal (e.g., enhanced border enforcement following 1994 and post-9/11 legislation) anti-immigrant policies and practices made life in Chapulin riskier for Latinx individuals and families long before the 2016 election.

Several participants (providers and patients alike) even recalled the ways in which relatively recent state and local anti-immigrant policies forced many Latinx individuals and families out of Chapulin County altogether. Leticia, a behavioral health provider specializing in child and family wellbeing, had been a leader of a prominent Chicano community organization in the state for forty years, but Law X shook her organization to its core. For the first time in her career, she found herself teaching three- and four-year-olds what to do if they encountered an immigration enforcement vehicle in their neighborhood or in front of their house. With a mixture of anger and incredulity, she described the situation to me:

> What we sadly had to face was the reality of having to train our children how to manage and navigate [parental detention and deportation]. So we had big sessions with families and their children to show them what a border truck, you know the green trucks, look like. … Where do you go when you come home and the bus is dropping you off and you see that there is one of those cars over at your house, what do you do?

Leticia also explained that the broader community organization for which she worked operated about 3,000 multifamily units in those years, which meant she witnessed how "overnight we had keys left in the boxes or in the doors or on the counters, and families just fled." Even though her organization never asked for any identifying information from those they supported, clients told the organization workers that they were scared.

Leticia highlighted the sheriff's office's role in traumatizing the local Latinx community through intimidation and racial profiling. "They were just pulling people over," she said. "The profiling that was denied [by the sheriff's office] for all those years was evident in our black and brown family environment." As a behavioral health provider, this meant that Leticia was dealing with traumatized children who did not know how to articulate that trauma:

> Think of yourself, an adult, right? You get, you have a trauma that affects you, you get an upset stomach, you get a headache, you get anxious. Now visualize that with an eight, nine, thirteen-year-old kid, right? The eight and nine-year-olds probably don't even know how to explain what's going on physically but the 13- and 14-year-olds may act out aggressively. That's how they display that anxiety.

Like other providers (and one state legislator) whom I interviewed in Chapulin, Leticia remembered schools closing during that time as students disappeared with their family. "In all that time [of Law X], we're thinking to ourselves … what's the message? What's the right thing to be saying to our families right now?" she reflected. "It was just so overwhelming at the time and still when I think about it, I can't believe that we lived through it." Leticia stressed that those were "not normal times for us." Without skipping a beat, she added, "And they still [in 2018] are not normal times, federally."

Like Leticia, clinic patient Noemy also vividly remembered when times became "not normal" in Chapulin and worried about the ways in which federal policies after the 2016 election were beginning to mirror those traumatic times in Chapulin. I met Noemy at Dr. Young's free clinic, where she had first come in for a routine pap smear and was now meeting with staff to transition to a more long-term clinic at one of the regional Federally Qualified Health Centers (FQHCs). Noemy shivered in the clinic conference room where we met, in part due to the blasting air conditioning and in part, it seemed, because she was recalling a particularly traumatic time for her family. She and her family had been living in Chapulin County since 2003, when they came from Mexico striving to make ends meet. Things were stable until Law X was passed:

> When that [law passed], I returned [to Mexico] because of the fear… and I said, 'What if … they catch me, and my little girls? … They are so small, if they get me – because with that law, even if they saw you walking in the street and saw that just because you were Latino, they were going to detain you.

Noemy could not bear thinking of what would happen if she were detained and separated from her children. Between the sheriff's federally-sanctioned collaboration with ICE and DHS through Secure Communities and the clear message from the state legislature that Latinx residents (legal or otherwise) would not be allowed to go about their lives in peace, she decided to return to Mexico with her whole family.

Realizing that they could not make ends meet in Mexico, Noemy and her husband eventually returned to Chapulin County. Many of the provisions of Law X had been challenged in court by then, as had local law enforcement leadership, and Noemy hoped that the changes would bring better days for her family. Still, she could not shake the feeling that she had made a huge mistake in leaving the U.S. in the first place. "We got so nervous that, maybe instead of doing the right thing, we did the wrong thing." Noemy struggled to justify the decisions she had made for her family when uncertainty turned to panic, such as leaving one daughter behind in

Mexico because their constant fear and movement had foreclosed her chance for DACA. Looking back, Noemy wondered whether they should have tried to stay through the hard days. As uncertainty surged again after the 2016 election, Noemy wondered what would happen now that – from her point of view – Chaupulin's former immigration priorities seemed to have become national policies under the Trump administration. "We'll wait to see what happens," Noemy mused. "It's all that's left for us to do."

Providers and clinic workers also told me that, during the heyday of Law X, local law enforcement sometimes increased their presence near hospitals and mobile clinics to intimidate immigrant patients and prevent them from seeking care.[13] Clinic workers recalled seeing sheriffs' and ICE vehicles parked outside of healthcare facilities. Many recalled patients having to make difficult decisions during Law X's full enactment, as the collision of federal and state immigration laws forced undocumented immigrants into more precarious situations and raised the stakes of everyday decisions – such as what to do in the event of a medical emergency. An outreach worker from a large FQHC described the "huge struggle" the clinic faced during those years. **"**We lost so many people on [Medicaid], so many children on [Medicaid] … when [Law X] came out," she remembered. "It was so horrible. It took some time. It took at least a year and a half to start getting people to start trusting and getting back on it." One county hospital administrator told me they nearly had to close their facility because so many of their patients suddenly disappeared. Whether they left Chapulin or merely went into hiding locally, she could not say, but it was clear that they did not feel safe seeking health care.

[13] These activities contravened DHS' 2011 memorandum on "sensitive locations," which held that immigration enforcement activities would only occur near locations such as schools, churches, and hospitals in exceptional cases. Reports from communities suggest that such "sensitive locations" are increasingly subject to immigration enforcement activity (Burnett 2017).

One nurse I spoke with, Maya, worked at a County Emergency Department during the peak of Law X and noticed "a lot more hesitancy" among immigrant patients to seek health care in those years. One case in particular stood out in her mind:

> I had a woman come in and was having a heart attack. We didn't know at the time, but she had every other symptom in the book, and she just did not want to step into the ER. She was outside and her daughter, who had citizenship, came in and said this is the situation. I was on triage that day, so I kept telling her, 'It's okay.' I even went out there to communicate with her, 'It's okay. You can come in. We will treat you. We will do what we need to do.' 'Yeah,' [she said], 'but what happens if I get admitted and then if I get a doctor that just doesn't support my status …' All these worries were preventing this woman who was full on having a heart attack from coming in.

Maya explained that in order to persuade the patient to cross the threshold from the parking lot into the Emergency Room, she had her supervisor come out and offer to admit the patient as a Jane Doe. "If us putting you in as a Jane Doe makes you feel any different, which for some patients it did, we would do that," Maya recalled. Such a workaround – invoking the protective anonymity of "Jane Doe" for fearful noncitizen patients in crisis – highlights the complexity of navigating the overlapping exclusions of Chapulin's contemporary biopolitical assemblage.

Another nurse, who was also an administrator at the county hospital, witnessed sheriff vans parked outside her building during the time of Law X, and their labor and delivery service numbers dropped as people moved away or went into hiding. She recalled patients' fears vividly, especially when it came to medical paperwork:

> [We'd ask] in Spanish or even in English, 'Do you have your papers?' And what we were talking about is their prenatal [labs] ... They were thinking we were talking about their legal paperwork. So they would start turning, walking away. 'No, no, no,' we'd have to tell them. 'No, no, no, not those. We don't care about that. We're here to take care of you, we do not care [about your legal status].'

Nursing providers' realization that such a seemingly innocuous bureaucratic term – "*papeles*" – could so terrify patients emphasizes the symbolic violence of the biopolitical assemblage of Chapulin County in recent years. There is nothing inherently charged or noteworthy about the

word “papers”, but this particular assemblage imbues it with discursive power and injurious potential in relation to noncitizens facing a health crisis.

“De vida o muerte”: Medical Legal Violence, Difficult Decisions, and Torqueing Bodies

Even though times had been hard before the 2016 election, with a brief reprieve after the DOJ took the teeth out of Law X, when I conducted fieldwork in mid-2018 there was a growing sense that Chapulin – and the country at large – might be returning to darker days of enhanced immigrant surveillance. This perception was driven by 1) a maelstrom in English- and Spanish-language media around family separation drama at the border in the summer of 2018, and 2) new bureaucratic hurdles to charity care enrollment involving mandatory Medicaid applications.

In June 2018, I spoke with Dr. Francis for a provider’s perspective on the recent political tumult. Dr. Francis was the medical director of a small free clinic in Chapulin County similar to Dr. Young’s, and she spoke about how difficult it had been to get specialty care for undocumented immigrants in the county over the four years that she had worked at this particular clinic. Dr. Francis was used to bureaucratic barriers to noncitizens’ health but had noticed new barriers to care that complicated her efforts to pave pathways to services. Recently, while navigating one of her noncitizen, uninsured patients through the usual medical-legal bureaucratic hoops to get a thyroid biopsy at the county hospital, Dr. Francis discovered that the county was now requiring that all patients apply for Emergency Medicaid before ever having a financial eligibility interview for charity care. This meant that they could not finance care without making themselves legible to a federal agency (see also: Asad 2019 on federal legibility and “system embeddedness”). Previously, when non-acute noncitizen patients would meet with a financial counselor at the hospital to finance care, many who were ineligible for Medicaid or reluctant to

apply for government benefits would apply for charity care or work out a payment plan in installments. Now, everyone had to apply for Medicaid first. Only once they were denied could they move forward with financing or charity care applications.

Dr. Francis explained that these bureaucratic hurdles were a new development, and that they fit the trend of growing barriers that emerged since the Trump administration began. These barriers were making it much harder for her to get undocumented patients the care they needed, and the obligatory Medicaid application exacerbated the situation. "I think that undocumented [patients] are scared to do that application," she remarked, "because obviously the government will now know they exist by having that application online." She added that many of her patients were working through their pain and avoiding hospitals, waiting until their conditions got out of control and the emergency room was their only option. Even though many of her patients showed up to her clinic acutely ill and in need of emergency services, they would not risk going to the hospital. "I tell them that they will get treated," she added, "and that they will not be deported for going to the emergency room, but they never go." She recalled a particular patient whose brother and son had already been deported, "so he won't go near anywhere." Dr. Francis continued, saying:

> A lot of our patients will just wait until they're on death's door, and they don't realize that when they go to the emergency room, that they will actually get treated, and that there's the possibility of getting on Emergency [Medicaid] there. So they just don't ever go to the hospital because in their mind they can't get treated because they're undocumented.

Even if a noncitizen patient could overcome the hesitation to apply for Medicaid and qualify for Emergency Medicaid in a "life or death" case, this situation by no means guaranteed adequate treatment. Nurse practitioner Marie, a wound care specialist I met at Dr. Young's clinic, told me that most of her immigrant patients were people who came in shortly after surgical hospitalizations. They needed follow-up care but were unable to afford it because they

were either uninsured or covered by Emergency Medicaid for only the "life or death" portion of their care. Marie expressed frustration that many of her patients' conditions were a direct result of delays in care due to lack of health access. She described how cancer patients, for example, usually received a late diagnosis when their cancer was already at a more advanced stage. And only when that cancer created an acute emergency – such as a bowel obstruction in the case of colon cancer – would Emergency Medicaid cover immediate treatment. "Of course [they] get their colon taken out and the cancer gets removed, but then they never get the post-op chemo radiation. That doesn't get done," she explained. Such incomplete clinical engagement is precisely how the biopolitical assemblage of contemporary Chapulin County disproportionately torques noncitizens in health crises. Intersecting exclusions perpetually force them into narrow spaces of eligibility that require patients to forgo or delay care in ways that twist and contort them until bodily injury is all but inevitable.

When I met Marie at the wound clinic, she was attending to patient, Guillermo, whom I had just interviewed (see Chapter 4). Guillermo embodied Marie's frustration with the way Chapulin's biopolitics disproportionately torqued noncitizen patients in Chapulin. Guillermo had undergone several toe and tendon amputations due to complications from diabetes, and he qualified for Emergency Medicaid because of his low income and need for regular dialysis following diabetic kidney failure.[14] With the exception of dialysis, however, Emergency Medicaid only covered acute hospitalizations – thus trapping Guillermo in a vicious cycle of morbidity. Without comprehensive insurance, Guillermo could not afford the prescriptions necessary to keep his diabetes in check, so he only received medication and insulin when he was

[14] In the U.S., treatment of end-stage renal disease (ESRD) is provided through Social Security Disability (SSDI) coverage – for which undocumented immigrants are ineligible. Some states have elected to define outpatient dialysis as an emergency service which can therefore be covered through Emergency Medicaid (Rodriguez 2015). This was the case for Guillermo.

hospitalized for grave diabetes complications. He also had to resort to ad hoc follow-up care at the free clinic rather than with a primary care provider or his surgeon. His inability to achieve a stable medication regimen or post-operative care meant he was frequently hospitalized, and his disability increased as this vicious cycle eroded his health.

Like some of the patients whose situations I describe below, Guillermo had to weigh the risk of illness/injury against the risk of detention/deportation when he became gravely ill. He was undocumented and had stayed "off the radar" for most of his life, and he was willing to apply for Medicaid not because he was unafraid of getting "in the system" but because he had a $210,000 hospital bill and no way to pay it. And the assemblage of immigrant-exclusionary practices and policies at the local and state level, overlaid by the federal terrain of noncitizen exclusions from economic and health spheres, created a hazardous topography that violently torqued Guillermo. While he was able to fit within the financial and biological eligibility requirements for Emergency Medicaid once his advanced diabetes brought him to the edge of death, the limitations of that coverage meant that he was (as I describe in more detail in chapter 4), literally and continually torn to pieces in the process.

"It's all in limbo… It's something that's a little unstable."

Of course, as Bowker and Star (1999) suggest, assembled topographies are not static but dynamic, shifting landscapes. This is why they propose a "plate tectonics" approach to classificatory systems, an approach I adapt here to my examination of the contemporary assemblage of noncitizen health potential in Chapulin County. While the general federal trend over the past twenty years has been toward greater exclusion of noncitizens from "normal" social spaces, there have been brief moments when the avenues to inclusion have broadened rather than narrowed. This was especially true when President Obama announced deferred immigration

action through the 2012 DACA and 2014 DAPA executive orders. These programs signaled a symbolic aperture in federal priorities toward some classes of noncitizens, and – in the case of DACA – hundreds of thousands of immigrants chose to come "on the radar" to reap the benefits of work authorization and deportation protections.

There are parallels between DACA and Medicaid in terms of the kind of risk/benefit decisions that Dreamers (as DACA-recipients have been called) and noncitizens facing health crises have had to make in recent years. Depending on the topography of federal immigration priorities at any given time, noncitizens who fear punitive immigration action must determine the conditions under which they are willing to become legible to federal immigration agencies (Asad 2019). These decision-scapes can be seen through examples of undocumented immigrants navigating a shifting federal topography of immigration policy that destabilized the assemblage of immigrant health in Chapulin County. The cases described below exemplify the difficult decisions participants had to make for not only themselves, but for their family members, with consequences that reverberated beyond the clinic. They illustrate the ways that noncitizens' wellbeing is often temporally and spatially determined in ways that sometimes seem cruelly capricious as they change from moment to moment, administration to administration.

I met the first of these patients, Javier, while conducting ethnographic observations at Dr. Young's free clinic. He had accompanied his 82-year-old father, Jacinto, to the clinic for prostate, heart, and blood pressure issues. Jacinto lived primarily in Mexico but had fallen ill while staying with family in Chapulin County. Although I had initially intended to speak with Jacinto, Javier interrupted frequently to explain things his father said and to add his own perspective. Soon Javier was speaking at length about his own experiences as an undocumented immigrant negotiating Emergency Medicaid services for himself and DACA for his three

children. For example, when he injured his legs once, Javier had to receive emergency care at the county hospital, which is where he was enrolled in Emergency Medicaid. He described what happened when he showed up in the Emergency Department with unspecified leg injuries. "They made me fill out some forms in which they tell you, 'You're going to take [Medicaid], yes? Okay,'" Javier recalled. "They fill out your forms … but you already took [Medicaid]," he continued. "Possibly it will cover [your treatment]. …But if you don't get it, obviously they'll send you a bill or they'll say, 'You owe however much. How can you pay it?'"

Despite Javier's suspicious nature and precarious legal status, he seemed to trust certain federal agencies when he perceived the immediate benefit justified the potential risk. This included his use of Emergency Medicaid, as well as his decision to enroll his three children in DACA before they graduated high school. The latter decision was made during the Obama administration at a time when Chapulin County was governed by aggressive anti-immigrant policies. Emergency Medicaid protected Javier's earning potential, and DACA bolstered his children's security in a space where it took very little to detain Latinx individuals (regardless of their legal status), so the risk-benefit calculation fell in favor of engaging with federal protections.

Our conversation took place in June 2018, at a moment when DACA's future was very much in doubt. This destabilization emphasized the temporary nature of federal benefits and qualified gratitude that Javier expressed, and it threw their capriciousness into relief as he and his family continued to live under the threat of them being taken away. When I asked Javier about his children's status, he replied that things had gotten "a little complicated" under what he referred to as Trump's "political reforms." He expressed gratitude for Obama's "benefits" but explained that it was hard to know what Trump was planning to do or what his vision was for

immigration. “Because he says one thing and then later another,” Javier said. One day the president might announce immigration reform, but the next, “‘You know what? Everybody out.’” “It’s all in limbo,” Javier continued. “That [Trump] could wake up tomorrow on the right side of the bed, or he could wake up on the wrong side and make one decision or make another decision. It’s something that’s a little unstable.” As Javier lamented:

> You can’t make plans… You [Ms. Van Natta, a U.S. citizen] can make plans, you can construct, build your plans, but [we] can’t because you don’t know what will happen to you tomorrow, and it’s something that makes you impotent, because you can’t reach your potential, you don’t give what you should, because you’re afraid…

Unlike fellow clinic patient Noemy, whose family was displaced by fear over immigration law uncertainty, Javier wagered on trusting the federal government during the Obama administration over risks at the state level in order to secure temporary legal and medical relief. Now that Chapulin’s politics seemed to have become national priorities under the Trump administration, however, Javier felt like his family’s precarious position even more acutely. Like Noemy, he felt paralyzed by doubt over how to proceed or what would happen now that his children were on a government register.

“When it’s an emergency, then we take that risk.”

The capriciousness of the plate tectonics of noncitizen healthscapes made it difficult for Chapulin County’s undocumented immigrants and mixed-status families to determine how to balance their health needs against the fear of becoming visible to the punitive arms of immigration enforcement agencies. As I described above, local law enforcement practices had long undermined the perceived safety of healthcare centers as “sensitive locations” by intensively promoting federal immigration enforcement to intimidate Chapulin’s noncitizens. This aggressive criminalization spurred many eligible undocumented immigrants – like Javier’s children – to pursue DACA when it became available, but it also made them feel vulnerable

when the Trump administration de-legitimated the program. And the symbolic shift away from inclusion toward enhanced enforcement against all "illegal" and liminally legal immigrants complicated the decisions of noncitizens in health crises.

The perceived enjoining of punitive immigration agencies with federal health benefits made some patients fear the potential of healthcare institutions as potential sites for surveillance and exclusion. This raised the stakes of risk calculation and begged the question: how sick is sick enough to warrant the possibility of becoming visible to immigration agencies? In this section, I present the case of Sebastián and Laura to illustrate this tension. I signal how the assemblage of local and state anti-immigrant practices and policies, alongside threats of enhanced immigration enforcement and a crackdown on noncitizens' benefits use by the Trump administration, produced intersecting fears of detention, deportation, disability, and death for a family in crisis. In this case, only when death seemed imminent was this family willing to take the risk of detention/deportation that they most feared.

I first noticed patient Sebastián when I saw him hobbling through the clinic with his beleaguered adult daughter and caregiver, Laura, close behind him. A mechanical drain funneled a red viscous liquid away from Sebastian's groin and into a plastic receptacle. It turned out that Sebastián and Laura (both undocumented immigrants) had a long wait in clinic before the urologist would be available to see Sebastián, so they had some time to kill and did not mind spending it talking to me. As we settled into the clinic's conference room, I learned that Sebastián had recently left the hospital after a month-and-a-half of inpatient treatment and was now staying at a charity respite center for what I gathered was congestive heart failure and liver and kidney failure. He was in terrible shape, scooting his walker forward miserably and wearing a vacant and defeated expression. I suspected that Sebastián would not be particularly chatty, and

I was right, but Laura seemed to have a lot she wanted to get off her chest. She also received medical care in Chapulin County and was going through her own health issues, so she was able to speak about her own and her father's struggles (of which there were many) while we awaited Sebastián's urologist.

Laura and Sebastián began by describing Sebastian's recent plunge into grave medical crisis. Sebastián had had never really gone to the doctor because he had always been healthy as far as he knew. He only agreed to go to the emergency room once his genitals had become so swollen (Laura gestured to indicate something between the size of a large grapefruit and a small melon) that he felt he no longer had a choice. By then, he was in crisis and had to be admitted to control the fluid overload that was, he would learn, destroying his organs. Laura explained that they had agreed to enroll her father in Emergency Medicaid to cover his emergency care costs, but this did not include his follow-up care or rehabilitation. That was why he was coming now to the free clinic for specialist appointments and was staying at a charity respite center while he recovered. Laura regretted having waited so long to get her father into care, saying that maybe if they had acted sooner, he would not have ended up so ill and on dialysis now. But Laura explained that there were so many reasons for people like them to be afraid to seek help. It was not just the diagnosis they feared, she told me, but also the cost and the possibility of deportation.

For her part, Laura had been getting health care through the county hospital and a local community clinic. She knew she had diabetes, but she had been without medication for months because – as a low-income, uninsured (and, given the exclusions I described in the dissertation's introduction, functionally uninsurable) single mom – she could not afford it. Now that her father's health was declining, however, she was frightened that her own condition could also deteriorate rapidly or get so out of hand in the time it took to decide that the consequences would

be irreparable – as had been the case for her father. Laura had only found out the previous winter that she had diabetes, and she already suffered from foot pain and numbness. She had gone to the emergency room last December when could no longer bear her discomfort, and there she was diagnosed with diabetes. Now she worried about what would happen if she could not keep the disease in check. Yet with the outstanding bills for her own emergency visit and with her father's declining health, she was even less able to afford medication.

When I asked Laura whether she had thought about applying for Emergency Medicaid for her own emergency care costs, she explained that she was too afraid under the current federal administration to apply for anything through the government. She had enrolled in Emergency Medicaid several years ago for delivery of her U.S.-born children, but now the idea of applying for Medicaid even on behalf of her citizen children made her stomach churn. While she was willing to enroll her father in Emergency Medicaid because he was, as Dr. Francis put it, "at death's door," she was not willing to do the same for her own relatively slow-moving health crisis. The risks were similar – becoming visible to the federal government and potentially vulnerable to deportation through that visibility – but Laura did not feel her own situation met the threshold of urgency to warrant such a gamble. And given Emergency Medicaid's definition of "emergency" as a "life or death" situation, it is likely that county Medicaid administrators would have agreed with her on that count even if she did risk applying. With the classificatory assemblage of noncitizens' health in Chapulin designed to squeeze out people like Laura, it is no wonder she denied for herself what she reluctantly accepted for her father. The risk of being deported and separated from her children was greater than her current health concerns. Because of this, Laura was willing to literally sacrifice her feet and her health to diabetes to avoid the possibility of getting caught and squeezed in those narrowing eligibility passageways that would

not guarantee her health but would put her (she believed) in the path of immigration enforcement.

Laura began shaking visibly when she thought about what might happen to her children if she were deported, and she started to cry. Things were tough under Law X, she explained, but she took "precautions" and tried to stay out of trouble so that she could support her family as a single mother. As cautious as she was back then, however, she was nevertheless arrested once at a routine traffic stop. The police told her that she had a problem with one of her car's lights. When they discovered that Laura was undocumented, she was taken to jail and shackled at the wrists and ankles. Laura was frightened and humiliated, but she felt fortunate that she only had to spend one night in jail and that the people from "immigration" were kind to her. They asked if she wanted to see a judge, and she said she did, but they released her without her ever seeing an immigration judge or explaining any follow-up to her. "The truth is that in that moment they told me I could go," she recalled, "I left at a run to see my children."

Laura did not want to tempt fate with another run-in with immigration agents, especially now that things had, from her point of view, gotten much worse than the days when the state anti-immigrant law was in full force. Ever since "the new president" came to office in 2017, she felt that everything had become much harsher for immigrants – at least that was what the news and everyone around her was saying. "Now they're saying so many things," she remarked, "and yes, you get scared, you take your precautions." When I asked what type of precautions Laura had to take, she reiterated that she must avoid driving or asking for help from service agencies because she feared being deported without her children:

> You don't ask for help, because they already said they're going to report you or something. That's the fear, asking for help. Maybe there are places like [this clinic] where they don't, but not like at the hospital where they ask if you have insurance or not, that's the fear. … When they ask that, I tremble. … Like now when we were at the

> hospital [with my dad] … When you finally reach that limit, when it's an emergency, then we take that risk… that once they give us [medical] attention, they can report us. And now lately times are more difficult, the truth is for me things are more difficult today than a few years ago… You don't look for help, but when it gets to be an emergency, sometimes I get to thinking, maybe if [my dad] had seen a doctor sooner, maybe now he wouldn't be going to dialysis.

Like Javier, who had accepted Emergency Medicaid for himself and DACA for his children, Laura's family had been living only partially in the shadows over the past decade living in Chapulin County. Laura had enrolled herself in Emergency Medicaid and her U.S.-citizen children in full-scope Medicaid prior to the beginning of the Trump administration, and her father was enrolled in Emergency Medicaid during the time of our interview in June 2018. But as Laura said, these days only an emergency as grave as her father's would warrant such a risk. Her own diabetes complications, and her children's regular health care, were harder to justify than her father's near-death experience. Even Laura's 27-year-old younger sister, who also had diabetes, feared using any health care services because she believed doing so would prompt the government to take away her DACA. Ironically, even though the more "legal" members of Laura's family were eligible for health care and entitled to it, she worried that their taking advantage of it would enable the federal government to use health care as a justification to penalize her family. And with the future of DACA in doubt and the looming public charge rule change proposal, this fear seemed well founded.

Medical legal violence happens when people like Laura and her family avoid health care until moments of crisis because exclusionary immigration and health laws have forced them into dangerous spaces of liminality. Laura's arrest under Law X made her even more fearful, and uncertainty over DACA kept her sister out of the clinic despite her own serious illness. Only when Laura feared for her father's life was she willing to risk their exposure to government surveillance, but she feared that asking for help left them vulnerable to deportation. Like nurse

Maya's heart-attack patient, anti-immigrant laws forced Laura's family into dangerous situations that might have been avoided if they had felt secure enough seek care before a health crisis. Yet the particular constellation of state and federal immigration and health laws that existed in Chapulin over the past several years constrained their options for care until they reached the life-death decision threshold that outweighed their deportation fears.

CONCLUSION

On January 8, 2019, President Trump addressed the nation in primetime regarding a "crisis" that he argued warranted $5.7 billion for a border wall and potential state of emergency (Trump 2019). He spoke of physical barriers and security personnel to delineate the boundaries between U.S. citizens and Latinx migrants, and clearly this bold posturing has resonated with a sizeable portion of the U.S. population. Yet the visibility of the immigration stalemate staked in terms of such concrete boundaries risks overlooking the many subtle ways in which boundaries of belonging are also being forged in vital spaces where immigrant and mixed-status families' lives unfold. By enjoining punitive immigration laws at state and federal levels with complex federal health bureaucracies, immigrant patients come to perceive healthcare institutions as potential sites for surveillance and exclusion. To prevent immigrants from full social inclusion, the contemporary assemblage of noncitizen health in Chapulin County expands medical legal violence and deters immigrants from prioritizing health in favor of security.

Chapulin County represents a near archetype of the kind of prevention through deterrence strategies that inflict medical legal violence on noncitizens living in the U.S. Well before the 2016 election, Law X in Chapulin funneled Latinx immigrants into the path of local and federal law enforcement. It made it impossible for many to go about their daily life, closing down opportunities for education, employment, housing, and health care. It confined many, like Laura,

to their homes and encouraged others, like Noemy, to self-deport. That was the idea, after all: to make life so unbearable that the individuals and families whom state leaders found undesirable would not just keep to the shadows but disappear entirely.

The Trump campaign took this same message and gave it a national platform, and that platform has been realized in federal immigration policies. Despite the fact that several provisions of states' anti-immigrant laws were struck down by federal courts, the Trump administration has consistently taken a firm stance against migration (both legal and "illegal") into the United States by rejecting visa applications, separating families and altering family reunification precedents, and denying asylum opportunities (NILC 2018). They have promised to build a wall and continued to funnel immigrants through the harshest, most unforgiving terrain while blaming cruel nature and incorporeal policy for the fate of ill-fated, irresponsible immigrants.

Yet as Americans' collective attention turns to the battle over the wall and the legitimate humanitarian crisis of migrant deaths at the border, the insidious bureaucratic violence unfolding through the bolstering of existing laws and increasingly exclusionary channels of Medicaid documentation plays out offstage. A topographical approach to noncitizens health in the 21st Century U.S. demands tracing the specific, dynamic associations of actors/actants, policies, institutions, and infrastructures to understand how boundaries are contested and possible futures enabled or foreclosed. The physical boundaries that capture our attention today – the desert, the border, the wall – act in close association with the less visible, but no less important, moments when the parameters of the contemporary immigration debate were delimited: the 1994 prevention through deterrence strategy, the 1996 immigration and welfare reforms, and present-day health and immigration legislation – including the ACA and the public charge rule change.

When an undocumented immigrant in Chapulin County shows up at the emergency room in a medical crisis that finally tips the balance of fear from deportation to disability or death, that patient has unwittingly traversed an assemblage of medical legal violence that has made such a choice both possible and necessary – less of a crossroads than a dead-end. This assemblage expands legal violence through healthcare bureaucracies and institutions to maximize the exclusion of immigrants and immigrant families from U.S. society. The Trump administration did not create all of these laws, but it has cleverly constructed new blockades from existing legislative infrastructure that optimize their exclusionary potential. Including vital services in federal immigration governance subtly forces many immigrant patients and mixed status families toward "heart-wrenching" decisions that play out in the shadows, beyond the drama of the "border crisis" or the associated battle-lines of the government shutdown. In these ways, the newly converging boundaries of U.S. immigration and health exclusions raise the stakes of illness and injury for thousands of immigrants living in Chapulin County and beyond and underscore the lines between those who are deemed worthy of citizenship and those who are not.

Chapter 4: States of Exception: Bare Life and (Non)citizenship in the contemporary United States

INTRODUCTION

States of Exception and Emergency

In the previous two chapters, I described how medical legal violence functions to exclude noncitizens from U.S. society by leveraging health care and health institutions. In Coral County, the 2016 election upended clinics' approaches to softening legal violence through creative health care provision while potentially conscripting them in medical legal violence. In Chapulin County, anti-immigrant policies at state and federal levels torqued noncitizen patients out of medical eligibility in ways that caused physical harms. In both cases, I presented examples of noncitizens who had lived in the U.S. for decades and were deeply embedded in its society, and who nevertheless remained excluded from political participation and frozen out of basic social institutions, including health care.

In this chapter, I argue that the accelerating symbolic violence of crimmigration in the contemporary U.S. represents a reactionary effort to ensure the continued political exclusion of non-white noncitizens, especially those from Latin America. I focus specifically on a form of legal violence that typifies the Trump administration's approach to immigration law: the state of emergency. While the Trump administration's place within the broader historical arc of U.S. political economy is not unusual, there is a generalized sense – in the country, the world, and among my participants – that its specific tactics of legal violence are remarkable. By pairing this foreclosure from opportunities to demand basic social and political rights with noncitizens' economic inclusion as a source of cheap, captive labor, this inclusion/exclusion dialectic (De Genova 2013) produces both direct bodily harms, as well as cumulative and compounded biological consequences.

Taken together, the symbolic violence of anti-immigrant rhetoric and policy that the Trump administration has harnessed to dehumanize immigrants and keep them in a state of exception (Agamben 2005), and its codification into medical legal violence, produce participants' experiences of being indispensable yet disposable labor, and facing both immediate and compounded injury. This condition is the result of historically continual processes in the global political economy of capitalism, and in that sense this is partially a story of the uninterrupted legal violence of the status quo. Yet there is historic specificity in how that condition is defined in the contemporary U.S., at a time when the collective national gestalt feels decidedly exceptional. In order to understand this tension, I leverage the work of scholars who discuss the *state of exception* both as the product of ongoing historical processes (such as capitalism and white supremacy) and in terms of the historically specific physical and discursive spaces where particular groups of people are dehumanized and made disposable.

As I mentioned in the introduction to this dissertation, the concept of legal violence involves the collision of structural violence (Galtung 1969, Farmer 2003) and symbolic violence (Bourdieu 2000). Structural violence encompasses the ways that political-economic and social inequalities become institutionalized harms, and symbolic violence captures how such violence becomes normalized. Neoliberal capitalism and white supremacy rely upon the insidious institutionalization of class and racial inequalities to survive, and the economic inclusion and socio-political exclusion of noncitizens help reproduce this systemic momentum by separating economic output from political input. Millions of noncitizens of color contribute to economic production without the prospect of political representation (because of barriers to naturalization,

criminalization, and the constant threat of deportation), and this ensures a relatively captive pool of racialized labor for the U.S. in a way that neutralizes their political potential.[15]

This notion of disposability underscores the political economy of U.S. labor in relation to Latin American migrants, and I draw attention here to the twin phenomena of *injury* and *disposability*. De Genova (2013) theorizes the process whereby (im)migrants are delegitimized and included in labor pools through exclusion from social life as the "obscene of inclusion" – which he places in contradistinction to the "scene of exclusion" at the U.S.- Mexico border (De Genova 2013, 1180). As De Genova (2013: 1185) explains:

> The 'inclusion' of these deportable migrants, of course, is finally devoted to the subordination of their labour, which can be best accomplished only to the extent that their incorporation is permanently beleaguered with the kinds of exclusionary and commonly racist campaigns that ensure that this inclusion is itself, precisely, a form of subjugation.

This inclusion/exclusion dialectic uses the spectacle of the U.S.-Mexico border and the rhetoric of invasion to divert attention away from the mundane political economy of migrant labor and the more subtle expansion of legal violence that increasingly criminalizes noncitizens as they build their lives within the United States, in spaces well beyond the border.

Furthermore, for noncitizens, unlike minorities born in the U.S., deportability becomes a prime mechanism of the subjugation De Genova describes. Even "authorized" immigrants are not exempt from this threat, and their continuous surveillance and precarity assure the relative docility of this particular labor segment. As De Genova and others (e.g., Park 2011, Brotherton & Barrios 2011, Golash-Boza 2016, Asad 2019) remind us, protracted deportability is the definitive condition of noncitizens in the U.S, and it is a particularly racialized condition at that. Because both "illegal" and "legal" noncitizens – and in some cases (such as treason) even

[15] This is similar to the way in which political movements – in labor, civil rights, etc. – have been neutralized in the U.S. through criminalization and incarceration.

naturalized citizens – are indefinitely subject to deportability, De Genova refers to this precarious condition as "profoundly disciplinary" (De Genova 2013, 1188).

Other scholars examine the inclusion/exclusion dialectic that De Genova describes on more global terms, often as they grapple with Foucauldian notions of biopolitics. Agamben (1998) argues that the "bare life" of human beings – the abject reality of their biology that precedes and endures in political life – has always been at the heart of sovereign power. According to Agamben (1998, Kindle location 145), "Bare life remains included in politics in the form of the exception," and he emphasizes Carl Schmitt's argument that "sovereign is he who decides on the state of exception (Schmitt 1985, 5). Put simply, the "state of exception" is a condition determined by a representative of the state (typically one behaving in the capacity of the executive) in a time of apparent emergency or crisis that enables the suspension of rights (constitutional or otherwise) and the suppression of public law. It is *exceptional* in that it should, theoretically, be a temporary condition that will subside when the threat to the state is neutralized.

Yet Agamben and others (e.g., Mbembe 2003, De Genova 2013, and Weheliye 2014) stress the ways in which this state of exception, once conceived, tends to continue indefinitely. Agamben further explains that "the voluntary creation of a permanent state of emergency (though perhaps not declared in the technical sense) has become one of the essential practices of contemporary states, including so-called democratic ones" (Agamben 2005, Kindle location 38). While Agamben's argument initially arises from his (and others') analyses of Nazi Germany, he also emphasizes that such characteristics have also marked the 21st Century United States, through legislation such as the 2001 Patriot Act, the 2003 invasion of Iraq, and the related use of Guantánamo as space where human rights and citizenship norms are regularly transgressed.

Mbembe (2003) extends this perspective to emphasize the ways in which the existence of today's states of exception (such as occupied Palestine) owes much to the racializing projects of slavery, colonialism, and apartheid, which kept people "alive but in a *state of injury*" (Mbembe 2003, 21; emphasis in original). This injury accompanied the stratification of people within the same geographical space along axes of socioeconomic and political inequality. As such, Mbembe restates sovereignty as "the capacity to define who matters and who does not, who is *disposable* and who is not" (Mbembe 2003, 27; emphasis in original).

Understanding the relationship between sovereign power, the state of emergency, and defining "who is disposable and who is not" is key to contextualizing the contemporary relationship between the U.S. government and noncitizens today. Long before I finished my dissertation research, I had begun thinking of the space that noncitizens occupied amidst expanding legal violence – whether as "undocumented", liminally legal, or lawfully present immigrants – as a state of exception. As I considered the implication of noncitizens and health institutions and personnel in the collective phenomena I would come to call medical legal violence, I began to pay special attention to the ways that laws shifted toward greater or lesser social inclusion by treating noncitizens as exceptional. I observed how this exceptionalism tended to result in bodily and institutional torqueing (see Chapter 3) as people tried to fit into categories that had been explicitly designed to exclude them. I also began to notice, as many did, the ways that the Trump administration expanded legal violence against particular groups – namely Latinx migrants and residents of Muslim-majority countries – through heightened symbolic violence. The point of actions like the Muslim travel ban[16] or family separations at the

[16] On January 27, 2017 (six days after his inauguration), President Trump signed an Executive Order banning foreign nationals from seven Muslim-majority countries from visiting the country for 90 days, suspended all Syrian refugees' entry indefinitely, and prohibited any other refugees entering the country for 120 days (ACLU 2019).

border[17] was not really to uphold existing law nor forge new laws through collaborative processes, such as congressional legislation. The point was to suspend rights quickly and dramatically, and the power of executive order enabled President Trump to do so. With this tool he could declare crises and create spectacles that demanded constant attention.

While every president in the nation's history has possessed this power of executive order, the particular way that President Trump has wielded it in relation to migration has been remarkable. For example, on February 15, 2019, President Trump declared, "by the authority vested in me by the Constitution and the laws of the United States of America," that there was a national emergency at the southern border. This fixation on the "border crisis" and the rhetorical – and lately operational – "state of emergency" belie an almost medieval preoccupation with sovereign territorialism and government by spectacle and fiat. As Foucault (2004/2007) argues, the symbolic shift from a territorial sovereign, through disciplinary control of highly classified populations, toward a securitizing state concerned with managing uncertainty through calculative rationality did not mean that one form of power replaced another; rather they became covalent. In other words, the serial developments in the evolution of biopolitics – sovereign, disciplinary, and securitizing – remain ever present in the technologies of power of contemporary societies. This is important because, as I argued in Chapter 2, disciplinary techniques are still very much at play in the governing of noncitizen patients and immigrant-serving health institutions in the United States today.

[17] As I mentioned in the dissertation introduction, this "zero-tolerance" policy, announced on April 6, 2018, directed federal prosecutors to criminally prosecute all adult migrants entering the country without authorization. Because the 1997 *Flores v. Reno* settlement, this led to the separation of adults from their children and generated widespread public outcry. It later emerged that not only were families being separated, but the administration was unable to keep track of those they had separated – and thus unable to reunite many families (CLINIC 2018).

To be clear, in my dissertation research I avoided asking specifically about the 2016 election or President Trump unless participants brought it up first. I did not want to preemptively dichotomize the situation in those terms, but the issue invariably emerged in interview after interview. In the examples below, I focus on this state of exception, buttressed lately through a "state of emergency" and narrative of protracted crisis, to illustrate how the spectacle serves to deflect attention away from the everyday violence of noncitizens' economic inclusion and socio-political exclusion. These examples underscore both the direct and compounded harms that often render Latinx immigrants disposable in ways that are nearly impossible for noncitizens to remedy given the expanding medical legal violence of immigrant health in the U.S. While I am by no means the first to observe this inclusion/exclusion dialectic, I highlight a historically specific shift during the end of the Obama administration and beginning of the Trump administration that enables new insights into how this violence unfolds slowly and methodically in even the most disparate local political environments.

Defining the Enemy

Sovereignty distinguishes itself by the ability to define the space beyond law where human rights may be suspended. One of the most straightforward ways to do this in a representative democracy like the U.S. is to criminalize those who must be excepted, thereby designating their behavior and/or existence as illegal or extralegal. Much as systematic criminalization and incarceration has disenfranchised millions of African Americans in the U.S. (Alexander 2010), the criminalization of immigrants, crimmigration, enables effective exclusion of noncitizens from U.S. society. Given the threat of demographic changes to the U.S. political status quo – particularly the perceived displacement of white, conservative voters by Latinx voters who are unlikely to vote in line with their interests – crimmigration represents an effective

mechanism for reproducing existing power structures. And while crimmigration is a long unfolding process that transcends particular periods of political leadership, there is no doubt that the Trump administration has raised the stakes of this phenomenon.

During interviews and observations, participants mentioned the (then-recent) political transition as they reflected on their own experiences as immigrant patients in the contemporary U.S. In Coral County, as I describe in Chapter 2, the 2016 election represented a biopolitical turning point. In Chapulin County, the Trump administration triggered both a chilling continuation of earlier exclusionary policies at the state and local level and raised a disconcerting question mark over what the future would have in store. In both sites, participants expressed frustration over what they perceived as increasing anti-immigrant sentiment and its apparent legitimation and institutionalization by the Trump administration.

Several of the patients whose experiences of economic exploitation and biological torque I describe below spoke to me of feeling increasingly criminalized since the Trump administration took control. Their comments illuminate what it feels like to be constructed as an enemy while inhabiting a state of exception. Esteban, a Coral County resident injured during a workplace fall, told me in April 2017 that he was witnessing the greatest surge in discrimination that he had experienced since he arrived in the U.S. in the early 1980s. Back then, he had been arrested by immigration agents during a workplace raid – an experience that humiliated and dehumanized him. President Trump's anti-immigrant rhetoric reignited this humiliation, and Esteban believed this distressing political turn and heightened racism were reducing economic opportunities for Latinx immigrants:

> Since [Trump's presidency] the American isn't offering much work anymore to Latinos ….Now that this Mr. Trump arrived I see that he opened the doors to those who don't

> like Latinos. Many who are – who I'd consider Nazis, right? [Trump] wants a certain quality of people, tall like Hitler wanted.[18]

Esteban also said he believed there were a lot of people in Coral County who agreed with President Trump on this, and they were starting to assert themselves with more confidence. Esteban said he supposed this was because they wanted "more benefits" for themselves, and perhaps they thought that kicking out all the Latinos would ensure this. While I had become accustomed to both serious and satirical accusations of fascism and racism levied against the Trump administration by the political left in the U.S., I was surprised to hear them from someone who was not subject to such English-language media echo chambers.

Felipe and Tomás, two migrant workers I met in Chapulin County, recalled similar surges in anti-immigrant sentiment following the turbulent political changes at the state and federal levels in recent years. Both Felipe and Tomás had been working in Chapulin County during the years of the omnibus immigration bill I refer to as "Law X" and felt the anti-immigrant sentiment acutely despite having "papers" to protect them. They were frustrated that the Trump administration seemed to have revived this discriminatory trend just as it had been winnowing in Chapulin. As Felipe lamented:

> They don't leave you in peace anymore. People are already scared [in this red state], but they were feeling pretty good because [those laws were] about to go away. And now they haven't gone away because this government that entered sheltered [that bigotry] again, and it's the same again.

[18] This interview took place several months before clashes between white supremacists and counter-protestors in Charlottesville, Virginia, on August 11 and 12, 2017, captured the nation's attention. White nationalist and self-styled "alt-right" groups had planned "Unite the Right" rallies in conjunction with protests against the removal of a Confederate statue from a local park, and confrontations with counter-protestors turned violent. After the Virginia governor declared a state of emergency and the August 12th rally was suspended, a white supremacist drove his vehicle through a crowd of counter-protestors, leaving one woman dead and several wounded. In the wake of these troubling events, President Trump drew widespread criticism for condemning violence "on many sides" and refusing to explicitly denounce white supremacists (Sotomayor *et al.* 2017).

When I asked which level of government Felipe was referring to, Tomás broke in to clarify. "Trump, federal," he said. Felipe repeated that this was a frightening situation, especially for people who did not have papers – which, as he had reminded me – was harder to achieve these days. "[Those without papers] don't leave the cave because if they leave the shadows, the force [ICE] will catch them."

Roberto, a landscaper with diabetes[19] in Chapulin, expressed similar frustration but uniquely drew a continuous thread between the days of Law X, the Trump administration, and the U.S. political economy. He described how the state fell economically in response to "Law X" but had started to recover a bit before Trump came to office. "But with all this with the new president [Trump], things aren't so normal…," he remarked:

> If it were up to [President Trump], he'd throw out 11 or 12 million [undocumented Latinos] that are here. He'd already have thrown them out. But, if he'd thrown them out… the U.S. would go down. … Because there'd be no more workforce. Right now, the United States, everyone, all the big industries, the big companies, they know perfectly well that the Mexican laborer, or the Hispanic laborer, is the cheapest. And we're the battle horses, because we're always at the foot of the cannon. … We almost never miss work, we're not problematic, we're really hardworking. Here we are, holding out. ... Sometimes I wish that [Trump] would just keep things stable and let everybody work.

Even Víctor, a Coral County resident who lived in a more progressive region than Roberto and had gained legal permanent residence around the time that he was diagnosed with colon cancer (see Chapter 2), saw similar writing on the wall. He had hoped to bring his wife and children to the U.S. from his home country, but after President Trump took office he believed it would be impossible. He hoped that Trump would not be reelected and that whoever took his place would have a different approach to immigration. "With this guy [Trump], nothing can be

[19]All cases of "diabetes" mentioned in this chapter refer to Type 2 diabetes, which – like many chronic illnesses – is disproportionately prevalent among low-income people of color in the U.S. – including the Latinx community (CDC 2017). The links between structural violence and diabetes among Latinx individuals is well documented (e.g., Montoya 2011, Mendenhall 2012, Horton 2016).

done. He's got a lot of laws. They've changed, they've taken away a lot of laws from us," Víctor lamented. When I asked which laws he meant, Víctor specified that Trump was especially targeting sanctuary sites. Víctor was less worried about how this would affect him – "that's why I have my papers" – but was troubled by how such threats would affect his friends and family in the area. He warned them not to get into trouble and to drive carefully because a simple traffic ticket would be enough to detain and deport them. That's why, Víctor said, "I always go about with my immigration papers here." He showed me all the copies of immigration documents he kept on his person, a practice Víctor started after Trump's election just in case "they [law/immigration enforcement] stop me on the street and don't believe that I have my residence." After nearly three decades living and working in the U.S., and after finally obtaining his green card, Víctor still took precautions because he knew chances were high (and getting higher) that he would be seen as a criminal and treated as such unless he "took care" in this way.

Each of these participants resented the rising tide of vilification and discrimination that the Trump administration's anti-immigrant rhetoric seemed to have intensified and legitimized in recent years. As Esteban (in Coral County) and Roberto, Felipe, and Tomás (in Chapulin County) made clear, this sentiment was not new; they had experienced it before under other particular immigrant policy regimes. The difference now was that the sentiment was federally justified in ways they had not experienced in the many decades they had lived and worked in the U.S. The sweeping categorization of Latinx (im)migrants as the enemy of America – rather than a fundamental engine of economic productivity and social cohesion – seemed both remarkable and unjust to them. The examples that follow demonstrate how this lately remarkable expansion of existing legal violence – of an exclusionary framework decades (even centuries) in the making

– deftly leverages the symbolic violence of crimmigration in injurious ways that maintain Latinx (im)migrants' economic inclusion and sociopolitical exclusion.

States of Injury

Nearly all of the patients I spoke with across both sites had been living and working in the U.S. for several years, if not decades. Occasionally I spoke with individuals who had recently arrived in the U.S. or continued to migrate periodically for work, but the majority had built lives and families in the U.S. and planted deep roots here. Many came specifically to work here in order to create opportunities for their families in the U.S. and in their countries of origin. Collectively, they worked in a variety of jobs, including landscaping, construction, sanitation, dry-cleaning, restaurants, and agriculture. Most worked in physically demanding jobs without health benefits or worker protections. They all contributed to the U.S. economy through their labor and taxes, but few were able to secure adequate social benefits from the federal government when their bodies buckled under the strain of that labor. They put everything into the system, they produced and they consumed, but they were unable to rely on that system as U.S. citizens could. Nor could they exercise political will to resist that system, and in this sense, they were particularly vulnerable to exploitation and criminalization.

Some of the patients I spoke with experienced direct bodily harms from their extended residence in the state of exception. Economic exploitation alongside sociopolitical exclusion resulted in the injury and discarding of disposable workers once they could no longer fulfill their economic role. While some patients eventually found a remedy in the form of legalization or naturalization, the legal violence that stymied their legitimate inclusion in U.S. society kept all of them in harms' way until significant damage had already been done. For many, this injury was a direct result of their work under exploitative conditions.

Esteban and I met in April 2017 at a Coral County Community Clinic administrative office. Esteban explained that he had been living and working in the U.S. for more than three decades and seldom interacted with the healthcare system until suffering a relatively recent injury. He had fallen while working on a job (he did not specify the task, but it sounded like a construction job), and the impact broke his ribs and split his spleen in two. After being treated at the Emergency Department, support staff at the Coral County clinics helped him apply for state-funded, full-scope Medicaid to cover ongoing treatments. These were necessary because the injury had damaged Esteban's circulation and seriously impaired his liver. When possible, he did whatever day labor work he could manage to earn a little extra money for himself and his U.S.-born son, but he was barely getting by. He hoped rather than believed that he would recover soon so that he could get back to work, but he could not count on any disability or income assistance to spur that recovery or ease his situation if recovery proved impossible.

Esteban had first come to the U.S. almost four decades ago and worked in a restaurant until he was arrested during a workplace raid in 1981 and deported to Guatemala. The experience shocked him deeply because he had supposed that if he worked well and kept his head down, he would be sure to get a good salary and go on with his life. "But sometimes it doesn't matter," he said, and he described being treated "as if we [Latinos] were extraterrestrials." He recalled the dehumanizing shame of his immigration arrest and the consequences it had for his future, saying:

> They put shackles on your feet, all as if you were a grand assassin. … Because of this they've denied me everything, all the opportunities to get my residency, my citizenship, everything.

That Esteban's life had been destabilized by an on-the-job injury and chronic illness is not in itself unique. U.S. citizens and noncitizens alike might be expected to experience similar "biographical disruptions" (Bury 1982) in the face of injury and illness. A key difference,

however, is that the socioeconomic decline that accompanied Esteban's physical fall was exacerbated by his illicit status and recent wave of anti-immigrant sentiment – both of which he expressed as threats to his wellbeing. Esteban spoke with pride of how hard he had worked in the U.S., and he seemed to have internalized the idea that the role of Latinx immigrants was to shoulder the work that Americans would not. "Sometimes they have us demolish houses when it's not good for your health," he remarked. "The Latino does that. The American doesn't do that." He explained that it was in their nature (the nature of "*el latino"* or "*los latinos*" as he put it) to do physical labor at the behest of American supervisors who were able to do the intellectual and managerial labor.

Esteban seemed resigned to the fact that he was valuable in U.S. society only as a source of manual labor, even while he articulated the exploitative nature of this relationship. Only when he reflected on the discrimination he had faced, and when he considered that he may not be able to return to work because that same work had worn his body down, did he express his disappointment. Just as he resigned himself to his position within the U.S. political economic system, he resigned himself to the possibility that his health might be irreparable.

What Esteban did not say explicitly, but what his present situation starkly illustrated, was that he was simultaneously included in U.S. society on the basis of his economic potential and excluded from it as a criminal alien who could no longer sustain that economic activity once that very activity broke him. Even though he was barred from becoming a full political member of U.S. society, he nevertheless found ample opportunities for economic inclusion (in restaurants, in construction, or doing odd jobs as a day laborer) when he was healthy. There was a place for someone like him, and he internalized his role as a manual laborer who must contribute through

physical exertion. Once that labor became untenable, however, he understood that there was no place for him in that system and – except for the clinic – nowhere to turn for relief.

Hundreds of miles away in Chapulin County, Cristina found herself facing a similar dilemma. She had lived in the U.S. for more than three decades, and for most of that time she had actually lived in the same state as Esteban. She had left that state in order to escape neighborhood violence and give her children a safer life, but she regretted losing the full-scope Medicaid that she and her U.S. citizen children were able to access when they lived there. Cristina had been diagnosed with diabetes 19 years ago when she lived in the blue state, and she explained that her Medicaid helped her keep the disease in check during that time. When she came to Chapulin County, however, she struggled to get and keep adequate healthcare coverage. As an authorized worker with a tax ID, she was sometimes able to get jobs that provided health insurance, yet she could never seem to make enough money to afford her premiums, deductibles, or copays with private insurance through her employers. Once Cristina finally did manage to get on top of her insurance payments, she got septicemia, which she believes was due to her work in sanitation. She was hospitalized for three days and told by the doctor she could not work for a month and a half. Because she was no longer working, she lost her insurance and received a bill for $30,000 for her hospital stay.

Cristina worried that going back to her old job would put her back in the vicious cycle of inconsistent insurance and potential injury.[20] In an effort to boost her income a little without getting locked into that spiral, Cristina took a part-time job that paid $2 per hour more than

[20] The torque I describe in this chapter is not unique to noncitizens but also other U.S. citizens who are disproportionately subjected to structural violence. I focus here on the particular aspects of structural and symbolic violence that are related to legal status, but similar embodied effects among U.S. citizens are comprehensively detailed by Eubanks in her book *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor* (St. Martin's Press 2017).

anywhere else she had worked previously. This job as a dishwasher required her to wear plastic boots that were often soaked by the spray from whatever she was washing, and this led to a bone infection in one of her feet. As someone who had been living with poorly controlled diabetes for some years, this bone infection became life-threatening and required amputation of one of her toes. "I think that because of that job, I am how I am now," she lamented as she mourned her recent disabling experience. "Without feet, what am I good for anymore? … You say, 'It's two dollars more.' You think it's a little more, but it cost me my toe."

Having lived in both a blue state and a red state, Cristina experienced the gamut of immigrant inclusion and exclusion, and she dearly wished to become a citizen. And although she was technically eligible for citizenship, she could not pass the exam nor afford a civil surgeon (the physicians who oversee immigrants' medical examinations for entry) to confirm that she had cognitive impairments that limited her ability to pass the exam. Cristina's record was good, but realistically she was locked out of naturalization.

This situation struck Cristina as unfair. She explained that the difference between citizens and noncitizens was the ability to demand one's rights. "[We] also have rights because I work and I pay my taxes," she argued, "but they don't see it that way." She described feeling belittled because she was asking for support now, which hurt because she knew she had paid taxes for years and supported the state the whole time she was working. "I haven't stopped working since I arrived here," Cristina remarked, describing how the staff at the hospital took out her record of everywhere she had been seen for medical attention, and it was bursting with papers in her medical file from all the jobs she had done over the years. "I've been really hardworking," she said. "But my body can't anymore, it's tired now."

Cristina saw herself as a legitimate neoliberal subject of the United States – one who may earn social deservingness through his or her economic productivity – even if she was not technically a citizen of the country in which she had lived and worked for decades. Like Esteban, she found ample opportunities to work – probably even more than he could given her work authorization – but she similarly suffered an on-the-job injury that rendered her disposable. And whereas Esteban was permanently excepted from citizenship because of his prior deportation, Cristina was functionally excluded from the U.S. body politic because of her low income, limited English proficiency, and lack of cultural capital. Despite their distinct positions on the documentation status continuum (Joseph 2016), neither Esteban nor Cristina was immune from the structural and legal violence that left them permanently injured. And given the medical legal violence to which their location in the protracted state of exception subjected them, both found it nearly impossible to remediate that harm through timely, effective, and affordable medical intervention.

Slow Death

While some patients I spoke with suffered injuries directly in the course of their labor, the majority embodied a more cumulative and compounded kind of harm, one exacerbated by decades of being economically included under exploitative conditions but socially excluded from remedies to that exploitation. Being excepted from protective social institutions and treated as disposable harmed their bodies in subtle ways that are impossible to pin on an isolated event, but taken together they slowly disabled and disintegrated them nonetheless. This exemplifies Galtung's (1969) and Berlant's (2007) conceptualizations of "slow death." Given that the nature of structural violence is to inflict ongoing, insidious harms through embedded social institutions and arrangements rather than overt interpersonal injury (see dissertation Introduction), the cases

below highlight the compounded consequences of harms that are embodied over decades of living within the state of exception.

I met Roberto in December of 2017 while observing an eligibility encounter in which he was renewing his sliding fee scale discount at one of Chapulin County's large FQHCs. He and his wife both had diabetes but were undocumented and therefore could not qualify for insurance, so they relied on the clinic for their regular lab work and medication discounts. Roberto explained that he had been living in Chapulin since about 2003 and therefore had witnessed the transformations in immigrant policies there over the past several years. Roberto had been a licensed welder back in his native Mexico, but without papers he could not get a similar license in the U.S. Even so, he found related work in a metalworking shop and made good money there for one year before Law X took hold. After Law X was implemented, the company began checking everyone's work papers, and Roberto had to seek employment elsewhere.

Roberto found a job as a landscaper and settled into his new role relatively well. Slowly, however, over the twelve years he worked for the same boss, he found he could no longer manage the physical effort of his work. He got dizzy and had trouble standing, and he was thirsty all the time. Roberto felt exhausted and struggled to carry the gasoline-powered leaf-blower on his back day in and day out. One day he looked in the mirror and scarcely recognized himself. "Oh no," he said to himself, "What a horror… What do I want to live like this for? What am I good for?... I'm not even going to be able to work."

This physical decline, and the fear of losing work, finally brought Roberto to the clinic a year ago, where he was diagnosed with advanced diabetes and immediately placed on an insulin regimen. Roberto had not realized his situation was so grave, but the doctor told him he had been flirting with a coma and was in bad shape. She also diagnosed him with high blood pressure and

advised him to avoid undue stress at work – advice Roberto found difficult to follow because he was always rushing not to fall behind on his jobs. Roberto took these diagnoses hard, and at his lowest point he considered suicide. With his family's and the clinic's support, however, Roberto began to get his blood sugar and hypertension under control and was delighted that he had the energy to work hard again. So much of Roberto's life was wrapped up in his economic activity, and he was desperate at the thought of chronic illness rendering him useless. True, he would have preferred a job with better wages and health benefits, but after Law X he had discounted such possibilities. Given this reality, and given that he – a low-income, undocumented immigrant living in a place with anti-immigrant policies – could do nothing to change that reality, he held fast to the one job he could count on. And he relied on the clinic to keep him fit enough to do so for as long as possible.

A few months after I met Roberto, I accompanied some nurses and medical assistants from his clinic to a remote watermelon farm where they conducted free blood pressure and glucose checks for migrant workers and enrolled anyone who was interested in the clinic's sliding fee scale program. The heat was oppressive in the concrete mess hall where we set up shop, and I overheard a nurse react with alarm to one of the worker's blood pressure readings. The nurse told patient Tomás that his pressure was dangerously high and warned that if it did not reduce before they left, she would send him to the emergency room. Tomás brushed aside these concerns and chalked up his acute hypertension to a tough day at work. He acknowledged that he had a history of high blood pressure, but he rarely felt the symptoms of it. "Now I feel a little fatigued," he allowed, "but later [my blood pressure] will calm down from its agitation on the job. We spent the day out there crouching and jumping in an oven [under the blazing sun] with our sacks, that's all."

Later, in an interview I conducted with him and fellow worker Felipe, the men discussed the terms of the arrangement that allowed them to work in the U.S. with legal authorization with certain limitations. Felipe explained that everyone working in the fields alongside them had a work permit. Everyone was given six months for the season and had to return to their home countries at the end of that time. He stressed that this was work permission only, and that they had no liberty of movement beyond what the *patrón* who arranged for that permission allowed. Felipe added that everyone carried a card that their *patrón* gave them, which indicated how far from the camp they were allowed to wander. (This was about a 60-mile radius, enough to include the nearest urban center where they could do shopping and such.) In the event that ICE demanded identification, they were to present that card – with its travel restrictions – as proof that "they came to work." "They can't leave from here, from the job, they just have to stay here," Felipe explained. "Once they leave here, they've lost, and immigration grabs them and takes them away."

This work authorization did not include health care, and therefore Felipe and Tomás were eager to avoid the emergency room. Felipe recalled one time when he thought he was having a heart attack and had to be rushed to the hospital in an ambulance because he feared he would die. Fortunately, it was not a heart attack, but unfortunately it left Felipe with a $1,500 bill for the ambulance (which, perhaps surprisingly, is not uncommon for uninsured patients) and $3,000 for the Emergency Department visit.[21] Because he had no insurance in the U. S. and because he made too much as a migrant worker to qualify for Emergency Medicaid, Felipe was ineligible for health insurance. He intended to pay the bills in full, and he was hoping to work out a payment plan with the hospital and ambulance company. "It doesn't matter," he said implacably. "I owe

[21] Ambulance transport costs are notoriously opaque and remarkably expensive, but it is difficult to state an average due to high variation (Bailey 2017).

it, and I have to pay it. The trick now is not to get a black mark. Because if I don't pay it, they'll send it to collections, and I'll be in trouble." Felipe's principal concern now was not his health, but his credit. This preoccupation surprised me, and I clarified that Felipe was indeed worried about his credit in the U.S. When he confirmed this, I was struck by how the U.S. could hardly ask for a more perfect neoliberal subject in a perpetual state of exception: Felipe could work in the U.S., contribute to its economy, consume on its financial terms and within its systems of credit, but he was barred from any social or political inclusion.

Tomás listened to Felipe's cautionary tale about the ambulance and hospital bills and assured the nurses and me that he would not be going to the ER today. He supposed aloud that all this crouching down, springing up, and burying heavy things in the ground had wrought some havoc with his blood pressure today by "agitating" his heart. He assumed that after all these years, the physical demands must be taking their toll. That was just the way it was. "I don't feel sick," Tomás said simply. "I don't feel anything."

Like Roberto and Tomás, Coral County patient Víctor had also worked to the edge of his physical limits for many years. "Out of necessity, because I didn't have papers, I worked too much. I felt bad, and I came to this clinic." For 25 years, Víctor had been working as a cook and delivery driver at a local pizzeria, and he often also had to take care of the owner's children at the restaurant. Víctor resented this because it put him behind with his own work, and he often had to stay late into the night to make up the time. This meant that he could not go to the clinic for check-ups or to stay on top of his health issues, like hypertension and high cholesterol. Over the years, Víctor noticed his health declining, but there was little he could do about it. His bosses would not give him time off to go to the clinic, and it was no longer open when he got off work.

In 2017, Víctor was diagnosed with colon cancer and had to quit his job in order to undergo treatment. He said that his boss came looking for him and demanded that he return to work, but Víctor refused. "My health comes first," he said. Fortunately for Víctor, by the time his boss came looking for him, he had finally been granted permanent residence through his brother's sponsorship. He was able to qualify for Medicaid to cover his cancer treatments and chronic illness management, and he began applying for income and housing benefits until he could get back on his feet. Because of his political legitimacy, Víctor was one of the few patients I interviewed who was able to push back against the exploitative conditions under which he had been working and seek benefits to soften their physical blow. The damage was done, but the bare life of his economic inclusion was tempered in a small way by his forward movement toward legalization and naturalization.

Unlike Felipe, Tomás, and Víctor, Chapulin County patient Guillermo had no authorization to live or work in the United States. I came across Guillermo (whom I mentioned briefly in Chapter 3) while doing observations at Dr. Young's free clinic in Chapulin. He was waiting for the wound clinic to open so he could have a recent amputation debrided (a procedure in which damaged tissue was extracted from a wound), and he was happy to chat with me until that time. He sat on an exam table with a bandaged foot elevated while a vacuum device drained fluid and dead tissue away from his wound. When I asked Guillermo what type of surgery he had recently that required outpatient debridement, he replied that he was not entirely sure. He guessed it had something to do with an infection following an amputation that required another surgery to remove some infected tendons, 16 days in the hospital, and a postoperative vacuum drain.

Guillermo told me that he did not know all the details, just that they needed to clean out what was dirty. His nonchalance seemed to stem from the fact that he had already undergone several amputations on his feet due to diabetes complications and now also attended dialysis regularly, so it was difficult to keep track. He gestured toward his foot as he recounted the experiences. "About around here I don't have toes anymore," he said. "First they cut off one toe and then they cut off another, and then they cut off all three, and then they cut a little bit in the back, just like that." He also showed me on his arm where he had surgery to create a fistula for dialysis. "They take out the blood and put it back in me again," he told me simply.

Like almost everyone with whom I spoke in Chapulin, Guillermo only sought health care once he was experiencing grave symptoms of illness that prevented him from working. Before he fell ill, he worked a variety of jobs, including picking tomatoes in Canada as a migrant agricultural worker and working in factories and construction jobs across nearby states. Over time, however, as legal violence expanded to exclude noncitizens from "normal" social and economic spaces, Guillermo found it difficult to secure work permission or good jobs that would accept him without it. After entering the U.S. permanently as a self-described "*mojado*" ("wetback" – a slur usually referring to someone who crossed without papers at the Rio Grande), and despite his (il)legal status, Guillermo found work and settled in with a good boss at a flooring company in Chapulin, where he stayed for about 15 years.

Unfortunately, Guillermo had to leave that job when he fell sick. "It's been about seven or eight years now that I can't work," he recalled. "I know how to work in a lot of things, it's just that because of my feet I can't, I don't have the strength, I get tired, I get dizzy, all because of the diabetes and all the cuts on my feet." Guillermo added that he knew he had diabetes and that it was already "a little advanced" by the time he was formally diagnosed but thought there was

little he could do about it regardless. He was ineligible for insurance, and his work complicated the situation. Installing floors was hard enough on his body without the diabetes to worry about, but the nature of the work was especially damaging to his diabetic feet. He spent all day kneeling with his toes against the floors while he measured, cut, and set materials, and this caused irreversible harm. "That's when they went chop, chop, chop," he explained. Without his toes, and with his need to attend dialysis several days a week, Guillermo could no longer work. He regretted having to leave his boss of 15 years, but he explained that his boss knew he could no longer meet the physical demands of the job and worried Guillermo might sue him if he sustained further injury.

As I mentioned in Chapter 3, Guillermo was able to obtain Emergency Medicaid to cover his emergent hospitalizations and dialysis, but not his medications or follow-up care. Even though he felt lucky to have continuous work, he wished he had papers so he could have had health insurance and paid into social security and other government benefits schemes. "Yes, I've wanted [papers]," he affirmed, "I want them, because what with me being unable to work anymore and everything, with all that I was working, yes I wanted the government to help me a little bit." Guillermo explained that he spent so many years working in the U.S. but tried, and failed, to do his taxes. He believed that maybe if he could have paid into the system, perhaps he would have been worthy of disability or income assistance (like U.S. citizens would be) now that he needed them.

As it was, Guillermo now found himself profoundly incapacitated with no idea of how he would continue to support himself. The man who had once put all his vital energy, almost his whole life, into feeding Canadians and Americans and building their homes now subsisted on donations from a church and Emergency Medicaid for acute diabetes care and regular dialysis.

Should that help run out, or should it prove insufficient, Guillermo was prepared to return to Mexico to die. "When the day comes when I feel that I have no strength left, that I'm dying," he explained, "I'll have to rush back to Mexico. Just to reach my mom and dad, to arrive, to grab them and hold them and give them each a kiss … That's what I plan to do."

Like other patients I interviewed, Guillermo's lack of legal status in the U.S. made him an easily exploitable source of physical labor – an exceptional laborer whose economic contribution need not be offset in any way by social or political concessions. He was simultaneously *included* in the U.S. political economy and *excluded* from the minimum recognition of humanity that formal U.S. citizenship enables (though admittedly does not guarantee). Only when he became an economic drain, by racking up tens of thousands of dollars in emergency and dialysis bills that he could never pay, did he become eligible for Emergency Medicaid. Yet this vital inclusion nevertheless excluded comprehensive care for medication or follow-up visits, meaning that he would remain caught indefinitely in a vicious cycle of diabetic crises, dialysis, and amputations. He was *included* in federal healthcare coverage solely to manage the costs of what would otherwise be uncompensated care. Otherwise, he would remain *excluded* in a state of bare life until he could no longer survive.

Guillermo's situation, though extreme, was not unique. Indeed, it echoed the experiences of other patients I spoke with in Coral and Chapulin counties from 2015-2018. These stories revealed the iterative and cumulative harm that chronic social exclusion, alongside intensive economic inclusion, wrought on noncitizens' bodies and lives. Like Guillermo, Esteban and Roberto were permanently locked out of citizenship – and its attendant social and political benefits – because of their irregular status. This exacerbated the illness and injuries they suffered after decades of working physically demanding jobs in the U.S. Felipe and Tomás, who had

regular permission to work in the U.S. as migrant agricultural laborers, were similarly excluded from healthcare coverage or political participation. And although Cristina and Víctor benefitted in some ways from their relatively comprehensive legal status, it was insufficient to protect them from exploitative working conditions or guarantee them adequate medical coverage. Together, these examples highlight both the acute and compounding injuries that the state of exception inflicts on Latinx noncitizens, regardless of their particular (il)legal status, and suggests the potential "slow death" that such a state enables.

Becoming the Enemy

Only one of the patients I interviewed across both sites described having become a naturalized citizen, and her case exemplifies the biopolitical stakes of the inclusion/exclusion dialectic I have described in this chapter. Like those whose cases I discussed above, Coral County resident Mónica had also been disabled by an on-the-job injury and discarded by the economic system, but her ability to naturalize as a U.S. citizen marked a possible departure from the state of exception that had harmed her. I met the friendly 64-year-old in the spring of 2017, and she began by explaining that of the 38 years she had been living in the U.S., she spent 32 of them working for the same local dry-cleaning company. As a legal permanent resident, she was able to get health coverage through her employer, but they cut all health services in 2000. Then, a few years ago, she injured her arm on the job. Her employer blamed her for the accident and withheld payments and the retirement savings she had accumulated during her three decades working for the company. Although the work had been physically demanding, being without it put Mónica in a difficult situation. She had no education, spoke almost no English, and could not read or write in any language. Yet she had a place in U.S. society as long as she could work. When she was injured, not only did she lose her ability to perform manual labor, but she also lost

income and savings in one fell swoop. Friends encouraged her to sue her employer, but she had no money to pay a lawyer or any idea of how to start such a process if she did. The state of exception Mónica had inhabited maximized her economic inclusion while exposing her to physical and social injury, and when her economic activity directly harmed her body, she was rendered immediately disposable.

The difference between Mónica and the patients I discussed above, however, was that soon after her injury she became a U.S. citizen and therefore was able to enroll in Medicaid and financial assistance and register to vote. It had taken Mónica 25 years and three failed attempts, but she finally succeeded in getting U.S. citizenship in 2016. Mónica informed me conspiratorially that she had cast her vote for Hillary Clinton before declaring, "Well, we lost." Despite the discouraging outcome of her first vote in the U.S., Mónica was politicized by the campaign and became a volunteer political activist campaigning to expand Medicaid services in the region. She felt strongly that others should benefit from what had been out of her reach for decades: comprehensive health care.

Yet that Mónica had crossed the great citizenship divide did not make her immune from feeling the rising anti-immigrant sentiment acutely. Like the patients I described above, Mónica also opined about President Trump's rhetoric toward immigrants and how she felt this damaged the public image of people like her. She worked hard and contributed much to U.S. society, but she acknowledged that some immigrants got into trouble. "And we all pay for them," she remarked, "because we were also illegal." (It struck me then that although she had been legally present and working to adjust her status for nearly three decades, Mónica nevertheless considered herself formerly "illegal".) Thus in addition to struggling against the challenges of being an illiterate, monolingual Spanish-speaking immigrant with no formal education and no

job prospects who had lately been disabled and discarded by the U.S. economic system, Mónica felt discursively criminalized and had internalized that de-legitimation. In spite of these hurdles, however, Mónica ultimately became a U.S. citizen, qualified for the social benefits schemes she had paid into for decades, and became a Democratic voter and political activist for those very social benefits programs. Gaining citizenship at such a polarized moment sparked Mónica to exercise her newfound political will toward greater social inclusion of people who, like her, might be injured by the inclusion/exclusion dialectic of contemporary U.S. non-citizenship.

CONCLUSION

The kind of political potential that Mónica embodies represents a significant hazard to the current balance of power in the U.S., but there are several ways to stop people like her from destabilizing the status quo. One is to prevent them from entering the country in the first place – a fact made clear by the prevention through deterrence strategies I mention in Chapter 3 and reified by the Trump administration's fixation on building "the wall". Another strategy is to criminalize migrants once they get here and make it impossible for them to be fully incorporated into the nation's political life, and it is this latter approach on which I have focused in this chapter. The protracted state of exception that includes noncitizens economically but excludes them socially and politically accomplishes the aim of neutralizing the potential of Latinx migrants to become part of the U.S. body politic, and the state of emergency reifies the boundaries of exception – underscoring on more aggressive terms who is disposable and who is not.

The examples I described here illustrate both the acute and compounded harms of systematic sociopolitical exclusion that has long been unfolding and vehemently resurges when the existing balance of power is threatened. As the proportion of Latinx citizens rises in the U.S.,

so too does the anxiety of those who fear that their interests may be poorly served by such a demographic transition. This story is not new; it is as old as the United States itself. The difference is merely in the specific tropes and tactics that are leveraged to counter that political potential to preserve the institutionalized white supremacy and capitalist arrangements that reproduce that status quo. The moment of anti-immigrant furor that we are witnessing now, and its crystallization in President Trump's state of emergency, represent a collective reaction against the perceived (though not functionally real) softening of the state of exception by the Obama administration. It is a racialized reaction against the sense that Latinx individuals and communities might be gaining legitimacy beyond their labor potential in the U.S., and the discursive construction of an "invasion" of migrants "pouring over the border" resonates with people who are anxious about being displaced or even (as the Charlottesville rally-goers declared) replaced. In the U.S. (and probably elsewhere, though that is not the focus of this dissertation), one of the most effective ways to neutralize a political threat is to criminalize it, and thereby permanently disenfranchise it. The recent state of emergency is a firm symbolic move to bolster the longstanding state of exception – and its concomitant criminalization and state of injury – that preserve the disposability of people like the patients I discussed here while making it nearly impossible for them to push back against it.

Chapter 5: Dissertation Conclusion

This was not the dissertation I set out to write when I began research in 2015. I imagined that by pursuing doctoral research on the heels of my role as a surgical case manager for undocumented immigrants in a progressive region, I would contribute to finding solutions to the biopolitical exclusion that I had witnessed but was as yet unable to articulate in sociological terms. While I now understand that almost no one completes the dissertation they envisioned at the outset – nor should they, or what would be the point of research? – I was unprepared for the direction this project would take as unanticipated political tumult gripped the nation in the course of this work. When I defended my dissertation proposal amidst a surprising political transition, I had to decide whether to abandon the project I had imagined or adapt to the new reality and go wherever the data would lead me. I chose the latter, and this timely yet reluctant dissertation is the result.

Throughout this dissertation research and analysis, I have faced tension between the daily barrage of relevant information on immigration and health policy from the 24-hour news cycle and a more measured sense that the present moment is not in fact a major departure from the existing dynamics of (non)citizenship in the United States. I have tried to be faithful to the widespread sense of upheaval that the Trump administration has generated and the way uncertainty has proliferated since 2017 without overstating its uniqueness. I have tried – sometimes with great difficulty – to take a step away from my news feed to ask myself: what is really different now? To what degree do participants see present political changes as particularly noteworthy or potentially life-changing? Do the latest political transitions in the U.S. represent a departure from the past, or a doubling down on some of our more troubling characteristics as we

build our collective future? These questions remained ever-present as I considered my data and began assembling a small piece of the story they told.

Summary of Key Findings

Each of my data chapters illuminates the biological stakes of changing immigration and health policies in the contemporary United States. In Chapter 2, I examine how the 2016 election changed the nature of clinical care in a "blue state" county that struggled to adapt to enhanced immigration enforcement priorities at the federal level. I describe how noncitizen patients and the clinics that served them responded to what I referred to as "medical legal violence" – the expansion of legal exclusions of noncitizens through health institutions and clinical care. In Coral County, this led clinic workers and noncitizen patients to perceive once-trusted medical-legal bureaucracies as potential tools for federal biopolitical surveillance. In Chapter 3, I consider my "red state" site as an assemblage of bureaucratic obstacles, punitive immigration laws, and restrictive health policies that subjected Latinx immigrants to medical legal violence. I demonstrate how local and federal immigration policies have interacted synergistically with exclusionary health policies to trigger serious health consequences for immigrant individuals and families.

In Chapter 4, I leverage data from both sites to illustrate how the accelerating symbolic violence of crimmigration has facilitated the continued political exclusion of Latinx noncitizens from full social belonging in the U.S. I focus on the discursive and material "state of emergency" as a form of legal violence typifying the Trump administration's approach to immigration law, and I argue that the symbolic violence of anti-immigrant rhetoric and increasing legal violence has interacted synergistically with existing structural violence to keep Latinx immigrants in a "state of exception" (Agamben 2005). I describe how the codification of these compounding

forms of violence has resulted in participants' experiences of being indispensable yet disposable labor, with embodied consequences in the shape of both immediate and compounded injury.

Sociological Implications of the Research

Despite the methodological challenges of conducting immigrant health research during what felt to many like an especially anti-immigrant moment, the timing of this dissertation research was in many ways fortuitous. The relatively extreme symbolic violence of anti-immigrant sentiment during the 2016 presidential campaigns and through the first years of the Trump administration put noncitizens in the spotlight and raised the biopolitical stakes of political debate. The accelerating polarization of civic discourse threw clashing values around immigrant incorporation into stark relief. While this has resulted in something of an existential crisis for the American public and a growing hazard for noncitizens living in the U.S., it also provided a unique opportunity for timely scholarly investigation and theoretical intervention. Given that I was already in the field and poised to examine many of these questions from the beginning of my research, I was well-positioned to witness these changes in real time as they unfolded.

Long before the 2016 election, scholars had already identified legal status as a structural determinant of health in the U.S. (e.g. Davies *et al*. 2006, Castañeda 2009, Quesada *et al.* 2011, Zimmerman *et al*. 2011, Castañeda *et al.* 2015). My research supports many of their arguments but updates the contours of this particular structural exclusion for a changing biopolitical reality. First, unlike the bulk of existing research that dichotomizes legal status in health analyses, this dissertation advances the literature on the variegated health consequences of stratified legal status by presenting data from participants with a range of legal statuses – undocumented, asylum seeker, legal permanent resident, and naturalized citizen. Secondly, it illustrates the

potential health consequences of *uncertainty* as well as actual policy change. This dissertation uniquely captures a volatile moment of rising fear and uncertainty in immigrant communities and focuses on how perception shapes noncitizens' health choices. Finally, it captures both patients' and clinic workers' perspectives to render a more complete picture of contemporary biopolitical negotiations.

This research also engages with scholarship on structural and symbolic violence, with particular focus on the ways in which they impinge on noncitizens in the form of legal violence. By considering Foucauldian notions of biopolitical social control alongside existing conceptualizations of legal violence, I expand the scope of sociological analysis to the space of the clinic. This enables a more thorough consideration of the *biological consequences* of legal violence – both in its structural and symbolic aspects – on noncitizens' bodies, as well as the detials of how these harms are intensified by anti-immigrant practices and policies. Further, by exploring some of the specific assemblages through which medical legal violence expands in two distinct fieldsites, I have drawn attention to how micro-, meso-, and macro-level structures and processes reproduce and compound these different types of violence in noncitizens' bodies.

In addition to its historical specificity, this dissertation also weaves in aspects of the *longue dureé* history of noncitizens' sociopolitical exclusion (as well as truncated economic inclusion) to contextualize the nature of biopolitical exclusions that my data exemplify. I locate the tension between biological risks and socio-political risks within the trajectory of both health and immigration policies in the contemporary U.S., since both intersect to shape noncitizens' health decisions today. This abbreviated engagement aligns with the robust body of existing scholarship on crimmigration, and I provide empirical evidence of how this accelerating phenomenon materially affects noncitizens facing health crises. My data underscore how the

symbolic and legal violence that constructs noncitizens as criminals puts them in harm's way while foreclosing opportunities for remediation when that harm leads to physical injury and/or illness. These findings suggest that there are embodied consequences of crimmigration that exist somewhere between sociopolitical exclusion and direct injury.

Limitations of the Research

This dissertation is subject to a number of limitations that constrain the analytical scope and generalizability of the data. Primary among these regards my commitment to anonymize not only the research participants, but the implicated sites and policies as well. When I began this research in 2015, I was not concerned about identifying the region and relevant policy context of my fieldsites, and I looked forward to carrying out an in-depth historical contextualization of bureaucratic documents and developments to better frame my own empirical findings. The 2016 presidential campaigns and election made me rethink this openness. While I had always intended to anonymize my research participants given 1) their precarious legal status (in many cases) and 2) the health information that they might share during interviews or observations, the realization that clinics might face federal reprisals over assisting undocumented immigrants gave me pause.

In an effort to gauge how much of the specific policy context I could ethically reveal in my writing, I consulted with the National Immigration Law Center (NILC). A senior staff attorney told me in no uncertain terms that publishing on some of the policies and practices that emerged in my data would be irresponsible and could very well jeopardize noncitizens' healthcare access. I took this response seriously and elected to use pseudonyms for people, places, policies, and bureaucratic practices. While I was particularly concerned about reprisals against my "blue state" site given its sanctuary status after 2018, I decided to be consistent in my handling of specifics across both sites. This will of course make it difficult for readers to

understand fully the nuances of each site in relation to noncitizen health or grasp the relevance of my finding to other sites and research projects. I acknowledge this challenge and have strived to provide as much detail as I could to render these empirical stories accurately and situate their implications beyond the two sites at hand.

Further, I recognize that having only two field sites – different though they are – limits the generalizability of my findings. Had I more time or resources, I would have liked to include more fieldsites to encompass the variability of health and immigration policies across the U.S. – including new immigrant destinations in the interior of the country. Given time and funding constraints, however, I selected two states that were as different as possible regarding their respective immigrant reception contexts (Portes & Rumbaut 2014). I also chose two states that elected to expand Medicaid following passage of the ACA. While it would no doubt be worthwhile to examine a state where this was not the case, the similarities in health terrain allowed me to refine my comparative focus on the role of citizenship in shaping health potential in juxtaposed immigrant policy regimes. Still, this selection limits the generalizability of my findings.

Another key limitation regards the participant sample I selected for this particular research. While early versions of this project envisioned including only clinic workers, as the political climate became more volatile I decided it was important to render patients' perspectives alongside those of clinic and community affiliates. This was a challenging prospect, however, because that very volatility often made it more difficult to recruit patient participants. I avoided using words like "immigrant" and "undocumented" in my recruitment materials and initial encounters with prospective patient participants, and this vagueness on my part made it difficult to recruit patients systematically. Attempts to build rapport and maintain anonymity also led to a

lot of beating around the bush in interviews, and I often was only able to determine someone's status or get to the meat of the interview until long after the interview had begun. Ideally, I would have preferred to sample systematically across the documentation status continuum (see Joseph 2016b) with an even distribution of age, gender, and national origin across participants. Nevertheless, I was usually able to ascertain much of this information through interviews and observations, and in retrospect I think my choice to avoid leading with potentially stigmatizing questions about such characteristics (legal status, national origin, etc.) allowed me to build trust and rapport with suspicious patients.

Recommendations for Future Research

This dissertation suggests a number of directions for future research in the field of citizenship and health. My research found that even the *perception* of enhanced immigration surveillance had consequences for how noncitizens and their clinic providers made decisions about their health. Journalists had already begun identifying a chilling effect on immigrants and mixed-status families seeking health care in the wake of the Trump administration's promises of enhanced immigration surveillance and enforcement (Chapter 2), and my data align with this suspected trend. More research is needed to determine whether such a decline in health service utilization is indeed occurring and, if so, at what rate and with what potential consequences. Quantitative and longitudinal studies are best suited to such an investigation, and their findings will be especially relevant to clinicians and policymakers concerned with immigrant and mixed-status families' wellbeing.

As campaign promises continue to become policy in the months and years ahead, research will be needed to determine the direct and indirect effects of policy changes on noncitizens' health access and potential. For example, my research concluded before the public

charge rule change went into effect, which means participants could only speculate about how it might impact them. As agencies implement the rule change, scholars should be attuned to both the possible chilling effects and actual penalties imposed on immigrants who run afoul of the new parameters of "public charge." Even before the rule change goes into effect, academic researchers should identify safety-net clinics and social service agencies that are likely to be impacted and track its potential implications in quantitative and qualitative terms.

My findings also have implications for conceptualizations of "biopolitical citizenship" (Foucault 1978, Petryna 2002, Epstein 2007). Although I did not engage with this notion directly in the dissertation, it was always in the back of my mind as something I intended to return to eventually. While the notion of citizenship as a biological project is as old as citizenship itself, one driven by obsessions with kinship and racial or ethnic sameness and/or difference (Rose & Novas 2005), my data suggest that a novel iteration of biopolitical citizenship is emerging alongside biomedicalization processes and biopolitical bureaucratization in the U.S. (Clarke *et al.* 2003). As Lakhani and Timmermans (2014) describe, biopolitical citizenship unfolds when "individuals present their biology to another state actor [usually a medical expert]… who performs a formal classification of their biology that individuals then appropriate to make demands on the state or that the state uses to grant citizenship rights" (2017:363). Several scholars (Petryna 2002, Ong 2003, Rose & Novas 2005, Benjamin 2013, Biehl 2013, Nguyen 2008, Rose 2007) have applied this notion of biopolitics to explore citizenship in contemporary societies across the globe, asking what types of emerging subjects and subjectivities arise in the era of biomedicine as a regime of governance and source of governmentality. As the federal government increasingly relies upon biometric information as an arbiter of belonging or

exclusion (Farahany *et al.* 2018), it is essential that scholars attend to the possible consequences and disproportionate impacts on particularly vulnerable noncitizens.

Conclusion

Ultimately, the biopolitical exclusion of noncitizens that has taken place over the course of this dissertation research is not novel in the broader arc of U.S. history. Yet the discursive irruptions (Foucault 1972) of the Trump administration give scholars the opportunity to observe the contours of this exclusion in a new, brighter light. Everything is illuminated, and every exclusion can be witnessed and named with more explicitness and precision than ever before. Unlike previous federal administrations that obscured the harms of their immigration policies behind guises such as welfare reform (Clinton), the war on terror (G.W. Bush), or the supposed prioritization of criminal removal in favor of noncriminal aliens (Obama), the Trump administration's policies are boldly anti-immigrant in ways that sharpen scholarly analyses into structural and symbolic violence and biopolitical social control in the contemporary U.S.

Through this dissertation research, I have availed myself of a kind of natural experiment in immigration and health policy that I witnessed from 2015 to 2018 in two unlike states. I found that anti-immigrant policymakers were increasingly able to leverage medical bureaucracies to expand legal violence against noncitizens in the U.S., resulting in biological harms while reproducing existing social inequalities. I presented empirical evidence of these impacts and suggested that the biomedicalization of citizenship boundaries in the U.S. has material consequences not only for the health of noncitizens and mixed-status families, but also implicates sociological understandings of citizenship in the United States more broadly.

CODA

This dissertation reflects a particularly challenging moment in history for noncitizens negotiating health care in the United States, and I acknowledge that the story I present here is a fairly bleak one. I would have liked to convey a more uplifting message as I conclude this phase of the project, but at the same time I know that things could have been worse for the patients I encountered. That they were not is a testament to the incredible work of the clinics I observed. Time and again, the structural, symbolic, and legal violence I have described in the preceding pages was met by the subtle, collective resistance of clinic workers – often in the most mundane ways. When the intersecting violences of the state of exception that noncitizen patients inhabited torqued them into illness and injury, the clinics I observed fought valiantly to keep them whole. While it is impossible to include all things in one dissertation, in this coda I highlight their efforts and celebrate their many successes.

As I drafted the previous chapters, I frequently consulted fieldnotes I had written that were bursting with the everyday, repetitive clinic tasks that seldom make for compelling reading by outsiders.[22] Yet having been a case manager myself, I understood that there were many ways one could approach the bureaucratic hurdles between a patient and their potential healthcare coverage or service. Frontline workers have the opportunity to act as facilitators or gatekeepers for those who enter their queue, and every single worker I encountered chose the former. Beyond the fact that this was an explicit, essential characteristic of the institutional culture at each site I observed, clinic workers often expressed personal reasons for their humane approach to health provision. Many had been undocumented immigrants themselves or currently held DACA status.

[22] I also realized that it would be unwise to publicize some of these workflows and workarounds during such a politically polarized time.

Others were the children of immigrants who witnessed, and often tried to resolve, their parents' struggles to get such services themselves.

On several occasions, participants (patients and clinic staff alike) distinguished the clinic approach to *facilitating* health care from the approach of federal social and health service agencies to *gatekeeping* such care. Multiple participants in both states told me that agency case workers seemed to be trained to perceive applicants as prospective service abusers or fraudsters and to vet them accordingly. Whether this is true is beside the point; that applicants *felt* that this was how they were being treated at Medicaid and Department of Economic Security offices was often sufficient to discourage them from returning. In addition to these barriers, I also witnessed immigrant rights advocates warn noncitizens against applying for any benefits for themselves or their families at government agencies if those offices were located in the same buildings as local or federal law/immigration enforcement agencies. As the preceding chapters illustrate, the intensification of federal immigration enforcement priorities made interacting with government agencies an even more distressing prospect than it had been.

At the clinics where I conducted ethnographic observations, on the other hand, workers made it clear that they were not out to "catch" fraudulent applications or raise barriers to health care, but rather to remove as many obstacles as possible. Such statements were not merely lip service. I saw it in the subtle ways workers addressed patients with warmth, respect, and discretion regarding their legal, health, and economic status. They put a sympathetic human face to the cold bureaucratic systems that were designed to exclude noncitizen patients by default, and they found ways to get patients as much care as they possibly could. Whereas regulatory agencies at the federal level have increasingly dehumanized noncitizens by reducing them to their economic productivity without concomitant means to attend to their human vitality, the

clinics I observed continuously redeemed this humanity through their ethos of health as a human right and fundamental pillar of the Hippocratic oath.

The clinics I observed in Coral and Chapulin counties serve as an example of resistance against the inclusion/exclusion dynamic that I describe in Chapter 4, and in so doing take their place in the historical collective of exceptional spaces (such as the Underground Railroad and Historically Black Colleges and Universities) that push back against racialized oppression by enabling individuals and communities to thrive. Many of the clinics I observed began as migrant-serving institutions whose *raison d'être* was to bring health care to Latinx agricultural workers, and many continue this effort as a key pillar of their work today. In this way, contemporary immigrant-serving clinics function as a space of positive, life-affirming exception within a state of negative, life-denying exception. Amidst the compounding chaos of immigration and health policy destabilization, these clinics have remained open and welcoming, and they continue to provide vital services despite being increasingly constrained by the medical-legal infrastructure that otherwise threaten to create conditions of "bare life". It is a difficult act to balance, and they are not always aware of all the risks or possible unintended consequences, but they manage incredible feats in the face of federal priorities that make life unbearable for those who are often cast as illicit, undeserving, and disposable. For their tireless work, I express my profound admiration.

REFERENCES

Agamben, Giorgio. 1998. *Homo Sacer: Sovereign Power and Bare Life.* Trans. by Daniel Heller-Roazen. Meridian: Crossing Aesthetics – Kindle Edition.

Agamben, Giorgio. 2005. *State of Exception*. Translated by K. Attell. Chicago: University of Chicago Press.

Alexander, Michelle. 2010. The new Jim Crow: mass incarceration in the age of colorblindness. New York: New Press.

American Civil Liberties Union (ACLU). 2019. "Timeline of the Muslim Ban." Accessed April 2, 2019. (https://www.aclu-wa.org/pages/timeline-muslim-ban)

Arizona State Senate. 2010. "Fact Sheet for S.B. 1070." Jan. 15, 2010. Accessed Dec. 1, 2018. (https://www.azleg.gov/legtext/49leg/2r/summary/s.1070pshs.doc.htm)

Asad, Asad. 2019. "On the Radar: System Embeddedness and Latin American Immigrants' Perceived Risk of Deportation." *SocArXiv Papers* (https://osf.io/preprints/socarxiv/dcgfw/).

Asad, Asad, Clair, Matthew. 2017. "Racialized legal status as a social determinant of health. *Social Science & Medicine* doi*:* http://dx.doi.org/10.1016/j.socscimed.2017.03.010

Bailey, Adrian J., Richard A. Wright, Alison Mountz, and Ines M. Miyares. 2002. "(Re) producing Salvadoran Transnational Geographies." *Annals of the Association of American Geographers* 92(1): 125– 44.

Bailey, Melissa. 2017. "$3,660 for a four-mile ride? Ambulances are hitting patients with surprise bills." *Los Angeles Times*. Accessed April 2, 2019. (https://www.latimes.com/business/la-fi-ambulance-surprise-charges-20171129-story.html)

Benjamin, Ruha. 2013. *People's Science: Bodies and Rights on the Stem Cell Frontier.* Stanford: Stanford University Press.

Bergeron, C. 2013. "Issue Brief: Going to the back of the line: A Primer on Lines, Visa Categories, and Wait Times," *Migration Policy Institute* Issue Brief, March 2013.

Berlant, L. 2007. "Slow death (sovereignty, obesity, lateral agency)." *Critical Inquiry* 33(4):754–80.

Biehl, João. 2013. *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

Bourdieu, Pierre. 2000. *Pascalian Meditations*. Translated by Richard Nice. Stanford University Press.

Bowker, Geoffrey C. and Susan Leigh Star. 1999. *Sorting Things Out: Classification and Its Consequences*. Cambridge, MA: MIT Press.

Boyd-Barrett, Claudia. 2018. "Fear Pushes More Immigrants to Avoid Seeking Medical Care." *California Health Report* Feb. 5, 2018 (http://www.calhealthreport.org/2018/02/05/fear-pushes-immigrants-avoid-seeking-medical-care/).

British Broadcasting Company (BBC). 2018. "Why the US is separating migrant children from their parents." Jun. 15, 2018. Accessed Jun. 16, 2018. (https://www.bbc.com/news/world-us-canada-44503514)

Brotherton, David, and Luis Barrios. 2011. *Banished to the Homeland: Dominican Deportees and Their Stories of Exile*. New York: Columbia University Press.

Burnett, John. 2017. "DHS Under Pressure Over Alleged Violation of Policies on Sensitive Locations." *National Public Radio: All Things Considered.* October 20, 2017. Accessed April 2, 2019. (https://www.npr.org/2017/10/20/559113178/dhs-under-pressure-over-alleged-violation-of-policies-on-sensitive-locations)

Bury, Michael. 1982. "Chronic illness as biographical disruption." *Sociology of Health and Illness* 4(2): 167-82.

Calamur, Krishnadev. 2016. "What Europe's Far Right Sees in Trump's Win." *The Atlantic*, November 10. Retrieved January 20, 2017 (http://www.theatlantic.com/international/archive/2016/11/trump-far-right-europe/507314/).

Capps, Randy and Michael Fix. 2013. "Immigration Reform: A Long Road to Citizenship and Insurance Coverage." *Health Affairs* 32(4): 639-642.

Castañeda, Heide. 2009. "Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic." Social Science & Medicine (2009): 1-9.

Castañeda, Heide, Holmes, Seth M., Madrigal, Daniel S., DeTrinidad Young, Maria-Elena, Beyeler, Naomi, Quesada, James. 2015. "Immigration as a Social Determinant of Health," *Annual Review of Public Health* 36: 1.1-1.18.

Centers for Medicare and Medicaid Services (CMS). 2014. "Eligibility for Non-Citizens in Medicaid and CHIP." Accessed Dec. 16, 2014 (https://www.healthcare.gov/immigrants/).

Chacón, Jennifer. 2009. "Managing Immigration through Crime". *Columbia Law Review* 109:135-148.

Clarke, Adele, Janet K. Shim, Laura Mamo, Jennifer R. Fosket, and Jennifer R. Fishman. 2003.Biomedicalization: Technoscientific transformations of health, illness and U.S. biomedicine. *American Sociological Review* 68(2): 161-194.

Cohn, D'vera, Jeffrey S. Passel, and Kristen Bialik. 2019. "Many immigrants with Temporary Protected Status face uncertain future in U.S." Pew Research Center. Accessed April 1, 2019. (https://www.pewresearch.org/fact-tank/2019/03/08/immigrants-temporary-protected-status-in-us/)

Catholic Legal Immigration Network, Inc. (CLINIC). 2018. "Timeline: Family separations under the 'zero-tolerance' policy." Accessed April 1, 2019. (https://cliniclegal.org/resources/timeline-family-separations-under-zero-tolerance-policy)

Centers for Disease Control and Prevention (CDC). 2017. "National Diabetes Statistics Report, 2017: Estimates of Diabetes and Its Burden in the United States." Accessed April 4, 2019. (https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf)

De Genova, Nicholas P. 2014. "Immigration 'Reform' and the Production of Migrant 'Illegality'" in *Constructing immigrant "illegality": critiques, experiences, and responses*, edited by C. Menjívar and D. Kanstroom. New York: Cambridge University Press.

Department of Justice (DOJ). 2012. "Statement of Attorney General Eric Holder on Supreme Court's Ruling Arizona v. United States." Jun. 25, 2012. Accessed Dec. 18, 2018. (https://www.justice.gov/opa/pr/statement-attorney-general-eric-holder-supreme-court-s-ruling-arizona-v-united-states)

Department of Homeland Security (DHS) of the U.S. 2013. "Clarification of Existing Practices Related to Certain Health Care Information." Accessed Dec. 1, 2015 (https://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf)

Department of Homeland Security (DHS) of the U.S. 2017. "Immigration Data & Statistics". Accessed Jan. 20, 2017 (https://www.dhs.gov/immigration-statistics).

Department of Homeland Security (DHS) of the U.S. 2018. "DHS Announces New Proposed Immigration Rule to Enforce Long-Standing Law that Promotes Self-Sufficiency and Protect American Taxpayers." Accessed Sept. 22, 2018 (https://www.dhs.gov/news/2018/09/22/dhs-announces-new-proposed-immigration-rule-enforce-long-standing-law-promotes-self).

Department of Homeland Security (DHS). 2018. "DHS Statement on Tragic Death of Minor at Border." Dec. 14, 2018. Accessed Dec. 15, 2018. (https://www.facebook.com/homelandsecurity/posts/2256926350986655?__tn__=-R)

Doty, Roxanne Lynn. 2007. “States of Exception on the Mexico-U.S. Border: Security, ‘Decisions,’ and Civilian Border Patrols. *International Political Sociology* 2007(1): 113-37.

Dunn, Timothy J. 2009. *Blockading the Border and Human Rights: The El Paso Operation That Remade Immigration Enforcement.* Austin: University of Texas Press.

Emanuel, Ezekiel. 2014. "Ch 1: How did we get here?" in *Reinventing American Health Care*. New York: PublicAffairs.

Engels, Friedrich. 1987. *The Condition of the Working Class in England in 1844.* Penguin, London.

Epstein, Steven. 2007. *Inclusion: The Politics of Difference in Medical Research*. Chicago: University of Chicago Press.

Farahany, Nita, Saheel Chodavadia, and Sara H. Katsanis. 2018. “Ethical Guidelines for DNA Testing in Immigrant Family Reunification.” Bioethics.net. Accessed Dec. 12, 2018. (http://www.bioethics.net/2018/12/ethical-guidelines-for-dna-testing-in-migrant-family-reunification/)

Farmer, Paul. 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley and Los Angeles: University of California Press.

Federal Register. 2018. “Inadmissibility on Public Charge Grounds: A Proposed Rule by the Homeland Security Department.” Oct. 10, 2018. Accessed Oct. 11, 2018. (https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds)

Foucault, Michel. 1972. *Archaeology of Knowledge*. New York: Pantheon.

Foucault, Michel. 2004. *Security, Territory, Population: Lectures at the Collège de France 1977-1978*. New York: Picador.

Fragomen, Austin T. 1997. “The Illegal Immigration Reform and Immigrant Responsibility Act of 1996: An Overview.” *International Migration Review* 31(2): 438-460.

Galtung, Johan. 1969. "Violence, Peace, and Peace Research." *Journal of Peace Research* 6(3): 167-91.

García Hernández, César Cuauhtémoc. 2015. *Crimmigration Law*. Chicago: American Bar Association Publishing.

Gilens, Martin. 1999. *Why Americans Hate Welfare: Race, Media and the Politics of Antipoverty Policy*. Chicago: University of Chicago Press.

Golash-Boza, Tanya. 2016. “Feeling Like a Citizen, Living As a Denizen: Deportees’ Sense of Belonging.” *American Behavioral Scientist* 60(13): 1575–1589.

Goldring, Luin, Carolina Berenstein, and Judith K. Bernhard. 2009. “Institutionalizing Precarious Migratory Status in Canada”. *Citizenship Studies* 13(3): 239– 65.

González-Barrera, Ana and Jens Manuel Krogstad. 2016. “U.S. immigrant deportations declined in 2014, but remain near record high”. *Pew Research Center* Aug. 31, 2016. Retrieved Jan. 23, 2017 (http://www.pewresearch.org/fact-tank/2016/08/31/u-s-immigrant-deportations-declined-in-2014-but-remain-near-record-high/).

Grinberg, Emanuella and Castillo, Mariano. “US authorities fire tear gas to disperse migrants at border.” CNN. Nov. 26, 2018. Accessed Dec. 13, 2018. (https://www.cnn.com/2018/11/25/us/san-ysidro-port-of-entry-closed/index.html)

Gusmano, Michael K. and The Hastings Center. 2012. “Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care.” Retrieved March 6, 2015. (http://www.undocumentedpatients.org/issuebrief/health-policy-and-access-to-care/).

Healthinsurance.org. 2018. “Medicaid Coverage in Your State.” March 24, 2018. Accessed Nov. 18, 2018.

Heeren, Geoffrey. 2015. “The Status of Nonstatus.” *American University Law Review* 64: 1115-1181.

Hernandez, Jill. 2014. “The Alien Exclusion: The Affordable Care Act and the Oblique Rights of Those on the Margins” in *The Affordable Care Act Decision: Philosophical and Legal Implications,* edited by A. Fritz and M. Hall. New York: Routledge.

Holmes, Seth. 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States.* Berkeley, CA: University of California Press.

Horton, Sarah. 2016. *They Leave Their Kidneys in the Field: Ilness, Injury, and Illegality among U.S. Farmworkers.* Berkeley, CA: University of California Press.

Ibarra, Ana. 2017. “Fearing Deportation, Parents Worry About Enrolling Undocumented Kids in Medi-Cal.” KQED California Healthline, May 16, 2017 (https://www.kqed.org/stateofhealth/330339/fearing-deportation-parents-worry-about-enrolling-undocumented-kids-in-medi-cal).

Immigration and Customs Enforcement (ICE). 2018. “Secure Communities.” Mar. 20, 2018. Accessed Dec. 12, 2018. (https://www.ice.gov/secure-communities)

Jerome-D’Emilia, Bonnie and Patricia D. Suplee. 2012. “The ACA and the Undocumented.” *American Journal of Nursing* 112(4): 21-27.

Joseph, Tiffany D. 2016a. What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms." *Journal of Health Politics, Policy, and Law.* 41(1): 101-16.

Joseph, Tiffany D. 2016b. "The Growing Citizen-Noncitizen Divide: Life along the Documentation Status Continuum." American Dilemmas Seminar, Political Science Department, Brown University, Providence, RI, February 24.

Kaiser Family Foundation (KFF). 2015. "Key Facts About the Uninsured Population." Retrieved Dec. 1, 2015. (http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/).

Kaiser Family Foundation. 2016. "Key Facts about the Uninsured Population". Accessed Jan. 19, 2017 (http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/).

Kennedy, Kelly. 2018. "Deportation fears have legal immigrants avoiding health care." *Associated Press* Jan. 22, 2018 (https://apnews.com/9f893855e49143baad9c96816ec8f731).

Kurzban, Ira J. 2008. "Criminalizing Immigration Law". *Continuing Legal Education*. 2008 Immigration Law Conference, University of Texas.

Lakhani, Sarah Morando and Timmermans, Stefan. 2014. "Biopolitical citizenship in the immigration adjudication process." *Social Problems* 61(3): 360–79.

Light, Donald W. 2000. "The sociological character of health-care markets" in *Handbook of social studies in health and medicine*, edited by G. L. Albrecht, R. Fitzpatrick, and S. C. Scrimshaw. Thousand Oaks, CA: Sage.

Lowrey, Annie. 2017. "Trump's Anti-Immigrant Policies Are Scaring Eligible Families Away from the Safety Net." *The Atlantic*, Mar. 24, 2017 (https://www.theatlantic.com/business/archive/2017/03/trump-safety-net-latino-families/520779/).

Macías-Rojas, Patrisia. 2016. *From Deportation to Prison: The Politics of Immigration Enforcement in Post-Civil Rights America*. New York: New York University Press.

Marrow, Helen B. 2012. "Deserving to a point: Unauthorized immigrants in San Francisco's universal access healthcare model," *Social Science & Medicine* 74 (2012): 846-54.

Marrow, Helen B. and Tiffany D. Joseph. 2015. "Excluded and Frozen Out: Unauthorised Immigrants' (Non)Access to Care after US Health Care Reform," *Journal of Ethnic and Migration Studies* 41(14):2253-2273.

McAdam, Doug and Karina Kloos. 2014. “How Did We Get Into This Mess?” *Deeply Divided: Racial Politics and Social Movements in Post-War America*. Oxford: Oxford University Press.

Mendenhall, Emily. 2012. *Syndemic Suffering: Social Distress, Depression, and Diabetes among Mexican Immigrant Women.* New York: Routledge Press.

Menjívar, Cecilia. 2006. “Liminal Legality: Salvadoran and Guatemalan Immigrants’ Lives in the United States.” *American Journal of Sociology* 111 (4): 999–1037.

Menjívar, Cecilia, Abrego, Leisy. 2012. “Legal Violence: Immigration Law and the Lives of Central American Immigrants.” *American Journal of Sociology* 117(5): 1380-1421.

Montoya, Michael J. 2011. *Making the Mexican Diabetic: Race, Science, and the Genetics of Inequality*. Berkeley, CA: University of California Press.

National Conference of State Legislatures (NCSL). 2012. “State Omnibus Immigration Legislation and Legal Challenges.” Aug. 27, 2012. Accessed Dec 1, 2018. (http://www.ncsl.org/research/immigration/omnibus-immigration-legislation.aspx)

National Immigration Law Center (NILC). 2014. “Major Benefit Programs Available to Immigrants in California.” Accessed May 14, 2015 (http://www.nilc.org/benefitsca.html).

Nguyen, Vinh-Kim, Cyriaque Yapo Ako, Pascal Niamba, Aliou Sylla, and Issoufou Tiendrébéogo. 2007. “Adherence as therapeutic citizenship: impact of the history of access to antiretroviral drugs on adherence to treatment”. *AIDS* 21(suppl 5):S31-S35.

Oberlander, J. 2010. "Long time coming: why health reform finally passed." *Health Affairs* 29(6):1112-1116.

Obama, Barack. 2014. “Remarks by the President in Address to the Nation on Immigration,” November 20, 2014 (https://www.whitehouse.gov/issues/immigration/immigration-action#).

OpenJurist.org. 2017. “Holley v. Lavine.” Accessed May 25, 2016. (http://openjurist.org/553/f2d/845/holley-v-lavine).

Ong, Aihwa. 2003. *Buddha Is Hiding: Refugees, Citizenship, the New America*. Berkeley: University of California Press.

Oprysko, Caitlin and Hesson, Ted. “Trump administration rejects responsibility for death of 7-year-old girl in Border Patrol custody.” Politico. Dec. 14, 2018. Accessed Dec. 15, 2018. (https://www.politico.com/story/2018/12/14/nielsen-migrant-girl-death-border-patrol-1063729)

Park, Lisa Sun-Hee. 2011. *Entitled to Nothing: The Struggle for Immigrant Health Care in the Age of Welfare Reform*. New York: New York University.

Passel, Jeffrey S. and D'Vera Cohn. 2015. "Pew Hispanic Center: Unauthorized immigrant population stable for half a decade." Accessed on Nov. 20, 2015. (http://www.pewhispanic.org/2014/11/18/chapter-2-birthplaces-of-u-s-unauthorized-immigrants/).

Petryna, Adriana. 2002. *Life Exposed: Biological Citizens After Chernobyl*. Princeton, NJ: Princeton University Press.

Philbin, Morgan M., Flake, Morgan, Hatzenbuehler, Mark L., Hirsch, Jennifer S. 2017. "State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States." *Social Science & Medicine* 2017: 1-10.

Pinderhughes, Howard, Rachel A. Davis, and Myesha Williams. 2015. *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma*. Prevention Institute, Oakland CA.

Plumer, Brad. 2013. "Congress tried to fix immigration back in 1986. Why did it fail?" *Washington Post* Jan 30, 2013 (https://www.washingtonpost.com/news/wonk/wp/2013/01/30/in-1986-congress-tried-to-solve-immigration-why-didnt-it-work/?noredirect=on&utm_term=.df3968180939).

Ponce, Ninez, Lucia, Laurel, and Shimada, Tia. 2018. "Proposed changes to immigration rules could cost California jobs, harm public health." UCLA Center for Health Policy Research. Dec. 4, 2018. Accessed Dec. 10, 2018. (http://healthpolicy.ucla.edu/publications/Documents/PDF/2018/publiccharge-factsheet-dec2018.pdf)

Portes, Alejandro, and Rumbaut, Rubén G. (2014). *Immigrant America: A Portrait [4th Edition]*. Berkeley, CA: University of California Press.

Pourat, Nadereh. 2015. "Undocumented Immigrants Eligible for DACA/DAPA: Who Are They?" Presented at the UCLA Center for Health Policy Research 2015 Health Policy Seminar Series, March 31, 2015 (http://healthpolicy.ucla.edu/newsroom/press-releases/pages/details.aspx?NewsID=213).

Quesada, James, Kain Hart, Laurie, Bourgois, Philippe. 2011. "Structural Vulnerability and Health: Latino Migrant Laborers in the United States." *Medical Anthropology* 30(4): 339-362. doi: 10.1080/01459740.2011.576725.

Rodriguez, Rudolph. 2015. "Dialysis for Undocumented Immigrants in the United States. *Advances in Chronic Kidney Disease* 22(1): 60-65.

Rodriguez, Nestor and Cristian Paredes. 2014. “Coercive Immigration Enforcement and Bureaucratic Ideology” in *Constructing Immigrant 'Illegality': Critiques, Experiences, and Responses*. Cambridge: Cambridge University Press.

Rose, Nikolas and Carlos Novas. 2004. “Biological Citizenship” in *Blackwell Companion to Global Anthropology*. Oxford: Blackwell.

Rose, Nikolas and Carlos Novas. 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Blackwell Publishing.

Rose, Nikolas. 2007. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.

Sainsbury, Diane. 2012. *Welfare states and immigrant rights: the politics of inclusion and exclusion.* Oxford: Oxford University Press.

Schmitt, Carl. 1985. *Political Theology: Four Chapters on the Concept of Sovereignty*. Translated by G. D. Schwab. Cambridge: MIT Press.

Sommers, Benjamin D. 2013. “Stuck between Health and Immigration Reform — Care for Undocumented Immigrants”. *New England Journal of Medicine* 369(7): 369:593-595.

Sontag, Deborah. 2008. “Immigrants Facing Deportation by U.S. Hospitals.” New York Times, August 3. Retrieved January 20, 2017 (http://www.nytimes.com/2008/08/03/us/03deport.html).

Sotomayor, Marianna, Phil McCausland, and Ariana Brockington. 2017. “Charlottesville White Nationalist Rally Violence Prompts State of Emergency.” Reuters/NBC News. Accessed April 1, 2019. (https://www.nbcnews.com/news/us-news/torch-wielding-white-supremacists-march-university-virginia-n792021)

Spade, Dean. 2015. *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law.* Durham: Duke University Press.

Stumpf, Juliet. 2006. “The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power”. American University Law Review 56: 367-419.

Trump, Donald J. 2019. “President Donald J. Trump’s Address to the Nation on the Crisis at the Border.” Jan. 8, 2019. Accessed Jan. 9, 2019. (https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-address-nation-crisis-border/)

Turner, Bryan. 1997. “From governmentality to risk: some reflections on Foucault's contribution to medical sociology.” Pp. ix-xxi in Foucault, Health and Medicine, edited by Alan Petersen and Robin Bunton. London: Routledge.

UCLA Center for Health Policy Research (CHPR). 2018. “AskCHIS.” Accessed March 20, 2019. (http://healthpolicy.ucla.edu/Pages/AskCHIS.aspx)

U.S. Census Bureau. 2017. "QuickFacts." July 1, 2017. Accessed Dec. 1, 2018. (https://www.census.gov/quickfacts/fact/table)

U.S. Census Bureau. 2018. "QuickFacts." Accessed March 30, 2019. (https://www.census.gov/quickfacts/fact/table/US/PST045218)

U.S. Customs and Immigration Services (USCIS). 2008. "DNA-Sample Collection and Biological Evidence Preservation in the Federal Jurisdiction [73 FR 74932] [FR 100-08]." USCIS.gov, Dec. 10, 2018. Accessed Dec. 18, 2018. (https://www.uscis.gov/ilink/docView/FR/HTML/FR/0-0-0-1/0-0-0-145991/0-0-0-165820/0-0-0-169744.html)

United States Citizenship and Immigration Services (USCIS). 2014. "Early American Immigration Policies." Retrieved Jun. 4, 2015 (http://www.uscis.gov/history-and-genealogy/our-history/agency-history/early-american-immigration-policies).

United States Citizenship and Immigration Services (USCIS). 2014. "Executive Actions on Immigration." Retrieved Jun. 4, 2015 (http://www.uscis.gov/immigrationaction).

Van Natta, Meredith, Burke, Nancy J., Yen, Irene H., Fleming, Mark D., Hanssmann , Christoph L., Rasidjan, Maryani Palupy, and Shim, Janet K. 2018 "Stratified Citizenship, Stratified Health: examining Latinx legal status in the U.S. healthcare safety net." *Social Science & Medicine.* Doi: https://doi.org/10.1016/j.socscimed.2018.10.024

Varsanyi, Monica W., Lewis, Paul G., Provine, Doris Marie, Decker, Scott. 2012. "A Multilayered Jurisdictional Patchwork: Immigration Federalism in the United States." *Law and Policy* 34(2): 138-58.

Viladrich, Anahí. 2011. "Beyond welfare reform: Reframing undocumented immigrants' entitlement to health care in the United States, a critical review". *Social Science and Medicine* 74: 822-829.

Weheliye, Alexander G. 2014. *Habeas Viscus: Racializing Assemblages, Biopolitics, and Black Feminist Theories of the Human*. Durham: Duke University Press.

Publishing Agreement

It is the policy of the University to encourage the distribution of all theses, dissertations, and manuscripts. Copies of all UCSF theses, dissertations, and manuscripts will be routed to the library via the Graduate Division. The library will make all theses, dissertations, and manuscripts accessible to the public and will preserve these to the best of their abilities, in perpetuity.

Please sign the following statement:

I hereby grant permission to the Graduate Division of the University of California, San Francisco to release copies of my thesis, dissertation, or manuscript to the Campus Library to provide access and preservation, in whole or in part, in perpetuity.

Meredith J. VanNatta _____ 5/31/2019

Author Signature Date